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CLINICAL CASE REPORT

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Helping patients master core conflictual relationship themes in psychotherapy

Brin F. S. Grenyer | Ely M. Marceau

School of Psychology and Illawarra Health and Medical Research Institute, University of Wollongong, Wollongong, New South Wales, Australia

Correspondence
Brin F. S. Grenyer, School of Psychology and Illawarra Health and Medical Research Institute, University of Wollongong, Northfields Clinic, 1 Northfields Avenue, Wollongong NSW 2522, Australia.
Email: grenyer@uow.edu.au

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Abstract

An important component of case formulation is to understand the patient's difficulties in the context of their relationships. The Core Conflictual Relationship Theme (CCRT) method provides a clinical guide for understanding the narratives of relationship conflicts told during therapy. We follow the case of Barbara, a 60 year old with a long history of chronic shyness. Her narratives follow a common CCRT: she wishes to feel safe, but fears that others are out to get her, which makes her withdraw. These patterns have pervasively repeated themselves in the past, present, and across different relationships (self, family, partners, colleagues). The therapist responds carefully by creating safety, tolerating her fears, and working to overcome these CCRT patterns, thus reducing her impulse to withdraw from treatment. Psychotherapists from many theoretical orientations can learn how patients mastering these repetitive negative CCRTs can lead to more adaptive relationship patterns that improve their mental health.

KEYWORDS
interpersonal therapy, object relations, psychodynamic therapy, schema-focused, therapeutic alliance, transference-focused

Patients often come to psychotherapy seeking to master conflicts they have not been able to solve (Grenyer, 2002). Relationships are at the core of our mental health and psychotherapists can see and work with these conflicts through three "lenses." First, helping the person improve their relationship with themselves. Often people come to psychotherapy with low self-esteem, not knowing who they really are or where they want to go, and feeling afraid, confused and depressed about themselves, and sometimes even suicidal. Psychotherapy helps us to learn to understand who we are, and to learn to love and accept ourselves and feel good about our place in the world. Second, helping the person improve their relationships with other people. Getting our needs and wishes met in relationships in a healthy way requires skill, understanding, and control. Third, we all need to work on our relationships with the broader community—including with families, partners, parents, teachers, or workplace managers. The narratives patients tell when they come to psychotherapy generally fall into these three areas: how they feel about themselves, how they feel about others close to them including family, and how they feel about other important people such as workplace colleagues or those in authority.

The Core Conflictual Relationship Theme (CCRT) method helps the psychotherapist analyze and work with these relationship narratives patients tell in treatment. One of the fundamental assumptions is that we all approach new relationships based on our experiences and expectations from previous relationships (Grenyer, 2002). These experiences set up powerful interpersonal schemas or scripts about our own self-worth, including how we expect to be treated by others and how we, in turn, respond. These repeating CCRTs become part of what is brought to therapy. Psychotherapy treatment works because it is a special relationship that provides a powerful opportunity to change repeating personality patterns with the self and with others. Psychotherapy provides a space of healing the past and helping the patient start to write a new narrative for the future that is healthier and more hopeful.

The CCRT was developed from a long tradition in psychotherapy research of seeking to understand and measure personality function (Luborsky, 1977). Indeed, it is interesting to speculate how the formative influences on Lester Luborsky, the developer of the CCRT, came from his early work in Raymond Cattell's psychological laboratory and work on intrapersonal psychological structure. Other highly influential researchers at that time for both Luborsky and Cattell were Christine Morgan and Henry Murray. Morgan and Murray (1935) analyzed phantasies from Thematic Apperception Test responses into a tripartite structure of how (1) motives expressed (2) towards or away from others leads to (3) feelings of satisfaction or dissatisfaction (see p. 293). Luborsky's CCRT method also has three elements and is very similar in approach. First are the wishes of the speaker, which correspond in psychoanalytic theory to needs that often reflect attachment themes. The wish (W), for example, might be to obtain love and nurturing. The second element is the reactions of others (RO) to the patient, such as hostility or aggression. The third is the response of the self (RS); for example, withdrawing and becoming depressed. The three elements of the CCRT (i.e., W, RO, and RS) therefore code the dynamics of the relationship interaction, and document the basic attempt by the patient to get their needs or wishes met. They narrate the expression of a wish, how this was received and responded to by another person, and then how this response of the other in turn affected them.

Luborsky turned personality study from a one-person approach (e.g., Cattell's 16 personality factors) to a two-person approach, where the interaction between two objects (self and other) are studied. By including the "other," Luborsky realized he had the opportunity to, therefore, measure transference. The reason for this was because the "other" was how the patient described their relationships, from their own point of view (vs. a third person or observer view). The person's perceptions of their relationships thus contain within them the possibility of distortions typical of subjective experience. The CCRT captures the conflict between the patient's needs expressed as wishes, and the meeting of these wishes, in the response from others and the self. The narratives told by patients in psychotherapy often show marked conflicts, which generally involve wishes being met with negative responses from others and the self. Extensive research evidence into the CCRT demonstrates a unique and pervasive pattern for each patient in the early phases of psychotherapy, supporting the notion of a "template" that "repeats," deriving specifically from each patient's unique upbringing and inheritance. CCRTs of early memories of parental figures are similar to relationship episodes about other people in the present: a result consistent with the view that the

transference template originates in early experiences. The CCRT thus shows high concordance with Freud's discovery of the transference, in that CCRT patterns expressed about others come to also be "transferred" or expressed toward the therapist (Luborsky & Crits-Christoph, 1998). How therapists are impacted by these interpersonal processes is thus known as "countertransference" and is being empirically studied using the CCRT (Bourke & Grenyer, 2011, 2017).

Although the CCRT has its roots firmly in psychodynamic understandings of transference, as a tool it can inform any therapy approach and thus can be seen as both atheoretical yet highly useful within different theoretical approaches. For example, cognitive behavior therapy describes maladaptive core beliefs—essentially the negative CCRT-responses of others and CCRT-responses of self—and aims to modify them through therapist disputation and practicing new behaviors. Dialectical behavior therapy emphasizes invalidation as a core mechanism—akin to a negative CCRT of other—which can be modified through a combination of mindful diffusion, therapist validation, and interpersonal effectiveness skills. Transference focused therapy describes conflicts between self and others, which become modified through therapist interpretation—a process that can described by the CCRT. Schema focused therapy describes a variety of CCRT patterns learnt from childhood and how these repeat in the present, with a goal of recognizing and modifying these relationship patterns to become more adaptive. Acceptance and commitment therapy starts with the CCRT-W wish component and how our thoughts and behaviors prevent us from better meeting our needs or values—essentially how our CCRTs need modification through a set of planned strategies. Mentalization based treatment based on attachment theory describes the importance of understanding (or "mentalizing") both the self CCRT-RS patterns and other CCRT-RO patterns and how these relate to each other. Metacognitive Interpersonal Therapy is one good example of a therapy explicitly informed by the CCRT (Dimaggio et al., 2020). In all these contemporary psychotherapies there is a recognition that the core relationship between the therapist and patient (known as the therapeutic alliance) is the bedrock of therapeutic change, in that it can serve to heal negative CCRT patterns and help the patient negotiate better relationship patterns with themselves and others inside and outside of therapy through a focus on more effective ways to fulfil wishes and needs (Grenyer et al., 2022).

Psychotherapy outcome research utilizing the CCRT exemplifies the scientist-practitioner model as there are strong and reciprocal links between its use as an empirical methodology and clinical tool to inform therapists' case formulation and in-session interventions. Here, we summarize some key outcome studies utilizing the CCRT and describe how this has advanced our understanding. For a comprehensive overview of early CCRT research studies, readers are directed to *Understanding Transference* (Luborsky & Crits-Christoph, 1998). One influential early study investigated whether different CCRT elements emerged according to levels of personality functioning and integration but found that similar CCRT content emerged in terms of W, RO, and RS (Diguer et al., 2001). In this sense, the study shows that CCRT *content* may, on average, be similar across individuals regardless of the severity of personality psychopathology, illustrating the cross-cutting application of this clinical tool in understanding relationship themes. Other work has since shown that severity of pathology can be understood by studying the *pervasiveness* of CCRT themes—how often the same theme appears again and again in a person's narratives—which relates to complexity and severity of symptoms (Hegarty et al., 2019).

On the other hand, several subsequent CCRT studies have investigated whether specific clinical populations or diagnostic groups show unique thematic content in their CCRTs. For example, in borderline personality disorder (BPD), some common themes emerged that could distinguish this group from other personality disorder diagnoses (Drapeau & Perry, 2009) or uniquely predict levels of BPD symptoms (Drapeau et al., 2010).

CCRT outcome research has also examined the therapist-patient relationship. In particular, the therapist's emotional reactions to the patient (i.e., countertransference) have been fruitfully explored using this methodology. Countertransference reactions can be particularly difficult for therapists to manage in the treatment of more complex presentations. One study looked at the different CCRT themes evoked in therapists in relation to patients with BPD compared to those with major depression (Bourke & Grenyer, 2011). Although therapists had a consistent CCRT-W wish to help both patient groups, BPD patients CCRT-RO response of other patterns included more

withdrawing, criticizing, and rejecting of the therapist compared to depressed patients. These findings confirm how the dyadic interaction between patients and therapists reflect underlying psychopathology yet can be modified across treatment by analyzing the interplay of CCRTs told by both patients and therapists (Wiseman & Tishby, 2017). Aside from exploring the therapist-patient relationship, the CCRT might also be a beneficial framework to guide the supervisor-supervisee relationship in clinical supervision, facilitating effective reflection on counter-transference to improve therapeutic work (Messina et al., 2018). How these processes unfold in therapy and supervision are described below in the case description of Barbara.

Other approaches using the CCRT in psychotherapy outcome research have utilized the methodology to predict treatment response. For example, patients with comorbid depression and personality disorder who showed an early response to psychotherapy could be distinguished from those who did not based on CCRT profiles in session three of their treatment (Hegarty et al., 2019). Patients with a more negative CCRT-RO, expecting others to be unreliable, aggressive and less supportive, took longer to improve, highlighting the importance of understanding and anticipating these relational challenges early in case formulation. These empirical studies of the CCRT rely on valid and reliable scoring of relationship narratives, through which the W, RO, and RS categories are derived. Over time, the methodology used to guide the process of scoring and rater agreement has evolved, fostering greater accuracy and simplicity for the research use of this method (Albani et al., 2002; Luborsky & Crits-Christoph, 1998; Parker & Grenyer, 2007)

Notwithstanding the research utility of the CCRT, one of the important features of the CCRT approach in clinical practice is how each of the three components (wish, response of other, response of self) can be an area for fruitful investigation in case formulation. The "wish" component taps into both short term and longer-term needs and values. Short term questions can include "what are you hoping for in this relationship?," or "what is the one thing to improve in your relationship, that would make next week be a better week for you than the one you have just had?." This can help identify important areas of unmet need. It can be important too for the therapist to keep an eye on the patient's longer-term goals, wishes, values, needs and intentions. Questions can thus also include "where would you and your relationships like to be in five years' time?," "what is important to you in living a life worth living?," "what are some interpersonal things you'd like to be doing more of into the future?" In relation to the response of self-component, these can often be important ways to connect with the patient especially in the early sessions with questions such as "how are you feeling about this?," "what was your reaction to hearing this?" or "tell me about the personal impact on you from these relationships."

Therapists find that it is the CCRT-RO, the response of other component, that is both most fruitful to pursue but also the most difficult and conflictual to manage. This is in part because the conflicts the patient has with others outside of therapy are at risk of also coming into the therapy room and being played out with the therapist. This of course is the great discovery of Freud—that relationship templates or schemas keep repeating themselves and do so in the transference relationship as well (Freud, 1914/1958). This makes it very important for the therapist to identify the CCRT early, and be vigilant about it being repeated in the therapy relationship. In the case study below, we chart the progress of a successful therapy using the CCRT and see how the patient's fears of others makes it hard for them to also relate to the therapist. Also considered are a range of techniques used, including specific attention to prevent the CCRT pattern from damaging the therapy relationship or leading to premature dropout from treatment.

1 | CASE ILLUSTRATION

1.1 | Presenting problem and client description

Barbara was a 60-year-old female who had recently been diagnosed with schizoid personality disorder. She grew up in a very strict family that kept to itself. She was shy and withdrawn as a child with very few friends. Her upbringing

left her unprepared for life. She had lived alone most of her life, and her only social contact was to help a religious charity. For many years she took anxiety medicines as prescribed by an old doctor, who recently passed away. The death of her doctor, and her coming under the care of a younger doctor at the same practice, presented an opportunity for change. Her new local doctor was curious about her and wanted to reach out and help beyond prescribing medicines. As a consequence, the doctor had recently referred Barbara to psychotherapy to help with increasing somatic worries.

During the first sessions of psychotherapy, she spent most of her time talking about her medical and somatic complaints. She described to the therapist how "I've been feeling very green lately, like I'm getting sick or have a problem with my stomach. Sometimes it feels like it's bleeding inside. It's like there's blood weeping into my stomach and I get this metallic taste in my mouth, like there are vapors boiling up through my throat." Extensive medical investigations revealed no underlying pathology. To strengthen the alliance early, the therapist accepted these complaints at face value and wanted to show support and compassion for the patient's suffering. The patient went on, "before I eat, I feel pretty normal, but once there is something in there I can feel the food weighing down on me, sitting there becoming rotten." The therapist responded in a neutral way, "So there is a sense that food doesn't feel nourishing or satisfying" to which the patient responded, "Well I know I need to eat, because otherwise I get very lightheaded and can't concentrate and want to sleep all the time." Trying to bring these experiences into the room the therapist inquired, "Is this a problem you have right now, in here today?" to which the patient responded "I was feeling unwell when I got up this morning, and I nearly rang to cancel. But now that I'm here it's starting to settle." In this exchange we can observe how the therapist closely followed the patient's lead, remained neutral, but also moved the focus into the here and now so the two of them could begin to feel safe sitting together in the room.

However, the underlying discomfort the patient experienced was always close to being felt. She dressed in an eccentric way, with mis-matched brown clothes that smelt of incense and left a faded mystic counterculture impression, and were probably acquired second-hand from a charity shop. She presented in the room as aloof and hard to get to know, sometimes falling into silence as she retreated from self-disclosure. Her descriptions at times seemed unusual and bizarre, for example when she stated "the only thing I let in is my cats, which are my guardian angels." There were accompanying descriptions of the cats having special ancient Egyptian healing powers. When the therapist responded, "It feels like the cats help you - to - sort of keep you company or as protectors" it was clear from the sudden change in the patient's face - becoming ashen white - that this comment was felt as intrusive. At this point Barbara quickly gathered up her bags to leave stating "I think I've said more than enough, and it is getting late so I must be going." This patient-therapist dance between moments of connection and then retreat punctuated the work.

In another early session Barbara described how she lived alone in the dark, in fear of others breaking in. She described to the therapist that "the only time I'm really happy is when I'm at home. I lock the doors and windows and turn out the lights and become really still, listening… It is amazing what you can hear if you really listen. Once I thought someone was trying to open all the windows - thank God I already had bars on all of them." Barbara told these things in a plain, monotone, and almost boring way. However, as she was describing these things, the therapist noticed a sense of terror welling up inside herself toward Barbara. On later reflection, the therapist started to understand how strong feelings in the patient were being stirred up in herself. This gave the therapist some idea of how deep-seated emotions in the patient were being communicated. Because the feelings were not in awareness (unconscious), Barbara would leave medical doctors and her psychotherapist feeling anxious and afraid, holding the terror that Barbara could not face, whilst Barbara herself would leave feeling a little lighter from the consultation.

2 | CASE FORMULATION

When thinking in psychotherapy through the lens of the CCRT, the therapist often tries to discern the underlying relationship narrative that is being told again and again, akin to the transference template forever repeating the old relationship conflicts in the present. It became clear that because Barbara cannot trust herself, she is not able to

trust others. Because she'd been taught by her parents that the world is not safe, she internalized their fears and lived by them. By being reclusive and alone so much, she also had developed odd and eccentric beliefs about the world. Because other people found Barbara strange, they kept away from her, which left her more alone and suspicious. As these narratives were told again and again, it became clear what was Barbara's CCRT. Her CCRT was in the form that "she wishes to feel safe, but fears that others are out to get her, which makes her withdraw." As well as characterizing her CCRT, it also helped to explain her underlying schizoid personality organization. In the room, the therapist felt that Barbara was highly vigilant, and that extra attention needed to be given to reinforcing safety and the therapeutic alliance. At the same time, there was another feeling that Barbara was always hovering one step away from withdrawing from treatment in fear, projecting onto the therapist that they were going to hurt her.

Based on this CCRT case formulation, it was clear that the therapist had a number of strategies to undertake in treatment. First, they had to pay particular attention to the CCRT-W component (the patient's need for safety); thus therapy needed to be made safe. This was done through particular attention to consistency and predictability of the sessions, through a nonconfrontational professional therapist stance that was neither too warm nor too cold but able to be tolerated by this very sensitive patient. Second, the therapist had to look for and anticipate that the CCRT-RO—the expectation of the response of other that the patient would repeatedly see danger and threat in her interpersonal relationships, including in the therapist-patient relationship. Third, that the patient's CCRT-RS—the tactic of the patient to withdraw—needed to be monitored and that threats of premature termination needed careful planning. Given the pervasive and at times unconscious or out of awareness way this CCRT pattern repeated itself, the therapist had to work hard to hold onto the unprocessed terror in the patient, and when in the presence of the patient had to recognize and tolerate the nausea and dread that would show up in the room.

2.1 | Course of treatment

A core challenge in the treatment was how to work with this patient who brought so much discomfort at being in therapy into the room. Siting with her terror and working hard to be supportive and strengthening the therapeutic alliance were critical early steps. The early risk, and one that stayed present throughout the treatment, was that Barbara's fears would be enacted and she would drop out of therapy early. The risk was therefore that she would enact her CCRT in therapy. Early in the therapy the therapist brought up in conversation this issue, stating "I know that sometimes coming here and talking to me will feel too hard and even threatening, so I wanted to discuss this with you so we both recognize the risk of you feeling like dropping out early from our work together." Bringing awareness of this into the room, and having Barbara understand and confirm that this was a real risk, helped both therapist and patient to be able to discuss this as a challenge. By thinking and talking about this, they were able to identify key early warning signs and agreed that they would both be willing to continue to attend and discuss these, rather than giving into fears and not attending. The therapist presented this to the patient as a key challenge that both of them needed to face, normalizing that either of them from time to time might feel it would be easier to pull out than continue on with the treatment. Barbara said she "appreciated the honesty" in this conversation, and it helped to prevent her from dropping out following these discussions with the therapist.

A key task for the therapist was to continue to try to see the world the way Barbara saw it. In the middle phase of therapy Barbara talked about her work in the charity warehouse. The role involved sorting old, donated furniture, cleaning it and preparing it to be sold in the charity shop. Apart from attending medical appointments, this was the one weekly social outing that Barbara had in her life. The work meant she did not need to mix with others very often, and she was often left alone in the warehouse to get on with the cleaning and sorting. However, as expected by her CCRT, she still perceived others in the warehouse were unsafe. The male warehouse manager came up in her told narratives, with her stating, "He always seems to be watching me, I mean, even if he's not there I feel like he's around, criticising me." These paranoid ideas that she is being observed in a critical way demonstrated a strong

CCRT-RO—the expectation that others will hold negative harming thoughts about her. In the therapy room, she also demonstrated a reluctance to attach to the therapist, despite over time some small connections starting to form between the two of them. It was clear to the therapist in these sessions that there was an underlying desire for closeness in Barbara that kept her coming reliably to therapy, despite her fears.

In supervision, the therapist remarked to her supervisor "I feel scared. But that is not normally me, I don't get scared with most of my patients, there is something here that is troubling me. And I mean, this is an old lady that like couldn't hurt a fly." It was clear in the interactions that a sense of unsafety was unconsciously being communicated in the transference, making it hard for the therapist themselves to feel clear headed and relaxed in the room.

The challenge for the therapist was to be sensitive to, and try to avoid, the situation of Barbara seeing the therapist as malevolent. As a therapeutic strategy, to avoid a strong enactment of the patient's CCRT-RO, the therapist chose to align themself with the patient's fear of others. This was done in a deliberate way. In a discussion of Barbara's fears of others, she described over and over again as having bars on all the windows in her apartment. The therapist commented, "I'm so glad to hear that because it is really important that we ensure you are safe in order for us to do this work together." At that point the therapist also included some limited self-disclosure, saying to Barbara "I also have bars on my windows, you never can be too careful these days," thus reflecting that this was common in her neighbourhood. This was experienced by the patient as strongly validating and the patient showed visible relief at the therapist's remark. The therapist's self-disclosure at this point was a deliberate strategy to help to build a bridge to Barbara by resonating with her underlying fears whilst demonstrating compassion for how she viewed the world.

When working in the CCRT method in therapy, one of the important tasks of the therapist is to uncover the early roots of the relationship pattern—and especially the RO. Given the long and slow work done by the therapist to establish a strong therapeutic alliance to this point, the time was ready to deepen the work and look for the roots of the CCRT pattern. During the middle section of the therapy, she asked Barbara, "Was there a time in your life when things didn't seem so safe, when things happened that made you realise how important safety is?" This led to an important moment in the therapy and a shift: Barbara described how during her early years she was an excruciatingly shy child, always fearful of others, and much more comfortable when alone. She described how she had developed a fantasy world with her dolls and cats. At school she kept largely to herself and upon matriculation the opportunity to go to the city to work as an administrator in a bank was presented to her and so she took lodgings in a shared apartment with a number of other women who were also working in the bank.

She described how during that time "one of the girls in my lodging introduced me to a man, a printer, who went out with our group. Once a week on Saturday night we would go to a favourite restaurant where they made huge pots of hot food - meatballs, spaghetti, veal knuckles, that sort of thing. There were usually six of us, and everyone else had partners so this man sort of became mine.

I thought I liked him, and one night I agreed to go out with him, just the two of us. That was when he put a knife to my throat and raped me and said lots of bad things that made me feel sick and disgusting, then he pushed me out onto the street. For the next few weeks, he sent me threatening messages, he even watched me leaving and coming home to my apartment. One day he wasn't there so I called my sister, and we emptied my apartment and I've never been back since. He stayed friends with the group, so I had to go away, and I never saw those friends again. That was all a long time ago."

It was clear to the therapist that these early experiences, both the fear of others that her parents lived by, and the subsequent rape experience reinforced the CCRT that others are not safe and withdrawing from the world was justified. The therapist stated simply, "I'm so sorry those things happened to you." These hard to be told stories were difficult for the patient and therapist to bear —a great deal of unprocessed emotions showed up including terror, anger, sadness and loss. The primary goal of the therapist during this processing was to prevent the patient from being overwhelmed by a CCRT-RO enactment of experiencing the therapist as unsafe.

It was also clear that as their relationship developed, Barbara started to identify with the therapist as a younger version of herself. Some weeks after describing her rape experience, she said to the therapist, "You need to be

careful; the world isn't what it seems." The therapist, understanding the underlying communication but also the fears of the patient said, "I'm so pleased for you to help me in this way. I can say to you that I will never hurt you or threaten to kill you. I want to help you find a way to live where you feel safe and gives you some happiness." This intervention had a double intention of both validating Barbara's fears of others whilst reinforcing that the therapist held in mind her darker underlying fears in relation to the transference relationship. Barbara was emotionally moved at this point, becoming tearful, and said "thankyou." Following these exchanges and the broader working through of her traumas and the impact on her life, Barbara was able to see how other more adaptive CCRT patterns might be able to be activated.

Towards the end of the therapy Barbara told the therapist, "Before my sister passed away, I did find some happiness, especially when we went away to the mountains in summer. It was so beautiful there, the birds. There was a mountain lake that was very cold and clear, but on a very hot day we would swim there, and it was special. After a cold swim I would lie under the mountain trees looking up at the sky and we would talk and drink some wine and even though my life had taken some bad turns I felt happy and peaceful in those special moments." These memories and her experiences within the therapy showed her that there were good reasons to reduce her CCRT-RO pattern of expecting others to be malevolent, and that withdrawing from life was not always a good choice. The therapist helped her to expand upon the choices that Barbara had for her future, commenting that "in here, with me, we can take some of those mountain paths and see if we can also find a tree to sit under that gives you that sense of peace." Barbara found it uncomfortable to confront her fears and the possibility of future happiness, commenting "I'm scared, it seems too difficult at my age" but after a moment of tears, looked up hopefully at the therapist and said "I'll give it a try."

2.2 | Outcome and prognosis

During this work, the therapist helped Barbara uncover all the good reasons why the world seemed so unsafe. Slowly a trauma background was told. Barbara as an early adult was raped by a person she had developed some feelings toward. The relationship with this person became violent and controlling, and she found herself being intimidated. After joining with Barbara so closely through this story, the therapist was able to connect with this fear and reinforce that therapy is safe enough, just as her relationship with her sister had safe memories. Barbara's experience with the therapist brought up feelings about a time when she both felt safe and close to others. This provided a powerful narrative disconfirming her usual relationship patterns. Over the course of the therapy, Barbara was able to feel safe enough to take some risks with intimacy in the therapy, and then in her life outside of therapy. Towards the end of the treatment, she commented on how "what helped me was the opportunity to talk about my life, without the fear of going back into a deep depression. I've found myself trusting my therapist so much, that I feel ready to come off all my medications. I've booked myself on a holiday and I'm looking forward to being part of the world again."

3 | CLINICAL PRACTICES AND SUMMARY

Identifying and working with the patient's CCRT in therapy is very fruitful. Core negative CCRT patterns, especially if they are pervasive and tightly held onto, can be hard to change. Research on the CCRT has taught us that a person's main CCRT pattern does not disappear after therapy, rather it is still present to some extent in the patient's life. However, what changes is that many more adaptive and positive relationship patterns begin to emerge and flourish, reducing the power and frequency of the older styles of relating to others and the self. This confirms the old adage that psychotherapy does not change the personality itself, but it does change how flexible and adaptive the person becomes, leading to more of their wishes, needs and intentions being fulfilled.

As we saw in the case study of Barbara, the therapist in treatment can seek to help the patient disconfirm and modify old unhealthy relationship patterns. This is done in two ways. First, by the things they say to the patient to help them understand themselves and their relationships with others. Second, by giving the patient a new experience of a relationship. Psychotherapists start this work by taking an active and curious stance towards the world of the patient, turning most of the focus onto here-and-now day-to-day relationship problems and conflicts. By using these relationship skills and strategies the therapist can provide new reasons to patients to hope for a better life and to take steps to bring that about. By using the CCRT, therapists can help or organize in their mind the ways the patient tries to approach relationships with both others and themselves, and the core repetitive themes that keep them stuck. The CCRT also provides guidance for how the therapeutic relationship could be threatened. The therapist realized that there was a risk Barbara could enact her CCRT pattern, see the therapist as malevolent and so withdraw and drop-out. Actively being aware of this, discussing the pattern, and being willing to repair ruptures in the relationship were all strategies the therapist needed to keep them both on track with the therapy work. Future research would benefit from understanding how these CCRT processes are applied in different types of therapies and their differential impacts on outcome.

Barbara was eventually able to understand why her main negative CCRT pattern ("to feel safe, but I fear that others are out to get me, so I withdraw") made sense in terms of her early upbringing and trauma. She also came to understand that as a rule to live by it came at a high cost. By finding other CCRTs that were of a different, more positive form including examples of trusting her sister and joining with her in moments of happiness made her recognise that there were other ways to see the world that were not so black and white. Through experiencing the therapist as safe and developing trust in the intimacy of this relationship, a powerful alternative relationship pattern emerged that she wanted to test out further in her life. By both recognising her core CCRT, but also encouraging and trusting in alternative relationship patterns, Barbara slowly began to develop some mastery of her CCRT, both in terms of understanding it but also controlling it so it did not become as pervasive as it had been in the past. This process of mastering her relationship conflicts and working through these core challenges in psychotherapy provided the opportunity for her to approach the future in a new way (Grenyer, 2002).

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ORCID

Brin F.S. Grenyer http://orcid.org/0000-0003-1501-4336

Ely M. Marceau http://orcid.org/0000-0003-0209-9377

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