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## Stereotypical Relationship Patterns and Psychopathology

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### Key Words

Psychotherapy research  
Interpersonal behavior  
Relationship style  
Transference  
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### Abstract

**Background:** We explored the relationship between the consistency of relationship patterns and the severity of psychopathology. **Method:** Relationship patterns were assessed by means of Relationship Anecdote Paradigm interviews rated according to the Core Conflictual Relationship Theme (CCRT) method. The repetition of the same type of CCRT components across relationship narratives indicated stereotypical patterns. **Results:** Subjects treated in an inpatient setting (n = 25) told narratives with more consistent patterns than subjects in an outpatient setting (n = 32). Relationship episodes of normal adults (n = 23) were more flexible compared with the two clinical groups. Especially repetitions of the wish component were closely associated with the severity of psychopathology assessed by SCL-90R. **Conclusions:** The consistency of relationship patterns seems to be connected with the severity of psychopathology.

### Introduction

Psychological well-being can be understood as a state of mind in which a person is able to choose his/her way of dealing with others in specific situations from a repertoire of different possibilities. Experiencing certain situations and behaving in them in a way that is judged as psychologically healthy can be defined as choosing actions that are adequate to the situation and to the interacting partners. In contrast to this, psychopathological interactions seem to be contained within more rigid boundaries [1].

Psychodynamic therapists relate individual relationship styles to mental representations of interpersonal relationships which are developed around wishes and affects. They follow Freud [2], who defined these relationship

styles ('stereotype plates') in the individual's repetitive behavior as a transference process. Feelings, anxieties or expectations are thought to be derived from past relationships and transferred to present relationship behavior. Psychodynamic therapies focus on these transference processes in order to change the patient's maladaptive, repetitive relationship patterns. Thus the psychodynamic literature emphasizes the pervasiveness of relationship styles across different interpersonal situations.

Luborsky et al. [3] defined and operationalized the Core Conflictual Relationship Theme (CCRT) which applies across a variety of human interactions. Whereas psychodynamic therapists propose that individuals hold to one predominant stereotypical relationship pattern, the social cognition literature additionally emphasizes the sit-

uational specificity of schemas [4]. Surprisingly, in psychodynamic as well as in social cognition literature only few empirically gained data exist on the pervasiveness of stereotypical relationship patterns.

Benjamin [1] reanalyzed characteristic patterns and unconscious wishes in personality disorders by means of the Structured Analysis of Social Behaviour method, a tool to identify an individual's relationship style. Crits-Christoph et al. [5] studied the consistency of interpersonal themes of patients in psychotherapy. The authors investigated the extent to which patients display similar interpersonal themes across multiple narratives of their interactions with others. Interpersonal themes were measured using a new instrument called the 'Quantitative Assessment of Interpersonal Themes' method, which assesses the wishes, responses from others, and responses from self that occur in narratives about interactions with others. Statistically proven evidence of repetitiveness was found in 60 patients in psychotherapy.

Taking wishes, affects and response classes as representatives of the psychoanalytic construction of the 'mental apparatus' [2], the wish components are generally considered as less flexible than the response components. Response or reaction classes are seen as fantasies around basic wishes [6], though differences in fantasy life across diagnostic groups are discussed [7]. The wishes are more likely to be unconscious while reaction components are more conscious and under cognitive control. The latter are easier to change in different situations, while the basic wishes remain the same over different situations. Wishes and reactions from the other are topics for change concerning the patient's relationship behavior during psychotherapy. Luborsky et al. [8] demonstrated that the pervasiveness of the responses from the other and the response of the self decrease during psychotherapy and that change in the pervasiveness of the CCRT correlates with good symptom outcome.

Severely disturbed patients are expected to show very rapid and intense transference reactions. Freud [2] mentioned the intensity of transference in hospitalized, severely disturbed patients. Pfeffer [9], in his classical observations, found that transference patterns of patients even some years after treatment were similar to the transference during the analysis; but they had lost their strength.

These considerations lead us (see [30]) to the following hypotheses concerning the patient's stereotypical relationship patterns: (1) There is a relation between the severity of psychopathology and the extent of stereotypical patterns in interpersonal relationships. (2) In interpersonal

**Table 1.** Numbers, means and standard deviations of the socio-demographic variables for the normal, outpatient, and inpatient group

	Total	Normal adults	Outpatients	Inpatients
<i>Age, years</i>				
Mean	26.5	28.0	26.1	25.7
SD	4.1	3.2	4.7	3.8
<i>Sex</i>				
Male	50	13	23	14
Female	30	10	9	11
<i>Marital status</i>				
Single	50	16	19	15
Married	23	6	10	7
Div./sep./wid.	1	1	3	3
<i>Education, years</i>				
Mean	12.9	13.5	12.4	12.7
SD	3.0	2.9	3.1	3.1

relationships wish components are less variable than response components. This is hypothesized not only for subjects with psychosomatic or psychiatric symptoms but also for normal controls.

## Method

### Subjects

Narratives of relationship episodes from a total of 80 subjects, at ages ranging from 18 to 35 years (mean = 26.5, SD = 4.1), were investigated. 23 were normal adults, 32 subjects were treated as outpatients, and 25 were treated in an inpatient clinic for psychosomatic patients. 30 of the subjects were male and 50 were female (for other sociodemographic variables see table 1). There were no statistically significant differences between the groups with regard to the sociodemographic variables.

The members of the group of normal adults had never been in psychotherapy before. They were contacted via newspaper ads and were paid for the interview. The two clinical groups were treated at the Clinic for Psychosomatic Medicine and Psychotherapy at the University of Göttingen. The diagnoses in the two clinical groups comprised a spectrum of eating, affective, and personality disorders (according to ICD-10 [10], see table 2). None of the clinical subjects was psychotic or addicted to drugs at the time of the study. The severity of the patients' psychopathology was not assessed clinically (e.g. by the DSM Global Assessment of Functioning Scale). It will be determined as part of the methodology (see data from the SCL-90R).

**Table 2.** Patient diagnoses according to the ICD-10 [7]

Outpatients (n = 32)			Inpatients (n = 25)		
F50.2	Bulimia nervosa	11	F50.2	Bulimia nervosa	7
F50.0	Anorexia nervosa	3	F50.0	Anorexia nervosa	2
F32.0	Mild depressive episode	4	F32.0	Severe depressive episode	4
F32.1	Moderate depressive episode	4	F33.1	Recurrent depressive disorder	2
F40.0	Agoraphobia	2	F40.0	Agoraphobia	2
F45.0	Somatization disorder	2	F45.0	Somatization disorder	2
F42.0	Obsessive-compulsive disorder	3	F42.0	Obsessive-compulsive disorder	2
F60.1	Schizoid personality disorder	1	F44.4	Dissociative motor disorder	1
F60.6	Anxious avoidant personality disorder	1	F60.4	Histrionic personality disorder	1
F60.3	Emotionally unstable personality disorder	1	F60.3	Emotionally unstable personality disorder	2

### Assessment of Stereotypical Relationship Patterns

To study relationship patterns which are narrated by the patient we used Luborsky and Crits-Christoph's [11] CCRT method. The basic idea of the CCRT is that a person's conscious or unconscious wishes induce interactions with others. The subject's interaction partner reacts to the relationship behavior which – in a third step – leads to reactions of the person's self. These three different components of an interactional sequence, i.e. the subject's wishes, needs or intentions (W), the responses from others (RO), and the responses of self (RS), contribute to the structuring process of relationships. The CCRT system is a standardized method for the assessment of these components in narratives of relationship episodes. In each relationship episode told by a subject, W, RO and RS have to be identified and assigned to a CCRT standard category (SC) (34 SC for the wishes, 30 SC for RO, and 30 SC for RS, for details of the scoring procedure see [11]). Each of the SC within each CCRT component is again translated into more encompassing categories, referred to as clusters. These clusters (8 for each of the three components) represent a more abstract level of the CCRT operationalization.

The CCRT has proven to be a reliable instrument for research purposes [12]. Crits-Christoph and Luborsky's [8] empirical findings on the reduction of pervasiveness in the CCRT through therapeutic treatment encouraged us to use the CCRT as a tool for our purpose. We identified the relationship patterns in videotaped Relationship Anecdote Paradigm (RAP) interviews [13] (for coder agreement see [14]). To get memories of personal and problematic encounters, the subjects are free to tell any ten incidents about any people. The RAP interviewers gave the following instructions:

'This interview is a way of telling about your relationships. For this we can spend 1 h, usually it takes 30–50 min.

Please tell me some incidents or events, each involving yourself in relation to another person. Each incident should be a specific event or a concrete situation with someone else which has been personally important or a problem for you in some way. I would appreciate it if you could tell me about that event like a scene in a movie.

The person you tell me about can be anyone. Some events should be from the present and some from the past.

For each event, please tell me when it occurred, with whom it occurred, some of what the other person said or did, and what happened at the end.

Tell me about at least ten of these incidents. I shall let you talk. I shall only interrupt if something is unclear.'

The RAP interviews were conducted by doctoral students who were not involved in the psychotherapeutic treatment of the patients. All interviews were rated from the videotape according to CCRT standard categories described in a German translation of the Luborsky CCRT manual [15]. The standard categories were then translated into a structure of 8 clusters for each component.

Referring to a frequency measure for Murray's Thematic Apperception Test (TAT) [16], Crits-Christoph and Luborsky [8] introduced a formula for identifying stereotypical patterns. They called it pervasiveness of the final CCRT, with the final CCRT being the sequence of the most often identified W, RO, and RS components.

$$\text{Pervasiveness} = \frac{\text{number of relationship episodes (RE) with the final CCRT components}}{\text{total number of REs in the session}}$$

The pervasiveness is directly connected with the construct validity of the CCRT since it tries to give a quantitative answer to the question: How central is the central theme? But merely focussing on the final CCRT does not take into account what is told by the subjects and coded by the raters besides the final CCRT. Computing the pervasiveness of the final CCRT disregards the distribution of other contents of the relationship episodes, which were rated in standard categories and translated into clusters. Subjects who report W, RO, and RS components from a wide range of standard categories may have resources in a wide range of relationship experiences. Therefore, we also computed the dispersion [17] of W, RO, and RS components in the relationship episodes told in the RAP interview. The dispersion answers the question 'How flexible are all themes in one interview?'. This tool measures the spread of a nominally scaled variable. In other words, it is a measure for stereotypical repetitions with respect to wishes, reactions of objects and reactions of self across relationship episodes.

The dispersion derives from Gini's concentration measure C. The formula for dispersion is:

$$\text{Dispersion} = \frac{C}{C_{\max}} = \frac{1 - \frac{\text{sum of squared relative frequencies of codings in each cluster (for W, RO, or RS components)}}{\text{maximum value of C for a given number of codings (for W, RO, or RS components)}}}{C_{\max}}$$

**Table 3.** Average number of codings from one interview (mean ± SD)

Groups	n	Number of coded components			
		W	RO	RS	Total
Normal adults	23	16.4 ± 3.6	20.7 ± 3.6	26.5 ± 5.3	63.6 ± 9.4
Outpatients	32	15.6 ± 4.4	21.3 ± 4.9	25.8 ± 5.2	62.8 ± 12.0
Inpatients	25	18.0 ± 7.2	25.3 ± 8.1	32.6 ± 10.1	76.0 ± 23.4
Total	80	16.6 ± 5.3	22.4 ± 6.1	28.2 ± 7.7	67.1 ± 16.7

**Table 4.** Dispersion across groups and components on the cluster level (mean ± SD)

Groups	n	Dispersion		
		W	RO	RS
Normal adults	23	0.907 ± 0.058	0.928 ± 0.040	0.933 ± 0.035
Outpatients	32	0.858 ± 0.073	0.849 ± 0.088	0.908 ± 0.048
Inpatients	25	0.828 ± 0.090	0.842 ± 0.125	0.906 ± 0.059
Total	80	0.863 ± 0.080	0.870 ± 0.098	0.915 ± 0.049
MANOVA	d.f. (b)	d.f. (w)	F	p
ME groups	2	77	9.5	<0.001
ME components	2	76	28.1	<0.001
IE groups comp.	4	154	3.1	0.016

ME represents the main effect in the analysis of variances.  
IE represents the interaction effect in the analysis of variances.

The maximum value of C ( $C_{max}$ ) for a given number of codings (for W, RO, or RS components) identified in one RAP interview, should be computed as follows:

Total number of codings (m) (either W, RO or RS)	$C_{max} =$
1-8	$1 - m \cdot (1/m)^2 = 1 - (1/m)$
9-16	$1 - [(m - 8) \cdot (2/m)^2 + (8 - (m - 8)) \cdot (1/m)^2]$
17-24	$1 - [(m - 16) \cdot (3/m)^2 + (8 - (m - 16)) \cdot (2/m)^2]$
25-32	$1 - [(m - 24) \cdot (4/m)^2 + (8 - (m - 24)) \cdot (3/m)^2]$
33-40	$1 - [(m - 32) \cdot (5/m)^2 + (8 - (m - 32)) \cdot (4/m)^2]$
41-48	$1 - [(m - 40) \cdot (6/m)^2 + (8 - (m - 40)) \cdot (5/m)^2]$

The dispersion runs from 0.0 for stereotypical repetitions of codings in one cluster through 1.0 for codings equally distributed over all eight clusters indicating high flexibility.

Example: If for one subject in one RAP interview, 14 wishes are coded by a rater and these 14 wishes are distributed over the 8 clusters as follows (cluster 1 = 0; cluster 2 = 0; cluster 3 = 1; cluster 4 = 2; cluster 5 = 4; cluster 6 = 6; cluster 7 = 1; cluster 8 = 0), the concentration C for wishes is:  $C = 1 - ((0/14)^2 + (0/14)^2 + (1/14)^2 + (2/14)^2 + (4/14)^2 + (6/14)^2 + (1/14)^2 + (0/14)^2) = 0.704$ .

The maximum value of C for a given number of 14 wishes is:  
 $C_{max} = 1 - ((14 - 8) \cdot (2/14)^2 + (8 - (14 - 8)) \cdot (1/14)^2) = 0.867$ .

In this case, the dispersion of wishes ( $C/C_{max}$ ) equals  $(0.704/0.867) = 0.812$ .

High dispersion scores indicate more flexible patterns while low dispersion coefficients indicate highly stereotypical repetitions of codings in the same cluster.

#### Assessment of the Severity of Psychopathology

The subjects completed the German version of Derogatis's SCL-90R. Comprising 90 items, the SCL-90R uses nine symptom constructs (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic-Anxiety, Paranoid Ideation and Psychoticism) and three global measures for quantifying psychopathology and overall psychological distress [18]. In the present study, the Global Severity Index (GSI) was used to determine the degree of psychopathology. The GSI indicates the mean score of a subject on all 90 items. The subjects belong to one of the three subsamples: normal adults, outpatients, inpatients. Clinically it was hypothesized that there was an increase of the patients' severity of psychopathology across these groups.

The inpatients were asked to fill out the questionnaire after being interviewed. The outpatients and the group of normal adults took the questionnaire home and were asked to send it back to the clinic within the following 7 days. Of the total of 80 subjects, 65 completed the SCL-90R. The remaining 15 subjects (3 normal adults, 6 outpatients, and 6 inpatients) did not send the questionnaire or had omissions in their SCL data.

### Statistical Procedures

A repeated measures analysis of variance (ANOVA) was conducted with the dispersion score on the cluster level as the dependent variable, the group status (normal adults, outpatients and inpatients) as a three-level independent variable, and the CCRT components (W, RO, and RS) as the three-level-within-subject factor indicating repeated measures. Additionally, correlations of the dispersion in W, RO, RS components on the cluster level with GSI scores were computed and tested for significance for the total sample and within each group.

## Results

Table 3 reports the average number of codings identified by the raters from the relationship episodes within one interview.

Comparing the three components, we find the lowest number of codings for wishes. This result is in accordance with the raters' experience that reaction components are easier to identify and that wishes are more rarely expressed by the subjects. The highest total number of components was coded for the inpatient group. Inpatients produce the most material that prompted the raters to class it with a CCRT standard category.

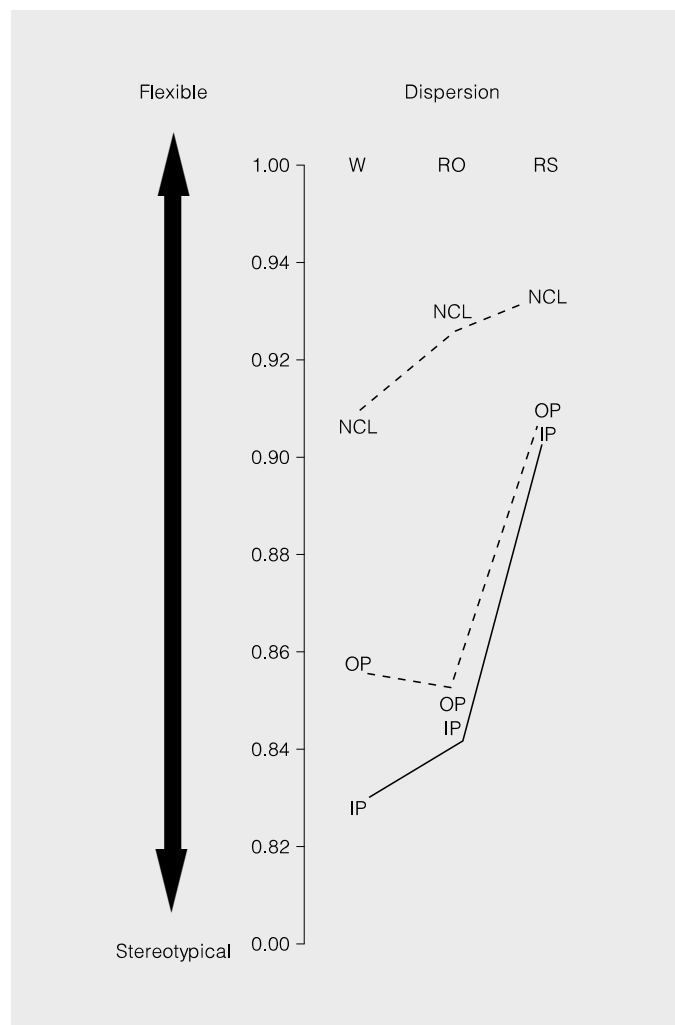
In table 4 mean dispersion scores are given for the wishes, object reactions and reactions of self for the three different subject groups at the cluster level.

Our hypothesis that normal adults show the highest dispersion in all three components was confirmed. A significant difference emerged for the main effect groups (for F statistics see table 4).

Figure 1 gives an overview for the results of the three groups. It also illustrates the main effect for the components: RS is the most variable component; additionally, W shows the best potential to distinguish the three groups (F statistics for the interaction of groups and components in table 4). While the two reaction components distinguish the clinical groups from the normal adult group ( $t_{(78)} = -3.64$ ,  $p < 0.001$ , for dispersion of RO;  $t_{(78)} = -2.18$ ,  $p < 0.05$  for dispersion of RS), they do not indicate a remarkable difference between the two clinical groups ( $t_{(55)} = 0.28$ ,  $p = 0.78$  for dispersion of RO;  $t_{(55)} = 0.15$ ,  $p = 0.88$  for dispersion of RS).

The same computing procedure was repeated at the level of CCRT standard categories. The analysis revealed basically the same effects as at the cluster level.

The differentiation of the sample by the subjects' clinical status (normal adults, in- and outpatients) was confirmed by their GSI scores. All three groups are significantly different from each other (normal adults: mean



**Fig. 1.** Mean scores for dispersion across groups and components at the cluster level. NCL = Nonclinical subjects; OP = outpatients; IP = inpatients.

GSI = 0.24 (SD = 0.15); outpatients: mean = 0.97 (SD = 0.57); inpatients: mean = 1.38 (SD = 0.68)).

Correlations of the dispersion scores in W, RO, RS components with the GSI scores are given in table 5. (Examinations with the nine SCL-90R symptom subscales did not reveal additional information.)

For the total, the highest correlations emerged for the W component. Correlations between the RS component and the GSI scores were not significant. These results confirm the comparison of means for dispersion scores in the three groups (F statistics, table 4).

We found conforming correlations only concerning the inpatient group ( $r = -0.32$  for the dispersion of the wish component). Owing to the lower number of subjects, these

**Table 5.** Correlations of dispersion scores in W, RO, RS components with GSI scores at the cluster level

Groups	n	Dispersion		
		W	RO	RS
Normal adults	20	0.18	0.18	0.07
Outpatients	26	-0.01	-0.15	0.01
Inpatients	19	-0.32	0.19	0.36
Total	65	-0.39*	-0.25*	-0.09

1-tailed significance; \*  $p < 0.05$ .

correlations are statistically not significant. In the inpatient group we found, in addition, a relatively high but nonconforming correlation in the RS component ( $r = 0.36$  for the dispersion), indicating an increase of variability with the severity of psychopathology. This result will be discussed later.

## Discussion

Engaging in interactions requires a complex process which takes into account new information and old experiences. Interactions can be described as situations that offer new information for the subjects involved. New information involves variables such as certain personality traits and states of the partner as well as central wishes and fears. Situations offering new information reveal the subject's own wishes, needs and intentions towards the partner and they activate the subject's schemas of relationship with others. There may be different patterns for different situations and different partners. All new information about the subject's inner state, the partner and the context of the interaction needs to be perceived, judged and integrated or rejected. Some of this information might be expected to be too conflictual for the inner psychological balance. If new, incoming information needs to be rejected, the subject will use defense mechanisms, for instance by projecting affective states on the partner or by totally repressing it. Defense mechanisms serve to stabilize the inner psychological balance [19].

We assume that mental schemas provide people with certain rules about how to interact with the environment. A schema may be defined as a way to organize events or information [20]. It is, at the same time, the product and the producer of individual-environment interactions. A schema for interpersonal relationships covers basic infor-

mation about how to behave and feel in interactions with others [21], i.e. what to wish, how to perceive and interpret the actions and statements of the significant others, and how to react in response to them. When engaging in an interaction, one of these schemas has to be activated. If a situation provides new information, it can be integrated in this activated schema by assimilation or accommodation as described by Piaget. The next interaction of the same type will be carried out according to the recently changed schema.

The process of integrating new information in already existing schemas can be regarded as normal development. The repertoire of possible interaction patterns gets larger, more elaborate, and more flexible throughout human development. Psychodynamic theory explains a subject's flexibility and ability to adapt to new and sometimes unfamiliar situations through a subject's perceptions of, and experiences in, past interpersonal relationships [22]. If the subject's history of relationships with significant others has led to very stable and negative maladaptive patterns [23], we expect the processing of new information to be less flexible. Under these circumstances, the neurotically disturbed patient often takes the 'safer' way, i.e. he avoids any information that could disturb the inner psychological balance. This strategy limits the risk of making new and challenging experiences which are difficult to integrate and may be overtaxing.

Since interaction cannot be avoided in general, the only way of dealing with new and sometimes challenging situations may be to hold on to already existing relationship patterns without integrating new information. The subject concentrates on relationship patterns he is used to. He initiates familiar interactions even though they did not bring satisfaction in the past. This leads to a relationship pattern that becomes more and more maladaptive [24, 25].

These theoretical considerations are supported by the main results of this study. They suggest that the severity of psychopathology is connected with more stereotypical relationship patterns in narratives of relationship episodes. The repetitions of wish components seem to have a high potency to discriminate between the three groups of subjects. There is support for our first hypothesis that there is a relationship between the severity of psychopathology and the extent of consistency in interpersonal relationships.

There is partial support for the second hypothesis that the wish components in narratives about interpersonal relationships are less flexible than response components: for the two clinical groups the reaction-of-objects component is as consistent as the wish component. But the RS

component is most flexible. We may summarize that the fantasies grouped around the core wishes are arranged in a way that the perceived ROs are still strongly associated with these wishes. One consequence of this result for psychotherapeutic treatment could be to focus not only on the patient's wishes but, in parallel, also on her/his way of interpreting the partner's reactions.

If we assume that narratives about interpersonal relationships give us some information about an individual's mental schema, the results confirm the hypothesis that patients with a high degree of psychopathology use less flexible schemas than less disturbed patients or normal adults. Following the assumption that these schemas are, at the same time, the product as well as the producer of individual-environment interactions, we expect these patients to engage in future interactions according to what can be identified as their most important interpersonal pattern. It seems unlikely that these patients will engage in future interactions that are very different from those interactional experiences they report during the RAP interview. This assumption remains to be proven in future investigations (see below).

Our results demonstrate that this might be most important for the inpatient group. The inpatients are the only group within which we find the correlation between stereotypical relationship patterns and the severity of psychopathology. The higher the inpatients' degree of psychopathology, the more rigid are their wishes concerning their relationships. But we also find a nonconforming correlation for the RS component within this group. Here, a higher degree of psychopathology is connected with more flexible RS components. Patients with severe psychopathology seem to have highly consistent wishes in their interactions but they seem to have more problems controlling their own reactions towards their objects. Combining these results with those of the comparison between groups we can expect a curvilinear relation between the variability of narrated self-reactions during an interview and self-reported severity of psychopathology. Responses of Self are rated to be less stereotypical in the outpatient group compared with the normal adults group; and there is a tendency within the inpatient group for the consistency to become instable again at a higher level of psychopathology.

In summary, the patients' wishes seem to be a meaningful element in understanding their interpersonal behavior. Stereotypical wishes are connected with a higher degree of psychopathology as defined by the GSI scores of the SCL90 checklist. These central wishes of severely disturbed patients are probably a very significant source for their future interactions.

Inducing wish-fulfillment directly refers to the concept of transference. In our paradigm, transference is a resource for engaging in interactions according to what people are used to and what they feel familiar and safe with. Assessing reported relationship patterns through RAP interviews is not a measure for transference per se since stereotypical narratives about relationship episodes do not directly say anything about how the individual will perceive and perform his current interaction (with the interviewer) or the following interactions with other partners (predictive validity). But the stereotypical relationship patterns assessed through RAP interviews can give us an idea about how the individual is prepared for the interactions to come. Therefore, we can assume that the identification of stereotypical patterns in the RAP interview is a tool to assess the disposition to transference processes for future interactions.

Future research should aim to establish the predictive validity of the CCRT by combining the RAP measures with the behavioral assessment of current interactions, for instance with the therapist. We expect individuals with highly consistent relationship patterns identified in RAP interviews to perceive and behave in a current interaction similarly to their most pervasive CCRT. According to the theory, we also expect subjects with highly rigid relationship patterns to show higher disclosure levels [26] and to employ a higher proportion of immature defense mechanisms [27, 28]. Future research should try to elucidate this aspect, especially with respect to the patient's affective states [29]. Since rigidity increases with the severity of psychopathology, we want to address the question of whether assessing the rigidity of wishes in narratives about relationship episodes is a meaningful measure only for more severely disturbed patients. Finally, we would like to point out that the results reported here are preliminary and that we need a larger sample, especially of the patient group, to better understand whether our findings apply to other patients as well.

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