From a Psychoanalytic Narrative Case Study to Quantitative Single-Case Research

19

Horst Kächele, Cornelia Albani, and Dan Pokorny

Contents

19.1 The Psychoanalytic Narrative Case Study 365

19.2 Empirical Single-Case Studies 367

19.3 Psychoanalytic Process 368

19.4 Methods 369

19.4.1 Systematic Longitudinal Descriptions 369

19.4.2 Core Conflictual Relationship Theme 372

19.4.3 Clinical-Guided Judgments 374

Conclusion 375

References 376

Abstract

Narrative case studies concerning the psychoanalytic process date back more than a century; Breuer and Freud were the pioneers of this research path. A great shift in methodology occurred after the development of computers that could work with both text and numbers. On the one hand, it became possible to store detailed, verbatim protocols of therapy sessions. On the other hand, it was possible to analyze derived quantitative data by using sophisticated statistical procedures. This is exemplified in three different methods that analyze different psychoanalytical cases. We conclude by mentioning that research on the psychoanalytic process has to start with clinical experience, which can be used when introducing new observational tools to check for the appropriateness of each tool. This is made possible by the synergetic work of people and processes that were mentioned above.

H. Kächele (✉)
International Psychoanalytic University Berlin, Berlin, Germany

Sonnenweg 25, 89081 Ulm, Germany
e-mail: horst.kaechele@ipu-berlin.de

C. Albani
SINOVA Hospital Aulendorf, Aulendorf, Germany

D. Pokorny
Department Psychosomatic Medicine and Psychotherapy, Ulm University, Ulm, Germany

19.1 The Psychoanalytic Narrative Case Study

Historically, in psychoanalysis' oral tradition and loosely documented cases, vignettes were used as the principal means of reporting the insights that originated from the therapeutic situation. Breuer's (1893–1895) reporting on a young

O.C.G. Gelo et al. (eds.), *Psychotherapy Research*,
DOI 10.1007/978-3-7091-1382-0_19, © Springer-Verlag Wien 2015

lady's (Anna O.) cloudy talking nourished in his colleague Freud the idea that one should tell these clinical observations as stories to accurately depict what had transpired.

Freud was aware of the imperfections of his case histories. In his *Studies on Hysteria*, we detect a note of both amazement and self-justification in his remark that indicated that his case histories "read like short stories" and "lack the serious stamp of science" (Freud 1895, p. 160). Yet, in the very next sentence, he also rejects artistic ambitions: "I must console myself with the reflection that the nature of the subject is evidently responsible for this, rather than any preference of my own" (ibid).

The model that Freud suggested was creatively continued by the growing number of psychoanalysts who reported the discoveries from the consulting room, mainly in the form of case vignettes (e.g., Ferenczi 1927). Until today, in the psychoanalytic literature, the "vignette" is still the primary form of presentation. A vignette is characterized by unity, subtlety, and refinement and serves to illustrate typical psychodynamic connections. In regard to vignettes, the implications for the analyst's therapeutic actions are secondary when compared to this focus of interest. Therefore, they hardly describe how the analyst actually works and what he feels, thinks, and does. Therefore, it seems useful to at least distinguish between *case histories* that focus on the psychodynamic properties of a disorder and *treatment reports* that focus on the technicality of how to perform the therapeutic work.

The genre of treatment reports is clearly characterized by a quantitative increase over the last few decades, which was detailed by Kächele (1981; see also Kächele et al. 2009, Chap. 3). More analysts have been willing to make their clinical work accessible to readers (e.g., Klein 1961; Winnicott 1972; Dewald 1972; Thomä 1961). Providing adequate presentational critical discussion within the profession could be on sound footing.

Thus, psychoanalysis became a narrative science by using narration that led to narrative truth (Forrester 1980; Spence 1982). To highlight the importance of this methodological decision, one has to imagine what the development of chemistry would be like if chemists would have started the habit of providing stories about what they had observed in their test tubes: a science of chemistry based on reported colors, of blue and red and green reactions in the little tubes after having performed a certain experiment. Imagine a science of musicology with musicians sharing their most personal experiences by writing case histories or by letting consumers speak about their emotional involvement after a piano concerto. What is wrong with such an approach? It is possible that a person could build a science of musical experience by collecting a large sample of these reported subjective testimonies. This approach would not work for chemistry, which is why the alchemist tried in vain to find the recipe for how to make gold. One should remember the work of the brothers Grimm, the two professors from Göttingen in Germany, who systematically started out collecting orally transmitted fairy tales. After many decades, a well-developed field of fairy-tale research exists that uses highly sophisticated methods to analyze the available large collections of fairy tales from all over the world (Propp 1928).

Until today, we encountered prominent authors who emphasized that the clinical encounter was best reported via the narrative (Michels 2000). Indeed, there are good reasons for maintaining the tradition of clinical reporting because it conveys the subjective evidence of the reporting person (e.g., a therapist or a patient). Therefore, describing the origin and changing functions of case studies have become a topic that is discussed by qualitatively minded researchers who examine the place of novellas as a scientific form of representation and communication (Frommer and Rennie 2001).

The problem that we face is that in psychoanalysis, each of the diverse psychoanalytic cultures often remains within its own confines and largely ignores case studies from other branches of the discipline (Luyten et al. 2006). Therefore, more research-minded psychoanalysts have explicitly indicated the following:

> Today, the historically fertile narrative procedure of Freud is no longer able to carry the responsibility for the existence of psychoanalysis, even though they still are still a major tool for didactic and identity formation of the members of the analytic community because case stories may be a rich material means of communication (Stuhr 2004, p. 63).

19.2 Empirical Single-Case Studies

In 1971, Wallerstein and Sampson concluded that it was necessary to conduct formalized and systematized examinations of the therapeutic process in psychoanalysis: "Our central conviction is that the informal case study, in spite of its forceful power of conviction, has certain realistic and obvious scientific limitations" (p. 47). In the same year, Luborsky and Spence (1971) asked the psychoanalytic community to provide "specimen cases":

> Ideally, two conditions should be met: the case should be clearly defined as analytic…, and the data should be recorded, transcribed and indexed to maximize accessibility and visibility (1971, p. 426).

A few years later, Hartvig Dahl introduced the term "the specimen hour" (Dahl et al. 1988) to provide for the interested public the transcript of session five of the completely tape-recorded treatment of Mrs. C. This implied that there are not only "specimen dreams" in psychoanalysis, which is a term that Freud coined, but there are also specimen cases that have to be studied in their own rights. In our view, the decisive criterion that should be used to attribute the label "specimen" should be its public accessibility, which allows for critical, nonpartisan discussion. The development of textbanks has become part of this requirement (Mergenthaler and Kächele 1988).

However, the number of papers that call for formalized single-case research far outnumbers the number of papers that report on such detailed single-case studies (Leuzinger-Bohleber 1995).

Single-case studies are not confined to tape recording; any systematic gathering of treatment-relevant material can be used to document a treatment (see Chap. 20 with regard to the possibility of considering the narrative text that is produced by clinicians in regard to their treatment being a form of secondary qualitative data that needs to be further analyzed by using the specific procedures of qualitative data analysis). Detailed clinical case reports are, in our view, necessary and act as a bridge to the more formalized systematic case studies. Given their material qualities, they could have been and still can be the object of more formal empirical studies. A few of the detailed case reports that are mentioned above provide sufficient material that can be used as a starting point in formalized evaluations.

The introduction of tape recording into the psychoanalytic treatment situation opened a new window in the process that was ardently debated for a long time, and for most analysts, it is still controversial. Audio recordings of the psychoanalytic dialogue do pose a number of substantial clinical and ethical problems, although, in regard to scientific reasons, they provide true progress (Kächele et al. 1988). They allow an independent, third-person perspective on the analytic, interpersonal transaction; in regard to the analyst's and the patient's internal modes of experience, they are silent, but ideally, they may be able to provide an estimation of this based on the participant's testimony. The recording of these cases has led to the creation of many theoretical and technical issues.

Overviews of the methodology were presented by Kazdin (1982), Hilliard (1993), Iwakabe and Gazzola (2009), and Fonagy and Moran (1993). The latter summarized the topic succinctly:

> Individual case studies attempt to establish the relationship between intervention and other variables through repeated systematic observation and measurement .....The observation of variability across time within a single case combines a clinical interest to respond appropriately to changes within the patient, and a research interest to find support for a causal relationship between intervention and changes in variables of theoretical interest. The attention to repeated observations, more than any other single factor, permits knowledge to be drawn from the individual case and has the power to eliminate plausible

> alternative explanations. (Fonagy and Moran 1993, p. 65)

The most prominent case in the Anglo-American literature is the case of Mrs. C who was treated by Hartvig Dahl (as we know by now). Weiss, Sampson, and their research team (1986) reported on a host of experiments that were performed on the case material. Within this team, G. Silberschatz was an important member who was guided by Dahl in his doctoral dissertation in New York on Mrs. C in 1978. Years later, Dahl presented his FRAMES concept on the material of session five (1988); his colleague Bucci (1988, 1997) approached the case from a different vantage point by identifying emotional structures. Another major work on Mrs. C was the application of the Jones Psychotherapy Process Q-Set (PQS) as a method for systematic inquiry of the whole process (Jones and Windholz 1990).

19.3 Psychoanalytic Process

For many years, the Ulm Psychoanalytic Process Research Study Group has implemented a program that examines the material bases of psychoanalytic therapy. We were and are convinced that only the careful exploration of the patient's interaction with the analyst can illustrate the central aspects of psychoanalytic treatment and enable an empirically driven theory of the process.

However, we encounter a multiplicity of meanings and models regarding the notion of the "psychoanalytic process" (Compton 1990). Opinions differ regarding whether models have to be tested, but language games are useful for those who use these models (Wittgenstein 1921/2014). Our investigations were guided by a working model of the process, which encompasses all of the steps of the process, from the start of a patient/analyst contact to the termination of this relationship. The methodological specificity of the psychoanalytic process is produced by the analytic method, which prescribes a specific discourse—with evenly hovering attention and free association being functional units. The impact of these rules on both of these parts sets a process in motion that transforms the covered processes within the patient (e.g., transference dispositions) into relationship patterns between the patient and the analyst.

In psychoanalysis, similar to other fields of human intervention, theories exist about how the process should be supported empirically; at present, these thoughts are used to a much greater extent as instruments for theory criticism. The process model of psychoanalytic therapy as an "ongoing, temporally unlimited focal therapy with a changing focus," which was described in the Ulm textbook *Psychoanalytic Practice* by Thomä and Kächele (1987, Chap. 9), has been posited as a claim that is based on one's own clinical experience. After all, the aim suggests guidelines regarding how psychoanalytic processes are currently conceived and practiced.

Our starting point for this conception was the awareness of various technical elements, such as working alliance, transference and countertransference phenomena, and resistance, whose combinations then generated the different forms of psychoanalytic therapy. The manifold therapeutic processes that exist in reality between the poles of macroprocess and microprocess reveal fluid boundaries in the macro field, which comprises so-called psychoanalysis proper, analytic psychotherapy, and short therapy in the field of individual therapies (Kächele 2010). These generic descriptions were questioned when the criterion, which is unable to be specified externally, of the "analytical process" was introduced on the basis of variables that concerned the setting. For instance, the extensively published case of Dewald (1972) was described by two out of three training analysts of the American Psychoanalytic Association as being psychoanalysis, but by the third only described it as analytical psychotherapy. Even the use of the couch by no means guarantees that the process will be described as "psychoanalytic" when it exists by virtue of functioning transference/countertransference (Schachter and Kächele 2010). Process models at a micro level, which is formulated, for example, by von Zeppelin (1987) who used the cognitive-affective regulation system for intrapsychic processes, are claimed to be valid for

all of the psychoanalytically oriented therapeutic approaches (Kächele 2010).

In its use of the focus concept, the Ulm process model primarily aims to have a medium level of description. The concept of "focus" is semantically quite diffuse because we also speak of "focusing" and may be referring to relatively short-term processes. The focus concept that was introduced by French (1952) formed a part of his cognitively oriented analysis of dreams; this concept was used by Seitz (1966) in the Chicago consensus study, in which French was also involved. Here, the focus came to be seen as the least common multiple, which was understood clinically by the concept of "prevailing transference." An interactive, process-oriented conception of the focus was crystallized from the work that was developed in Malan's focal therapy workshop (1963, p. 272). Our conception of the focus relates to a structure that extends over a longer period of time and involves a longer sequence of sessions. For quite some time, the Ulm Psychoanalytic Process Research Study Group has been working on the empirical identification of such structures. A number of methods at different levels of abstraction from the clinical work have been used for this purpose. It seemed obvious to organize research along poles that stretch from the traditional case history to very formalized methods, which correspond to qualitative approaches and hard-nosed quantitative methods (Kächele 1992; see Chap. 13 for an overview of quantitative approaches to the study of the psychotherapy process).

19.4 Methods

We shall illustrate empirical approaches in regard to our recorded cases:

First, we introduce our method of systematic longitudinal description and Dahl's (1983) evaluation strategy of the therapist's topic index (see Sect. 19.4.1). Second, we refer to the systematic analysis of the method of Core Conflictual Relationship Theme (CCRT; Luborsky and Crits-Christoph 1998) and its Leipzig-Ulm category system (CCRT-LU; Albani et al. 2008) in a longitudinal fashion (see Sect. 19.4.2). Third, we present results that relate to the empirical identification of process phases on the basis of systematic clinical ratings that are given to the first half of another psychoanalytic case (Kächele 2009) (see Sect. 19.4.3). Finally, a future strategy that is based on computer-aided text analysis will be mentioned as an outlook to future sophisticated approaches in psychoanalytic process research.

19.4.1 Systematic Longitudinal Descriptions

Systematic longitudinal descriptions require quite a different way of approaching the clinical material that is in contrast to the episodic, highly selected narrations that are at the heart of vignettes. The decisive feature resides in a preselection of points of interest from the researcher's point of view and of a sampling procedure, which is independent of the clinician's point of view. The raw material may consist of session notes or be available via transcripts. The complex array of interactions of a treatment process is considered with the help of these preset points of view: these clearly represent the researcher's interests. They might vary from case to case. For example, for patient "Christian Y,"[1] anxiety and transference were the key notions; for "Amalia X," hirsutism was the key notion (male type of hairiness), along with the development of her quest for heterosexual relations, that was of prominent interest. The material basis of these systematic descriptions was based on verbatim transcripts of different samples that were created during the history of the purposes of different studies.

First, the contiguous groups of 5 sessions that started the blocks of 50 sessions were transcribed (sample a1 below). Second, the sample (a1) was enhanced by the sample (a2), which led to a joint sample (a) that consisted of the contiguous groups of 5 sessions that started the blocks of 25 sessions. The strategy (b) had the goal of investigating the subsequence of sessions with

[1] Throughout this text, the patients are named in concordance with our procedure that is explained by Thomä and Kächele (1987).

regular distances. In contrast, the strategy (c) targeted the irregular distances; the aim was to exclude the bias that was caused by potentially possible periodically occurring events. Finally, the strategies that were mentioned under strategy (d) were used for particular research questions. The concluding sample of available transcribed sessions is a union of these particular samples.

Sampling Strategies (Examples)

(a) Sessions 1–5, 26–30, 51–55, 76–80, 101–105, 126–130, . . ., 501–505, 513–517.
  (a1) Sessions 1–5, 51–55, 101–105, 151–155, ...
  (a2) Sessions 26–30, 76–80, 126–130, 176–180, ...
(b) Sessions 1, 11, 21, 31, 41, 51, 61, 71, 81, 91, 101, ...
(c) Blocks of limited numbers of sessions that are drawn in random distance from one another out of the total population of sessions.
(d) Selected session segments, such as dreams, were transcribed.

The task of systematically reading the verbatim records of the sessions and then writing up condensed summaries of the content and transactions of the sessions still remains very close to clinical narration. When third party, uninformed people produce these descriptions, we feel that they can procure a fairly reliable perspective of what happened. This clinical-descriptive step permits an evaluation that is under certain formal constraints: the report is no longer dictated by the narrator's epic perspective that characterizes the traditional case study approach. Instead, by using a systematic sample, the assumption is made that repeated descriptions in fixed time intervals capture the decisive processes of change that have occurred.

We have prepared a fairly extensive report on our first case of Christian Y through the joint endeavors of the treating analyst, a second psychoanalyst, and a clinical psychologist who worked together through group discussion (Kächele 2009, Chap. 4). A similar systematic description was prepared for our second research case, patient Amalia X, by two graduate students. They focused on systematic changes of the patient's transference and other aspects of the treatment (Kächele et al. 2009, Chap. 4).

Two medical students succeeded in creating the report regarding the story of Amalia X's analysis by repeatedly reading the 110 sessions that represented one-fifth of the analysis. Therefore, their narrative achieved an acceptable "interreader" reliability according to the treating psychoanalyst and other colleagues who worked with the material (Leuzinger-Bohleber 1989). We think that they have achieved more than narrative truth.

The material that was available after such an effort was generated into a report; the voluminous collected verbatim records (thousands of pages) were elegantly compressed into a readable hundred-page account. Such a booklet can serve many purposes in addition to it being a valuable achievement in itself. It provides easy access regarding the orientation for the whole case, and it is more detailed and more systematic than a traditional case history, which tends to be more novella-like. However, the systematic description record marked the orderly progress of things. One can rearrange the qualitative data by concatenating all of the transference descriptions, and by doing this, one can gain a good view regarding the development of major transference issues, which are investigated through the use of the CCRT. Based on these analyses, the following titles for groups of sessions that were established by the sampling strategy (a, see above) were formulated.

1–5	The analysis as confession
26–30	The analysis as an examination
51–55	The bad, cold mother
76–80	Submission and secret defiance
101–105	Searching for her own rules
116–120	The disappointing father and the helpless daughter
151–155	The cold father and the daughter's desire for identification
176–180	Ambivalence in the father relationship
201–205	The father as seducer or judge of moral standards
226–230	Does he love me—or not?
251–255	Even my father cannot change me into a boy

276–280	The Cinderella feeling
301–305	The poor girl and the rich king
326–330	If you reject me, I'll reject you
351–355	The powerless love to the mighty father and jealousy
376–380	Separation for not being deserted
401–405	Discovery of her capacity to criticize
426–430	I'm only second to my mother, first-born are preferred
451–455	Hate for the giving therapist
476–480	The art of loving consists in tolerating love and hate
501–505	Be first in saying goodbye
513–517	Departure symphony

It is not by chance that these descriptions sound similar to titles of fairy tales. At any given point in treatment, the relationship between the patient and the analyst is couched in a narrative pattern that clinicians are very apt to spot. Systematic clinical descriptions thus rely on the very capacity of narrative accounting, but by using the systematic sampling technique, these accounts change in their nature. Systematic clinical description is a way to recount the treatment in a mixed mode. To introduce some objectivity into the narrative accounts that are based on verbatim records, we recommend using two readers who are to agree about the information in their accounts.

A similar task was performed by other students who went through the video recordings of the 29 sessions of the patient "DER STUDENT" many times and wrote down an account of the treatment in a short form (one page per session) and a long form (three pages per session), which have been distributed within the PEP study group[2] to provide a shared basis for detailed discussion of the results that use different methods (Kächele et al. 1990a, b).

[2] The PEP study group that was directed by Klaus Grawe and Horst Kächele "Psychotherapeutische Einzelfallprozessforschun" investigated two cases, one from Ulm (The Student) and one from Berne (The Forward) with quite a variety of process methods.

19.4.1.1 Topic Index

For the determination of thematic structures, it is necessary to be certain of what is being discussed. An initial convenient approach might be to use the therapist's process notes; however, a more exact observation should be based on the evaluation of video or audiotape recordings by an observer who was not involved in the process. Dahl introduced the method of the Topic Index to psychoanalytic process research in a seminal paper in 1972; this became an important source for our ideas regarding how to organize a working model of focus-oriented process research.

The method of the Topic Index assumes that patterns of thematic work can be represented by configurational analyses of the statistical patterns of single topics that are a part of the conversation. By using the therapist's detailed knowledge of his patient, "the analyst had identified 58 variables of specific interest in the case and had coded the presence of each of these in abbreviated transcripts of 363 sessions" (Dahl 1983, p. 42). Through the use of the statistical technique of factor analysis, Dahl could extract common variability among several of these clinical topics, which were then represented as descriptive mathematical organizations. The six factors then were named, taking into account the leading topics. A graphical representation portrayed the type of information that resulted from this procedure. Thus, the descriptive richness of a clinical case description was replaced by quantitative preciseness, which allowed for the determination of *phases* and *foci*.

It may be of historical interest that the case was treated by an experienced analyst who, for personal reasons, had to stop the treatment, and the patient was handed over to a young female candidate. The findings of Dahl's study clearly demonstrate the downhill course of the treatment.

We first used this approach for a comparative descriptive study of a patient's and her analyst's topics over the course of the psychoanalytic case of Amalia X: again, the two medical students rather than the analyst extracted from the verbatim transcripts the presence or absence of topics

in a sample of evenly distributed blocks of five sessions over the whole course of treatment (22 × 5 sessions) and weighted them in a simple fashion. The resulting graph is a map of thematic events and was used for the purpose of descriptively mapping out the expansion of focal themes (Thomä 1975).

We also used this approach for a systematic description of the video-recorded, psychodynamic short-term therapy (DER STUDENT), again by using two external observers who recorded the presence or absence of the tailored topics every 10 min. This procedure led to a fine-grained web of a 5 × 29 session topic index for 10 topics. A first version of the description was supplemented by the therapist's comments (Kächele et al. 1999, Unpublished manuscript).

The summarizing technique regarding the interrelations of the various topics is a special issue that is still open because a correlational approach implies that the correlations between the variables remain stable over time (see Luborsky's comment to the P-technique 1995). Stable correlations only report on the change of factors' scores; however, they miss the aim of treatment, which relates to changing the connections between topics. Therefore, other statistical models have to be used; as Russell and Czogalik (1989) demonstrated, Markov models can be useful for the analysis of the interlinking of thematic sequences.

19.4.2 Core Conflictual Relationship Theme

The second approach for identifying focal areas was first performed by a continuous analysis of the sessions of the case THE STUDENT by using Luborsky's CCRT method, with original category system of Luborsky and Barber. The results showed that ramifications of the wish formulation can be found over the course of the 29 sessions, and these relate to the clinically formulated focus topics (Kächele and Albani 2001). This same strategy was applied after studying a large longitudinal sample of the psychoanalytic case of Amalia X (Albani et al. 2003). The study used the hierarchal system CCRT-LU of relationship categories.

The method of Core Conflictual Relationship Theme (CCRT) was invented in the 1970s by Lester Luborsky, and it was developed by him and his collaborators at Pennsylvania University. The method was intended for analyzing narrative material in therapy session transcripts. Within the relationship episodes, three types of relationship elements were able to be identified and coded, according to the three lists of standard categories. The most frequent elements constituted the core theme.

The development of the system CCRT-LU at the universities of Leipzig and Ulm began with the aim to rectify certain minor discrepancies in the original CCRT category system. This led to the complete redesign of the system structure (Albani et al. 2008; www.ccrt-lu.org)—*logically unified* is the second meaning of the acronym suffix LU. The rich database that was available made it possible to analyze the absolute frequencies of CCRT-LU components, as well as the complex structure of the data.

For the first time, the process of a long-term psychoanalytic therapy was studied with the CCRT method. The relatively large number of reactions on the subject when compared to the reactions for other CCRT studies may be because this was a psychoanalytic therapy and the patient was particularly encouraged to reflect her feelings and thoughts. Though the negative reactions of the objects and of the patient still predominate the final phase of the therapy, a significant increase in the positive reactions of the patient became apparent. The patient also described the reactions of the objects more positively at the end of the analysis, but these changes could not be statistically established. The component "subject-related wishes and reactions of the subject" reveals that over the course of the therapy, the patient was able to expand her freedom of action and acquire new competencies, and her depressive symptoms decreased. Starting in therapy phase VII, Amalia X (out of XXII) was in a position to perceive and express aggressive wishes, and starting in therapy phase XV, these gain relevance in action.

Particularly, when this was contrasted with the dominant feelings of dissatisfaction and fearfulness at the inception of the therapy, the change in Amalia X became apparent.

Alongside the basic theme that was manifested in each of the absolute highest frequency categories ("nuclear conflict"), each of the therapy phases also showed typical categories that characterize thematic foci in the sense of French's *focal conflicts* and that can be operationalized by the CCRT-LU method. Thus, the CCRT-LU method makes it possible to structure this material by content.

In contrast with a clinical description, which uses metaphorical language to highlight a theme according to the subjective assessment of the clinical judges, investigation of the therapy phases by the CCRT-LU method makes a more differentiated (and less subjective) analysis of the themes possible, which is observed in therapy phase III. In the clinical description, the "bad mother" takes center stage, while in the CCRT-LU evaluation, other aspects emerge: "I feel good" (regarding the patient's newly gained/regained freedom of action). While the clinical description is limited to the transference configuration, the CCRT-LU method makes it possible to access interpersonal aspects inside and outside of the therapeutic relationship.

The CCRT method distinguishes different dimensions of relationship elements. This can be a reported reaction (R) that happened or the wish of the patient (W). Reactions are divided into the reaction of other relationship objects (RO) or of the patient—subject (RS). The hierarchical system of CCRT-LU goes a step further: ROS are the reactions of objects towards the subject, while RSO is the opposite; ROO or RSS are self-reactions of objects or subjects.

The strengths, as well as the limits, of the CCRT-LU method stem from its confinement to reports on relationship experiences by the patient herself. In other words, the investigation remains limited to those relationship experiences that the patient perceived and verbalized. The method provides no direct way of focusing on unconscious material or of assessing defense mechanisms at particular transcript points. However, the patients follow—often unconsciously—the repetitive schemas when describing the course of relationships. Hence, the evaluation remains very close to the clinical material, though it does reflect intrapsychic processes in the narratives of the interactions.

In the case of Amalia X, one central relationship pattern was found, which was represented by the most frequent CCRT-LU categories and could be seen as a "basic theme" or Freud's "Klischee" (Freud 1912):

- W: Amalia X wants to be understood by others.
- RO: Others are unreliable, dominant, and refusing.
- RS: She, by herself, responds with anxiety and feelings of guilt and draws herself back.

Moreover, the CCRT-LU category system allows for the determination of specific relationship patterns with different objects, including the instant, repetitive schemes of Amalia X, the teacher, with her school class (Albani et al. 2008):

- WOS: She wants to be accepted and respected by her pupils.
- WSO: She will be a good teacher for them.
- ROS: The pupils are undisciplined and do not respect her.
- RSO: She manages to discipline the class successfully.
- RSS: When reflecting upon this at home, she is depressed and disappointed by herself.

Apart from this, we captured object specific relationship patterns by using alternative methods of analysis (for detailed descriptions, see Pokorny 2008). For instance, similarities in her descriptions between her relationships with her father, her analyst, and her partner were found.

In this way, parallels between the patient's descriptions of her relationship with the therapist and other objects can be examined by using the CCRT method. Thus, the method makes it possible to capture structural aspects of the clinical transference concept. Nevertheless, the interactive aspects of the work on transference and the concomitant countertransference are not captured by the CCRT method.

In regard to the CCRT method itself, it is not possible to clarify how therapeutic changes arise.

On the whole, the relationship between the patient and her therapist seems to have been satisfying and positive for her—no other relationship is described with such a high rate of positive reactions towards the object of interaction.

This study shows that the CCRT method makes it possible to capture clinically relevant interpersonal aspects of the psychoanalytic process from the patient's point of view, which supports the Ulm process model. The analyst's contribution, however, is reflected only in the patient's narratives regarding her relationship with the therapist. Use of the CCRT method provides a way to structure the clinical material, develop clinical hypotheses, and check therapeutic focus during the course of therapy. This method is easily learned for clinical application, and the time that is required in formulating the psychodynamic connections for clinical use is minimal. Therefore, the method can accompany treatment over time.

The CCRT method can also be used to analyze manifest dream contents along the treatment process, which we demonstrated in a study on the psychoanalytic case of a patient with an anxiety neurosis who was called "Franziska" (Albani et al. 2001a, b). Differences between relationship patterns from episodes in dreams and from narratives apart of the dream session could be demonstrated. Relationship patterns in dream episodes revealed wishes more explicitly, and the most frequent responses were characterized by wish fulfillment and satisfying relationship experiences. However, narratives' objects were described as being distant and reluctant, and the patient felt anxious and nervous.

19.4.3 Clinical-Guided Judgments

Our third approach to the identification of thematic foci refers to the application of scaled assessments of clinical concepts in the case of the patient Christian Y (Kächele 2009). The basis of our study consisted of 11 × 5 sessions, which were selected at intervals of 50 sessions. The status of the treatment was evaluated by the systematic description of the process on the basis of the five-session periods. This joint clinical discussion of the research group was preceded by a classification of the 55 sessions, in random order, in accordance with the following clinically relevant concepts, which had to be rated on five-point Likert scales with regard to their intensity and degree of consciousness:

= Positive transference
= Negative transference
= Separation anxiety
= Castration anxiety
= Guilt anxiety
= Shame anxiety
= Diffuse anxiety
= Insight
= Working alliance

Evaluation of this guided clinical rating was carried out by three judges; the therapist was one of these judges. By using the factor analysis, the following five factors were identified:

Factor 1: Working alliance (assessed by rater B and C)
Factor 2: Positive transference as a defense against separation anxiety
Factor 3: Diffuse anxiety with aggressive transference
Factor 4: Working alliance (assessed by the analyst)
Factor 5: Shame and guilt anxiety

On the basis of our detailed clinical knowledge and of the understanding of the course of treatment that was achieved by the research group in the systematic description study, we tentatively formulated four focus-related periods of treatment (we call them "periods" here to distinguish them from "phases" that are described above):

Period 1 (sessions 1–5, 51–55, 101–105): maintenance of defense
Period 2 (sessions 151–155, 201–205): intensification and access to consciousness of the early positive object relation in the transference
Period 3 (sessions 251–255, 301–305, 351–355): alternation of pregenital-positive clinging transference and aggressive distancing in the transference
Period 4 (sessions 401–405, 451–455, 501–505): consolidation of the aggressive transference

t.1 **Table 19.1** Classification matrix of the discriminant analysis in the case of Christian Y

t.2	Observed period	Predicted period 1	2	3	4	Total	Correct
t.4	1	**12**	0	2	1	15	80 %
t.5	2	2	**6**	1	1	10	60 %
t.6	3	3	4	**5**	3	15	33 %
t.7	4	5	1	0	**9**	15	60 %
t.8	Total	22	11	8	14	55	58 %

Period 1 is characterized predominantly by a friendly attitude on the part of the patient, who approaches the analytical process with a great deal of interest and seemingly good defenses, which is judged based on the verbal exchange within the sessions. The problem of separation emerges only incipiently in the transference; the aggressive transference is predominantly unconscious and not very intense. Feelings of guilt and shame alternate in their intensity.

Period 2 is characterized predominantly by the mobilization of the separation problem in the analytic situation; aggressive aspects of the transference are manifested only in individual sessions.

In period 3, the therapeutic aim of reactivating aggressive impulses in the transference, which underlines the severe anxieties, is achieved for the first time; at the same time, the alternation with a symbiotic-clinging position is marked.

In period 4, one can discern a perceptible decline of the friendly, conciliatory object relation, which is replaced by an openly negative aggressive transference.

It should be noted that this study was performed when the treatment was not yet completed; therefore, future periods are to be expected when the entire course of analysis that lasts for approximately 1,200 sessions is studied.

The clinically derived focus formulations were then checked by a formal algorithm. By using the five factors of the rating investigation, discriminant analysis was used to calculate linear functions by which the membership of the individual session within the four periods can be predicted (see Table 19.1). In this way, each of the 55 h is assigned by the discriminant analysis to one of the four periods. The comparison of the predicted and real period membership confirmed the relative homogeneity of each of the four periods in terms of the sessions that were assigned to them.

The overall rate of the correct prediction, 58 %, is 2.3 times higher than the 25 % that is expected by random rating. With the exception of period 3, we find a dominating type of session in each period; the results of period 3 clearly indicate that all four types of sessions are parsed over this period, which indicates that there was no stable topical preference. Let us note that this prediction was based on the values of the five factors only, which correspond clinically to the focal schemes, which we created based on our joint clinical discussion.

Conclusion

The empirical approaches mentioned in this chapter are just a few examples from the field of single-case methodologies that have been developed over the last few decades. A future step in our endeavor regarding the development of descriptive tools for the identification of focally determined phases in analytic treatments is based on the combination of the clinically derived, through the use of systematic and controlled judgment procedures, ratings of clinically relevant concepts with a more stringently definable computer-assisted content analysis tool (Kächele and Mergenthaler 1983; Mergenthaler 1985; Kächele 1986). We would underscore that the empirical attempt to test psychoanalytic process theories needs descriptive tools that are capable of mastering the large amount of data that is involved in such a task.

We are convinced that psychoanalytic process research has to start from the clinical experience, which can lead to the introduction of new observational tools that can be checked in regard to their appropriateness. Once we are able to go beyond clinical descriptions, we may be in a better position to decide which model of process fits the data best. Then, the clinical issue can be solved

regarding what the relationship between the various phases of treatment may be and what its relevance for the ultimate treatment outcome is.

References

Albani C, Kühnast B, Pokorny D, Blaser G, Kächele H (2001a) Beziehungsmuster in Träumen und Geschichten über Beziehungen in einem psychoanalytischen Prozeß (Relationship patterns in dreams and stories about relationships in a psychoanalytic process). ForumPsychoanal 17:287–296

Albani C, Pokorny D, Blaser G, König S, Geyer M, Thomä H, Kächele H (2001b) Zur empirischen Erfassung von Übertragung und Beziehungsmustern - eine Einzelfallanalyse (On the empirical study of transference and relationship patterns – a single case study). Psychother Psychol Med 51:1–10

Albani C, Pokorny D, Blaser G, König S, Thomä H, Kächele H (2003) Study of a psychoanalytic process using the core conflictual relationship theme (CCRT) method according to the Ulm process model. Eur Psychother 4:11–32

Albani C, Pokorny D, Blaser G, Kächele H (2008) Beziehungsmuster und Beziehungskonflikte. Theorie, Klinik und Forschung. Vandenhoeck & Ruprecht, Göttingen

Breuer J (1893–1895) Case I. Fräulein Anna O. In: Breuer J, Freud S (eds) Studies on hysteria. In J. Strachey (eds and trans) The standard edition of the complete psychological works of Sigmund Freud, vol 2. Hogarth Press, London, pp 21–47

Bucci W (1988) Converging evidence for emotional structures: theory and method. In: Dahl H, Kächele H, Thomä H (eds) Psychoanalytic process research strategies. Springer, Berlin, pp 29–49

Bucci W (1997) Pattern of discourse in good and troubled hours. J Am Psychoanal Assoc 45:155–188

Compton A (1990) Psychoanalytic process. Psychoanal Q 59:585–598

Dahl H (1983) On the definition and measurement of wishes. In: Masling J (ed) Empirical studies of psychoanalytical theories. The Analytic Press, Hillsdale

Dahl H (1988) Frames of mind. In: Dahl H, Kächele H, Thomä H (eds) Psychoanalytic process research strategies. Springer, Berlin, pp 51–66

~~Dahl H (1998) The voyage of el Rubaiyat and the discovery of FRAMES. In: Bornstein RF, Masling JM (eds) Empirical studies of the therapeutic hour. American Psychological Association, Washington, DC, pp 179–227~~

Dahl H, Kächele H, Thomä H (eds) (1988) Psychoanalytic process research strategies. Springer, Berlin

Dewald P (1972) The psychoanalytic process. A case illustration. Basic Books, New York, NY

Ferenczi S (1927 [1964]) Bausteine zur Psychoanalyse (Fundamentals of psychoanalysis), vol 2, Praxis (Practice). Internationaler Psychoanalytischer [Huber], Wien [Stuttgart – Bern]

Fonagy P, Moran G (1993) Selecting single case research designs for clinicians. In: Miller N, Luborsky L, Barber J, Docherty J (eds) Handbook of psychodynamic treatment research. Basic Books, New York, NY, pp 62–95

Forrester J (1980) Language and the origins of psychoanalysis. Macmillan, London

French TM (1952) The integration of behaviour. Basic postulates, vol 1. University of Chicago Press, Chicago, IL

Freud S (1895) Studies on hysteria. In: Strachey J (ed and trans) The standard edition of the complete psychological works of Sigmund Freud, vol 2. Hogarth Press, London

Freud S (1912) The dynamics of transference. SE XII: 97–108

Frommer J, Rennie DL (eds) (2001) Qualitative psychotherapy research. Methods and methodology. Pabst, Lengerich

Hilliard RB (1993) Single case methodology in psychotherapy process and outcome research. J Consult Clin Psychol 61:373–380

Iwakabe S, Gazzola N (2009) From single-case studies to practice-based knowledge: aggregating and synthesizing case studies. Psychother Res 19(4–5):601–611

Jones EE, Windholz M (1990) The psychoanalytic case study: toward a method for systematic inquiry. J Am Psychoanal Assoc 38:985–1016

Kächele H (1981) Zur Bedeutung der Krankengeschichte in der klinisch-psychoanalytischen Forschung (On the relevance of case history in clinical psychoanalytic research). Jahrb Psychoanal 12:118–177

Kächele H (1986) Die Maschinelle Inhaltsanalyse in der Psychoanalytischen Prozessforschung (Computer-based content analysis in psychoanalytic process research). PSZ, Ulm

Kächele H (1992) Narration and observation in psychotherapy research. Reporting on a 20 year long journey from qualitative case reports to quantitative studies on the psychoanalytic process. Psychother Res 2:1–15

Kächele H (2009) Psychanalytische Prozesse. Methodische Illustrationen und methodologische Reflexionen (Psychoanalytic processes. Methodical illustrations and methodological reflections). Munich Electronic Database, München. http://edoc.ub.uni-muenchen.de/10558/

~~Kächele H (2010) Distinguishing psychoanalysis from psychotherapy. Int J Psychoanal 91:35–43~~

Kächele H, Albani C (2001) Die Arbeit an einem zentralen Beziehungsmuster als Musterbeispiel klinisch relevanter Empirie (Work on a core conflictual relationship pattern as a sample of clinically relevant research). In: Cierpka M, Buchheim P (eds) Psychodynamische Konzepte. Springer, Berlin, pp 169–190

Kächele H, Mergenthaler E (1983) Computer-aided analysis of psychotherapeutic discourse – a workshop. In: Minsel W-R, Herff W (eds) Methodology in psychotherapy research. Proceedings of the 1st European conference on psychotherapy research. Lang, Frankfurt a. M., pp 116–161

Kächele H, Thomä H, Ruberg W, Grünzig H-J (1988) Audio-recordings of the psychoanalytic dialogue: scientific, clinical and ethical problems. In: Dahl H, Kächele H, Thomä H (eds) Psychoanalytic process research strategies. Springer, Berlin, pp 179–194

Kächele H, Dengler D, Eckert R, Schnekenburger S (1990a) Veränderung des zentralen Beziehungskonfliktes durch eine Kurztherapie (Change of the core conflictual relationship conflict by a short term therapy). Psychother Psychol Med 40:178–185

Kächele H, Heldmaier H, Scheytt N (1990b) Fokusformulierungen als katamanestische Leitlinien (Focal formulations as guidelines for a follow-up study). Psychother Psychol Med 35:205–216

Kächele H, Scheytt N, Schwendele W (1999) Der STUDENT – eine detaillierte Verlaufsbeschreibung (THE STUDENT – a detailed description of a treatment process). In: Kächele H, Grawe K (eds) PEP-Projekt. http://www.horstkaechele.de/plib/index.php?id=1_23_22 (Unpublished manuscript)

~~Kächele H, Albani C, Buchheim A, Hölzer M, Hohage R, Jiménez JP, Leuzinger-Bohleber M, Mergenthaler E, Neudert-Dreyer L, Pokorny D, Thomä H (2006) The German specimen case Amalia X: empirical studies. Int J Psychoanal 87:809–826~~

Kächele H, Schachter J, Thomä H (eds) (2009) From psychoanalytic narrative to empirical single case research. Implications for Psychoanalytic Practice. Routledge, New York

Kazdin AE (1982) Single case research designs: methods for clinical and applied settings. Oxford University Press, Oxford

Klein M (1961) Narrative of a child analysis. Hogarth Press, London

Leuzinger-Bohleber M (1989) Veränderung kognitiver Prozesse in Psychoanalysen. Bd 2: Eine gruppenstatistische Untersuchung (Change of cognitive processes in psychoanalyses, vol 2: A group-statistical study). PSZ/Springer, Berlin

Leuzinger-Bohleber M (1995) Die Einzelfallstudie als psychoanalytisches Forschungsinstrument (The single case study as a psychoanalytic research instrument). Psyche – Z Psychoanal 49:434–480

Luborsky L (1995) The first trial of P-technique in psychotherapy research. A still-lively legacy. J Consult Clin Psychol 63:6–14

Luborsky L, Crits-Christoph P (eds) (1998) Understanding transference: the core conflictual relationship theme method, 2nd edn. American Psychological Association, Washington, DC

Luborsky L, Spence DP (1971) Quantitative research on psychoanalytic therapy. In: Bergin AE, Garfield SL (eds) Handbook of psychotherapy and behavior change, 1st edn. Wiley, New York, NY, pp 408–438

Luyten P, Blatt SJ, Corveleyn J (2006) Minding the gap between positivism and hermeneutics in psychoanalytic research. J Am Psychoanal Assoc 54:571–610

Malan DH (1963) A study of brief psychotherapy. Tavistock, London

Mergenthaler E (1985) Textbank systems: computer science in psychoanalysis. Springer, Heidelberg

Mergenthaler E, Kächele H (1988) The Ulm textbank management system: a tool for psychotherapy research. In: Dahl H, Kächele H, Thomä H (eds) Psychoanalytic process research strategies. Springer, Berlin, pp 195–212

Michels R (2000) The case history. With commentaries by S. Pulver, S. B. Bernstein, P. Rubovits-Seitz, I. Szecsödy, D. Tuckett, A. Wilson. J Am Psychoanal Assoc 48:355–375

Pokorny D (2008) Datenanalyse mit ZBKT-LU (Data analysis with the CCRT-LU). In: Albani C, Pokorny D, Blaser G, Kächele H (eds) Beziehungsmuster und Beziehungskonflikte. Theorie, Klinik und Forschung. Vandenhoeck & Ruprecht, Göttingen, pp 174–214

Propp WJ (1928) Morfologia delle fiabe. Einandi, Torino

Russell RL, Czogalik D (1989) Strategies for analyzing conversation: frequencies, sequences or rules. J Soc Behav Pers 3:221–236

Schachter J, Kächele H (2010) The couch in psychoanalysis. Contemp Psychoanal 46:439–459

Seitz P (1966) The consensus problem in psychoanalysis. In: Gottschalk LA, Auerbach AH (eds) Methods of research in psychotherapy. Appleton Century Crofts, New York, NY, pp 209–225

~~Silberschatz G (1978) Effects of the therapist's neutrality on the patient's feelings and behavior in the psychoanalytic situation. Unpublished doctoral dissertation, New York University~~

Spence DP (1982) Narrative truth and historical truth: meaning and interpretation in psychoanalysis. Norton, New York, NY

Stuhr U (2004) Klinische Fallstudien (Clinical case studies). In: Hau S, Leuzinger-Bohleber M (eds) Psychoanalytische Therapie. Eine Stellungnahme für die wissenschaftliche Öffentlichkeit und für den Wissenschaftlichen Beirat Psychotherapie. Forum Psychoanal 20:63–66

Thomä H (1961) Anorexia nervosa. Geschichte, Klinik und Theorie der Pubertätsmagersucht. Huber/Klett, Bern/Stuttgart; English (1967) Anorexia nervosa. Yale University Press, New Haven

Thomä H (1975) Prozessbeschreibung mit dem Topic Index (Description of a treatment process using the Topic Index). Vortrag an der Psychosomatischen Klinik, Universität Heidelberg

Thomä H, Kächele H (1987) Psychoanalytic practice, vol 1. Principles. Springer, Berlin; paperback. Aronson, New York, 1994

von Zeppelin I (1987) A process model of psychoanalytic therapy. In: Cheshire N, Thomä H (eds) The self and its symptoms. Wiley, New York, NY, pp 149–165

~~Wallerstein RS, Sampson H (1971) Issues in research in the psychoanalytic process. Int J Psychoanal 52:11–50~~

Weiss J, Sampson H, Group TMZpr (eds) (1986) The psychoanalytic process: theory, clinical observation, and empirical research. Guilford Press, New York

Winnicott DW (1972) Fragment of an analysis. In: Giovaccini PL (ed) Tactics and techniques in psychoanalytic therapy. Hogarth Press, London, pp 455–693

Wittgenstein L (1921/2014) Tractatus logico-philosophicus. Logisch-philosophische Abhandlung. Suhrkamp, Berlin

Author Queries

Chapter No.: 19 217213_1_En

Query Refs.	Details Required	Author's response
AU1	Reference(s) "Dahl (1998); Kächele (2010); Kächele et al. (2006); Silberschatz (1978); Wallerstein and Sampson (1971)" are not cited in text. Please cite or delete it from the list.	