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NARRATION AND OBSERVATION IN PSYCHOTHERAPY RESEARCH

Reporting on a 20-Year-Long Journey from Qualitative Case Reports to Quantitative Studies on the Psychoanalytic Process[1] (1992)

Horst Kächele

Psychotherapy Research as a field of institutionalized research activity has been made visible by establishing the Society for Psychotherapy Research (SPR) in 1968. For many years it was tied up to the Anglo-American world. With the establishment of a European-continental chapter, a growing awareness of research activities outside led to the 1987 meeting in Ulm which paved the way to integrate the European continent into the self-concept of SPR. Reporting on the work of the Ulm group allows for an overview on a 20-year-long journey from qualitative case reports to quantitative studies on the psychoanalytic process, which entails the notion of narration versus observation.

When the Ulm group began its work in the early 1970s, first focusing on the extensive analysis of a single case treated by H. Thomä, it seemed promising in many ways. It would help us to bridge the gap between the clinical and the scientific approach and it would enable us to keep qualitative and quantitative avenues in touch with one another. Therefore it has been our strategy first to investigate within the single case where narrative accounts of the therapists were available, and then to aggregate the cases only when we felt safe enough not to violate the specifics of the single case.

Studying the psychoanalytic process involved other strategic decisions as well. As we all know, out there is a multiplicity of meaning of the notion "psychoanalytic process"; so many theories, so many models of the analytic process (Compton, 1990). There is no shared opinion whether models have to be tested or are but language games useful for those who use them. Our investigations have been guided by a working model of the process which encompasses all of the steps along the way from the start of a patient/analyst contact to its termination. 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 as functional units. The impact of these rules on both parts sets in motion a process which transforms covered processes within the patient (transference dispositions) into relationship patterns between patient and the analyst.

So our task was defined mainly as a descriptive enterprise, as a job to develop tools with which to describe the vast number of verbal transactions that make up a psychoanalytic treatment. In terms of a well-known distinction of how to proceed in setting up a research program, we used both the so-called bottom-up approach and the top-down approaches, where one sets out to test a piece of theory which serves as a guiding tool of what data to select.

Bottom-up approaches start with very low-level theories, everyday theory so to speak, first establishing descriptive worlds. This may be seen as something like going out and catching butterflies in the wilderness. Indeed, confronted with a long-term psychoanalytic treatment it is not an easy choice to decide what part of the material deserves careful descriptive work. The bottom-up methods are defining observables not all of which have clear relationship to the clinical theory of psychoanalysis. However, we thought careful observational work supported by systematized narrative knowledge would have reverberations on our theorizing of the process.

Our leading idea was to use descriptive data of different quality to examine clinical process hypotheses. Our methodological conception was inspired by Helen Sargent's (1961) recommendations for the Topeka project—consisting of a four-level approach; on each level different methods with appropriate material representing different levels of conceptualization had to be worked on:

1. clinical case study
2. systematic clinical description
3. guided clinical judgment procedure
4. computer-assisted and linguistic text analysis

This multi-level multi-method approach reflected our understanding that the tension between clinical meaningfulness and objectivation could not creatively be solved by using one approach only. Up to now this approach has been applied to a total of four cases varying in amount of work performed in the different domains.

1. Clinical case study

I already have made clear that we highly appreciate the research based case study approach; it does fulfill an important function in orienting about the total picture, it provides an overview that might be helpful when interpretation of results of more stringent methods are called for. Anyone interested in this traditional way of reporting can fulfill his curiosity by peeping in the second volume of our

textbook on psychoanalytic practice (Thomä & Kächele, 1994). So I may continue by discussing the method of systematic clinical descriptions.

2. Systematic clinical description

Systematic clinical descriptions import quite a different way of approaching the material. The complex array of interactions of a treatment process are considered with the help of preset points of view; they clearly represent the researcher's interest. They might vary from case to case. For example, for patient Christian Y^2 "anxiety and transference" were the key notions; for Amalia X it was the hirsutism (male type of hairiness) and the development of her heterosexual relations that were of prominent interest. All treatments were completely tape-recorded; one case (Christian Y) was completely transcribed; the others, due to restricted financial means, only partially. The material basis of these systematic descriptions was based on verbatim transcripts of different samples:

Sampling strategies

a. sessions 1–5, 26–30, 51–55, 76–80, 101–105, 126–130, . . .
   a.1. sessions 1–5, 51–55, 101–105, 151–155, . . .
   a.2. 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 eight sessions drawn in random distance from one another out of the total population
d. all items (like dreams) within the first 100 sessions versus all items in the last 100 sessions.

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 moves very close to clinical narration. In producing these descriptions by third, uninvolved persons, we feel that they can procure a fairly reliable perspective of what has happened. This clinical-descriptive step permits an evaluation that is under some formal constraints: no longer the report is dictated by the narrator's epic perspective which characterizes the traditional case study approach. Instead, by using a systematic sample the assumption is made that the repeated description in fixed time intervalls captures the decisive processes of change that have occurred.

The material available after such an effort looks like a little book; the voluminous collected verbatim records—thousands of pages—have been elegantly compressed to 100 pages of a readable account. This booklet can serve many purposes besides its being a valuable achievement in itself. It helps for an easy access to an orientation on the whole case, being more detailed and more systematic as a traditional case history which tends to be more novella-like, whereas

the systematic description record marks out the orderly progress of things. One can rearrange the qualitative data, concatenating all transference descriptions one after the other and by doing so gain a good view on the development of major transference issues.

It is not by chance that these descriptions remind one of titles of fairy tales. At any given point in treatment the relationship between patient and analyst is organized in a narrative pattern which clinicians are very able to spot. Systematic clinical descriptions thus rely on the very capacity of narrative accounting, but 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. In order to introduce some objectivity to the narrative accounts based on verbatim records, we recommend two readers and impose on them to agree upon their account.

An even more condensed version of a systematic clinical description can be achieved by using a so-called topic index (Simon, Fink, Endicott & Gill, 1968). A long list of items (like father, mother, body, friends—the more direct, the better) is scanned for presence or absence in a session. There are elegant graphical means to represent these yes/no decisions, which lead to a topographical description of the treatment process (Thomä, 1975).

3. Guided clinical judgement procedures

In order to get more control over the descriptive reliability, one has to narrow down the window of observation. This is achieved by selecting theoretical concepts for which observational referents can be specified. Concepts are unlike the ingrediants of a compound, though we might think of it that way; they are imposed on the material and help us to abstract the material. Our favourite concepts for which manual guided clinical judgment procedures were developed and applied were the following:

1. "Transference, Anxiety and Working Alliance" (Grünzig, Kächele & Thomä, 1978; Kächele, Thomä & Schaumburg, 1975)
2. "Changes in self-esteem" (Neudert, Grünzig & Thomä, 1987)
3. "Suffering" (Neudert & Hohage, 1988)
4. "Emotional insight" (Hohage & Kübler, 1988)
5. "Cognitives changes during psychoanalysis" (Leuzinger-Bohleber & Kächele, 1988)

Study 1 was done on the case Christian Y; studies 2–4, on the case Amalia X; and study 5 used two additional cases, Franziska X and Gustav Y, from which also larger samples in verbatim form are available.

The results of these guided procedures are graphical representations like linear or non-linear curves, replacing the rich fabric of narratives by unidimensional

series of values which mark the transition from a qualitative to a quantitative view of things. By this very procedure we suddenly are able to speak of high and low transference, of little change or great changes along a continuum mapped out by the investigator. The loss in descriptive richness is balanced by a gain in greater control of the phenomena under discussion.

Such seductive charts induce the illusion to have mastered the complex dimension. However, we have to keep in mind that these standardized evaluations are built on the working rule to freeze in the process of interpretation in a way that reliable judgments can be made. Everyone who has worked in this rating business is aware that training of raters often means depriving them of their natural tendency to increase information by interpreting data but instead reducing information by selective attention.

A main research question on this level of description was: Can we use these this kind of dimensional descriptions in order to identify "phases of process" that would support our theoretical notion of the psychoanalytic process (Kächele, 1988)? As described in more detail elsewhere, "we conceptualize psychoanalytic therapy as an *ongoing, temporally unlimited focal therapy with a changing focus*" (Thomä & Kächele, 1994, p. 347).

4. Computer-assisted and linguistic text analysis

Our way to handle the complexities of treatment processes had begun with improving on the traditional case study by introducing the systematic time-sampled clinical description, then turning to rating approaches, thus reducing the interpretative excess in order to get better control. One step further along the continuum between narration and observation consisted in directing our attention to the very raw material that was provided by the verbatim records.

It is more than appropriate to acknowledge on this special occasion that the discovery of this approach was directly influenced by Hartvig Dahl and Donald Spence, whose seminal papers (Dahl, 1972, 1974; Spence, 1969, 1968; Spence & Lugo, 1972) opened my eyes to the possibilities of the computer as a tool to considerably increase the descriptive power.[3]

We got started by implementing the program described by Spence (1969) and found it useful for dealing with small amount of text material (Kächele, Thomä, & Schaumburg, 1975). In 1975, we got hold of the program EVA ("Elektronische Verbalanalyse," developed by K. Holzscheck), which had been devised for the analysis of newspaper headlines. The amount to be processed with psychoanalytic material made a revision necessary, which was performed by E. Mergenthaler in the following years (so called EVA-Ulm & TAS). Since then, the use of the computer as tool has been broadened to include not only dictionary-based content analysis, but to refer to textanalysis in a more general sense (Mergenthaler and Kächele, 1988, 1991). The concept to develop a formal institution called "Ulm Textbank" arose out of the pure necessity to handle the

growing datacorpus of our own. It was only after a while that we realized that this in itself was a valuable objective to serve the field, by providing textual material on many different forms of therapy and providing various forms of textanalyses (Mergenthaler, 1985).

We have used computer aided textanalyses in quite a few investigations, most of them exploratory-oriented, to find out what descriptive powers of this easy-to-do strict observational methods would be producing results that evoke narrative efforts to make sense out of them"

1. Verbal activity (Kächele, 1983)
2. Long-term transference trends (Kächele, 1976, 1990)
3. Personal pronouns (Schaumburg, 1980)
4. Redundancy in patient's and therapist's language (Kächele & Mergenthaler, 1984)
5. Classification of anxiety themes (Grünzig, 1983; Grünzig & Kächele, 1978)
6. Emotive aspects of therapeutic language (Wirtz & Kächele, 1983)
7. Change of body concepts (Schors & Kächele, 1982)
8. Cognitive changes during psychoanalysis (Leuzinger-Bohleber & Kächele, 1988)
9. Changes of latent meaning structures (Mergenthaler & Kächele, 1985)
10. Affective Dictionary (Hölzer, Scheytt, Pokorny, & Kächele, 1989)
11. Parts of speech (Mergenthaler, 1990; Parra, Mergenthaler, & Kächele, 1988)
12. Core conflictual words (Kächele, 1991)

To illustrate my point that the more observational one´s approach is, the more narrative interpretation is needed, I summarize our data on the verbal activity in two psychoanalytic treatments (Kächele, 1983).

Verbal activity is easily measured by the computer; either one uses the one-off patterns analysis by direct recording, as developed by Feldstein and Jaffe (1963) or, if verbatim transcripts are stored in a computer, counting words is all you need.

Our figures for the overall verbal activity in the two dyads of psychoanalytic cases showed that the total ratio varies between 1:1.1 to 1:4.0. This way of looking at verbal activity was not yet very informative, so we analyzed the distribution of verbal activity by forming classes of sessions of varying verbal activity and focused on the patients Christian Y and Amalia X treated by the same analyst Amalia displayed a wide spectrum of verbal activity in different hours; the analyst, in contrast, was fairly restricted in his verbal activity, role specific as a textbook perspective of psychoanalysis would prescribe.

However, in the other case, where the patient Christian exhibited an extremely restricted range, the analyst clearly shifted to more verbal activity. These data gave only a static view about a characteristic of the verbal exchange system. And we did not know what role silence plays. So E. Mergenthaler suggested

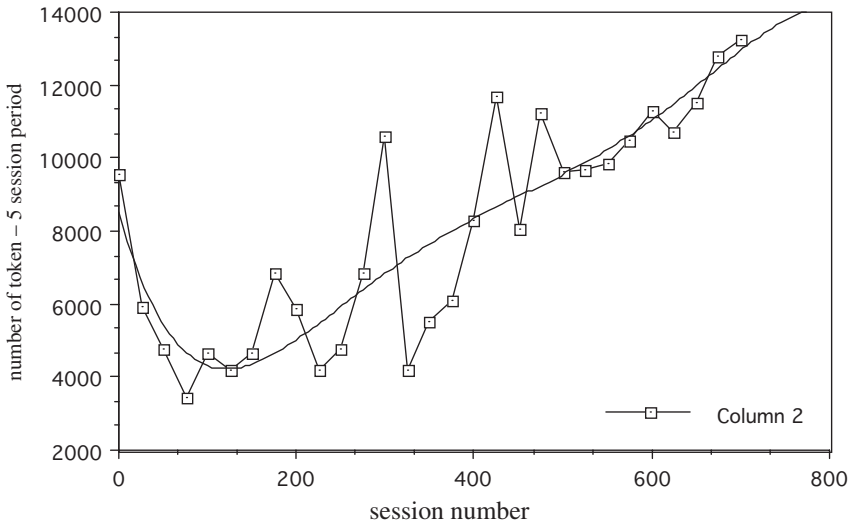

FIGURE 2.1 Verbal Activity of Patient Christian (Number of Tokens) Sessions 1–700

and constructed a three-dimensional graph neglecting the times when both speaker overlapped and calculated the relative proportions of both speakers and silence of the total session time.

Amalia's graph shows a wide variation of the patient from nearly zero to 100 percent, with the analyst moving around an average of 15 percent participation and a varying amount of silence. Correlation between patient´s and analyst´s activity was practically zero (0.04).

In the other treatment, we found both patient and analyst at a rather low verbal activity, with a lot of silence. The correlation of the two verbal activities based on 110 sessions was +0.30, which is highly significant. Studying verbal activity along the temporal axis of the treatments, we learned of another feature of the process. Patient Amalia was developing nicely her capacity to vary verbal activity over the course of treatment and her analyst behaved unobtrusively, even reducing his participation more and more as the analysis came to an end.

Patient Christian and the same analyst remained intertwined throughout session 1 to session 450, represented by every tenth session, which formed the basis of this measurement.

Being clinically well aware of what happened, we knew that these data described a very difficult analysis, with a patient that was most of the time silent, with an analyst who most of the time initiated verbal interaction, who tried to get the patient involved in the analytic task of using the space provided for him. At the end of this observational period one could discern a slow development of the patient's capacity to become a more active participant. It was only from session 500 onward that he developed the same verbal activity features that I

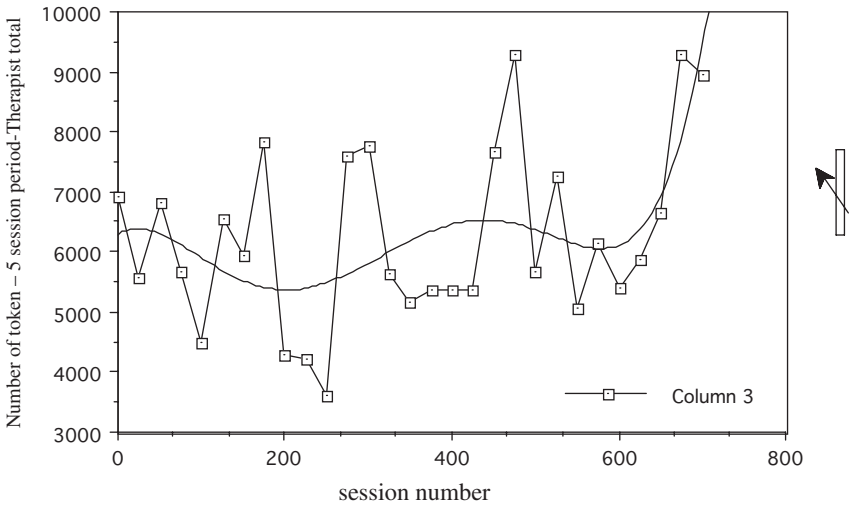

FIGURE 2.2 Verbal Activity Therapist of Patient Christian (Number of Tokens) Sessions 1–700

could demonstrate of the other patient. At a later time, when after 700 sessions the treatment had ended, the remaining sessions also had been transcribed and we repeated the measurement for patient Christian's verbal activity. This time we used another sample, taking five sessions in an even distance of 25 sessions for each data point.

To interpret the data from our clinical knowledge of the treatment it was fairly obvious that the patient went into a long regressive state characterized by a decrease in talking. The therapist stayed close to the patient's verbal activity without falling into the hole of regression but instead tried to verbally activate the patient. The correlation of verbal activity over the total treatment length was even larger in this larger sample (+0.43 Spearman rank).

The observational possibilities of the textbank system also allow for even a more detailed diagnostic of the way verbal activity is deployed. Instead of categorizing with Strupp´s intervention catalogue, we used the empirically demonstrable correlation between types of intervention and length of intervention (Kitzmann, Kächele, & Thomä,. 1974a, 1974b).

By analyzing the distribution of length of interventions using large sample of interventions (N = 14,000) we were able to point out that the analyst in the Amalia case transported his verbal activity by relying on short interventions, whereas with Christian he showed a shift in his spectrogram toward using a much higher proportion of medium and more lengthy interventions. We may be seduced to think from our clinical experience that good effective

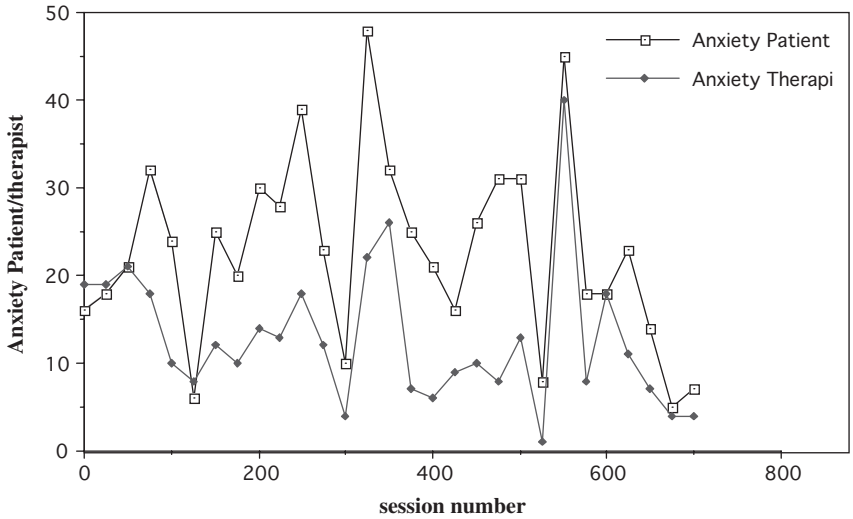

FIGURE 2.3 "Anxiety" Frequency

psychotherapeutic work does indeed take place through short remarks instead of bulky interpretations.

In order to better understand this treatment, we studied in detail the use of "Core Conflictual Words" (Kächele, 1991)—to paraphrase Luborsky's CCRT—in the analysis of patient Christian Y. This patient suffered from such severe anxiety neurosis that he was unable to leave the hospital for three years and was treated on an inpatient basis five times a week. His most frequent noun was the word "anxiety." Looking at the course of this word over the treatment for both patient and therapist displays a remarkable synchrony:

Now, it is a firm conviction in the psychoanalytic world that such severe states of anxiety have to do with repressed aggressive feelings toward the primary love object. We therefore selected the word "anger" and mapped its relative frequency over treatment.

A first inspection of the graphical representations underlines a very important feature: there is a striking covariance of these central concepts. Balint's thesis, that the patient has to learn the language of the analyst, can just as well be turned round by saying that both partners have to establish a constructive mixture of similarity and dissimilarity in talking about the inner world of the patient. The use of the word "anxiety" correlates between patient and analyst with +0.60; the use of the word "anger" even correlates +0.81 over the whole course of treatment. Though positive correlation of content are usual features of conversations, the figures for these two nouns were extremely high.

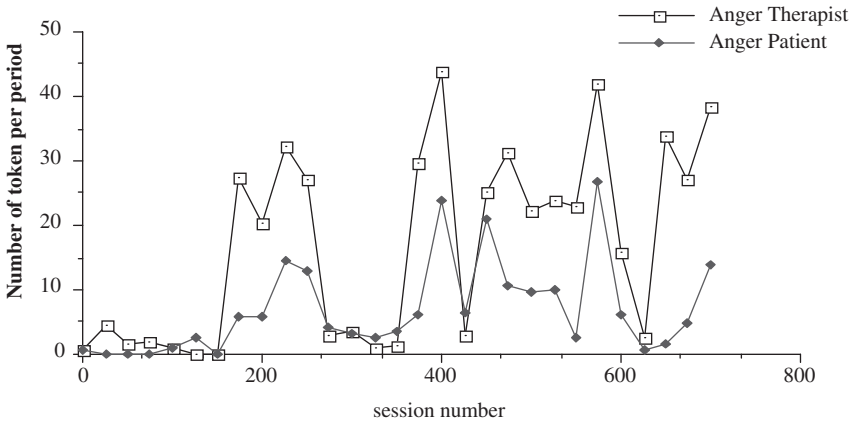

FIGURE 2.4 "Anger" Frequency—Patient/Therapist

However, the similarity with regard to the use of the word "anxiety" only refers to the process aspect. The degree of intensity of usage shows a striking difference. The analyst, through taking up this main complaint by the patient, is reluctant in its use. The word "anger," barely used as a element in the dialogue for more than 150 sessions, is heavily imported the first time into the dialogue by the analyst from sessions 175–255. It is in this phase of the treatment where the analyst tries for the first time to focus on the theoretically relevant connection of anxiety and anger .

There are quite a few other approaches of text analysis we have tried on our research cases. Analyzing the use of personal pronouns, we found quite different relationships in each of the four analytic cases that we have worked with. Impressive contingencies between the pronouns "I" and "you" in one case alternate, with insignificant relations of the same variables in the other (Schaumburg, 1980). As the analysis of personal pronouns was once introduced by Daniel Jaffe as a promissing measure for the "language of the dyad" (Jaffe, 1958), with exciting "tracking phenomena" observed in a series of nine interviews, I may make the point that our experience with large series of sessions does not support this early enthusiasm. Generalizations are not warranted. The same holds true for the grammatical aspect of the dyadic language system in psychoanalysis. Analyzing the use of passive constructions Beermann (1983) could demonstrate on our four analytic cases that each patient preferred special ways of constructing the passive voice; change in direction to more active forms took place in all four treatments.

Going back to the organizing notions of this talk—narration and observation—this approach clearly is naked observation of elements: generating only *data bruta*—which are but the letters of the therapeutic alphabet. In order to make sense out of them we have to find the words and sentences which

built up to narratives of interaction. These data would be meaningless if measured only as a single instance; they approach meaning by the repeated measurement. But looking at them as a series of events, they are easily placed into a frame of understanding this specific case. These data show shifts in patterns of language; by looking at them from this holistic view brings them into the horizon of representing a new language game. The manifold bottom-up approaches convinced us that careful descriptive work on the microprocesses is necessary to understand the working of the macroprocesses grasped by our clinical notions.

All results on psychoanalytic dialogues studied by these techniques underscore the dyadic nature of the process. Whatever microsystem is analyzed, one finds dyadic dependencies and specifics within dyads. This has been one of the reasons why the Ulm research paradigm has been so intrigued by the study of singular cases. This kind of work may seem not to be in the mainstream of the work done in SPR for various reasons. One seems to be our tenacious stand with investigating long-term cases in their full length and richness. This is connected to the maybe unique German situation that the societal perspective on psychotherapy research as represented by the agencies responsible for the funding of psychotherapy is still convinced that long-term treatment within the psychoanalytic frame of reference for a certain share of patients is the proper thing to do. Another reason lies in a strong support for basic research provided by the German Research Foundation. We therefore could concentrate on basic research since 1970, having received continuous funding since then for diverse projects all focused on the issues I have dealt with in this presentation.

COMMENTARY

FROM NARRATION TO OBSERVATION AND BACK TO NARRATION IN PSYCHOTHERAPY RESEARCH

From today I would have to add that my initial discussion of selecting a single-case approach was rather narrow. In the last decades single-case research has developed in many sophisticated ways, especially in the fields of social science. We encounter now titles like "Five misunderstandings about case-study research" (Flyvbjerg, 2006) that summarize its message with the Kuhnian insight "that a scientific discipline without systematic production of thoroughly executed case studies is a discipline without systematic production of exemplars" (p. 219). Besides being too narrow in reasoning why the Ulm program decided to study one psychoanalytic case extensively, I also was too short in describing the clinical insights gained by studying this one case so extensively.

The second level of our methodology – the "systematic clinical description" – stands up the test of time, although we have not seen an overwhelmingly number of cases reported in such a systematic and detailed way.

Level three in my lecture dealt with such measures that Lester Luborsky has aptly named "guided clinical judgments" and which make up the bulk of present treatment research.

These clinical concepts are—by necessity of such a method—narrowed down and will lose some of the rich clinical connotations which have been criticized by psychoanalysts working on conceptual research (Dreher, 2005).

In the two decades that followed, further studies have been performed on the German specimen case Amalia X, as reported in a recent volume (Kächele et al., 2006). Also, the role or position of the researcher is given greater critical attention. Single case research offers a rich opportunity for this process of putting findings back in the clinical context. Looking back on my lecture, I did miss this aspect. It is this interaction between clinical work and scientific study that should become standard in our field.

Notes

1 Revised version of the presidential address to the annual meeting of the Society for Psychotherapy Research, Lyon, July 1991. Correspondence to the author: International Psychoanalytic University, Berlin.

2 Throughout this text the patients are named in concordance with our procedure explained in Thomä and Kächele (1994).

3 Since this address was delivered in France, it seems useful to mention that the French word for computer, *ordinateur*, is much more suitable to catch the specific use of this tool in textanalysis, which is "ordering symbols."