Cornelia Albani, Dan Pokorny*, Gerd Blaser, Susanne König, Helmut Thomä* and Horst Kächele*
Clinic for Psychotherapy and Psychosomatic Medicine of the University Clinic of Leipzig
*Department of Psychotherapy and Psychosomatic Medicine of the University Clinic of Ulm

Study of a Psychoanalytic Process using the Core Conflictual Relationship Theme (CCRT) Method according to the Ulm Process Model

Abstract

The study presents a description of the course of a psychoanalytic treatment with the CCRT method according to the "Ulm Process Model." Reformulated CCRT categories are used. The rich database at our disposal made it possible to analyze not only the absolute frequencies of CCRT components but the complex structure of the data as well. Besides a basic theme characterizing the therapy as a whole, there are typical categories for each phase of the therapy. These can be understood as interpersonal aspects of the focus of the particular phase. This may be considered a contribution to the "Ulm Process Model".
Key words: CCRT, psychoanalytic therapy, Ulm process model

The study was supported by the Deutsche Forschungsgemeinschaft (FKZ Ge 786/1-2, Ka 483/12-2).

Introduction

The great volume of material that is brought to light in the course of a psychoanalytic treatment must be reduced to what is most significant. Events are not significant in themselves, however: significance is given to them. What an analyst considers significant in the analytic process depends on the criteria for meaningfulness he or she applies to the course of the psychoanalytic process. One idea of process will be more differentiated or more explicit than another, yet as a fundamental premise no treatment can be carried unless the therapist is in possession of conceptual models of courses of therapy which suggest ways of proceeding and criteria for evaluation.

A psychoanalytic treatment can be characterized in a great number of ways. Freud compared

the analytic process with a chess game and made analogies between the activities of the archeologist, the painter and the sculptor and those of the analyst. Freud's work, however, provides no definite conception of process beyond specifying a beginning, middle, and final phase (GLOVER, 1937). To this day the number of coherent models of the psychoanalytic process remains small (THOMÄ & KÄCHELE, 1996). In the Ulm Process Model (KÄCHELE, 1988; THOMÄ & KÄCHELE, 1985), psychoanalytic therapy is conceptualized as a continuing, temporally unlimited focal therapy with a changing, interactively developed focus. The sequence of foci is regarded as a result of an unconscious exchange between the needs of the patient and the resources of the analyst. The patient may make various "offers" within a certain period of time, but it is only the selecting activity of the analyst that can result in the forming of a focus. The mutual work of patient and analyst on one focus leads to further areas of concentration that would not have been possible without the preceding work. When the first focus has been worked through, access is gained to a second one; thorough exploration of the second focus may in turn make it possible to revisit the first focus in a qualitatively new way.

The thematic "offers" made by the patient may be understood in terms of what French calls "focal conflicts," which represent unconscious infantile conflict constellations (thematized by French as "nuclear conflicts"): in other words, they are the solutions generated under the pressure of the problem at hand. French, however, is left with an unresolved problem: "Still, searching for the patient's focal conflict is an intuitive art which cannot be completely reduced to rules." (FRENCH, 1958, p. 101)

The Core Conflictual Relationship Theme method developed by Lester Luborsky (LUBORSKY, 1977; LUBORSKY, ALBANI, & ECKERT, 1992; LUBORSKY & CRITS-CHRISTOPH, 1998) offers a way of making such focal and core conflicts operational. The aim of the present study is to investigate how effective the Core Conflictual Relationship Theme (CCRT) method is in depicting the therapeutic course of a psychoanalytic treatment according to the Ulm Process Model.

Current Status of Research and Aim of the Study

Although a considerable number and great variety of studies have been conducted with the CCRT method (for an overview, see LUBORSKY ET AL., 1999), to date there have been very few that follow courses of therapy with the CCRT method. The studies known to us are of short-term therapies (ALBANI, POKORNY, DAHLBENDER, & KÄCHELE, 1994; ANSTADT, MERTEN, ULLRICH, & KRAUSE, 1996; GRABHORN, OVERBECK, KERNHOF, JORDAN, & MUELLER, 1994; LUBORSKY, CRITS-CRISTOPH, FRIEDMAN, MARK, & SCHAFFLER, 1991). To our knowledge there have as yet been no investigations of long-term psychoanalytic therapies using the CCRT method. The aim of our exploratory study was to describe the course of the 517-hour psychoanalysis of the patient Amalia by the CCRT method. A guiding intention behind the study was to determine if and in what form the Ulm Process Model can be seen in a psychoanalytic treatment.

Clinical Description of the Patient Amalia

35 years old at the onset of therapy, Amalia was a teacher living on her own who came to treatment for increasing depressive complaints. She suffered from religious scruples with occasional obsessive/compulsive thoughts and impulses, although she had turned away from the church after a phase of strict religiosity. Respiratory complaints arose for periods of time.

In the order of siblings Amalia came between two brothers, to whom she felt and still feels inferior. Her father was absent for her entire childhood n initially due to the war, later for occupational reasons. Amalia took on the role of father and tried to be a replacement to her mother for her missing partner. At the age of three years Amalia contracted tuberculosis and was bedridden for six months. Then, because of her mother's dangerous case of tuberculosis, at the age of five Amalia was sent away (the first of the siblings to go) and lived with her aunt, where she remained for about ten years. She was dominated by the religious strictness and puritanical upbringing to which she was subjected by her aunt and grandmother. Since puberty, Amalia has suffered from an idiopathic hirsutism. The patient's entire development and social position were affected by the stigma of this virile syndrome, which could not be corrected and with which she tried in vain to come to terms. Among its effects were a disturbed sense of self-worth, deficient female identification and social insecurity, which made personal relationships difficult and rendered it impossible for Amalia to enter into any close sexual relationships. The hirsutism likely had a two-fold significance for Amalia: On the one hand it complicated her already problematic female identification. In Amalia's biography, femininity does not have a positive value. It is associated with illness (her mother's) and disadvantagement (in relation to her brothers). On the other hand, the hirsutism secondarily takes on a symptomatic quality as a manner of self-presentation: It becomes the patient's excuse for avoiding sexual relations.

In both clinical evaluation and psychological testing, the 517-hour-total psychoanalytic treatment has been judged a success; this is clear from all that has been written about it now (THOMÄ & KÄCHELE, 1997, p. 104 and KÄCHELE, 2000; KÄCHELE, SCHINKEL, SCHMIEDER, LEUTZINGER-BOHLEBER, & THOMÄ, 1999).

Empirical Studies on Changes in Amalia during the Course of Therapy

Detailed analyses of aspects of the course of therapy have been presented in a great number of studies. For example, NEUDERT ET AL. (1987a) used a category system of content analysis to study self-esteem in three areas: sexuality and female identity; achievement and success; aggressiveness and self-assertion. On the basis of a sample of 115 hours of analysis, an increase in positive feelings of self-worth and a decrease of negative feelings of self-worth were found in the course of the treatment.

In addition, our team examined the changes in the patient's suffering over the course of treat-

ment and determined a decrease in impaired functioning due to suffering as well as a decrease in helplessness towards the suffering (NEUDERT, HOHAGE, & GRÜNZIG, 1987b).
Comparison of the first and last eight hours on the variables of "emotional insight" (HOHAGE & KÜBLER, 1987) resulted in significantly higher values on the scales for "emotional accessibility" and "experiencing" at the end of the therapy.
A systematic observation of cognitive-affective aspects of the patient's dream life was analyzed by LEUZINGER-BOHLEBER (1989) on the comparison of the beginning and end of therapy, and by KÄCHELE ET AL. (1999) on the course of the therapy. A number of other studies on this psychoanalytical treatment can be accessed through the homepage of the Ulm research team (http://sip.medizin.uni-ulm.de/abteilung/buecher/Band_III/Cont.html). As part of the information available there, the systematic clinical description provides the transference configurations to which we refer in the course of the present study. These were determined by qualitative clinical means (KÄCHELE, SCHINKEL ET AL., 1999).

Table 1
Clinical Transference Configurations

Clinical Transference Configurations	Therapy phase	Session numbers
Analysis as confession	I	1-5
Analysis as a test	II	26-30
The bad mother	III	50-54
The offer of submission and secret defiance	VI	76-80
The search for norms of one's own	V	100-104
The disappointing father and helplessness of the daughter	VI	116-120
The distant, cold father and the incipient longing for identification	VII	151-155
Ambivalence in the father-relationship	VIII	176-180
The father as seducer or moral judge	IX	202-206
He loves me – he loves me not	X	226-230
Even father cannot make a son out of a girl	XI	251-255
The apron-strings feeling	XII	276-280
The poor maiden and the rich king	XIII	300-304
Fear of rejection	XIV	326-330
Helpless love for powerful father and jealousy of his wife	XV	351-355
Active separation and resisting abandonment	XVI	376-380
Discovery of her own critical powers, recognition of the analyst's deficiencies, new attempt at leave-taking	XVII	401-404, 406
The daughter held on the left hand – rivalry with the firstborn for the mother	XVIII	426-430

Clinical Transference Configurations	Therapy phase	Session numbers
Hatred for the bountifully giving analyst and growing out of this expectation	XIX	445-449
The art of love is to endure love and hate	XX	476-480
Mastering leave-taking: having worked through the oral-aggressive fantasy about the analyst	XXI	501-505
Farewell symphony: the return of many fears and discovery of many changes	XXII	513-17

It is not difficult to "invent" such descriptions, even as a non-specialist reading the transcribed sessions. Yet it is in fact a painstaking process: The texts are first read and reread with the utmost care by two medical students, who then prepare an extract which is in turn checked against the text for accuracy by two psychoanalysts. As a form of qualitative research, the resulting product is now finally gaining greater respect (FROMMER & RENNIE, 2001). From the beginning, the Core Conflictual Relationship method has occupied a middle position between qualitative evaluation and exact quantification. Let us now look at the first application of this method to a psychoanalytic therapy.

Method

CCRT Method

The CCRT method makes it possible to show internalized relationship patterns. It is based on an analysis of narrative episodes of the patient's relationship experiences. As these "relationship episodes" are the foundation of the method, the first step is to identify them. Three types of components are then determined: wishes, needs and intentions (W-component); reactions of the object (RO-component); and reactions of the subject (RS-component). Positive and negative reactions are categorized. Initially, formulation of the categories is kept as close to the text as possible ("tailor-made formulation"). Since the current American standard categories and clusters of the method have more than once been criticized (e.g. ALBANI ET AL., 1999), a reformulation of the category structures of the CCRT method was undertaken (for details see ALBANI ET AL., 2002). Unlike in the old system, a directional dimension was introduced into the wish component showing whether the activity comes from the object or the subject (WO – "What I wish the object to do for me" and WS – "What I wish to do for the object (or myself)"). This addition has proven relevant in initial studies.

In contrast to the old categories, the structure of the reformulated system has a consistent logic

to it (POKORNY, ALBANI, BLASER, GEYER, & KÄCHELE, submitted): All three dimensions are coded on the basis of the same predicate list, which is hierarchically structured. Reactions of the subject and object are analogous, and there is a complete analogy between wishes and reactions both of the object and of the subject (e.g. cluster A "Being attentive to someone": WO "The other should be attentive to me"; WS "I want to be attentive to the other"; RO "The other is attentive"; RS "I am attentive to the other"). In the resulting reformulation there is a predicate list of a total of 119 subcategories grouped into 30 categories, which in turn are grouped into 13 clusters. In the present study, the evaluation was done on the subcategory level, while the results were presented on the cluster level (for names of the clusters, cf. Table 2).
The Core Conflictual Relationship Theme (CCRT) is composed of the most frequent wish, the most frequent reaction of the object and the most frequent reaction of the subject.

Sample

The data were provided by the session transcripts of this completely taped psychoanalytic treatment, which are accessible in the Ulmer Textbank. A systematic time sampling was made of the transcripts by selecting blocks of 25 consecutive sessions with a 25-session interval between each block. In the present study we evaluated only the first and last time-blocks, here designated as therapy phases and numbered with Roman numerals. These were sessions 1-30 and 510-517. In addition, beginning with the 50th session blocks composed generally of five sessions were analyzed at 50-session intervals[1]. When a block was not found to contain at least ten relationship episodes, further sessions were added until a minimum of ten relationship episodes was reached. Our sample includes 11 of the 22 available blocks but has 92 sessions in it.
Evaluation of the sessions was carried out in random order by an experienced CCRT evaluator on the subcategory level. Subcategories were not assigned to the clusters until statistical evaluation was undertaken.

Statistical Analyses

Because of our rich database, it was possible to analyze not only the absolute frequencies but the complex structure of the data as well. On a two-dimensional contingency table, the variable "therapy phase" is set over against one of the CCRT variables (wish, reaction of the object and reaction of the subject). As the null hypothesis, the observed frequencies of the individu-

1 The sample description of the transcribed text of Amalia X (KÄCHELE, SCHINKEL ET AL., 1999) is based on 22 transcribed blocks of five sessions each, selected at 25-session intervals. The sessions analyzed here by the CCRT method were selected from half of the available sessions. For the sake of clarity and maintaining the connection to the other Ulm studies, we chose the numbering of 1-22 here as well. Thus the therapy phases examined here are the odd-numbered ones.

al dimensions are noted (e.g., wish clusters and therapy phases), and it is assumed that the two dimensions are independent, i.e. that the frequency distributions of the CCRT components are the same in all therapy phases. The alternative hypothesis, then, is that some categories occur more frequently in certain therapy phases than might be expected from the observed frequencies of the individual dimensions. This hypothesis of the homogeneity of the therapy phases is first globally tested by the generalized Fisher Test (Monte-Carlo method). In the following exploratory stage, using a one-tailed, classical Fisher test the CCRT categories are determined which occur more frequently than expected in a particular therapy phase. Thus both the absolute highest-frequency categories as well as the more-frequent-than-expected categories are presented. (For details of this process, see ALBANI ET AL., 1994; POKORNY ET AL., submitted).

Results

Reliability of the CCRT Evaluation

The CCRT evaluation was carried out by an experienced evaluator. In order to check for reliability and to avoid rater drift, during the evaluation process one session out of the 11 evaluated blocks was selected at random to be evaluated by a second evaluator. In this we followed the approach of LUBORSKY & DIGUER (1990). In the first step, agreement in the marking of the relationship episodes was checked, the criterion being an agreement within seven lines at the beginning and seven lines at the end of an episode. The percentage of agreement was 72% for the beginning of an episode and 69% for the end of an episode. In the relationship episodes whose marking was in agreement, agreement regarding the object of the episode reached 99%.

In the second step the relationship episodes were known, and agreement in the marking of the components was checked based on the criterion of seven words at the beginning and at the end of a component. The agreement at the beginning and the end of the component came to 76% for wishes, 96% and 95% for reactions of the object, and 94% and 96% for reactions of the subject. In the third step, the components were already given and the agreement regarding assignment to the standard categories and evaluation of the valence of the reactions was checked. Agreement regarding the valence of the reactions was a kappa coefficient of .78. For assignment to the standard categories (on the cluster level), the mean kappa coefficient was .68 (W .58, RO .60, RS .70).

Results of the CCRT Evaluation

In the 92 hours, altogether 579 relationship episodes were found, containing 806 wishes, 986 reactions of the object and 1103 reactions of the subject. The positivity index (number of positive reactions in relation to the sum of positive and negative reactions) came to 15.1% for reactions of the object and 23.9% for reactions of the subject.

Table 2 gives an overview of the frequency distribution of the categories on the cluster level.

Table 2
Frequency Distribution of CCRT Variables: Object-related Wishes (WO), Subject-related Wishes (WS), Reactions of the Object (RO) and Reactions of the Subject (RS) (Relative Frequencies in %, n = 579 Relationship Episodes)

Cluster		WO n=518	WS n=288	RO n=986	RS n=1103
A	Attending to	46.3	12.5	4.2	3.3
B	Supporting	26.6	4.9	5.1	2.4
C	Loving / Feeling well	14.3	19.8	4.4	6.0
D	Being self-determined	10.0	27.1	6.9	7.2
E	Being depressed	0	0	.3	6.4
F	Being dissatisfied / scared	0	0	1.7	24.2
G	Being determined by others	0	.3	5.3	15.3
H	Being angry / unlikable	0	0	4.7	15.5
I	Being unreliable	0	.3	19.3	.1
J	Rejecting	0	8.7	19.2	6.1
K	Subjugating	.2	6.2	13.6	1.4
L	Annoying / Attacking	0	2.8	7.3	1.4
M	Withdrawing	2.5	17.4	8.2	10.7

The Core Relationship Conflictual Theme (CCRT, most frequent categories of all) for the entire therapy is as follows:

WO: Others should be attentive to me (WO Cl A),
WS: I want to be self-determined (WS Cl D),
RO: Others are unreliable (RO Cl I),
RS: I am dissatified, scared (RS Cl F).

Table 3 presents the typical categories for each phase of therapy.

Table 3
Core Conflictual Relationship Theme (CCRT) in the Course of Therapy
(Absolute/Relative Frequencies in % in Relation to the Given Phase of Therapy)

Absolute highest-frequency categories	More-frequent-than-expected categories*
Therapy phase I, sessions 1-30, n = 30	
WO Cl A "Others should be attentive" (112/ 55)	**WO Cl A** "Others should be attentive" (112/ 55)
WS Cl D "I want to be self-determined" (42/37)	**WS Cl D** "I want to be self-determined" (42/ 37)
RO Cl J "Others reject me" (82/ 24)	**RO Cl J** "Others reject me" (82/ 24)
	RO Cl G "Others are weak" (24/ 7)
RS Cl F "I am dissatisfied, scared" (116/ 27)	**RS Cl F** "I am dissatisfied, scared"(116/ 27)
	RS Cl G "I am determined by others" (77/ 18)
	Negative RS 335/ 82
Therapy phase III, sessions 50-55, n = 5	
WO Cl A "Others should be attentive" (9/ 41)	
WS Cl M "I feel like withdrawing" (4/ 21)	
RO Cl J "Others reject me" (10/ 20)	**RO Cl F** "Others are dissatisfied, scared" (4/ 8)
RS Cl F "I am dissatisfied, scared" (11/ 26)	**RS Cl C** "I feel good" (7/ 16)
Therapy phase V, sessions 100-104, n = 5	
WO Cl B "Others should support me" (12/ 44)	**WO Cl B** "Others should support me" (12/ 44)
WS Cl C "I would like to love and feel good" (5/ 36)	**RO Cl M** "Others withdraw" (9/ 18)
RO Cl I "Others are unreliable" (12/ 23)	
RS Cl F "I am dissatisfied, scared" (25/ 42)	**RS Cl F** "I am dissatisfied, scared" (25/ 42)
Therapy phase VII, sessions 151-157, n = 7	
WO Cl A "Others should be attentive" (7/ 78)	
WS Cl J "I want to reject others" (3/ 43)	**WS Cl J** "I want to reject others" (3/ 43)
RO Cl I "Others are unreliable" (6/ 27)	
RS Cl F "I am dissatisfied, scared"(6/ 37)	
	Negative RO 22/ 100
Therapy phase IX, sessions 202-206, n = 5	
WO Cl A "Others should be attentive" (8/ 33)	**WO Cl D** "Others should be self-determined" (6/ 25)
WS Cl M "I feel like withdrawing" (4/ 31)	
RO Cl I "Others are unreliable" (11/ 26)	
RS Cl F "I am dissatisfied, scared" (11/ 22)	**RO Cl D** "Others are self-determined" (7/ 16)
Therapy phase XI, sessions 251-255, n = 5	
WO Cl A "Others should be attentive" (7/ 33)	
WS Cl A "I want to be attentive to others" (4/ 67)	**WS Cl A** "I want to be attentive to others"(4/ 67)
RO Cl I "Others are unreliable" (7/ 27)	
RS Cl F "I am dissatisfied, scared"(10/ 32)	

* Fisher Test, two-tailed, $p \leq .05$, W: n = 806, RO: n = 986, RS: n = 1103

Absolute highest-frequency categories	More-frequent-than-expected categories*
Therapy phase XIII, sessions 300-304, n = 5	
WO Cl A "Others should be attentive" (6/ 40)	
WS Cl M "I feel like withdrawing" (3/ 43)	
RO Cl J "Others reject me" (6/ 23)	
RS Cl F "I am dissatisfied, scared"(9/ 36)	
Therapy phase XV, sessions 351-355, n = 5	
WO Cl A "Others should be attentive" (19/ 54)	
WS Cl M "I feel like withdrawing" (5/ 36)	**WS Cl K** "I want to subjugate others" (3/ 21)
RO Cl I "Others are unreliable" (14/ 25)	
RS Cl H "I am angry, disagreeable" (17/ 28)	**RS Cl H** "I am angry, disagreeable" (17/ 28)
Therapy phase XVII, sessions 401-404, 406, n = 5	
WO Cl C "Others should love me" (7 30)	**WO Cl C** "Others should love me" (7/ 30)
WS Cl J "I want to reject others" (2/ 50)	
RO Cl J "Others reject me" (12/ 27)	
RS Cl G "I am determined by others"(9/ 25)	
Therapy phase XIX, sessions 445-449, n = 5	
WO Cl B "Others should support me" (17/ 33)	**WO Cl C** "Others should love me" (13/ 25)
WS Cl C "I would like to love and feel good" (11/ 37)	**WS Cl C** "I would like to love and feel good" (11/ 37)
RO Cl I "Others are unreliable" (25/ 23)	**RO Cl M** "Others withdraw" (18/ 17)
RS Cl F "I am dissatisfied, scared" (28/ 23)	**RS Cl M** "I withdraw" (25/ 20)
	Negative RS 42/ 91
Therapy phase XXI & XXII, sessions 501-517, n = 17	
WO Cl A "Others should be attentive" (40/ 45)	
WS Cl D "I want to be self-determined" (20/ 33)	**WS Cl L** "I want to annoy, attack others" (5/ 8)
RO Cl I "Others are unreliable" (46/ 21)	**RS Cl H** "I am angry, disagreeable" (45/ 19)
RS Cl H "I am angry, disagreeable" (45/ 19)	**RS Cl D** "I am self-determined" (37/ 16)
	RS Cl J "I reject others" (23/ 10)
	Positive RS 87/ 37

* Fisher Test, two-tailed, $p \leq .05$, W: n = 806, RO: n = 986, RS: n = 1103

As necessary background for the discussion to follow, it will be helpful to provide a detailed, systematic clinical description of the therapy and its thematic sections. The demand for such a presentation, far exceeding all customary requirements for case histories, was made by Kächele (1981) and could now be fulfilled by making the presentation available in all desired detail on the Internet (Ulmer Lehrbuch vol. 3, chap. 3.4.: http://sip.medizin.uni-ulm.de/abteilung/

buecher/Band_III/Cont.html). By taking up French's distinction between "nuclear conflicts" and "focal conflicts," we were able to determine that across all phases of the treatment one basic theme becomes clear in each of the most frequent categories of the CCRT procedure: Amalia's wish for attention (WO C1 A) and support (WO C1 B) from others; her experience of the others as rejecting (RO C1 J) and unreliable (RO C1 I); and her dissatisfaction and anxiety (RS C1 F). In each of the phases of therapy, the subject-related wishes are distinct.

The more-frequent-than-expected categories are characterized by the themes that distinguish the particular therapy phase from the other phases.

Initial therapy phase I (sessions 1-30) is characterized chiefly by Amalia's wish for kindly attention from others (WO C1 A). She speaks of her colleagues, by whom she feels "used" as a "dustbin" (RO C1 J) but with whom she cannot speak about her problems. Amalia envies her female colleagues for their relationships. She feels insecure in relation to her students (RS C1 G), thinking they regard her as an old maid (RO C1 J), and there are conflicts in which she does not feel properly supported by her director (RO C1 G). She describes her father as a sensitive, fearful and inaccessible person (RO C1 J, RO C1 G) and is disappointed at their distant and irritable relations (WO C1 A). A relationship episode with her father follows:

"P: … for example, when I come home, by car now, he won't even come out. I know from my colleagues that they have fathers much older, and they pick them up and carry their bags in and so on, and he doesn't even come. So when I get home, and maybe my mother opens the door, then I might go to the bathroom or something, or I'm taking off my coat and standing in the entryway, he doesn't come, he doesn't move. Or I go into the living room, and he'll be sitting in the other room, you see he somehow can't take a step towards a person …"[2]

In relation to her brothers she feels inferior and not taken seriously, either by them or by the family as a whole. She makes a theme of her dependence on the norms of the church, the opinions of others and on her mother, though her mother is the one she talks to. On the other hand, Amalia has the feeling she needs to be available for her mother and has feelings of guilt when she distances herself from her.

"P: … sometimes I really need my Sunday to just, well, and then there'll be something I have to do again, and then you see, my parents, they come around often, you know, my mother will call up and then she'll say, then, she'll just say: 'Come' and I've simply never managed yet to say, 'Please don't. I don't want you to.' or 'It won't work out' or …"

Her wish for change is expressed in her wish for autonomy (WS C1 D), which results from her experience of herself as dependent and weak, unable to set limits and dissatisfied. For this phase of the therapy, the high proportion of negative reactions on the part of the patient herself is particularly characteristic.

2 Transcript of the Ulmer Textbank.

In the ninth session, Amalia reports the first relationship episode with the analyst (out of a total of only four episodes in the initial phase):

"P: … (pause). You know, anyway today I was awfully, I am so dreadfully tired, I 've said that before and then today I really didn't have time to catch my breath from yesterday. The whole evening I was – well, I had a girl student visiting, who wanted something and so I didn't get to give it any thought, but just the same I started realizing some things yesterday and in that … Sure in a certain sense it was finished too, and what I'm left with as a question is always the same thing. Fine, I see it now, but what I am supposed to do and how is it supposed to go on and, and and what, I really didn't mean to say that, right.

T: With the students and the grading problem, you mean, if that is supposed to go on?

P: No, I mean here, how is this supposed to go on, when I lie here and tell you something and I try to understand it and you summarize it, then of course some things become clear, and nevertheless then I tell myself, what am I supposed to do with that, that's what was going through my head, and that's what I didn't want to say, because somehow it, because, I keep asking myself, if you recognize it, to what extent can you guide your actions by it.

T: how it will go on

P: and how it will go on, right, that was really the question. Somehow at the moment I experienced that as an insult to you, and therefore I couldn't say it."

This episode illustrates the description of the clinical transference configuration of these therapy phases: the analyst as father confessor and examiner, in front of whom Amalia is careful, reserved and uncertain but also beginning to come to terms with "authority." What is striking is that Amalia reports a great many relationship episodes in the initial sessions (on average 11 episodes per session), which makes sense from the clinical perspective: In the initial phase, the therapeutic relationship is being established and biographical material occupies a greater space.

In therapy phase III (sessions 50-55), Amalia describes episodes chiefly reflecting her wish to withdraw (WS C1 M), which she in fact succeeds in doing in relation to her mother and younger brother. The following episode with her mother gives a picture of the clinical description of this phase of the therapy as "the bad mother," but also shows that Amalia is exploring alternative types of behavior:

"P: No, otherwise on the weekend I actually have uh; well yes of course my mother called up again and wants, and would very much like me, uh, to come next weekend, or rather she would like to come, but I told her I wasn't sure yet what my plans were, and asked her to please wait, I mean, two or three weeks ago I would really have just, said, or let's say four weeks ago, uh please come and I have often said, yes please come, even when it wouldn't be convenient at all for me, and I just see that it, that it, uh would be perfectly ok alone,

that I, um, I really don't need to get so, so worked up all the time because now, now I'm sitting here all alone and so forth, and of course it would be nice, not to be sitting all alone that way all the time well it's not always but a great deal of the time for sure but, um, I could make a lot more of it, not that I didn't used to read before or didn't do this or that too, but I just feel better about it, um, I can honestly say."

Amalia is feeling better and experiencing moments of self-confirmation (she is driving alone again to take walks, painting again; RS C1 C), although there are confrontations with the parents of her students.

Her relationship to the analyst is also becoming a more frequent topic (in 17% of the episodes). She demands answers instead of silence from the professional authority (RO C1 J) and would like to give her own interpretations as well.

Therapie Phase V (sessions 100-104) is marked especially by Amalia's wish for support (WO C1 B). She feels that her director is judging her and discriminating against her because of her therapy (RO C1 J). She also is expressing her wish that the analyst give her clear answers and be open and honest with her. She experiences the analyst as the "most important person" (38% of all episodes deal with the analyst), but feels rejected by him. She is unsure who he is and what he thinks of her and complains of his changing the subject and of his keeping the rules secret (RO C1 M).

"P: You know, just this business with my boss, really went to show how difficult it is, uh, what with the self-assessment that you make of yourself, and the assessment others make of you, which you can always somehow sense or see, to hold the balance there, when the two of them clash. And that's where I feel you are someone I can assume, um, – right, I just feel – it's simply something like trust, and and nevertheless, after all that's why I went running to the C well, I didn't actually run to the bookstore, but I, I wanted to read it, because you see I keep wanting to know who you are, and uh, you, you can't help asking yourself the whole time, 'So who is this person that you are putting your trust in, and, and what kind of picture is he forming of you' – and, I mean, all those things that we've already spoken about,

T: um-hmm.

P: came back to me really powerfully – because – naturally I want to know: what kind of man is this, who has a profession like that, and a wife who also has a similar profession, uh, all that, that is somehow important. And then when you, if I can put it that way, to me it seems you change the subject, then I can't help asking myself: 'Why, why is he changing the subject – is he embarrassed – well, why is he embarrassed by that?' – or is it that he wants me to be independent, ok, right. it, of course it has to do with that. But, I just think it's kind of going down different tracks. I mean, if I trust a person, of course I am dependent in a way – thank God, I would say C and, and yet again at the same time I have to,

T: um-hmm.
P: I just need– at least here –to feel I have the right to sound you out, who you are and who I am – or rather I didn't put that quite right – who you are – it strikes me as very important, that, uh, why does he listen to me, right, it's another one of those questions. Why does he do that? What is interest in a person?
T: um-hmm.
P: What's behind it?"

According to the assessment by the CCRT method, the patient's "search for norms of her own," which was identified as a theme in the clinical description, appears to take place in two ways: on the one hand in coming to terms with her disappointed wishes for support, but also in her confrontation and identification with the analyst.
Amalia's wish to reject others herself (WS C1 J) becomes important only in **therapy phase VII** (sessions 151-157). Amalia is dissatisfied (RS C1 F) and is considering entering a convent. Alongside of her relationship to her father (who is the object of interaction in four of fourteen episodes of this phase), the focus of these sessions is the therapeutic relationship (the therapist is the object in six of the fourteen episodes of this phase). On the one hand she is afraid she is asking too much of the analyst; on the other hand she criticizes his interpretations and finds, for example, that does not laugh enough. During a visit by her parents she is disappointed that her younger brother is favored (WO C1 A), bringing back memories of her lifelong envy of her brother. In no other phase does Amalia portray the reactions of others so negatively as in this phase.

The wish that others should be self-directing (WO C1 D), characteristic of **therapy phase IX** (sessions 202-206), is aimed largely at her director, who lets himself be manipulated (RO C1 I) by a female colleague with whom Amalia is in rivalry and to whom she feels inferior (RO C1 D). From her analyst, Amalia wishes a direct answer to her concern that she might have caused herself damage in masturbation. She receives it (with some delay), in which process the therapist (by father transference) becomes a seducer and moral judge, as the clinical description emphasizes.

In therapy phase XI (sessions 251- 255), Amalia succeeds for the first time in initiating a date with a male colleague (WS C1 A). She wishes she were able to speak openly about sexuality with her mother (WO C1 A), recalling her cautious attempts to question her mother, and wonders about her mother's sex life. Amalia wants to understand what happens in analysis – she attends lectures by psychotherapists and reads publications by her analyst, but finds no answers, is unable to understand many things and feels inferior to the analyst (RS C1 F). The clinical description of therapy phase XI, "Even father cannot make a son out of a girl," strongly reflects the therapeutic conception of the analyst, who focused on the patient's penis envy. The

evaluation by the CCRT method, on the other hand, reveals above all Amalia's (new) openness ("I want to be attentive to others") in this therapy phase – both in the way she forms her relationships and in the way she confronts her own sexuality and femininity as she takes steps towards her mother.

During a three-week break in **therapy phase XIII** (sessions 300-304), Amalia decides to place a personal ad in a newspaper and receives several answers to which she in turn responds. She is afraid of how the analyst will react to this (WO C1 A), fearing his reproaches (RO C1 J):

"P: … In the weeks that you were away or unavailable, eh, I suddenly had the feeling I could "swim on my own" now. And then came my resolution that I will definitely not go on vacation with my parents this summer, that I'd do something on my own. I had answered this personal ad and made the decision to place one myself. And that was actually what I didn't want to tell you, because I was afraid you would interrogate me up and down and then you'd get angry and say, and then I was awfully afraid of what would come next and of course I've transferred that fear, but still it is sitting down there like an elemental force, that you will make an awful angry face and though you won't in fact forbid it, you'll say, 'So all has been for naught, you've understood nothing, and this treatment here just gets in the way of your doing what you want,' that was it I think."

The fact that her younger brother recognized her ad in the paper strengthens her wish to protect herself from her brothers' and parents' interference and judgments (WS C1 M), also intensifying her dissatisfaction and feelings of inferiority, as comes out clearly in the image of the "poor maiden" given in the clinical description.

In **therapy phase XV** (sessions 351-355), Amalia is disturbed (RS C1 H) by outward alterations (her analyst's department has moved, there is a new therapy room, noise from building site). She feels unprotected by the analyst (WO C1 A) and jealous of his own children (RS C1 H):

"P: … that you only moved up here to make it easier for you to take your children to school.
T: What do you mean easier?
P: Because I keep imagining your children will be going to school now in the, on Hochsträß and uh, and at first that made me, I mean, really furious."

She feels put under pressure both by her analyst and her father and thinks that there are expectations she has to fulfill. In her school, Amalia has confrontations with the janitor and her director (WS C1 K), in which she is able to adopt a more active posture and defend herself (RS C1 H). Her (unfulfilled) longing for her analyst's attention and her rage in its disappointment are also expressed in the clinical description: "helpless love for the powerful father and envy of his wife."

In **therapy phase XVII** (sessions 401-404), the analyst receives a bouquet of flowers which holds manifold symbolism. The bouquet was actually intended for a correspondent who had answered Amalia's next ad. At the same time it is an apology for the negative judgment of the analyst by Amalia's nephew, who knows the analyst from lectures and with whose criticisms of the analyst Amalia in part identifies (as also becomes clear in the clinical description). Amalia also identifies with her flowers, fearing that the analyst will not take good care of them (WO C1 C).

"P: I always really find it wonderful when someone knows how to take care of flowers. Most people take them and ram them in like a post in the earth, and let them sit in the vase till they hang their heads. No, you know, these ones especially began to droop last time, and I thought uh-oh,
T: I didn't understand, you were saying?
P: They were beginning to droop last time.
T: They,
P: They, the flowers began to droop.
T: the flowers right.
P: Right and so I thought, oh he's doing something wrong, that shouldn't be happening. And so naturally I was very glad today that you, that you did understand after all, how to give them the right amount of water and food."

Through her correspondence with various men, Amalia explores her relationship to men and recalls her brothers' air of superiority and the lack of validation she experienced through her father (RO C1 J):

"P: It was never a climate of affirmation, it was always, how it all comes back to me, oh God. It was always, if I wanted to be a girl, I was stopped, and if I wanted, I remember once, I put on ski pants and my father said then 'I don't happen to have three sons, I should like to request, not at the table, go get changed.' So I wanted to be a boy or to pretend it wasn't so important. It was always such an exclusive thing, the boys, I always had the feeling that my brothers, in spite of the connection I have to my younger brother, they did a better job of affirming each other and, and stayed together. Somehow behind my back they stuck together. After all they were the men and they were ok, and they were in the majority. Predestined from eternity to eternity. I don't know, it was just that way. A troublemaker and a liar, that's what I was, right and, ok yes. I have the feeling they were always watching to see what would come of it. They wanted to know just exactly what was different and what was going to come of it. And at the same time they always knew it in advance, what came of it. They just always knew everything better."

Therapy phase XIX (sessions 445-449) reflects Amalia's ambivalent experiences in her first relationship with a man. She wishes for a close, intense and also sexually satisfying relationship (WO C1 C, WS C1 C), but she is not sure of the affection of her partner (who still is attached to is ex-wife and also has other relationships) and is disappointed by his distance (RO C1 M, RO C1 I, RS C1 M).

"P: …and then he said, 'Listen, when it comes down to it, you know, our relationship doesn't justify such a thing, you basically have no right, uh, hmm, to keep me away from other relationships. It would be a different thing if we wanted to start a family and have children, then it is bad to go around with other women,' that's more or less what he said, and in retrospect it really shocked me terribly. And then when he called up on Monday, I had thought I wouldn't call again till Thursday, if he wants anything, let him do it, and then when he called on Monday, just as I had imagined,
T: first he wanted to put an end to it on Monday,
P: Monday was absolute rock bottom.
T: hmm
P: I thought, I really have to put an end to this. And on the telephone I was absolutely icy and didn't say an extra word but then of course he called again about the pills. So then we talked. And that's when he probably got the impression that I was, about putting an end to it, he probably sensed something, I don't know. I don't know. I never actually said 'I'm through.' And I never said 'Don't touch me again' or anything like that. Yes, indeed, we sure, oh we had such, talked so much on the telephone."

Insecurity, doubts about her physical attractiveness and guilt that she fails to live up to her mother's ideas of morality are the main traits of Amalia's feeling life, as becomes clear in high proportion of negative reactions in this phase. Here again, the clinical description and the CCRT evaluation contrast: While the clinical description chiefly emphasizes Amalia's ambivalent relationship to her analyst ("Hate directed at the bountifully giving analyst, and an incipient turning away from this expectation"), the CCRT focuses on her new relationship experiences outside of the therapeutic relationship.

In the **concluding phase XXI and XXII** (sessions 501-517) of her therapy, Amalia is chiefly occupied with coming to terms with the experiences of her last relationship and of a new one that is in the offing, though emotionally she still feels very strongly attached to her previous partner (WO C1 A). Set off by an invitation from her archenemy to a class gathering, intense feelings of hate awaken in Amalia, but she is able to come to terms with them (WS C1 L). In the professional sphere, despite a particular challenge from two teacher trainees whom she experiences as very pushy, she is able to assert her will (WS C1 D) and is proud of that (RS C1 D, RS C1 J, RS C1 H). The conclusion of the analysis and parting from the analyst are chief themes in this phase.

"T: …I mean, is there an idea, one that you have, as to what my way, my idea of coming to an end is?
P: That one's easy for me. Mine is quite bold. I just thought you would adapt yourself to me.
T: Um-hmm.
P: And it was just in these last sessions that I got that feeling. It was really a feeling that, yes of course, he'll do what I want. Whereas before, there was this kind of tugging, I felt like I was being tugged on a leash and I had the feeling, he doesn't understand a thing, he has some kind of peculiar idea of his own of how to finish. He won't tell it to me of course, so I don't know it. And it was like a real tugging. And now, for about three or four sessions I think, I haven't been counting, my mind is the way I was just telling you. It'll simply work that way. I'll be sitting in my tortoise shell, and the harvest will come in. Like I told you.
T: Um-hmm.
P: I'll just get up and go, and I liked that so much that I thought, there's nothing he'll be able to do but go along. That fact that it isn't quite his idea of things, and if he finds something more thematically, that is his problem. Because there will always be something to find …"

What is striking is the great number of positive reactions by Amalia in the concluding phase. The clinical description speaks of a "farewell symphony: the return of many fears and the discovery of many changes"; and this is powerfully evident in the CCRT evaluation of the concluding phase, which illustrates Amalia's newly acquired freedom of action.

Discussion

Within the framework of our study, it has become possible for the first time to examine a long-term psychoanalytic therapy with the CCRT method during its course. Thus, compared to previous studies of single cases using the CCRT method, it offers the most comprehensive sample to date.

The relatively great number of reactions of the subject compared with other CCRT studies may be due to the fact that this was a psychoanalytic therapy and the patient was particularly encouraged to reflect on her feelings and thoughts. The results of the evaluation by the CCRT method underscore the clinical assessment of the success of the therapy and support the results of previous studies done on this material. Though the negative reactions of the objects and of the patient still predominate in the final phase of the therapy, a significant increase in positive reactions of the patient becomes apparent. The patient also described the reactions of the objects as more positive at the end of the therapy, but these changes could not be statistically established. The component "subject-related wishes and reactions of the subject" reveals that in the course of the therapy, the patient was able to expand her freedom of action and acquire new competencies, and that her depressive symptoms decreased. The increase determined by NEUDERT ET AL. (1987a) in positive feelings of self-worth and the decrease in nega-

tive feelings of self-worth in the course of the therapy match the content changes of the subject's reactions in the present study. Moreover, the distinct increase in positive reactions of the patient herself further supports this finding. Starting in therapy phase VII Amalia is in a position to perceive and express aggressive wishes, and starting in therapy phase XV these gain relevance in action. Particularly when this is contrasted with the dominant feelings of dissatisfaction and fearfulness at the inception of the therapy, the change in Amalia becomes apparent.
Alongside of a basic theme manifested in each of the absolute highest-frequency categories ("nuclear conflict"), each of the therapy phases also showed typical categories which characterize thematic foci in the sense of French's "focal conflicts" and which can be operationalized by the CCRT method. Thus the CCRT method makes it possible to structure material by content.
Being confined to narrative material, the CCRT method manifests a limitation when compared with the clinical description, particularly in the initial phases: While the clinical description of the first two phases focuses on the meaning of the treatment ("Analysis as Confession," "Analysis as a Test"), the CCRT method can access such aspects only through relationship episodes with the analyst. Such episodes in particular, however, are rarely reported by Amalia at the beginning of the therapy.
In contrast to the clinical description, which uses metaphorical language to highlight a theme according to the subjective assessment of the judges, investigation of the therapy phases by the CCRT method makes possible a more differentiated (and less subjective) analysis of the themes, as is seen in therapy phase III. In the clinical description, the "bad mother" takes center stage, while in the CCRT 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 method makes it possible to access interpersonal aspects inside and outside of the therapeutic relationship.
Both the strengths as well as the limits of the CCRT 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 has perceived and verbalized. The method provides no way of including unconscious material (apart from the repetitive schemas that patients – often unconsciously – follow in describing the course of relationships) or of assessing defense mechanisms. Hence the evaluation remains very close to the clinical material, though it does reflect intrapsychic processes in the narratives of interactions.
Parallels between the patient's descriptions of her relationship with the therapist and others objects can be examined by means of the CCRT method. Thus the method makes it possible to capture structural aspects of the clinical transference concept. Nevertheless, the interactive transference currently in progress will not enter into the evaluation.
Although the method is called the "Core *Conflictual* Relationship Theme," Luborsky leaves the concept of conflict unclarified. Conflicts in the analytic sense between wish and defense, between different systems or levels or between drives (LAPLANCHE & PONTALIS, 1972) are not

captured by the method. The wish component makes it possible to describe conflicts between two wishes that occur simultaneously and are mutually exclusive. It might be most accurate to say that the CCRT captures the theme of the most frequent wish without immediately revealing the associated conflict itself. Therefore the CCRT should rather be understood as an indicator for capturing the patient's conflict. On the other hand, interpersonal conflicts are registered with great clarity and differentiation in the form of wish-reaction schemas. The ongoing interaction, however, is not captured; nor are the communicative and interactive functions of the narrative (QUASTHOFF, 1980) investigated within the therapeutic interaction.

With the CCRT method itself it is not possible to clarify how therapeutic changes have come about. In their studies, Crits-Christoph et al. (CRITS-CHRISTOPH, BARBER, & KURCIAS, 1993; CRITS-CHRISTOPH, COOPER, & LUBORSKY, 1998) showed a connection between the "accuracy" of the therapist's interpretations of the CCRT and the success of therapy.

It is now an uncontested fact that the quality of the therapeutic relationship is of critical importance for the success of therapy. On the whole, the relationship of the patient to her therapist seems to have been satisfying and positive for her – no other relationship is described with such a high rate of positive reactions of towards the object of interaction.

The present 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 support the Ulm Process Model. The analyst's contribution, however, is reflected only in the patient's narratives regarding her relationship to the therapist. Use of the CCRT method provides for structuring of clinical material, development of clinical hypotheses and checking on therapeutic focus during the course of therapy. The method is easily learned for clinical application and the time required in formulating the psychodynamic connections for clinical use is minimal, so that the method can accompany treatment throughout.

References

- ALBANI, C., POKORNY, D., BLASER, G. et al. (2002). Re-formulation of CCRT categories. *Psychotherapy Research;* 12: 319-338.
- ALBANI, C., POKORNY, D., DAHLBENDER, R. W. et al. (I994). Vom Zentralen-Beziehungskonflikt-Thema (ZBKT) zu Zentralen Beziehungsmustern (ZBM). Eine methodenkritische Weiterentwicklung der Methode des "Zentralen Beziehungs-Konflikt-Themas". *Psychotherapie Psychosomatik medizinische Psychologie,* 44: 89-98.
- ALBANI, C., VILLMANN, T. et al. (I999). Kritik der kategorialen Strukturen der Methode des Zentralen Beziehungs-Konflikt Themas (ZBKT). *Psychotherapie Psychosomatik medizinische Psychologie,* 49: 408-421.
- ANSTADT, T., MERTEN, J. et al. (I996). Erinnern und Agieren. *Zeitschrift für psychosomatische Medizin und Psychotherapie,* 42: 34-55.
- CRITS-CHRISTOPH, P., BARBER, J., & KURCIAS, J. S. (I993). The accuracy of therapists' interpretations and the development of the therapeutic alliance. *Psychotherapy Research,* 3: 25-35.

- CRITS-CHRISTOPH, P., COOPER, A., & LUBORSKY, L. (1998). The measurement of accuracy of interpretations. In Understanding transference: *The Core Conflictual Relationship Theme Method* eds. L. Luborsky & P. Crits-Christoph, Washington: American Psychological Association, 2 ed., pp. 197-212.
- FRENCH, T. M. (1958). *The Integration of Behavior Vol III: The reintegrative process in a psychoanalytic treatment.* Chicago: The University of Chicago Press.
- FROMMER, J., & RENNIE, D. (Eds.). (2001). *Qualitative psychotherapy research. Methods and methodology.* Lengerich: Past Science Publishers.
- GLOVER, E. (1937). Die Grundlagen der therapeutischen Resultate. *Internationale Zeitschrift für Psychoanalyse,* 23: 42-50.
- GRABHORN, R., OVERBECK, G. et al. (1994). Veränderung der Selbst-Objekt-Abgrenzung einer eßgestörten Patientin im stationären Therapieverlauf. *Psychotherapie Psychosomatik medizinische Psychologie*, 44: 273-283.
- HOHAGE, R., & KÜBLER, C. (1987). Die Veränderung von emotionaler Einsicht im Verlauf einer Psychoanalyse. Eine Einzelfallstudie. *Zeitschrift für Psychosomatische Medizin und Psychoanalyse,* 33: 145-154.
- KÄCHELE, H. (1981). Zur Bedeutung der Krankengeschichte in der klinisch-psychoanalytischen Forschung. *Jahrbuch der Psychoanalyse,* 12: 118-178.
- KÄCHELE, H. (1988). Clinical and scientific aspects of the Ulm process model of psychoanalysis. *The International Journal of Psycho-Analysis,* 69: 65-73.
- KÄCHELE, H. (2000). Casos modelo en investigación psicoanalítica. In A. P. Internacional (Ed.), *Proceso psicoanalítico: herramientes, metodos y resultados* (pp. 257-270). Buenos Aires.
- KÄCHELE, H., EBERHARDT, J., & LEUZINGER-BOHLEBER, M. (1999). Expressed Relationships, Dream Atmosphere & Problem Solving in Amalia´s Dreams – Dream Series as Process Tool to Investigate Cognitive Changes – A Single Case Study. In *Psychoanalytic Process Research Strategies II* eds. H. Kächele & E. Mergenthaler & R. Krause, Ulm: Ulmer Textbank
- KÄCHELE, H., Schinkel, A., Schmieder, B., Leutzinger-Bohleber, M., & Thomä, H. (1999). Amalie X – Verlauf einer psychoanalytischen Therapie. *Colloquium Psychoanalyse*, 4: 67-83.
- LAPLANCHE, J., & PONTALIS, J. B. (1972). *Das Vokabular der Psychoanalyse.* Frankfurt/M.: Suhrkamp.
- LEUZINGER-BOHLEBER, M. (1989). *Veränderung kognitiver Prozesse in Psychoanalysen. Bd 2: Eine gruppen-statistische Untersuchung.* Berlin, Heidelberg, New York, Tokyo: Springer.
- LUBORSKY, L. (1977). Measuring a pervasive psychic structure in psychotherapy: The Core Conflictual Relationship Theme. In *Communicative structures and psychic structures*, eds. N. Freedman & S. Grand, New York: Plenum Press, pp. 367-395.
- LUBORSKY, L., Albani, C., & Eckert, R. (1992). Manual zur ZBKT-Methode (deutsche Übersetzung mit Ergänzungen). *Psychotherapie Psychosomatik medizinische Psychologie,* 5 (DiskJournal).
- LUBORSKY, L., & CRITS-CHRISTOPH, P. (1998). *Understanding transference: The Core Conflictual Relationship Theme Method* (2 ed.). Washington: American Psychological Association.
- LUBORSKY, L., CRITS-CHRISTOPH, P. et al. (1991). Freud's transference template compared with the Core Conflictual Relationship Theme (CCRT). In *Person Schemas and Maladaptive Interpersonal patterns*, ed.

M. Horowitz, Chicago: University of Chicago Press, pp. 167-195.
- LUBORSKY, L., & Diguer, L. (1990). The reliability of the CCRT measure: Results from eight samples. In *Understanding transference: the CCRT method,* eds. L. Luborsky & P. Crits-Cristoph, New York: Basic Books, pp. 97-108.
- LUBORSKY, L., DIGUER, L., KÄCHELE, H. et al. (1999). A guide to the CCRT's methods, discoveries and future. *http://www.sip.medizin.uni-ulm.de/abteilung/projekte/CCRT/ccrtmain.html*
- NEUDERT, L., GRÜNZIG, H. J., & THOMÄ, H. (1987a). Change in self-esteem during psychoanalysis: a single case study. In *Self, symptoms and psychotherapy,* eds. N. M. Cheshire & H. Thomä, New York Chichester: Wiley & Sons, pp. 243-265.
- NEUDERT, L., HOHAGE, R., & GRÜNZIG, H. J. (1987b). Das Leiden als Prozeßvariable in einer psychoanalytischen Behandlung. *Zeitschrift für Klinische Psychologie,* 16: 135-147.
- POKORNY, D., ALBANI, C. et al.(submitted). About the logic structure of re-formulated CCRT-categories. Analysis of relationship pattens in a single case analysis. *Psychotherapy Research.*
- QUASTHOFF, U. (1980). *Erzählen in Gesprächen.* Tübingen: Gunter Narr Verlag.
- THOMÄ, H., & KÄCHELE, H. (1985). Lehrbuch der psychoanalytischen Therapie. Bd 1: Grundlagen (1 ed.). Berlin, Heidelberg, New York: Springer-Verlag.
- THOMÄ, H., & KÄCHELE, H. (1996). *Lehrbuch der psychoanalytischen Therapie. Bd 1: Grundlagen* (2 ed.). Berlin, Heidelberg, New York, Paris, London, Tokyo: Springer, English translation: Psychoanalytic Practice. Vol 1, Berlin, Heidelberg New York: Springer.
- THOMÄ, H., & KÄCHELE, H. (1997). *Lehrbuch der psychoanalytischen Therapie. Bd 2: Praxis* (2 ed.). Berlin, Heidelberg, New York, Paris, London, Tokyo: Springer, English translation: Psychoanalytic Practice. Vol 2, Berlin, Heidelberg New York: Springer.

Address of the author:

PD Dr. med. Cornelia Albani
University of Leipzig
Clinic for Psychotherapy and Psychosomatic Medicine
K.-Tauchnitz-Str.25
04107 Leipzig
Germany
Phone: (49) 0341-9718884
e-mail: albc@medizin.uni-leipzig.de