74. Kächele H (1988) Clinical and scientific aspects of the Ulm process model of psychoanalysis. *Int J Psychoanal 69: 65-73*

Horst Kächele

Clinical and Scientific Aspects of the Ulm Process Model of Psychoanalysis

In a consideration of the therapeutic process - i.e., the entire path travelled jointly by patient and analyst between the initial interview and termination - the plethora of events occuring on the way must be relegated to the background. The function and problems of process models in psychoanalysis must be approached from the point of view of the implicit or explicit control functions the assume in the implementation of the analysts‘ s objectives. For this reason, the discussion of process models is not a theoretical, abstract matter; they are in fact, in greater or lesser degrees of elaboration, a part of every psychoanalysts‘s day-to-day practical activity. The conceptions of process handed down from one generation of analysts to the next, often expressed only in metaphorical terms, contain unspoken theories, and Sandler (1983) is therefore right to call for the private dimension of the meaning of concepts to be brought into the open:

> Research should be directed towards making explicit the implicit concepts of practising psychoanalysts, and it is suggested that this process will result in the accelerated development of the psychoanalytic theory. The essentials of that theory must be those aspects which relate to the work the psychoanalyst has to do, and therefore its main emphasis needs to be clinical (1983, p.43).

I shall begin with some general considerations connected with the genesis of the the Ulm process model of the technique of psychoanalytic treatment. The conception of this model is the result of our confrontation with the developing field of research on psychotherapy - which can be dated to the formation of the Society for Psychotherapy Research in 1968 by Howard and Orlinsky - in which the development of a model in effect occupies the position to be assumed by further theoretical and empirical approaches whose volume become discernible only when the model itself is constructed.

The beginnings of the Ulm process model date back to a project in 1967/1968 when Thomä had an analysis then in progress monitored session by session by a another equally well trained analyst. In this project, both found that although they could often agree on the material presented by the patient, they frequently differed on the therapeutic steps appropriate in the light of this material. If the obvious personal differences between the two analysts are disregarded for the time being, striking differences in the analysis of the relevant connexions nevertheless remain in the use made of the available explanatory schemes, although, in the case of that study, both analysts had been trained at the same psychoanalytic institute and could therefore be assumed to have fundamentally similar explanatory models assimilated as part of their psychoanalytic identity. Twenty years later, a recent issue of a psychoanalytic journal - Psychoanalytic Inquiry Vol.7, No 2 1987 - takes up the question of "how theory shapes technique" allowing the interpretation of a clinical piece of work with as many as seven perspectives to start with. The editor‘s epilogue officially recognizes now what has been the subject of research of at least two decades:

One ineluctable conclusion emerges clearly from this study: an analyst‘s theoretical orientation has a marked impact on the way he thinks about patients and the way he works with them. This conclusion raises an equally striking question: how can clinicians who think and behave so differently get equally good analytic results ? (Pulver 1987, p.289)

Set aside the question of equally good results I think what we need are investigations on the process of interaction between the private theories and the clinical data provided by the patient. Therefore I am currently engaged in a project with a collegue (H. König, Tübingen) in which psychoanalytic sessions recorded by me are initially naturalized (in Spence‘s sense of the word) by my comple - mentary commentary or " session review" as described by A.E.Meyer (1981, 1987; see also Kächele,1985); this free - associative material is then worked on intensively by him on the basis of the verbatim transcript and the also tape recorded session review; he independently reconstructs the course of the session and, a few days after the session, I am interrogated on specific questions by him; in the process, a comprehensive explanation of my intervention strategy is demanded of me. We find that, working from the transcript alone, he can also arrive at an alternative reconstruction of the therapeutic process which is theoretically convincing to me, given his normative psychoanalytic competence

compared to my privileged viewpoint. After each such discussion, we can determine the relative importance in the analyst‘s current working model - to use a term introduced by Bowlby and reintroduced by Peterfreund (1983) - of prior biographical knowledge about the patient and his treatment so far on the one hand and general theoretical approach on the other. Spence‘s (1982) distinction between privileged and normative competence - i.e., between the biased therapeutic knowledge of the analyst by being involved in the process and the seemingly detached specialized knowledge of a third party observer uninvolved in the therapeutic process - turns out to be still too simple and too idealistic as the so-called uninvolved external participant turns to get very much involved with providing the better ideas, being convinced that he would have been the one and only one who knows the truth. This can be readily observed in the aforementioned collection of Sidney Pulver. An early example of the need to be different among analysts was provided by the famous consensus study by Seitz (1966). Studies of this kind regularly fail when more complex forms of analytic material are to be discussed; conversely, in the case of relatively context-free exerpt material from verbatim transcripts, perfectly satisfacctory agreement can be obtained if the assessors have equal normative competence, as we were able to show in a consensus study (Thomä et al.,1976).

In the explanation of the interactive foundation of the process approach, the point is not only that we react differently to the same material - because a social psychology of clinical judgment would already cover a great deal, as Beckmann (1974) showed in his investigation of the patient‘s and analyst‘s self-perception and perception of others; it is also a matter of allowing for the analyst‘s personal involvement in the material presented by the patient. In this connexion, Dahl, Rubinstein and Teller (1978), in a proposal to the Fund for Psychoanalytic Research, described a study of the phenomenon of subjective evidence in the formation of the analyst‘s judgment. In two groups of analysts, they asked each of the participating analysts to submit session material; all had to mark these passages of the material for the degree of evidence they felt with regard to a particular psychodynamic hypothesis espoused by the treating analyst himself. Quantification of the degree of evidence for this material consistently showed that the treating analyst was always the most convinced of the quality of his evidence (see also Dahl 1983). In my view, this convincingly proves that a selecting factor operates in the psychoanalytist‘s perceptional attitude when dealing with the

patient‘s productions; the demand to exercise evenly suspended attention precludes only the integration on the level of everyday expectancies; it may even further the interactional closure on the level of unconscious role expectancies as Sandler (1976) has pointed out. These various comments on judgment and evidence formation point to a confirmation of the bipersonal understanding of the analytic situation, where real relationship and transference issues are not dissected along the line of what is real and what is phantasy, but have to be looked at as constructions in social space.

For these reasons we consider the transference neurosis to be an interactional representation of the patient‘s intrapsychic conflicts in the therapeutic relationship, the concrete form assumed by which is a function of the dyadically negotiated process (Thomä & Kächele, 1975, 1987). This form is unique to each therapeutic dyad for the reasons stated, initially conferring on each psychoanalytic treatment the status of a singular history. However trivial this statement may be, it must be viewed against the background of other treatment model descriptions in which, in our view, insufficient attention is paid to this historical singularity.

Before going into more detail, I should like briefly to add further examples to the conception of the model, in order to illustrate the scope of this approach. It is very useful to start with references to Freud‘s models - i.e. to his typifications of the psychoanalytic process - as we all know and appreciate them. His comparison with the game of chess, and particularly the opening, implies rules which constitute the game and exist independently of particular circumstances; after all, chess is played by the same rules all over the world. Then there are the strategies and tactics applicable to the various phases of the game - e.g. , opening and end-game strategies,etc; these differ in accordance with the individual techniques of each player and are also regulated interactively in the dyadic situation, in that the individual player takes account of the presumed strength of his opponent in working out his strategies. Does psychoanalysis have something like a fixed set of game rules which can be specified in isolation from each concrete situation ? Many psychoanalysts still believe that the psychoanalytic method has this status, which can be determined in isolation from concrete objectives. Such a conception of the model of the psychoanalytic process could be justified by Freud‘ s reference to the organismic independence of

neurosis and its unfolding in the transference process, from which the role of the analyst could be derived at the same time:

He sets in motion a process, that of the resolving of existing repressions. He can supervise this process, further it, remove obstacles in its way, and he can undoubtly vitiuate much of it. But on the whole, once begun, it goes its own way and does not allow either the direction it takes or the order in which it picks up its points to be presented for it (Freud 1913c)

This organismic conception of the unfolding of the transference neurosis finds a contemporary echo in Fürstenau (1977), who also presents a process conception under the heading of "evolutionary structure of the unfocused individual psycho - analytic treatment" in which two overlapping growth processes determine the psychoanalytic work:

1) The process of gradual structuring and normalisation of the self with repeated phases of intense relapses which take a structural form into regressive crises and substitutive-supportive behaviour consistent with these on the part of the analyst.
2) The process of layer-by-layer scenic unfolding and working over of the existing fixations in the form of analysis of transference and resistance (Fürstenau 1977)

The first process dimension constitutes maturation of the ego and its content is probably substantially determined by the therapeutic factors referred to in psychotherapy research as the common helpful and conducive conditions though there is only scant systematic evidence to this; one notable exception is represented by the Meninger study (Kernberg 1972; Wallerstein 1985, p. 729). The second aspect of the process includes two parts, described by Fürstenau as "working over the existing pattern of relationship" and " building up of a new pattern of relationship"in which the specifically psychoanalytic concepts of therapy are contained. The process as a whole then falls into seven phases which display a linearity in which "late follows early".

When such models are discussed, it is necessary to clarify whether they are ideal, typical models which are to be understood normatively and thereby already assume a theoretical character, or whether they are empirical models which initially describe and then inductively generalize. Their reproductive function must not be understood as meaning that the image must resemble the orginal as closely as possible. To be precise, it is a matter of specifying in a model the structural, functional or behavioral analogy, to be defined in advance, which is to be reproduced or imitated. What Fürstenau‘s approach has in common

with our view is the use of phases within the treatment which can be organized around a thematically definable field. Where we would part from his conception is the algorithmic nature of his model, i.e., he proposes a fixed sequence of his seven phases where we would go for a heuristic stance to take up Peterfreund‘s distinction. Each graduation paper by a training candidate shows such phase structures, and it would be an interesting field of research in itself to study the clinical labeling processes with their more or less imaginative names. After all, in my opinion, the nomenclature used for the various phases of treatment reflects a process of condensation taking place in the analyst, in which he endeavours to put together the guiding principles of his therapeutic activity in the form of an entity.
We are less in agreement with Fürstenau‘s assumption that, in general, in each process, the sequence of phases is organized in the form of a linear working over of ontogenetic development. In terms of the ideas set out above on the interactive generation of a focus - i.e., from the interaction of the patient‘s topic and the analyst‘s scheme - we regard psychoanalytic therapy as a focal therapy without limitation of time and with a changing focus. Rather than a natural linearity, we consider the sequence of foci to be the result of an unconscious bargaining process between the needs or wishes of the patient and the possibilities of handling those of his analyst.

Before turning to further strategic and tactical aspects of this conception of the psychoanalytic process, I should like to give a very condensed clinical example just to point out the vagaries of a non-linear, non natural ontogenetics modeling approach of a psychoanalytic process:

Case formulation in terms of focal work (Kächele 1987)

The first phase of a psychoanalytic treatment of a 3o years old professio - nal woman was devoted to working on the actual triggering experiences leading to severe bouts of depression that had broken out in consequence of a number of disappointments that had shaken her self-regard. In this phase the patient denied consciously any involvement with the analyst as a person.
The second phase of treatment - after the overcoming her defensive need to terminate with the feeling of successful symptom removal- focused manifestly on the relationship with the patient‘s father, who had behaved seductively at the time of her puberty; the analyst was subjected to her

devaluation of the male world in the transference. At the same time she began to experience the therapist‘s room as a possession of hers.
The third phase was characterized by a repetition of her idealizing relation to her grandfather in the transference, the grandfather having been an object that provided the patient with security in her childhood, whereas mother and father turned out to provide very unstable relations depending on her well- behaving.
The fourth phase then concerned the Nazi past of her father; this phase concentrated on the working through of destructive fantasies in herself and defending against these in the transference by comparing her analyst to these projections. The working through of the tormenting fantasy of the atrocities her father might have committed as an SS officier and her now real concern with the injustice of the SS regime led into the fifth phase.
In the fifth phase, she was able to confront my hitherto supposed emotional unreliability as a repitition of the early mother, in which she expressed the wish to be able to sit face to face to me and reduce the frequency to one session a week: " I can only really study what is going on in you in your face; as long as you are sitting behind me, I am never quite sure whether you are really listening to me". In fact, she instantly picked up and responded to any reaction of rejection in me, but I was able to tolerate what was for me a very difficult phase of negative countertransference towards a fretful and provocative child by resorting to what had already been achieved.
The sixth phase dealt explicitly with termination issues that brought back the danger of loosing the "new object "again and involved working again on the separation issues that characterized her early life experiences.
The topic of basic mistrust in the therapeutic relationship had been postponed by this patient for a very long time, during which she worked on other topics. The outcome on each piece of work does in fact determine which topic can be opened next.The emergence of new theme - referring to J.Weiss presentation - can not be predicted in advance in terms of what theme comes next. This is dependent on the joint history of the dyad. Our process model does not lay down any rules but allows for this not consciously controlled interpersonal bargaining on what is possible between two people in the therapeutic setting. Experiences with change of analyst, less by intention more often imposed unto the patient either by frustrating fruitless analytic work or by the some unexpected change in the analyst‘s life, point to this aspect. The process model also does not distinguish between complete and incomplete analysis, but takes the dialectics of analysis terminable and inter - minable seriously to the extent that the process comes to a halt at the point when, in a words,

nothing important occurs any longer to either party or when the patient‘s ideas lead him away from the analysis and back into autonomous life.

Unlike an approach such as those of Fürstenau (1977) or indeed Kohut (1984), our process conception is not intended to model a process to be characterized as ideal but to promote a process view that endeavours to embrace the entire spectrum of therapies based on psychoanalytic theory. For this reason, information on time and space, on heuristics and therapeutic theory are also parts of this process model: Even if we do not base our process objective on a narrow sympto - matic conception fixed by convention only, we do demand that the objective be anchored in modes of behaviour and experience which are capable of being specified in some way or another. These may be and are changed during a process, if only as a result of this process; nevertheless, the relationship between objective and means remains central in a psychoanalytic technique, which we regard as a hermeneutic technology. We can adopt the appealing process metaphor of von Blarer and Brogle (1983) " that the way is the objective", if the way leads from statements of problems to their solution. We therefore plead for a heuristically oriented technique involving searching, finding and discovery, whose objectives is to create the best possible conditions for change.

I have so far confined myself to the level of pure argument involving clinical and theoretical aspects; I should now come to the empirical-systematic aspects. Although process theories ought in the long term to be supported empirically in psychoanalysis as in other fields of human interventions, they are in fact at present used to a much greater extent as instruments of theory criticims. A by no means secondary aim of the textbook on "psychoanalytic practice" by Thomä and myself (1987) is to initiate an open discussion about matters which are usually passed only in strictly codified form and have in fact now been practised differently for a very long time. In this sense, the Ulm process model is itself a heurististic technique; after all, it has the aim of suggesting the manner in which psychoanalytic processes are currently conceived and practised.
Our starting point here is a continuum of the various methods composed of elements whose combinations then generates the different forms of therapy. Examination of the continuum of the therapeutic processes existing in reality between the poles of macroprocess and microprocess reveals fluid boundaries in the macro field, which comprises so-called

psychoanalysis proper, analytic psychotherapy and short therapy in the field of individual therapies. The generic descriptions are called into question not later than at the point when the criterion of the "analytical process" is introduced, a criterion which cannot be specified from the outside, on the basis of variables concerning 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 psychoanalysis but by the third only as analytical psychotherapy. Even the use of the couch by no means any longer guarantees the attribute "psychoanalytic" for a process existing by virtue of functioning transference/ countertransference (Rangell 1981). Process models at a micro level, as formulated , for example, by von Zeppelin (1987,) using the cognitive-affective regulation system for intrapsychic processes and the interaction regulation model by Moser, von Zeppelin and Schneider (1981), lay claim to validity for all psychoanalytically oriented therapeutic approaches.

In its use of the focus concept, the Ulm process model primarily aims for a medium level of description. The concept of "focus" is semantically quite unsharp, as we also speak of "focusing" and may be referring to relatively short-term processes. The focus concept introduced by French (1952) formed a part of his cognitively oriented analysis of dreams; it was taken up by Seitz (1966) in the consensus study already mentioned, 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 the "prevailing transference". An interactive, process- oriented conception of the focus which crystallizes from the work then developed in Malan´s focal therapy workshop (1963, p. 272). Our conception of the focus relates to a structure extending over a longer period of time and involving a longer sequence of sessions. We have been working for a long time on the empirical identification of such structures. A number of methods at different levels of abstraction from the clinical process are used for this purpose.

I should like to discuss necessarily brief two empirical approaches: Firstly, I shall remind you of Dahl´s (1983) evaluation strategy of the therapist´s topic index and secondly, I shall present some results concerning the empirical identification of phases on the basis of systematic clinical rating on the first half of an analytic case. A third strategy based on computer-aided text analysis will be mentioned just as

an outlook to even more sophisticated approaches in psychoanalytic process research.

1) Topic Index

For the determination of thematic structures, it is necessary to ascertain what is being talked about. 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 audio tape recordings by an observer not involved in the process. Hartvig Dahl introduced the method of the topic index to psychoanalytic process research in a seminal papers in 1972 and 1974 (see Dahl 1983 for a summarizing presentation); these were an important source for my own ideas how to organize a working model of focus-oriented process research:

It seemed obvious to organize research of this kind along poles stretching from the traditonal case history to very formalized methods, corresponding to very qualitative approaches and very hard nosed quantitative methods. 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 being part of the conversation. Using the therapist‘s expert 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). With a statistical technique, called factor analysis, Dahl could extract common variability among several of these single clinical topics, which are then represented as descriptive mathematical organisations, called factors. The six factors then could be named taking into account the leading topics. The graphical representation protrays the type of information that results by this procedure. The descriptive richness of a clinical case description has been replaced by a quantitative preciseness which allows the determination of phases and foci now.

We first used this approach for a comparative descriptive study of a patient‘ s and her analyst‘ s topics over the course of a psychoanalytic case : not the analyst but two medical students extracted from the verbatim transcripts the presence or absence of topics in a sample of evenly distributed blocks of 5 sessions over the whole course of treatment (22 x 5 sessions) and weighted them in a simple fashion. The resulting graph is a map of thematic events and can be used for the purpose of descriptively mapping out the expansion of foci.

We are now using this approach for a more refined systematic description of a video-recorded analytic short term therapy, again using

an external observer that recorded the presence or absence of the tailor made topics every 10 minutes, so that we came up with a fine grained web of 5 x 29 session topic index for 10 topics. The summarizing technique for the interrelations of the various topics is a special issue still open, as the correlational approach of Dahl‘s approach implies that the correlations between the variables remain stable over time, whereas psychoanalytic technique has the explicit aim to change connections between topics. So other statistical models have to be invoked as Markov models for the analysis of the interlinking of the thematic sequences .
Another approach for identifying focal areas could be performed by a continous analysis of the sessions by Luborsky‘s CCRT method; first experiences with the CCRT as a process measurement for identification of foci are just tried on a short term case . The aim here will be to investigate what ramifications of the wish formulation can be found over the course of the 29 sessions and to what extent do these relate to the clinically formulated focus topics.
Our second approach to the identification of foci consists in the the application of scaled assessments of clinical concepts, which we have described in some detail elsewhere (Kächele 1986). The basis of our study consisted of 11 x 5 sessions, selected at intervals of 5o sessions. The status of the treatment was discussed on the level of systematic description of the process on the basis of the five sessions periods. This joint clinical discussion by the research group had been preceded by a classification of the 55 sessions, in random order, in accordance with the following clinical relevant concepts, which had to be rated 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 by three raters - the therapist among them - was carried out by statistical analysis and led to five factors:

Factor 1 : working alliance (assessed by rater B and C)
Factor 2 : positive transference as a defence against separation anxiety
Factor 3 : diffuse anxiety with agressive transference
Factor 4 : working alliance (assessed by the analyst)
Factor 5 : shame and guilt anxiety

On the basis of our accurate clinical knowledge and of the understanding of the course of the treatment so far achieved by the research group in the systematic description study , we tentatively formulated four focus-related phases of treatment:
Phase 1 (sessions 1-5; 51-55; 101-105):
Maintenance of defense
Phase 2 (sessions151-155; 201-205):
Intensification and access to consciousness of the early positive object relation in the transference
Phase 3 (sessions 251-255; 301-305; 351-355)
Alternation of pregenital-positive clinging transference and agressive distancing in the transference
Phase 4 (sessions 401-405; 451-455; 501-505)
Consolidation of the agressive transference
Phase 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 as judged from the verbal exchange within the sessions. The problem of separation emerges only incipiently in the transference; the agressive transference is predominantly unconscious and not very intense. Feelings of guilt and shame alternate in their intensity.
Phase 2 is characterized predominantly by the mobilization of the separation problem in the analytic situation; agressive aspects of the transference are manifested only in individual sessions.
In Phase 3 the therapeutic aim of reactivating aggressive impulses in the transference which underlie the severe anxieties is achieve for the first time; at the same time, the alternation with the symbiotic- clinging position is impressive.
In Phase 4 we see a perceptible decline of the friendly, conciliatory object relation, which is replaced by an anally tinged, negativistic agressive tranference.

It should be noted that this study was performed when the treatment was not yet completed, so further phases are to be expected when the whole course of analysis lasting for about 1200 session will be studied.

The clinically derived focus formulations then were checked by a formal algorithm: using the five factors of the rating investigation, a procedure called discriminant analysis was used to calculate a number of linear functions by which the sessions belonging to the four phases can be checked to determine whether the individual sessions have been assigned to one of the four phases on the basis of the five factor values only randomly or whether the asssignment is significant: Without reporting the details of the statistical procedure (see Biomedical Computer Program 1973, p. 221) it is important to understand the logics somewhat : each of the 55 hours is assigned by this method of discriminance analysis to one of the four phases - i.e., the linear combination of the five factors used yields an assignment value for each individual session, thus providing an empirical basis for discussion of the homogeneity of the phases at the level of sessions.
Summarizing the results of this classification procedure by the following classification matrix demonstrates the relative homogeneity of each of the four phases in terms of sessions assigned to it:
Classification Matrix

	Discriminant function				
Phase	1	2	3	4	N sessions
1	12	0	2	1	15
2	2	6	1	1	10
3	3	4	5	3	15
4	5	1	0	9	15

The four types defined by the discrimant functions 1- 4 which are based on a joint evaluation of the five factors represent correspond clinically to the focal schemes which we have evolved from our joint clinical discussion. With the exception of phase 3 we find a dominating type of session in each phase; the results of phase 3 clearly indicate that all four types of sessions are sparsed over the phase indicating no stabile topical preference.

A next step in our endeavour to develop a descriptive tool for the identification of focally determined phases in analytic treatments was the connection of clinically derived, by systematic and controlled judgment procedure objectified, ratings of clinically relevant concepts with the more stringently definable computer assisted content analysis tool. Without going into the details of this procedure (Mergenthaler 1985, Kächele 1986) we would like to state that the empirical attempt to test process theories needs descriptive tools that are capable to master the large amount of data involved in such a task. We are convinced that psychoanalytic process research has to start from the clinical experience which then by introducing new observational tools can be checked for its appropriateness . Once we have found the possibility to go beyond clinical description we may be in a better position to decide on which model of process fits the data best. Then the issue can be solved what the relationship of the various phases in treatment may be.

Bibliography

Beckmann D (1974) Der Analytiker und sein Patient. Huber Verlag, Bern

Blarer A von & Brogle I (1983) Der Weg ist das Ziel. Zur Theorie und Metatheorie der psychoanalytischen Technik. In S O Hoffmann (ed) Deutung und Beziehung. Kritische Beiträge zur Behandlungskonzeption und Technik in der Psychoanalyse. Fischer, Frankfurt pp 71-85

Dahl H, Rubinstein B & Teller V (1978). A study of psychoanalytical clinical inference as interpretive competence and performance. Proposal to the Fund for Psychoanalytic Research.

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

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

French TM (1952) The integration of behaviour. Vol. 1: Basic postulates. University of Chicago Press, Chigago

Freud S (1913c) On the beginning of treatment. S.E. 12, p.123

Fürstenau P (1977) Praxeologische Grundlagen der Psychoanalyse. In L F Pongratz (Ed): Klinische Psychologie. Hogrefe, Göttingen (Handbuch der Psychologie, Vol. 8/1, pp 847 - 888

Kächele H (1985) Zwischen Skylla und Charybdis - Erfahrungen mit dem Liegungsrückblick. Psychother. Med.Psychol. 35:306-309

Kächele H (1986) Die maschinelle Inhaltsanalyse in der psychoanalytischen Prozessforschung. PSZ-Verlag, Ulm

Kächele H (1987) Ist das Glück ein Ziel psychoanalytischer Behandlung ? Forum Psychoanal. in the press
Kernberg OF, Burstein E, Coyne L,Appelbaum A,Horwirtz L, & Voth H (1972) Psychotherapy and Psychoanalysis: Final report of the Menninger Foundation‘s Psychotherapy Research Project. Bull. Menn. Clin. 36: 1-275
Kohut H (1984) How does analysis cure ? University of Chicago Press, Chicago
Malan D H (1963) A study of brief psychotherapy. Tavistock, London
Mergenthaler E (1985) Textbank Systems: Computer science in psychoanalysis. Springer Verlag, Heidelberg
Meyer A E (1981) Psychoanalytische Prozessforschung zwischen der Skylla der "Verkürzung" und der Charybdis der "systematischen akustischen Lücke". Zsch.Psychosom.Med. Psychoanal. 27: 103-116
Meyer A E (1987) How analysts tick: Studies with the retroreport. In H Dahl, H Kächele & H Thomä (1987) Psychoanalytic Process Research Strategies. Springer Verlag, Heidelberg
Moser U, Zeppelin I von & Schneider W (1981) Objektbeziehungen, Affekte und Abwehrprozesse. Aspekte einer Regulierungstheorie mentaler Prozesse. Berichte der interdisziplinären Konfliktforschungsstelle der Universität Zürich, No 9
Peterfreund E (1983) The process of psychoanalytic therapy: Models and strategies. The Analytic Press, Hillsdale.
Rangell L (1981) Psychoanalysis and dynamic psychotherapy. Similarities and differences twenty-five years later. Psychoanal. Quart 50: 665-693
Sandler J (1976) Countertransference and role-responsiveness. Int. Rev. Psychoanal.3: 43-47
Sandler J (1983) Reflections on some relations between psychoanalytic concepts and psychoanalytic practice. Int. J. Psychoanal. 64: 35-45
Seitz P (1966) The consensus problem in psychoanalysis. In L A Gottschalk & A H Auerbach (eds) Methods of research in psychotherapy. Appleton Century Crofts, New York, pp 209-225
Spence D (1982) Narrative truth and historical truth. Meaning and interpretation in psychoanalysis. Norton, New York
Thomä H, Grünzig H J, Böckenförde H & Kächele H (1976) Das Konsensus - problem in der Psychoanalyse. Psyche 30: 978-1027
Thomä H & Kächele H (1975) Problems of metascience and methodology in clionical psychoanalytic research. Annual Psychoanal 3: 49-119
Thomä H & Kächele H (1987) Psychoanalytic Practice, Vol. 1 Principles. Springer Verlag, Heidelberg
Wallerstein R S (1985) Forty-two lives in treatment. A study of psychoanalysis and psychotherapy. The Guilford Press, New York

Zeppelin I von (1987) A process model of psychoanalytic therapy. In N Cheshire & Thomä H (eds) The Self and its symptoms. Wiley, New York