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Chapter 24
Single-Case Research: The German Specimen Case Amalia X

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Keywords Evaluation • Process research • Psychoanalysis • Single case

In a pivotal review of the problem of psychoanalytic treatment research some 40 years ago, Wallerstein and Sampson [1] enthusiastically recommended performing systematic single-case studies to enhance the field. Three decades later, Wallerstein [2] concluded: "that we are without warrant… to claim the greater heuristic usefulness or validity of anyone of our general theories over the others, other than by the indoctrination and allegiances built into us by the happenstance of our individual trainings, our differing personal dispositions and the explanatory predilections then carried over into our consulting rooms" (p. 1,251). In the same vein, Gabbard and Westen [3] urge that "we attempt to move from *arguing* about the therapeutic action of psychoanalysis to demonstrating and refining it" (p. 338). The best possibility for resolving these differences and for developing some consensus about the fundamental tenets of psychoanalysis rests on empirical research generating relevant data that can provide a basis for consensual agreement about fundamental psychoanalytic principles [4].

Historically in psychoanalysis, oral tradition and loosely documented case vignettes have constituted the principal means of reporting the insights originating from the therapeutic situation; the clinical encounter has well served as a field for discovery-oriented research [5]. When Dahl used the term "the specimen hour" [6] to designate session five of one of his tape-recorded psychoanalytic treatments which was transcribed in order to make the clinical material available to the general public [7], this implied that there are not only specimen dreams in psychoanalysis, as Freud stated, but also specimen cases. However, the number of papers calling for single-case research (for example [8]) still outnumber those reporting on single-case studies. Searching through the history of psychoanalysis for true single-case studies—excluding the Freud's cases—is enlightening (quoted from [9, chap. 3]).

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t1.1 **Table 24.1** Tabulated results of post-Freud psychoanalytic literature search for treatment reports of a certain size,
t1.2 searching for presentations that cover, using a rough measure, more than 30 pages in published form

t1.3 t1.4 Author	Case	Date of Treatment	Duration	Date of Publication	Type of Record	Size (page-count)
t1.5 Adler	"Fräulein R."	—	—	1928	after-session notes	146
t1.6 Traft	7-year-old boy	—	31 sessions	1933	in-session notes	161
t1.7 Wolberg	42-year-old man "Johann R."	1940	4 months 1945	1945	after-session notes	169
t1.8 Berg	young man	ca. 1940	—	1946	in-session notes	ca. 240
t1.9 Sechehaye	18-year-old-woman	1930	10 years	1947	after-session notes	107
t1.10 t1.11 McDougall/ Lebovici	9-year-old-body "Sammy"	1955	166 sessions	1960	in-session notes	270
t1.12 Klein, M.	10-year-old boy "Richard"	1944	93 sessions	1961	after-session notes	490
t1.13 Thomä	26-year-old woman "Sabine"	1958	304 sessions	1961	after-session notes	70
t1.14 Parker	16-year-old boy	1955	200 sessions	1962	after-session notes	355
t1.15 t1.16 t1.17 Bolland/ Sandler	2-year-old boy "Andy"	ca. 1960	221 sessions	1965	weekly report after-session notes	88
t1.18 Boor	22-year-old man "Frank A."	ca. 1960	580 sessions	1965	after-session notes	30
t1.19 Pearson	12-year-old boy "adolescent."	—	6 years	1968	after-session notes	140
t1.20 Milner	23-year-old woman "Susan"	1943-1958	15 years	1969	after-session notes	410
t1.21 Dolto	14-year-old boy "Dominique"	1968	12 sessions	1971	after-session notes	160
t1.22 Balint	43-year-old man "Mr. Baker"	1961	29 sessions	1972	after-session notes	130
t1.23 Dewald	26-year-old woman	ca. 1966	304 sessions	1972	in-session notes	620
t1.24 Winnicott	30-year-old man	ca. 1954	—	1972	after-session notes	240
t1.25 Argelander	35-year-old man	—	ca. 600 session	1971	after-session notes	75
t1.26 Stoller	30-year-old woman	—	—	1974	in-session notes	400
t1.27 Winnicott	2-year of girl "Piggle"	1964	14 sessions	1978	after-session notes	200
t1.28 Firestein	25-year-old woman	—	—	1978	after-session notes	30
t1.29 Goldberg	25-year-old man "Mr. I."	—	—	1978	after-session notes	108
t1.30 Goldberg	31-year-old woman	ca. 1966	600 sessions	1978	after-session notes	98
t1.31 Goldberg	22-year-old man "Mr. E."	ca. 1972	2 years	1978	after-session notes	134

As a bibliographic exercise, Kächele [10] reviewed the post-Freud psychoanalytic literature for treatment reports of a certain size, searching for presentations that cover, using a rough measure, of more than 30 pages in published form. Here, we tabulate those reports that at the time of the study met this criterion. Though some publications may have escaped the search, the overview ought to be informative and representative on the whole.

Table 24.1 lists the authors and identifies the patients, whenever possible citing their age, sex and any names by which they might be known in the literature, the dates and length of treatment, to the extent that this could be ascertained from the reports, as well as indicating the type of record and the approximate page count of the report in published form. Looking at the dates of publication in this sample, its incompleteness must be emphasized once again, and one is struck that from 1930 to 1959, there were six reports, while from 1960 to 1979, there were 20.

These extended clinical case reports constitute a bridge to the more formalized systematic case studies. Given their material qualities, they well could have been and still can be the object of more formal empirical studies. However, the introduction of tape recording into the psychoanalytic treatment situation opened a new window onto the process that for long was ardently debated and for most analysts is still controversial. Audio recordings of the psychoanalytic dialogue indeed do pose a number of substantial clinical and ethical problems, although for scientific reasons, they provide true progress [11]. They allow an independent, third-person perspective on the analytic, interpersonal transaction; with regard to the analyst's and the patient's internal modes of experiencing, they are silent and ideally have to be completed by the participant's testimony. The recording of these cases has opened up access to many theoretical and technical issues.

Single-case studies are not confined to tape recording; any systematic gathering of treatment relevant material can be used to document a treatment.

Overviews of the methodology of single-case studies have been presented by Kazdin [12, 13], Hilliard [14], Fonagy and Moran [15]. The latter summarized the topic succinctly:

> Individual case studies attempt to establish the relationship between intervention and other variables through repeated systematic observation and measurement…The observation of variability across time within a single case combines a clinical interest to respond appropriately to changes within the patient, and a research interest to find support for a causal relationship between intervention and changes in variables of theoretical interest. The attention to repeated observations, more than any other single factor, permits knowledge to be drawn from the individual case and has the power to eliminate plausible alternative explanations [15, p. 65].

For many years, the Ulm Psychoanalytic Process Research Study Group has implemented a program to examine the material bases of psychoanalytic therapy. We have remained convinced that only the careful exploration of the patient's interaction with the analyst can illustrate the central aspects of psychoanalytic treatment and enable an empirically driven theory of the process. Therefore, we have undertaken a sustained, multilevel, collaborative examination of what may be described as a "specimen case." Over the course of many years—even decades—studies of various kinds in qualitative and quantitative methodology have been made on the psychoanalytic treatment of our specimen case, "Amalia X."[1] Clinical vignettes and a psychodynamic summary of the case have been provided in the second volume of Thomä and Kächele's textbook *Psychoanalytic Practice* [18, 19]. The following clinical description of the patient has been quoted from this text:

> Amalia X (born 1939) was in psychoanalytic treatment (517 sessions) during the early seventies with good results. Some years later she returned to her former therapist for a short period of analytic therapy because of problems with her lover, many years her junior. Twenty five years later she consulted a colleague of mine as her final separation from this partner had caused unbearable difficulties and she again asked for circumscribed help.
>
> Amalia X came to psychoanalysis because the severe restrictions she felt on her self-esteem had made her vulnerable to depression in the last few years. Her entire life history since puberty and her social role as a woman had suffered from the severe strain resulting from her hirsutism. Although it had been possible for her to hide her stigma—the virile growth of hair all over her body—from others, the cosmetic aids she used had not raised her self-esteem or eliminated her extreme social insecurity. Her feeling of being stigmatized and her neurotic symptoms, which had already been manifest before puberty, strengthened each other in a vicious circle; scruples from a compulsion neurosis and various symptoms of anxiety neurosis impeded her personal relationships and, most importantly, kept the patient from forming closer heterosexual friendships.
>
> This woman, who was hard-working in her career, cultivated, single and quite feminine despite her stigma, impressed me positively. The analyst was relatively sure and confident that it would be possible to change the significance she attributed to her stigma. In general terms, he proceeded from the position that our body is not our only destiny and that the attitude which significant others and we have to our bodies can also be decisive. Freud's [20, p. 189] paraphrase of Napoleon's expression to the effect that our anatomy is our destiny must be modified as a consequence of psychoanalytic insights into the psychogenesis of sexual identity. Sexual role and core identity originate under the influence of psychosocial factors on the basis of one's somatic sex.
>
> The analyst's (H.T.) previous experience warranted the following initial assumptions. A virile stigma strengthens penis-envy and reactivates oedipal conflicts. If the patient's wish to be a man had materialized, her hermaphroditic body image would have become free of conflict. The question "Am I a man or a woman?" would then have been answered; her insecurity regarding her identity, which was continuously reinforced by her stigma, would have been eliminated; and self-image and physical reality would then have been in agreement. It was impossible for her to maintain her unconscious fantasy that she was a man, however, in view of her female genital. A virile stigma does not make a man of a woman. Regressive solutions, such as reaching an inner security despite her masculine stigma by identifying herself with her mother, revitalized old mother-daughter conflicts and led to a variety of defensive processes. All of her affective and cognitive processes were marked

[1] To avoid any association with Erikson's [16] "dream specimen of psychoanalysis," we emphasize from the outset that the examination of Amalia's treatment should be considered as our own specimen case. Since then, we have completed a report on the second specimen case Christian Y [17]; two more cases are to follow, Franziska X and Gustav Y.

by ambivalence, so that she had difficulty, for example, deciding between different colors when shopping because she linked them with the qualities of masculine or feminine ([18, 19], pp. 79).[2]

Given the paucity of systematic descriptive data on psychoanalytic cases, we have to accept that the various studies performed on the specimen case of Amalia X refer to parts and aspects of the treatment only, and must eventually be integrated so that the relationships among them, and thus the case as a whole, may be appreciated. Whether general conclusions can be drawn from our efforts remains an open question. The principle conviction which led us to start this enterprise was that psychoanalysis—like any other scientific field—requires careful descriptive work. This necessary step in research was dubbed as the "botanical phase in psychotherapy research" [23].

Luborsky and Spence's [24] statement concerning the requirements for specimen cases spells out quite succinctly what is at stake here. They write: "Ideally, two conditions should be met: The case should be clearly defined as analytic, and the data should be recorded, transcribed and indexed so as to maximize accessibility and visibility" (p. 426). The first condition has been met as well as possible, given the existing epistemological problem that there is no consensually agreed upon definition of the psychoanalytic process, by virtue of the fact that a reasonable number of colleagues considered this case to be truly "analytic." The treating analyst had a high reputation in the professional community, although all analysts have to demonstrate the nature of their work in each and every case. Based on the results of studies, it can also be said in retrospect that the treating analyst conformed to the fundamental psychoanalytic rules which predominated during the 1970s. Conforming to a specific method should not be confused with abiding by a law. Rather, we share the view of Gabbard and Westen [3] that the process should be conducted according to the principle of trial and error. Our stand on this issue remains exclusively within the professional community. [AU2]

The second condition formulated by Luborsky and Spence [24] is fulfilled by the utilization in our studies of the Ulm Textbank [25], in which audio recordings of 517 sessions of this psychoanalytic case are stored and kept available for investigation by members of the scientific community. Through many years of work, approximately half of the sessions in this case have been transcribed according to the rules of the Ulm Textbank [26]. Most of our investigations would not have been possible without these audio recordings and verbatim transcripts of the therapeutic dialogue.

We would like to emphasize the value that audio recordings create for empirical analytic studies of treatment reports and interdisciplinary research. The accessibility of psychoanalytic dialogue and the investigation of it by psychoanalytic researchers in collaboration with psychologists, linguists, or other independent scholars strengthen the foundation of psychoanalysis. In the past, too often, scholars wrote about psychoanalysis without having access to its primary data—a situation that may be compared to discussing the philosophical ideas of Socrates without having read any of the Platonic dialogues.

The Empirical Approach: A Multilevel Observational Strategy

Our long-term aim has been to establish ways of systematically describing the various aspects and dimensions of psychoanalytic processes and to use the descriptive data obtained in this way to examine process hypotheses. This included the generation of general process hypotheses as well as the specification of single-case process assumptions. Specifying how the psychoanalytic process should unfold must go beyond general clinical ideas by considering the kind of material brought forth by

[2] A report on the analytic technique in this case has been presented at the New Orleans IPA conference in 2004 [21], where the case has been discussed by a good number of analysts from diverse camps [22].

each patient and the strategic interventions most appropriate to achieving change in the dimensions of theoretical relevance specified for each particular case. Although our approach excluded the use of non-clinical measures to limit the intrusions on the clinical process[3], independent psychometric pre–post outcome data were used to assess the effectiveness of the psychoanalytic treatment, and these data have been published in the second volume of Thomä and Kächele [19, chap. 9.11.2].

Our methodological approach distinguishes four levels of case research, each working on different material studied at different levels of conceptualization [28]. These are: clinical case study (level I); systematic clinical description (level II); guided clinical judgment procedures (level III); linguistic and computer-assisted text analysis (level IV). Following Sargent's [29] recommendations, we chose this multilevel strategy based on our understanding that the gap between clinical understanding and objectification cannot be meaningfully bridged by using only one approach.

Level I: Clinical Case Studies

The clinical case study based on good memory or even accurate process notes of an analyst fulfils an important communicative function within the profession. As demonstrated by Dewald [30], there is a general acceptance of this form of case study as a tool for training. Astonishingly enough, these case studies have scarcely ever been the focus of formal scientific study.[4] Yet, exactly that focus is necessary to demonstrate their scientific value and thus their usefulness to our scientific community [5]. At present, there is increasing agreement regarding the critical need for carefully prepared case studies. Exactly how this may be achieved is still a key question in ongoing discussions (for example [32]).

As a contribution to these discussions, the second volume of the Ulm textbook [19] contains examples of this traditional form of reporting clinical material through the case study of Amalia X which focused on identification with the analyst's function (chap. 2.4.2); free association (chap. 7.2); anonymity and naturalness (chap. 7.7); examples of audio recordings (chap. 7.8.1); and changes (chap. 9.11.2).

Level II: Systematic Clinical Descriptions[5]

The level of systematic clinical description by trained observers is clearly distinct from that of clinical case study, but still remains close to clinical reasoning. In the case of Amalia X, these methods have been based on tape recordings of the whole treatment, supplemented by verbatim transcripts of one-fifth of the sessions (e.g., 1–5, 26–30, 51–55,…501–505). The use of verbatim records of the sessions allows for systematic access to clinical material by outside readers. Working with a systematic time sample assumes that systematic data analysis within fixed time intervals can capture the decisive change processes.

[3] In the 1970s of the last century—when this case was recorded—extra-clinical interviewing during the analytic treatment was not yet in our mind; today, this strategy has been shown not to be detrimental to the analytic process [27].

[4] Recently, we have completed a study on diagnostic features of 900 cases prepared for the final evaluation by candidates of the German Psychoanalytic Association with respect to gender [31].

[5] The material presented in the following sections is reported in great detail in the third volume of the Ulm textbook which has been edited by [9].

We used the following points of description for each five session block spread over the whole treatment from hour 1 to 517 with regular excluded intervals of 20 sessions:

1. External situation of the patient and treatment
2. Transference/countertransference situation
3. Relations of the patient to important "objects" outside the treatment, present and past
4. Working alliance
5. Important episodes within the five session block

This systematic description was initially prepared by two medical students and then revised and refined by two experienced psychoanalysts. The material available after such an effort can serve many purposes besides being a valuable achievement in itself (see [9, chap. 3]). It allows for an easy orientation to the whole case while being more detailed and more systematic than the usual novella-like case history. This systematic descriptive record marks out the orderly progress of clinical topics. One can rearrange the qualitative data (e.g., aggregating all transference descriptions one after the other) and thereby gain a good impression of the development of major issues, as illustrated by the following condensed description of the prevailing transference issues:

Systematic description of Amalia X's focal transference issues

001–005: The analysis as confession
026–030: The analysis as an examination
051–055: The bad, cold mother
076–080: Submission and secret defiance
101–105: Searching her own rule
116–120: The disappointing father and the helpless daughter
151–155: The cold father and her desire for identification
176–180: Ambivalence in the father relationship
201–205: The father as seducer or judge of moral standards
226–230: Does he love me—or not?
251–255: Even my father cannot change me into a boy
276–280: The Cinderella feeling
301–305: The poor girl and the rich king
326–330: If you reject me I'll reject you
351–355: The powerless love to the mighty father, and jealousy
376–380: Separation for not being deserted
401–405: Discovery of her capacity to criticize
426–430: I'm only second to my mother, first-borns are preferred
451–455: Hate for the giving therapist
476–480: The art of loving consists in tolerating love and hate
501–505: Be first in saying good-bye
513–517: Departure-symphony

An even more simplifying method to abstract the total content of a treatment is provided by the Topic-Index Method, based on the early work of Gill's research team [33], which was used by Dahl [34] to study the distribution of major themes throughout the treatment. Following this procedure, we assessed the presence of each topic in a binary (yes/no) format, and the resulting graphical matrix provided a good overview of when a certain topic was covered by the patient and/or analyst during the treatment [35].

Level III: Guided Clinical Judgment Procedures

This methodological level consists of qualitative, clinically informed judgments which are performed by two or more trained judges in a systematic fashion. This approach first records the data on a qualitative level, yet allows for the handling of such data with both parametric and non-parametric statistics. To perform this transformation, a simple scale is used to represent the dimensional aspect of any concept under study. This scale, being a more elaborate version of the binary "yes/no" distinction, marks the beginning of any measurement procedure. Luborsky [36] aptly called these "guided clinical judgment procedures" that utilize the skills with which a clinician records complex data. At this level of our research approach, various studies were performed on our specimen case as follows:

1. Change of emotional insight [37]
2. Change of self-esteem [38]
3. Types of subjective suffering [39]
4. Change in dreams [40]
5. Focal model of process [41]
6. Breaks between sessions and the analytic process [42]
7. Psychoanalytic technique assessed by the Psychotherapy Process Q-Sort method [43]

Summarizing these approaches focuses on what we have learned from them.

Change of Emotional Insight

The concept of insight is one of the key concepts in psychoanalytic treatment, although substantial measures of change in emotional insight have been rare. Hohage and Kübler [37] constructed a rating scale that differentiates between a patient's cognitive access (C-score) and emotional access (E-score) to her material. Added to this is a combined score of the specific construct called "emotional insight" which is fully described in Hohage's manual [44].

This approach consists not only of a quantitative assessment of insight itself but also of the cognitive and emotional involvement. Of course, change in emotional insight is only an indicator of an important step, portraying that the patient begins to reflect on himself and his involvement with other persons.[6] In such cases, the extent of the patient's increased experiencing of himself would be a relevant result. The patient Amalia X, however, from the outset of the treatment was psychologically minded and often dealt with her own thoughts and feelings (C-score unchanged). Even so, changes in her emotional experiencing (E-score) were of importance. When placed under the impact of psychic conflict, she appeared to strengthen her emotional access to her material, which indicates an important therapeutic change. For example, when under the pressure of imminent termination, she was able to remain emotionally involved. This supplemented the finding of generally increased insight scores.

Change of Self-esteem

Ever since Kohut rediscovered the positive aspects of narcissism, the concept of self-esteem has had the potential to be used as a unifying concept for a diversity of research lines both within and outside

[6] At the time this study was performed, the concept of mentalization was not yet around; today, it would be interesting to see whether the Self-Reflection Scale of Fonagy et al. [45] would correlate with the measure of emotional insight.

of psychoanalysis. In the personality research of recent years, self-esteem and a number of related concepts have played an increasingly important part, as Cheshire and Thomä [46] have shown. On the other hand, it has so far largely been neglected as a clinical-psychotherapeutic concept in the framework of empirical psychotherapy research. Yet, it is precisely this concept which can, in our opinion, most readily create meaningful links between process and outcome research because it is a variable equally relevant to both realms. If the process of therapy is understood as a gradual acquisition of certain attitudes and abilities, and if outcome is assessed in terms of the possession and availability of these attitudes and abilities, then researchers should gather information about those features of the patient that reflect this process of acquisition and the stability of its result. Hence, we believe in the importance of longitudinal and follow-up studies of these features.

Neudert et al. [38] developed a manual to assess the diverse aspects of this concept. The two central hypotheses about changes in overall self-esteem were confirmed: positive self-esteem increased significantly during the course of treatment, although the trend did not set in right at the start of treatment but only after wide fluctuations over the first 100 sessions, and negative self-esteem showed a significant and continuous decrease from the beginning of treatment. However, hypotheses regarding changes in acceptance by others were not confirmed, as there were no systematic trends. Nor were the hypotheses confirmed having to do with the relative incidence of different categories of material before and after focal working-through. On the other hand, there were indeed two confirmatory results for hypotheses about differences between correlations among categories: Self-esteem in connection with imagined heterosexuality improved significantly, as expected, and negative self-esteem in connection with autoeroticism decreased significantly.

Types of Subjective Suffering

Another key concept of psychoanalysis has been subjective suffering, that is, suffering that is not captured by standard psychiatric rating scales but rather reflects the patient's subjectivity. Neudert and Hohage [39] developed a manual-guided procedure that delineates forms of suffering in the patient's recorded communications. In their study on patient Amalia, they were interested in the following issues:

1. What was the total amount of subjective suffering during the course of treatment?
2. Which part of the patient's suffering during psychoanalysis was related to her psychoanalyst, which part had other sources, and what were those other sources?
3. How did the patient's suffering in relation to the psychoanalyst change over the course of treatment? Were there crises in the course of treatment, and, if so, what caused them?
4. How much of the suffering related to the analyst was in fact due to his abstinence?
5. What did the therapist do when he became the object of the patient's suffering?

The results indicated that the amount of total suffering throughout the treatment can be described as a monotonic and statistically significant negative trend, and that "helplessness in dealing with suffering" decreased significantly over the course of treatment. From the data, it was clear that suffering related to the analyst was low in comparison to the total amount of subjective suffering. However, the suffering experienced in relationship to the analyst increased slowly to a peak toward the middle of the treatment. Here, the suffering related to the environment evidently replaced the patient's suffering in regard to herself. Until that point, she had primarily been occupied with her own insufficiencies, insecurities, and inhibitions. Having overcome this, the data show that she began to tackle her environment even though doing so was painful for her, and the psychoanalyst became the primary *safe* object for her painful conflicts.

Change in Dreams

Even though most discussions about dreams in clinical practice focus on a single dream, it is evident that the reporting of dreams during a psychoanalytic treatment is one of the most regular phenomena. Some patients report dreams more and others less, and analysts differ as to the extent they use the dreams offered by the patient [47]. In compromise, both patient and analyst establish a non-conscious, non-intentional agreement on the relevance of dreams for the purpose of the treatment.

The Ulm dream study group investigated cognitive changes based on dream reports also in this case. The development of these cognitive functions was studied throughout the treatment using the total dream material of the transcribed sessions of Amalia X [48].

Our results related to three questions. First, what were the dreamer's relations to other people? It was obvious that Amalia X did not change with respect to her social relations in her dreams, which is remarkable when considering that she suffered from erythrophobic symptoms at the beginning of the treatment. The second question pertained to the global emotional atmosphere in the dreams. A list of adjective scales was used and by means of factor analysis, we identified a steady trend from negative dream emotions at the beginning to positive dreaming coloration toward the end of the analysis. The third issue focused on the problem-solving activity of the dreamer, and we observed a steady systematic change escalating as the analysis proceeds. Another issue in this study was whether the changes observed could be modeled as linear trends, and in the results, we found both stationary processes with variations in intensity (as in aggressive or anxious feelings) and changes that increased or decreased in a linear fashion over time.

The Ulm Focal Model of Process

At present, the number of coherent models of the psychoanalytic process still remains small. In the Ulm Process Model [18, chap. 9], psychoanalytic therapy is understood as a continuing, temporally unlimited focal therapy with a changing, interactively developing 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 Core Conflictual Relationship Theme (CCRT) method summarized by Luborsky and Crits-Christoph [49] offers a way of making such focal and core conflicts operational. The basic assumption of the CCRT method is that patients' accounts of interpersonal experiences contain typical internalized subject–object relationship patterns. Stories told in therapy reflect experiences, and for that reason, the CCRT method analyzes narratives of the patient's experiences in relationships ("relationship episodes").

The study by Albani et al. [41] investigated how effective the CCRT method would be in depicting the therapeutic course of the psychoanalytic treatment of Amalia X according to the Ulm Process Model. The data we evaluated were drawn from the first and last therapy phases (sessions 1–30 and 510–517, respectively), and beginning with the 50th session blocks of five sessions were analyzed at 50 session intervals, with a final sample of 11 blocks and 92 sessions.

The following pattern was found by counting the most frequent categories across all phases of therapy:

Wish toward the Object	*Others should be attentive to me*
Wish toward the Self	*I want to be self-determined*
Assumed Response of the Object	*Others are unreliable*
Assumed Response of the Self	*I am dissatisfied, scared*

This pattern formed a central focus, and this focus was worked-through in many therapy phases detailed in the study. Amalia X's wish for change was expressed in her desire for autonomy, overcoming her experience of herself as dependent and weak, as unable to set limits, and as dissatisfied. A basic theme manifested itself in each of the absolute highest frequency categories ("nuclear conflicts"), and each therapy phase showed typical clusters of CCRT categories which characterize thematic foci in the sense of French's [50] "focal conflicts" as operationalized by the CCRT method.

Both the strengths and limits of the CCRT method stem from its confinement to reports of relationship experiences by the patient herself. In other words, investigations remain limited to relationship experiences that the patient has perceived and verbalized. The method provides no way of including unconscious material other than the repetitive schemas that patients unconsciously follow in describing the course of relationship and of assessing defense mechanisms. This study showed that the CCRT method captures clinically relevant interpersonal aspects of the psychoanalytic process from the patient's point of view, supporting the Ulm Process Model, although the analyst's contribution was reflected only in the patient's narratives regarding her relationship to the therapist.

Breaks Between Sessions and the Analytic Process

The evolution of Amalia X's reactions to breaks during the course of the analysis was studied by Jiménez et al. [42] on the hypothesis that this could serve as an indicator of change achieved through the therapeutic process. The study was based on a sample of 212 transcribed sessions evenly distributed over the treatment and comprised three stages (1) A formal definition of a break in the treatment was determined by means of a histogram based on the attendance card. (2) Using the Ulm Anxiety Topic Dictionary, a computer-assisted method of verbal content analysis, an attempt was made to characterize the sessions correlated in time with the various types of breaks: this instrument defined the construct "separation session," which tended to appear immediately before the more prolonged breaks, but was also found sporadically in relation to shorter breaks. (3) A sample of separation sessions was investigated for transference responses by means of the CCRT: the components of the CCRT evolved in accordance with expectations, and the results were discussed in relation to the methodology used and the psychoanalytic theory of therapy.

Psychoanalytic Technique

The Psychotherapy Process Q-Sort [51] proved to be a reliable and relevant instrument for describing patterns of interactions in the case of Amalia X [43]. Comparison of sessions from the beginning and termination phases of a psychoanalytic therapy demonstrated clinically relevant differences between the two phases of treatment. The initial phase of the therapeutic interaction was characterized by the analyst's intensive and supportive treatment of the patient. A reciprocal influence existed between the patient's self-accusatory patterns, her embarrassment and feelings of low self-esteem, and the analyst's helpful interventions. The therapeutic technique consisted of clarifications as well as confrontations and interpretations of in-session behavior. This helped the patient become more forthright in exploring her thoughts and feelings. The description of the initial phase with this method pointed to the establishment of a good helping alliance early in treatment. In the end phase of the analysis, the patient had become capable of expressing aggressive feelings. Feelings of guilt had dramatically subsided, and the patient was able to talk well about difficult love relations. The topic of separation was openly discussed in the analysis, and the patient identified her ability to work with her dreams as expressing her internalization of the analytic function.

These findings are well supported by Akhtar's [52] comments on the specimen session 152:

[AU3]

> Dr. Thomä's technique shows flexibility, resilience, and broad-mindness. It is centered upon helping the patient achieve ego freedom though interpretation and transference resolution. However, it incorporates a variety of listening attitudes and a broad range of interventions that can be seen as preparatory for, as well as in lieu of, the interpretive enterprise (p. 690).

This clinically based evaluation fits well with the recent addendum to the study of technique in the case of Amalia X that was provided by the detailed analysis of the specimen session 152 by Levy et al. [53]:

> Our first impression of Session 152 of the analytic treatment of Amalia X is that the dialogue is complex, the associations very personal, and the exchange very intimate between a patient and analyst who have developed an excellent therapeutic alliance. In fact, this is a session requiring more than one reading in order to feel confident in one's rating. We experienced this hour as an entry into a very private world of dyadic meaning that requires careful attention to the process. (p. 18)

It is obvious that this detailed method of analyzing the interiors of an analytic exchange deserves a fuller, more systematized application to this treatment which is underway.

Level IV: Linguistic and Computer-Assisted Text Analysis

Systematic investigations on the special conversational nature of psychoanalytic technique have been made using materials from the Ulm specimen case. Koerfer and Neumann [54] focused on the patient's sometimes painful transition from everyday discourse to psychoanalytic discourse. These and other findings from that field of discourse analysis support the topical formulation of our "philosophy" of psychoanalytic therapy: Provide as much everyday talk as necessary to meet the patient's safety needs, and provide as much psychoanalytic discourse as feasible to stimulate the exploration of unconscious meanings in intrapsychic and interpersonal dimensions [19, chap.7.1].

Following Schafer's [55] ideas of action language, Beermann [56] studied the use of various syntactical variations in active and passive voice expressed by Amalia X over the course of treatment. Kächele [57] investigated the analyst's conversational strategies, focusing first on the analyst's verbal involvement, showing that in a productively evolving analytic process (as it happened in the case Amalia X), there was no correlation between patient's and analyst's amount of verbal participation. The analyst's verbal activity steadily declined over the course of the analysis, reflecting the analyst's recognition that this patient would be increasingly able to develop her own verbal space.

A distinction of formal and substantial aspects of the speaker's vocabulary (the term "vocabulary" referring to the number of different words or "types" that are used by a speaker) has been shown to be useful. Measures of types are interesting, since words stand for concepts and therapy may be viewed essentially as an exchange of concepts involving the assimilation of new material and accommodation of previous schemata. Thus, the analyst's vocabulary at the beginning of the analysis likely will both shape and reflect the patient's experiential world, and during the analysis, its evolution might run parallel to, or at least partly reflect, the conceptual and emotional learning processes that take place.

To explore this, we examined the analyst's characteristic vocabulary in the opening phase of Amalia X's analysis with a specific focus on the part of his vocabulary that he actively introduced in the dialogues (as distinct from following the patient's lead) [58]. Based on its frequency of occurrence of types, the analyst in the first 18 sessions characteristically emphasized four classes of nouns in his interventions: *technical nouns* that were part of his task to invite the patient's participation in the analysis; *emotional nouns* that were part of the analyst's technique to intensify emotions; *sexual*

bodily linked nouns that referred to the patient's embarrassed sexual self concept; and a few *topical nouns* that reflected aspects of the patient's life situation reported in the first sessions.

Computer-assisted vocabulary screening may be useful to identify basic interpretive strategies focusing on analysts' emotions. Reviewing previous works using computer-based vocabulary analysis based on Dahl's [59] emotion theory, we tested a systematic sample from our specimen case. The study confirms that in the treatments, a systematic change from negative "ME-emotions" to negative "IT-emotions" can be demonstrated [60]. This finding underscores the basic Freudian notion that self-referential complaints have to be transformed into object-related activities.

Last but not least, Mergenthaler's cycle model [61] was applied to the session 152 of the patient Amalia [62]. This approach working on the microscopic level of moment-to-moment interactions directly allows for a feedback process into the rich clinical discussions that have been the topic of many contributions of this session material.

Summary Comments

In view of the paucity of thorough clinical-empirical studies of psychoanalytic cases [9, chap. 3], Werbart [63] expresses the opinion that this work represents a major step in devising a methodology of sound empirical research into the process of analytic treatments. First, we have demonstrated *that* the empirical research can be done, and then we have shown *how* it can be done, given sufficient dedication and institutional support. Psychoanalytic treatment can be made the focus of objective and methodologically sophisticated research, leading to findings and discoveries that cannot be made by the treating analyst alone. The clinical perspective of the treating analyst is essential but is necessarily limited by his or her role as a participant observer of the analytic process. Supplementing this, formal systematic research opens the way to independent understandings of the mechanisms of change in psychoanalysis.

The studies of our specimen case not only support the notion that this analytic treatment led to considerable change in many aspects of the patient's cognitive and emotional functioning, but also demonstrate the usefulness of micro-analytic research techniques that help to identify and conceptualize change processes. The number of descriptive dimensions that are possible and necessary to describe these changes is not small. However, one conclusion can safely be drawn from the studies of our specimen case, which is that change processes exist and can be demonstrated by research methods that are reliable and valid. Both the process of change in psychoanalysis and in the patient's basic psychological capacities take place all along the way, and it is often but not always the case that they can be described in terms of linear trends along the continuum of the treatment.

The case of Amalia X is one of the most intensely studied, perhaps the most intensively studied, of all specimen cases. Almost all of the hypotheses tested were significant, thereby providing support for the underlying conceptions of psychoanalytic treatment that guided the studies. Although this substantiation is valuable, it is also of interest to consider the limitations of the studies. Except for the hypotheses relating to Amalia X's improvement in acceptance by others, which were paralleled by failure to improve her social relations in her dreams, in all other instances, we found what we expected to find, which may be a form of the association between investigator allegiance and treatment outcome [64]. Consequently, we were disappointed that more significant surprises did not emerge from the studies. The implication is that we need to develop and to address more innovative questions. One example has been developed by a Swiss research group studying Amalia's transcripts with a sophisticated linguistic methodology [65] thus generating a host of detailed, fine-grained analyses [66, 67].

A corollary of this failure to find new phenomena is that we did not come away from this array of studies with any new, convincing ideas of which were the most important mutative factors in her

substantial improvement. Although momentary affective patient–analyst interactions may have mutative effects (see Levy's [53] comment to session 152), we have concluded that a long-term view of the course of treatment is essential to identify structural changes in the patient. This emphasizes the extraordinary complexity of attempting to delineate the causes of mutative effects and reinforces the need for humility in approaching such endeavors. Often, the analyst's uncertainty is defended against by compensatory feelings of knowing all about analytic treatment, or, as Jonathan Lear [68] terms it, "Knowingness."

Having said this, we would like to assert that in the domain of examining mutative factors specifically in psychoanalytic treatment, single-case research has certain advantages compared to group studies. Conversely, with regard to the assessment of therapeutic benefit, group studies seem advantaged. Indeed, group studies seem to have solidly established the therapeutic efficacy of psychodynamic treatment [69, 80–82].

Any attempt to study mutative factors in psychoanalytic treatment in particular must deal with the unresolved epistemological problem that there is no consensually agreed definition of "psychoanalytic process." This is so vexing that it has been dealt with largely by denial of the existence of the problem. For example, the definition of psychoanalysis used by De Maat et al. [69] is: "the patient lies on a couch, and there are at least three sessions a week" (p. 2). As Gill [70, 71] has argued, these external criteria are insufficient. It is noteworthy that although the outstanding attribute of contemporary psychoanalysis is the diversity of theory and praxis, we know of no attempt to substantiate the characterization of a treatment as psychoanalytic that included psychoanalytic reviewers who were diverse in orientation.

Psychoanalysis, unfortunately, is a field lacking clear boundaries. We can say what it is not; we cannot say what it is. It is time, in agreement with Winnicott [72], Gill [70], Fosshage [73], and Cooper [74], to be more definite in stating that attempting to distinguish between psychoanalysis and psychoanalytic psychotherapy is futile. Having digested Sandell et al.'s [75] report from the Stockholm study demonstrating how strongly therapist attitudes influence change during treatment, we think that the field should move on. We propose Gill and Fosshage's suggestion that any treatment that focuses upon analysis of transference ("stereotyped rigidity," Gill [71]) be considered psychoanalytic treatment. However, many investigators use the term "transference" loosely to apply to all patient–analyst interactions. We propose that the term "transference" should be limited to patient behaviors that are characterized by "stereotyped rigidity" and are to some degree maladaptive. Of course, this involves a subjective clinical judgment, such as analysts regularly make in treatment, and raises the question of whether the patient's judgment or the analyst's judgment shall be privileged. This definition should take into consideration Gill's observation that there are often elements of plausibility in the patient's responses to the analyst. Given the complexity of assessing "stereotyped rigidity," analysts would have to undergo training in order to be able to achieve interrater reliability, especially if analysts of diverse orientations were included. Clearly, evaluating "transference" in the material of a single case has to be placed in some comparative perspective; to attempt such studies with large numbers of treated patients would be orders of magnitude more demanding. Therefore, if the intent is to study the causality in specifically psychoanalytic treatment (as defined by the presence of "transference"), the feasibility of doing so is greater in single-case studies than in group studies.

In addition, any psychoanalytic technique needs a strong focus on new experience to overcome the maladaptive patterns [18]. This kind of new experience must be fostered by a number of techniques, including supportive interventions that Schachter and Kächele [76] have termed Psychoanalysis-Plus. Processing the therapeutic relationship to a patient´s best use must be the clinical hallmark of good analytic work [77, 78]. How to evaluate the degree of new experience is still a formidable task that lies ahead. The investigation of the specimen case Amalia X has not yet come to an end.

As we have demonstrated, single-case research allows for a number of research methodologies to be implemented in order to better understand the universe each individual analytic dyad represents. "The careful scrutiny of the psychoanalytic process through concurrent use of multiple methodologies has created a comprehensive reference text that clinicians can use to improve their understanding of the mechanisms of change," comments Fonagy [79] on the full length account of this research enterprise.

We would like to encourage other research groups to single out a carefully documented, tape-recorded case and focus on the various dimensions of study. We want to encourage other psychoanalysts to open the privacy of their clinical work in the endeavor to improve psychoanalysis and clinical work by allowing others in the scientific community to carefully scrutinize their analyses. We recommend the training of researchers who are also trained as clinicians and the training of clinicians who are also trained as researchers, so that they may learn to identify with both the clinical and research tasks. We need analysts and researchers with the ability to support long-term commitment to making slow but cumulative progress. Systematic investigations are dependent on teams supported by institutions which promote cooperation between analysts in practice and full-time researchers. Implementation of such research will help to move psychoanalysis creatively beyond its contemporary crisis.

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Author Queries

Chapter No.: 24 0001331404

Queries	Details Required	Author's Response
AU1	Please provide complete details for the author "Helmut Thom™".	
AU2	In the sentence starting "Based on the results of studies…" please provide citations for "studies" if appropriate.	
AU3	Please check if "broad-mindness" should be changed to "broad-mindedness" in the quoted text starting "Dr. Thom™'s technique…".	
AU4	Please update the following Refs. [27,60,74].	