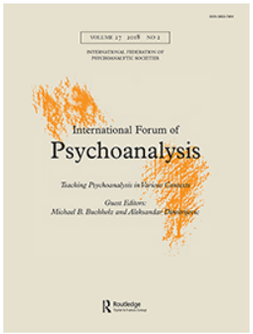

International Forum of Psychoanalysis

ISSN: 0803-706X (Print) 1651-2324 (Online) Journal homepage: http://www.tandfonline.com/loi/spsy20

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To cite this article: Michael B. Buchholz & Horst Kächele (2018) Teaching research methods to psychoanalysts: Experiences from PSAID, International Forum of Psychoanalysis, 27:2, 114-120, DOI: 10.1080/0803706X.2017.1296587

To link to this article: https://doi.org/10.1080/0803706X.2017.1296587

Published online: 08 Jun 2017.

International Forum of Psychoanalysis, 2018
Vol. 27, No. 2, 114–120, https://doi.org/10.1080/0803706X.2017.1296587

Teaching research methods to psychoanalysts: Experiences from PSAID

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Abstract
Here we introduce the dissertation program PSAID (Postgraduate Studies for the Advancement of Individual Dissertations), conducted at the International Psychoanalytic University in Berlin, Germany. We tell stories about our experience: about a wish to sum up in a dissertation after long years of clinical practice what has been learnt in diving deeply into human experience; about the fear of losing one's identity when something new is to be learned, either planning a research study or conducting an interview that has not clinical but research-driven orientations; about the "biography of theory" – what motivates therapists to make a choice between psychoanalysis or cognitive-behavioral therapy; about how the experience of listening changes when you do not hear a voice but read a transcript and understand how many details allude to a relationship and influence your perception and thinking; about the experience of seeing a voice visualized on an audiogram; about summing up certain characteristics of "situations" in the consulting room. We propose not only to distinguish "online/offline" research, but to include "situationism" as a third concept.

Key words: *PSAID, psychoanalysis, dissertation program, research, clinical practice, situationism.*

The debate concerning research in and on psychoanalysis has a long history. In his seminal paper, Glover (1952, p. 403) pictured the state of affairs as follows:

> An analyst, let us say, of established prestige and seniority, produces a paper advancing some new point of view or alleged discovery in the theoretical or clinical field. Given sufficient enthusiasm and pervasiveness, or even just plain dogmatism on the part of the author, the chances that without any check, this view or alleged discovery, will be quoted and requoted until it attains the status of an accepted conclusion.

Summing up the plethora of papers on the issue, Wallerstein (2009) introduced the distinction between research in psychoanalysis and research on psychoanalysis. Hartmann, Neubert, Läzer, Ackermann, Schreiber, Fischmann, & Leuzinger-Bohleber (2015, p. 2) has rephrased this distinction by distinguishing between clinical and extraclinical research:

> Today we can differentiate between two different groups of psychoanalytic research, the clinical and extra-clinical. By clinical research we mean the genuine psychoanalytic research in the psychoanalytic situation itself. Ulrich Moser and Ilka von Zeppelin (2009) describes it as on-line research while the extra-clinical research (the off-line research) take place after the psychoanalytic sessions and embraces a variety of different research strategies.

Although it would be timely to debate in detail what methodology in clinical research looks like, here we will report on our experiences from developing extraclinical research competencies in students of psychoanalysis at our university. Looking at these experiences, we think that the online/offline distinction can be complemented by a three-fold perspective.

Postgraduate Studies for the Advancement of Individual Dissertations

In 2012, we established a dissertation program – the Postgraduate Studies for the Advancement of Individual Dissertations (PSAID) – at the International Psychoanalytic University in Berlin, Germany. It was clear from the start that we could not involve participants in costly outcome studies; the focus we want to report here is on process research in a dimension that can be conducted by a single person using the help of other participants in the group.

In the beginning, many psychoanalytically trained colleagues applied to our program. Some of them were clinically very experienced; others were at some stage of their psychoanalytic training, most of

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(*Received 9 November 2016; accepted 13 December 2016*)

them just before graduation. All participants differed in terms of their age and experience, but they all had their own ideas of what they would like to study. One woman, experienced in psychoanalytic trauma therapy, wanted to use research methods to investigate what she viewed as the difference in transference when treating "normal" and traumatized persons. Another wished to check whether there was a difference when a person was first interviewed by a male or a female interviewer. Another wanted to study how the German insurance system distorts the entire psychoanalytic process. Yet another wanted to investigate whether child therapy carried out in a school context would differ from child therapy in the context of private practice. And yet another wanted to study how Facebook interaction makes people depressive, hoping to illustrate this by an adolescent he had in treatment. These and many similar ideas arose from clinical inspiration. They reflected the urge to clarify some difficulties encountered during days in lonely practice or under the pressure of caseloads in everyday treatment.

From colleagues working in psychiatric and psychotherapeutic clinics came other ideas. They wanted to find out whether the treatment of anorexia nervosa conducted using psychoanalytic concepts could be shown to be more successful than treatments with drugs or other nonpsychoanalytic regimens. These research interests were obviously motivated by conflicts at work. Not infrequently, it came out that the clinic's approach to treatment was officially not psychoanalytic; however, many psychologists in psychoanalytic training were employed and wanted to document the value of their profession.

Stories of change

Here we want to limit our report to those PSAID participants who generated their research interest from the base of a psychoanalytic profession. We illustrate by short stories our PSAID experience in order to highlight difficulties and progress in teaching research methods. We think that these stories have some impact in opening well-minded clinical colleagues from psychoanalysis to the world of research methodology and in exposing ourselves to a real dialogue over how completely different approaches display their potential to enrich each other.

"I fear I will lose my identity"

One participant brought into the debate her clinical interest in a study of how therapists' therapeutic skills might be influenced by whether or not they had children. She had planned an interview study with colleagues of different therapeutic orientations, and we discussed the types of question, the style of interviewing, the procedure of transcription, and how to organize a process enabling the researcher to learn something new. After a break, we began to analyze the first interview she had managed to transcribe. She had undertaken the interview in a very restrained and self-controlled fashion, copying her idea of what a good psychoanalytic interview might be: a neutral analyst, mostly silent, uttering no response or stance, inviting the telling of a story.

However, it did not turn out how she had expected. The interviewee, a female therapist of a different orientation, very quickly turned the tables and asked the interviewing analyst, "Do you have children yourself?" The analyst refused to respond, maintaining that an answer was not relevant for the interview. The interview went on, and the interviewer applied her preformulated questions. But there was a penetrating feeling that what she was getting was not really what she was looking for, and this was her reason for sharing this interview with the group.

When the group started its discussion, everyone seemed to understand what had happened, and the interviewer was overloaded with psychoanalytic interpretations of what had gone wrong. However, the methodological difference between a psychoanalytic interview with a patient who comes to the analyst with a personal problem and an interview in which the interviewer makes a request for information and narrations was hard to establish. During the PSAID debate, the interviewer remarked, "If I do another kind of interviewing, I fear I will lose my psychoanalytic identity."

This was the starting point for another debate. We questioned whether the concept of identity might be helpful here. How could such a concept help us to understand the specific problem this interviewer had had? Obviously, she used "identity" in a defensive fashion. What was being defended? What she had learned in her psychoanalytic training course? When the word "learning" appeared, it suddenly became clear: there is no abstract identity to be defended, there is something new to learn. When the discussion reached this point, she understood that she did not simply have to reproduce a psychoanalytic situation, but could apply her clinical experience in order to make a quite different situation accessible for her interviewee, so that *her* narrations could emerge in such a fashion that psychoanalytic interpretations could be considered as a reasonable starting point to access new material.

The "biography of theory"

Doing research – that this meant doing something different from psychoanalytic practice – was not

completely clear to the participants who came from psychoanalytic practice. The Freudian "bond," so often quoted, seemed to unfold a "shadow side" in this research context. If, as this formula suggests, every practicing psychoanalyst does research, why learn new methods?

This problem arose when another participant presented his project. As a former behavioral therapist who then had practiced for many years as a fully trained psychoanalyst, he wanted to find out how influential certain biographical decisions from these different schools of therapy were in having an impact on certain therapeutic orientations and in the formation of therapeutic qualities. This interesting question points to the "biography of theory" to which therapists direct their attention.

Well trained in statistical procedures, the participant used a mixed method design. Based on the theoretical – taken from the literature – assumption of different attachment patterns expressed by cognitive-behavioral therapists and psychoanalysts, he interviewed therapists from different orientations and developed the hypothesis that behavioral therapists use more "technical," "interventionist" language in self-describing therapeutic procedures than psychoanalytic therapists do. The participant transcribed his interviews with therapists and, as one of his strategies, used Atlas.ti qualitative analysis software to automatically query for the frequencies of certain verbs (and other indices) used by the two groups of interviewees. However, what he found was only a slight difference.

In our debates during the PSAID sessions, some of the participants who used conversation analysis (instead of interview methods) gave a hint of some evidence showing that even psychoanalysts do not talk in a warm and personal fashion right from the start of treatment with their patients. Beginning treatment psychoanalysts use technical vocabulary, for example a formal diagnosis (International Classification of Diseases or Diagnostic and Statistical Manual of Mental Disorders), describe abstract conflicts their patients have, and praise themselves for patiently not having delivered certain interpretations. In short, there is tendency to speak as technically as possible. However, from the study of later sessions (i.e., at least one year after beginning therapy), it seems that there is a "warming up" in vocabulary.

The participant then began to reanalyze his data and found some evidence for this new hypothesis. He identified a very important experience, which he formulated as: "I am learning something new *and* can apply my knowledge." The idea he is now following is that a longer duration of a therapeutic relationship is responsible for a warmer tone of talking about patients, and that this change might be independent of therapeutic orientation. This is especially relevant as behavioral therapies usually do not last for one year or longer. The application of a research perspective to this new view of the data helped the participant to develop a new evaluation strategy for his interviews that underlines the role of relationship development as a crucial variable.

The experience of listening to talk

Some of the participants engaged in studying the contributions of conversation analysis. There is a developing group of researchers (Buchholz & Kächele, 2013; Buchholz, Spiekermann, & Kächele, 2015; Peräkylä, Antaki, Vehviläinen, & Leudar, 2008) who apply conversation analysis to the study of therapeutic process. These researchers share the idea that "talk-in-interaction" is the universal feature of what therapists of every orientation do. Thus, the best choice for process research is to study therapeutic talk. The method of conversation analysis is founded in social sciences and linguistics, and offers an excellent opportunity for psychoanalytic process research (Buchholz & Kächele, 2013). One thing needs to be mentioned here: conversation analysts value the "sweet little nothings" of talk; they have an eye for the relevance of details that other approaches tend to overlook.

One participant analyzed the fourth therapeutic session of a cognitive-behavioral therapist. She listened very carefully to the audiotape and transcribed very precisely. And she was amazed and, even more, excited as she heard the patient, a young woman, began to tell a dream to her therapist. In a tone of outrage, however, the participant brought the (transcribed) start of this segment to our data session. What had caused her anger was the following. When the patient started to tell of her dream, the therapist called out something like "Wait!" and confessed to have cut her nail, which, as it was causing her some pain, she first needed to apply some (little) care to.

But there was even more reason for the participant's anger and outrage. When the patient had related her dream and let the therapist know that she had had a series of dreams of a similar kind, the therapist began to show a detailed interest in her patient's dream life. She asked many questions about the how, when, and what of her patient's dreaming, and learned that the patient defined herself as that "living in dreams" was a most important thing in her life. After approximately 10 minutes of talking in this manner, the therapist suddenly made a disparaging remark and informed her patient that she did not understand very much about dreams, and even less so about interpreting

them. And although admitting to her ignorance on dreams, she added that she had a staunch opinion on them.

Having heard the reading to this point of the transcript, the data session group of PSAID participants laughed, easily understanding the presenter's outrage. However, things continued in a similar vein. The transcript described the therapist explaining her resolute denial of dream life (which could be understood to deny the patient's presence in the treatment room) because of her own frequently reappearing dreams. Having patiently acknowledged the therapist's self-disclosure, the patient continues to tell her about a dream she had had the night before the session: She was in a forest, lying undressed on the ground having been mugged by a group of unknown people. Someone passed by, looked at her, saw her disastrous situation – and then left the scene without addressing a word to her. Having heard this dream, the therapist uttered some "information received token" and asked the patient a question concerning her symptoms.

After the flames of anger in the group had subsided, it was proposed that a precise understanding of the reason for this anger was needed. Three aspects turned out to be of outstanding importance:

1. The patient had had the dream after three sessions and was unconsciously preparing this fourth session. Thus, it was concluded that the dream itself did not need interpretation – it was the interpretation.
2. Patients obviously display an astonishingly high level of empathy toward their therapist's lack of understanding.
3. The telling of the dream is an allusion to the actual talk-in-interaction.

Viewed in this way, the presenter of the transcribed material formed a decision to work on dream-tellings (Mathys, 2011) and to better understand allusive conversations in therapeutic session. So what, precisely, is allusion? How can it be detected? In what formats does it appear? And are there more routes of allusion other than dream-telling?

This was a session where everyone participating suddenly understood the pleasure of working on the details of such a transcript. In addition, the clinicians announced later that they now understood what it meant to learn *new* research methods that were of value for clinical practice. A final remark on story: it is not only in cognitive-behavioral therapy that strange things occur – we chose this example only because the discussion surrounding it was a turning point.

The use of software for the analysis (Atlas.ti and Praat)

In the PSAID program, there is an intensive debate over how representative examples of this kind are. Clinicians know much allusive conversation, as do playwrights. But is there a theory? The state of the art seems to be to study many examples of this kind, starting from no more than an intuitive grasp of the kind "this is an example of what I am looking for." Whether this intuition is correct will be shown *after* analysis, not before. And the risk is of overlooking other examples where one's intuitive grasp of the material fails.

Process researchers have for many years been able to use powerful computer-aided research tools developed by qualitative researchers. We therefore organized courses in the use of such software, which proved to be very helpful. One participant, for example, had the idea that there has been a striking change in terminology in psychoanalytic case presentations. Whereas in the 1950s and 60s terms such as drive, ego-organization, conflict, Oedipus complex, interpretation, and so on prevailed, nowadays there has been a shift to terms like schizoid-paranoid position, splitting, ego-defenses, identity confusion, identity diffusion, transition object, and object relationships, with an accent on "inner" object relationships. The participant mused that this change in terminology could not simply be explained by theoretical trends; therefore, we considered the appearance of terminology, as terms from self- and relational orientations seldom appeared, at least in Germany's psychoanalytic debates. The participant thus set up an empirical project using unpublished case records generated in different psychoanalytic institutes. These case records were made for passing the exams (Lang, Pokorny, & Kächele, 2009). These case records were included in a new "hermeneutic unit" in the Atlas.ti program and then coded, partly automatically and partly by hand.

As a result. the participants began to understand how useful it is to test one's ideas, a conclusion that was also highlighted in another example. Praat (Boersma & Weenink, 2013) is an internationally used computer program to analyze prosody and the tone, pitch, intensity, and other features of a speaking voice. After we (Buchholz & Reich, 2015) had undertaken a first pilot study to analyze the first 10 minutes of a psychoanalytic session with an obsessive-compulsive patient, we were pleased to "see" how the clinical assumption of a special defense mechanism, isolation of affect, could be confirmed in the program's graphs. There is, of course, no one-to-one relationship between Praat graphs and emotional state and process, but what we learned, led by an experienced

linguist, Uli Reich, from Berlin's "Freie Universität, is how much undetected information lies in a human voice speaking. After we had organized a special course on using Praat, other PSAID participants included this kind of analysis into their dissertation projects.

Dive deeply into (verbal) data: The refinement of clinical listening

Choosing to use qualitative methods for process research is not a "weak" decision; these methods, especially conversation analysis, are rooted in "hard" empirical research programs. "Weak" does not describe the method; instead weak refers to the kind of "data," human talk-in-interaction in special institutional settings. What increasingly fascinates our participating clinicians is how close this kind of "seeing" is. They therefore develop a feeling of not being just at the periphery of research, but of bringing to research a rich bouquet of clinical flowers. Sometimes this leads to a process of mutual enrichment between qualitative methods and clinical experience, and to a mutual reformulation of preadapted opinions.

The difference between research approaches (qualitative, quantitative) and clinical profession must remain established. This difference has been clearly formulated by John Bowlby (1979, p. 4):

> In his day work it is necessary for a scientist to exercise a high degree of criticism and selfcriticism: and in the world he inhabits neither the data nor the theories of a leader, however admired personally he may be, are exempt from challenge and criticism. There is no place for authority.
>
> The same is not true in the practice of a profession.
>
> If he is to be effective a practitioner must be prepared to act as though certain principles and certain theories were valid; and in deciding which to adopt he is likely to be guided by those with experience from whom he learns. Since, moreover, there is a tendency in all of us to be impressed whenever the application of a theory appears to have been successful, practitioners are at special risk of placing greater confidence in a theory than the evidence available may justify.

Bowlby emphasizes the difference between profession and science, and does this with an eye to empirical research as being highly developed in recent years. However, something is incomplete. What professional practitioners do is not the "application of a theory," as Bowlby formulates. The term "application" can be used only in a context of technical apparatus. In human relationships, theory does not completely *direct* what someone does; instead theory has another function. It *informs* humans about something to look at. *What* one says and *how* the interaction is continued can never be fully predicted by a theory. Interaction is per se insecure as one can never fully know how the other will respond or what will come next. One social scientist, founder of the Chicago School of symbolic interactionism, and thus with a certain closeness to interaction analyses, once made a similar distinction: "Whereas definitive concepts provide prescriptions of what to see, sensitizing concepts merely suggest directions along which to look" (Blumer, 1969, p. 148).

Theories in psychoanalysis and other forms of psychological treatment act more as sensitizing concepts directing the professional in the treatment room where to look. However, what a clinician says and does and *how* cannot be neglected. It is accessible only after the show. When words are spoken and actions done, things become clear – and here is the entry point for the impulses coming from conversation analysis. This is why our participants sometimes had the pervading feeling of being deeply and emotionally touched by reading the transcript of an interaction between two people whom they had never met.

Laboratory, consulting room, and the art of conversation

Thus, it follows that more distinctions than were once proposed by Bowlby can enrich psychoanalytic theory and process research. Psychoanalysis must not be restricted in a division of "science or art," which does not fully depict its complexity. The online/offline distinction can be complemented. There is more in that (1) a *science that tests theories* and (2) a *science of conversation* help to refine talk-in-interaction, which is (3) professionally realized in *relative autonomy* from *theories tested* and *conversation studied*. If we call this professional realization "art," we have a threefold approach that should hold some attraction for the next generation.

Testing, conversation, and art are distinctions that define mental approaches or local areas: testing is done in the laboratory, not in the treatment room, but with clinical conversation it is vice versa. A scientific mindset operates in the laboratory, but not so in the consulting room. In the laboratory, one wants to find some congruence of data and theory, and apply skepticism and doubt to both data and theories. In the consulting room, one has to listen, detect new views, and set one's doubts aside while using theories and data to sensitize and inform. In the laboratory, some sort of generic truth is sought, whereas in the consulting room, the aim is to identify individual truths in order to help people change their lives for the better.

Guided by the online/offline distinction, the debate has (in our opinion) overlooked the level of artful "talk-in-interaction" or conversation. In the laboratory, conversation might be thought to be less important as there many other resources to be dealt with, but in the consulting room conversation is the only thing to hand. Here something new emerges, a third epistemic position that we wish to call "situationism."

Remarks about "situationism"

Situationism is made up of three components: two people, meeting in mutually unknown biographical and partially shared cultural contexts that they produce and reproduce, and a "face-to-face" interaction (Jaegher, Peräkylä, & Stevanovic, 2016). Skills of social understanding are required, while each participant knows that a high degree of unpredictability is co-present with a more or less high level of emotional arousal. These components are brought together in order to achieve some meaningful interaction and commonly work on the project of "psychoanalysis," which is broken down into many smaller part-projects (e.g. "What did you feel when your father … ?," "Can you tell more about this?," "There is something more in your thoughts … ," "You see here you withhold something … ," and so on). Both participants bring in their capacities of sense-making and, most often ignored in case reports, their bodies, which are immediately perceived and mutually reacted to.

What very quickly forms is a conversation process that gains a relative autonomy in terms of what the individual participants contribute. The relative autonomy of conversation makes things reported from one consulting room meaningful for the inhabitants of foreign consulting rooms. This relative autonomy of conversation was the experience our participants in PSAID had when realizing how deeply they were engaged – in studying transcripts of unknown people interacting and talking together. This third level of conversational autonomy can be studied as a sequence of situations. We propose here in a rough outline a set of methodological orientations that might guide laboratory workers as well as professionals in the consulting room. Process research, as proposed here and studied by the contributions of a group of gifted participants and experienced clinicians, should in the future develop a more finely outlined methodology.

The methodological rules of situationism (following the work of interactional social scientists such as Collins, 2004; Goffman, 1974, 1981; Handon & Yosifo, 2003; Schegloff, 1987) can be roughly outlined.

First, do not look primarily for diagnostic measures such as social background, attachment style, motivation, or personality type. These abstractions produce *generic* explanations; however, in therapy we look for *how* these variables (and many others) are *individually* realized (or not) in situated interactions.

Second, make talk-in-interaction the center of analysis. This generates data close to the situational dynamics. These dynamics are steered by gaze, body movements, and talk. Talk includes words, the embodied voice, and the rhythm used to achieve a definition of the situation.

Third, look for how a common ground (Enfield, 2006; Stalnaker, 2002) is, or is not, established. Common ground outlines the horizon we talk to; it is never a "given" but has to be established in situations.

Fourth, talk-in-interaction has the double potential to repair an imbalanced common ground *and* to tear the common ground to pieces.

Fifth, direct your attention to how common-ground activities are, or are not, managed successfully. Without a common ground situationally maintained by interactional and talking activities, every special technical procedure in psychotherapy carries a heavy risk of failure.

These guidelines (Buchholz, 2016) are usable for clinical practitioners as well as for process researchers interested in how such a complex project as a "psychoanalysis" is conducted by two people. One advantage of situationism is that the study of "dropouts" – those patients who leave treatment after a small number of sessions – must not be limited to their personality (disorders), attachment styles, and so on in order, then, to study the therapists' personalities, attachment styles etc. Obviously, the "matching" of the two could be studied online via audiotaped sessions. As clinicians know, there are many problematic situations, some of which can be described as types (the patient comes late, does not pay the bill, blackmails the therapist with suicidal threats, and so on). However, there are a lot of microanalytically detectable problematic situations that have been undescribed until today. Viewing conversation as carried out by two parties, informed by theories, and practiced always in co-created situations will cast a brighter light over understanding what is going on when therapies fail. This, and more, is a challenge, we think, for the future.

Relevance, contribution, recommendations

Teaching extraclinical research methods to students of psychoanalysis – be they candidates still in training or full-fledged clinicians – provides for them a special

outlook on the complexity of the psychoanalytic situation. Instead of being immersed in a total situation, being part and parcel of it the study of research methods generates a fresh look at the idiosyncrasies of any clinical encounter. As practicing analysts, we are part of the situation, and the concept of countertransference is never embracing enough to fully grasp what is going on between the two parties.

One may compare this to a supervisory process where the involvement of a third party allows the process to be overseen from outside, providing new insight. The refinement of special methodologies opens up insights that cannot be gained by clinical tools alone. We therefore recommend an immersion in extraclinical research as a training tool for aspects of the process that cannot be seen by the naked eye.

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