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Georg Bruns, Bremen

Research on Research: Taking Part in a Neuro-Psychoanalytical Research Project (HNPS) and its Impact on the Psychoanalytical Process (RoRS – Research on Research Study)

Psychoanalysts adhere to different views about the impact of patients' involvement in research activities on the psychoanalytical process. Little research has been done on this topic to date. When in my institute we started discussing about taking part in the HNPS or not there were two controversial opinions.

One of them was that taking part can disturb the psychoanalytical process in several regards, for example to destroy the intimate dyad of psychoanalyst and patient, or to provoke the precocious emerging of some fantasies out of the unconscious, or to fix the patient in an erroneous conviction that psychic actions are only caused by organic processes. Some colleagues even said it to be a kind of inhumanity to examine patients with a scanner knowing that not so few patients are becoming anxious in the scanner. Psychometric data were regarded irritating the psychoanalyst's natural coming up of knowledge on the patient and his countertransference towards him.

The other opinion was that research in general is necessary and useful for psychoanalysis and for the psychoanalysts involved and that especially this project will deliver interesting results. It was regarded to be a chance of common research of psychoanalysts and neurobiologists, who are one of the favourites of contemporary public research interests. These psychoanalysts believed that they could analyse all irritations induced by research activities. And they argued that the participation even may improve psychoanalytical treatment immediately because the analyst is more attentive to and more engaged for this treatment.

These opposite positions among my colleagues represent the ambivalence of psychoanalysts towards every kind of research which is not only psychoanalytical online-research.

So my idea was to use the HNPS as an excellent opportunity for research about the impact of research on psychoanalytical treatments. The HNPS seems to be a good subject for this research because the treating psychoanalysts and the researchers are different persons. The treating psychoanalysts are not members of the research staff. They decided even not to get to

know the psychometrical data of their patients and to rely only on their psychoanalytical data coming from the psychoanalytical process in order to stay unbiased.

The research on research project is primarily referring to psychoanalytical data and combining them afterwards with the regime of the HNPS tests and examinations. **The design** consists of:

- an intervision group
- writing a weekly short report
- filling in every two weeks the Psychoanalytical Process Rating Scale
- combining later, when HNPS has ended, the dates of psychometrical testing and scanner examination with the data of intervision, reports and PPRS
- additional qualitative data from follow up interviews in some special cases

Intervision group: It is held every month on the first Wednesday evening. Every session is recorded on a tape and will be transcribed, but from every session I also write minutes containing the themes of the evening and the group dynamics. Twelve different psychoanalysts have been present in these groups, but in each single session the number varies between 5 and 8. The transcriptions will be analyzed with the grounded theory (Strauss et Corbin 1990, Strauss 1994).

Weekly report: It is recommended to write it after the least session of each week. It should be no longer than a half page, and it should mention the important themes of the week, important events, manifestations of resistance, transference of the patient and ctf of the analyst.

PPRS: The analyst should fill it in every two weeks on a fixed day, for example each Tuesday (see appendix).

Combining dates and data: In order to prevent a bias the psychoanalysts are not informed when testings and examinations of the HNPS are made. So writing their reports and filling in the PPRS the analyst may know of a research date at university his patient had, but he is not preoccupied by his knowledge of the examination schedule of the patient. And often he may not know that the patient had such a date. Later when the HNPS has ended we can relate events of the analysis, based on the reports and the PPRS, with the patient's dates of his psychometrical and scanner examinations.

Follow up interviews: They are intended with those patients who have dropped out of the study and with their analysts after termination of the analysis.

Results: There are few results to date. I only can refer to the group sessions because we have not yet started to evaluate reports and PPRS.

Three patients have dropped out. Their drop out affected their analysts, two were disappointed, and they felt a decreasing interest in these patients.

Concerning the patients one patient felt the scanner examination like the repetition of some totally surprising situations of her life, the unexpected loss of a protecting object – the first when her father returned home after the war when she was five, a man she did not know, but she lost her mother as an exclusive object; when she was 20 and pregnant her parents threw her out of their house, and she was surprised again; and some years later she was operated and totally surprised by the anaesthesia. This patient could not stand the scanner examination, it had to be interrupted because of her anxiety. And she dropped out of the study. At that time the analysis had about 30 sessions.

One question of the psychometrical examination refers to sexual abuse. A woman became rather suspicious that a researcher had spoken with her analyst about her answer. This patient had dropped out of the HNPS too. A few weeks later she spoke to her analyst about sexual abuse by her stepfather. But the analyst didn't feel this to be a sign of trust but became afraid that the patient could stop also the analysis and that speaking about the abuse was the first announcement of her unconscious intention to do it.

The examinations seem to provoke unconscious anxieties of some patients which to talk about they are not yet able. This induces a complicated situation in the analysis, because these inductions may be too early when the analytical relationship isn't yet strong enough.

Sometimes the study shapes the surface of strong unconscious fantasies. For example a patient had a symbiotic fantasy with her analyst, and we could understand that it was the defence of paranoid fears and of her own aggression. The patient had got a CD with pictures of her brain. The symbiotic fantasy was to move together her brain picture and that of her analyst so that one was lying on the other and so melting them together.

Concerning the analysts they seem to feel responsible for the study and the influence it has on the patient because they recommended the patient to take part. Sometimes an analyst felt to lose the exclusiveness of the analytical couple, because for example they are involved in the participation of patients in the study. And in this study appear other significant therapeutic objects.

Patients seem to move sometimes feelings from the analyst to the research staff and vice versa. For example some patients felt angry about changing their timetables of examinations,

dates have been split and so they are more frequent – one patient spoke of a second treatment (Nebenbehandlung) by the study. But the analyst had the idea that the patient spoke about his anger at him.

All analysts involved in this study feel a greater interest in their research patients. Most of them are interested in getting to know the research methods applied, but they feel a conflict between staying restricted to the analysis and opening to a wider approach. A few analysts are interested to take part more actively in research activities, for example the evaluation of group session transcriptions.

What I can say to date is: the participation of patients in the HNPS influences the course of their analysis. Sometimes the examinations accelerate surfacing of unconscious material, and in some cases it may be precocious. Sometimes the study is shaping fantasies, it is not inducing the fantasy itself, not its core and content but its form, how it appears in the analysis. Evidently the patients then refer to the study as a common point of reference.

PPRS-short

Psychoanalytic Process Rating Scale¹

Initials of patient : _____

Code of rated case : _____

Name of rater : _____

Frequency of sessions per week : ... * 7

Rated week number : _____

Rated session : 1 2 3 4 5

Not rated because of : Holiday
 Illness
 Otherwise, please specify

Instructions:

1. Fill in the PPRS *immediately* after the assigned session. This will take you about five minutes.
2. Try and rate *all* items by circling one of the figures on the five-point scale that you feel is the most appropriate answer.
3. If the procedure or an item is not clear, please consult the manual.

¹ Juni 2003, Npi. The PPRS-short consists of contact-items (part I) of the PPRS developed by Folkert Beenen & Jan Stoker, June 2001. The PPRS is the result of statistical analyses of data gathered using the Periodic Rating Scale (Beenen & Stoker, 1997) in the period from 1997-2000 (N=860) covering 60 psychoanalytical treatments. The statistical analyses were carried out with the help of Arnold Goedhart. The Periodic Rating Scale (PRS) is a translation and adaptation of the Anna Freud Centre Session Rating for Children and Adolescents and the Anna Freud Centre Young Adult Weekly Rating Scale which were generously made available by Professor P. Fonagy and his staff. The PPRS (questionnaire, manual, statistical output) is available from the Department of Research and Quality Assurance, Netherlands Psychoanalytic Institute, Olympiaplein 4, 1076 AB Amsterdam, The Netherlands. Translated by Carol L. Stennes, February 2002.

Nature and quality of the contact development

	degree of presence				
P-01. Patient showed good quality of response to the interventions.	1	2	3	4	5
P-02. Patient was ready to explore thoughts and feelings.	1	2	3	4	5
P-03. Patient showed dissatisfaction with the treatment.	1	2	3	4	5
P-04. Patient exhibited rivalry with me.	1	2	3	4	5
P-05. Patient experienced own feelings as present in the other.	1	2	3	4	5
P-06. Patient showed that he/ she had benefited from the interventions.	1	2	3	4	5
P-07. Patient's affective mood: concerned – friendly – loving.	1	2	3	4	5
P-08. Patient showed feelings of being dominated by me.	1	2	3	4	5
P-09. Patient gave rational or intellectual explanations for his/her behaviour.	1	2	3	4	5
P-10. Patient was derogatory and denigrating towards me.	1	2	3	4	5
P-11. Patient showed an intensification of resistance between or within sessions.	1	2	3	4	5
P-12. Patient's affective mood: calm – contented – relaxed.	1	2	3	4	5
P-13. Patient was wary and suspicious of me.	1	2	3	4	5
P-14. Patient showed erotic feelings towards me.	1	2	3	4	5
P-15. Patient felt let down, betrayed, or deceived by me.	1	2	3	4	5
P-16. Patient reacted negatively and rejecting to interventions.	1	2	3	4	5
P-17. Patient's affective mood: bold – elevated – strong.	1	2	3	4	5
P-18. Patient enacted wishes appropriate to a younger person/ child/ infant.	1	2	3	4	5
P-19. Patient actively resisted examining thoughts, feelings, and motives with regard to the problems.	1	2	3	4	5
P-20. Patient showed active enjoyment of being in treatment.	1	2	3	4	5
P-21. Patient had problems with the ending of sessions.	1	2	3	4	5
P-22. Patient's reaction to a weekend, holiday break, and/ or termination was resentful – angry, hurt.	1	2	3	4	5
P-23. Patient's reaction to weekend, holiday break and/ or termination was sad – anxious.	1	2	3	4	5

degree of presence

T-01. I was active and engaged in my interventions.	1	2	3	4	5
T-02. I commented on the patient's resistance.	1	2	3	4	5
T-03. I felt involved.	1	2	3	4	5
T-04. I felt put upon, taken advantage of by the patient.	1	2	3	4	5
T-05. I felt angry.	1	2	3	4	5
T-06. I felt rejected by the patient.	1	2	3	4	5
T-07. I felt inadequate (not good enough).	1	2	3	4	5
T-08. I felt loving and warm.	1	2	3	4	5
T-09. I addressed the therapeutic relationship.	1	2	3	4	5
T-10. I made connections between the therapeutic relationship and past relationships of the patient.	1	2	3	4	5
T-11. I made connections between the therapeutic relationship and present relationships of the patient.	1	2	3	4	5
T-12. I focused my interventions on affect.	1	2	3	4	5
T-13. I commented about the patient's experiences as a small child or about the child within.	1	2	3	4	5
T-14. I referred to aspects of the patient's behaviour of which he/ she was previously not aware.	1	2	3	4	5
T-15. I made remarks on habitual aspects of the patient's behaviour.	1	2	3	4	5
T-16. I challenged the patient's view of some aspect of reality.	1	2	3	4	5
T-17. I commented on some consistent quality in the patient's thoughts.	1	2	3	4	5
T-18. I made links between behaviour outside the sessions to current material in the treatment.	1	2	3	4	5
T-19. My interventions were aimed at providing support and structure.	1	2	3	4	5
T-20. I had a good feeling concerning my functioning as therapist.	1	2	3	4	5
T-21. I felt at ease and responded in a relaxed way.	1	2	3	4	5

OTHER ITEMS:

IA-1.	1	2	3	4	5
IA-2.	1	2	3	4	5

Degree of presence: 1 = not present; 2 = slight; 3 = moderate; 4 = ample; 5 = marked.