# What can clinicians gain from research in psychoanalysis?

A personal summary by Imre Szecsödy MD, PhD (Swedish Psychoanalytic Society[1]) from five consecutively organised workshops, held at the Annual Conferences of the EPF in Prague 2002, Sorrento 2003, Helsinki 2004, Vilamoura 2005 and Athens 2006..

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The goal of psychoanalysis is complex; this can not be more clearly defined and made more explicit than as an aspiration on the part of the analysand and the analyst to promote autonomy, knowledge, emancipation, and health and to liberate the individual from some limitations and suffering. How do we reach our goals in psychoanalysis? What happens within and through the interaction between the analysand and the analyst? Does change lead to insight or insight to change? What does it signify that patients may feel equally understood by analysts belonging to different schools of thought, despite their divergent and often conflicting views of what is relevant and correct? What is specific? Is the analysis a process of acquired learning or a new beginning due to the analysand's relation to the analyst? What is curative? Are the factors, which vary and distinguish between different schools non-specific or specific?

The study of the process of change is a complex undertaking that can raise more questions than it answers. Results do not explain how the change occurred or what influenced it or brought it about. The individual case report has long tradition in the study of psychoanalytic process. Immersed in the clinical material the analyst - as a researcher - tries to identify (impressionistically) the different elements of the process, what changes, how it changes and why. A problem with using individual case studies for research is the unchecked or not systematically checked subjectivity of the observer and how unknown systematic biases are introduced by selecting data for presentation according to unspecified canons of procedure for determining its relevance.

To maintain psychoanalysis as a discipline, as a theoretical system and as a treatment method we have to have a commitment to the reflection of its own nature and structure and we have to be continuously interested in trying to study these questions. An examination of contemporary psychoanalysis reveals major disputes in both theory and techniques as well as conceded gaps in knowledge. The need within any scientific body for resolution of disagreements and additions to knowledge provides steady pressure for the development of improved research methods. Nevertheless systematic research and empirical research does encounter resistance within the psychoanalytic community. The main aim these workshops had, was to enhance and deepen discussion between "clinicians" and researchers, to learn more about how we can approach the study of a central question: ***How does psychoanalysis work?***

These workshops were neither a start nor an end of something but could be experienced as a continuation of a dialogue amongst analyst – as researchers and clinicians. In the service of this very aim do I attempt to give a summarising report from the workshops. First of all I wish to convey my sincere gratefulness to Henk-Jan Dalewijk, Peter Fonagy and David Tuckett for their stimulating trust, to the presenters, the discussants, co-chairs and all the participants that we did form and maintained a "work-group" atmosphere, to have an open discussion, with the aim to learn from rather than convince each other[2]. To quote Bion, we could*: "meet conflicts and challenges by testing our conclusions in a scientific spirit, seeking knowledge, learning from experience and continually questioning the best way to achieve its goal; in which there is a clear awareness of the passage of time and of the processes which have to do with learning and development".* [3]

The discussion of the **first workshop** in **2002 in Prague** was based on the presentation of two important and in their approach different projects. ***How to study the quality of psychoanalytic treatments? Report from the DPV katamnestic study*** was presented by Marianne Leuzinger-Bohleber (Sigmund Freud Institute, Frankfurt) and Ulrich Stuhr (University Clinic Hamburg-Eppendorf). The second paper ***Using the Psychoanalytic Process Rating Scale (PPRS) as a tool for research as well as quality assurance in clinical work***. was given by Jolien Zevalkink and Jan Stoker (Dutch Psychoanalytic Institute, Amsterdam).

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[2] The program of the workshops can be viewed attached as an appendix.
[3] By the way the passage of time: as you will be able to see from the attached programs, the available time for the first two workshops on Saturdays 09.00-17.30 was diminished to Sundays 08-45-12.30 due to ongoing and time-conflicting parallel programs.

The two papers complemented well each other. The first was about the katamnestic, follow up study, which was initiated by the research committee of the *German Psychoanalytical Association* (DPV). The major aim of the project was to study the patient's views of their psychoanalytic experiences and their effects retrospectively, at least 4 years after the end of psychoanalysis or psychoanalytic long-term treatment. They wanted also to compare the subjective views of the former patients with the ones of their former analysts, independent observers and results of tests and questionnaires used in psychotherapy-research. Professors Leuzinger-Bohleber and Stuhr gave detailed clinical descriptions about how the follow up interviews with former analysands were used in a psychoanalytic way, to gain a deeper perspective in how these individuals experienced and used analysis. (As the study is published in Outcomes of Psychoanalytic Treatment Eds:Leuzinger-Bohleber, M. & Target, M. (2002) London & Philadelphia: Whurr Publshers I shall only give a few quotations).

"*We conceptualised this study as an empirical, multi-perspective approach on the complex psychoanalytic processes and their results. We tried to apply the specific psychoanalytic methodology, which differs from an understanding of empirical research based on the notion of a unified science. Thus, we combined characteristic psychoanalytic research strategies (such as the analysis of transference/countertransference etc. in the follow-up-interviews, supervision, psychoanalytic evaluation in the research groups, narrative summaries of individual cases etc.) with non-psychoanalytic research strategies common in psychotherapy research (the use of a questionnaire, cost analysis etc.) Upon deciding on a retrospective study we shared the French colleagues' reservations that both by an inadequate understanding of science and by empirical observation of psychoanalyses and long-term therapies (e.g. in prospective studies) the object of research in psychoanalysis, the observation of unconscious conflicts and phantasies, could be seriously disturbed.*

It should be mentioned, that 91% of the members of the DPV supported and 401 former patients were willing to participate in the study and received a short questionnaire. 129 from these former patients were given an extensive questionnaire and were interviewed twice. Narrative single case studies were combined with quantitative, theory guided computerized content analyses, using a representative sub sample of transcribed follow-up interviews. The reports of the follow-up interviewers and the tape-recorded interviews were analysed by a wide range of different methods (expert-ratings on the *psychoanalytic* follow-up view of the treatments, content analyses, text analyses, qualitative analyses etc). Results of the questionnaire sample show that 80% of the former patients - average 6,5 years after the end of treatment-show positive and stable changes in their well being, personal development and their relationsships with others,

The follow-up proved to be clinically very interesting and relevant. *"The 62 colleagues who had been actively engaged in the study as interviewers maintained unanimously that active involvement in the follow-up study made them start thinking and were an emotional enrichment, which was of benefit to their psychoanalytic practical work. Many of them also told us that for the first time in their life they felt to be able to combine their clinical identity with one of a partially extra clinical researcher".*

The former analysts of the patient was also interviewed by a member of the research group, without having any information about the patient, to get two completely independent "stories" of the same therapy. .

"*One of the most striking clinical observation was, that in successful treatments both partners, patient and analyst, seem to remember and tell "the same story" (they e.g. report independently the same key events of the treatment and share their view of the global results of the treatment). If the treatment has not been so successful (especially treating severely disturbed patients) we have found much more divergences between the narrative of the patient and the one of the analyst. Regarding the treatments with negative results, both treatment technique and the underlying dynamic and adaptive processes of perception and insights seemed restricted and narrow. Some of the analysts described their painful memory that they were not able to enter into an 'inner, resonant' dialogue with the patient during a long time of treatment. Some of the former patients complained about an analogous perception. Some of them*

*mentioned their assumption that the analyst had forced his own concepts and ways of understanding on them."*

Before giving some details about the paper presented by Jolien Zevalkink and Jan Stoker Using ***the Psychoanalytic Process Rating Scale (PPRS) as a tool for research as well as quality assurance in clinical work*** I wish to give some background information. Since the end of the 80-ies the members of the Netherlands Psychoanalytic Institute were interested to study: "*Is it possible to confirm the presence of specific elements or characteristics of psychoanalytic treatments? if so, how do these influence the treatment process and its outcome? what are the specific effects of psychoanalytic treatment beyond or other than the reduction of complaints/symptoms and disturbed behaviour? is it possible to detect elements and processes that produce change (curative factors)?"* This last question was posed in an open qualitative study based on retrospective data from interviews with 16 analysands and their analysts. A combination of four curative factors emerged out of the material as being at the core of the psychoanalytic cure. (1) experiencing primary security [analysand], furnished by the analyst through attention, concern and acceptance. This accepting, non-judgmental attitude of the analyst encouraged (2) free expression of thoughts and feelings ('catharsis') by the analysand. In the interaction (3) the analyst actively offered structure [especially by setting boundaries] to the analysand. At the same time the latter received encouragement leading to a process of (re-) education. And (4) experiencing the direct emotional interaction in the relationship with the analyst led to new self-insight by the analysand, a process guided by the transference interpretations of the analyst. The study indicated that there were aspects of the function of the analyst as a new relational object that seemed important for outcome. These results were presented at the 38th IPA conference in Amsterdam in 1993 and at a workshop on Process and Effect research in Psychoanalysis in Stockholm 1994, where the first plans were formed for a European collaborative study (AHMOS[4]).

In the study that was presented in Prague, they did investigate whether: "*self-report instruments in the form of a questionnaire and a semi-structured report can be used to visualise the psychoanalytic process during treatment from the perspective of the psychoanalytic therapist in a systematic and standardised manner.* Furthermore, they wanted to know *whether small changes over time could be detected using such instruments"*. They "*wished also to apply an instrument that was user-friendly and could give relevant feedback to the analyst, especially for an analyst in a busy clinical practice"*. Therefore, they did examine whether the analyst evaluates the results of the instruments as a meaningful contribution to yearly discussions with colleagues about the patient's progress. In their earlier study they used a semi-structured interview protocol – composed from the ingredients of the psychoanalytic process-- one important problem arose. The comparison between the transcripts remained impossible because of great variance in length, depth and quality, caused by the different styles of interviewing. Therefore, they decided to use a more structured instrument for evaluating the process during treatment. The Psychoanalytic Process Rating Scale. (PPRS, Beenen & Stoker[5]) contains 82 items divided into 44 items describing contact development – represented in five factors - and 38 items describing psychic contents of the clinical material about four themes: Body and Self-esteem, Relationships, Sexuality, and Aggression. The degree of presence of each item is scored with a five-point rating scale ranging from not present (1) to markedly present (5). The therapist fills in the PPRS every other week directly after a randomised assigned session. A second interrelated instrument was developed: the Psychoanalytic Process Report (PPR). This consists of nine open-ended questions related to contact development and psychic contents of the sessions. The therapist is asked to answer these questions every two months and use material from the past two months to illustrate his/ her observations. The output of the scales together with process reports may help to raise the gathered data above a clinical intuitive level. The time series of this data are used to give yearly feedback to the analysts about the psychoanalytic process.

By using the PPRS and PPR, they did find that data on the psychoanalytic process can be collected in a more systematically and standardised manner. Furthermore, the data can be used to make comparisons within patients across various points in time and between patients

[4] See *An Open Door Review of Outcome Studies in Psychoanalysis* 2002 Ed. Fonagy P.(pp 352-356)IPA
[5] Benen F. & Stoker J. (2001) *The Psychoanalytic Procees Rating Scale.* Netherlands Psychoanalytisch Instituut.

from the same therapist, across therapists, and across treatments. *"The results provide process-oriented material, completed by reports about the more personal vicissitudes of the patient, which facilitates the identification of characteristics of the treatment over the years. We expect that the results can be used to analyse change over time and be related to other measures. We will soon have data to investigate this. Although we have not yet evaluated the use of the PPRS and PPR formally, the first results seem to be promising and colleagues have reacted enthusiastically to the present feedback after filling in the PPRS and PPR for about 8 months. The instruments seem to provide a 'view' on the psychoanalytic process during treatment and complement each other."*

Of the about 50 participants of the workshop, some had a prepared, written comment, while others took part more spontaneously in the discussion[6]. The high tension due to the two attitudes about how to relate to empirical research was mentioned: on the one side to risk maintaining the ivory tower of a psychoanalysis closed within the psychoanalytical community and cut out from the scientific and academic world, and on the other side a psychoanalysis becoming swallowed up by stronger and incompatible theories and methodologies from the outside. Nonetheless, the discussion focused mainly on: **What kind of research can best serve psychoanalysis?** As one Italian/Swiss analyst emphasised, she as many practising analyst "*have been attracted by the perspective to know what happens to the patients after the end of their analysis, wandering often what my former patients would do, how did they feel, what would they remember of the thousand words exchanged during many years spent on the couch, what kind of story would they tell themselves concerning the experience we shared together. And also I wandered if their subjective views did correspond and in what degree to that of their analyst, to mine. All these questions had no answer, except for those patients who came back after years. For those reasons I was really interested in the follow up research and I appreciated it very much. It allows us, clinical analyst, to enter this complex topic and to seize the importance of the theme*".

On the other hand, how ethical is it to contact former analysands after they terminated? French analyst seriously questioned this. "*In countries like France, psychoanalysis remains a quite private affair. The analyst never gets in touch with the patient after the end of the analysis … except when the analysand becomes an analyst. What effects can this intervention from the analyst have on the patient? It would reverse the demand which must be only on the patient side!*" They did hardly believe, that the DPV kind of katamnestic study could be conducted amongst French analysts. They stressed also that the "*psychoanalyst should not be focused on the purposive idea of the results. If the psychoanalyst is focused on curing, he will have to take care, to play the part of a "good mother", and avoid for instance the negative transference. What is the most important is not the aim, the end of the travel but the travel itself with all the circuitous paths. The therapeutic changes come along from the application of the psychoanalytic method*".

Some discussants called the point of view of the French colleagues as pronouncedly individualistic and contrasted it with a position that the community - not only the scientific community - has a legitimate right to request some cooperation from the analyst and the former analysand, as it has been this very community to provide the therapy/the analysis for the analysand - even if he himself had paid for it.

In many reports of the end of an analysis, emphasis is placed on how important it is that separation be worked through with all its implications: being able to grieve, to forgo the continuation of an emotionally important and satisfying relation and to relinquish illusions of infinity and immortality (subverting the Faustian syndrome). Many analysts refrain from offering the analysand the opportunity for contact in the future because they see the self-analytic function of the analysand as the most essential benefit of the treatment. However, a group who conducted a survey sponsored by the Denver Psychoanalytical Society were surprised at the finding that former analysands often contacted their analysts after "successful" terminations. They realized that they had in common a preconceived idea that after a well-implemented and successful analysis the analysand does not need any continued contact, and if he/she does so it is an indication that something has gone wrong. This fantasy was in stark contrast to the analysts' own experiences, since they themselves had usually sought re-analysis,

[6] Discussants: G. Bodin (Danemark), G. Bögels (Netherlands), K. Dietrich (Germany), A. Ferro (Italy), E. Gattig (Germany), D. Huber (Germany), A. Kluzer Usuelli (Italy & Switzerland), G. Klug (Germany), S. Lagerlöf (Sweden), I. Lust (Hungary), R Malcolm (Great Britan), R. Perron (France) R. Sandell (Sweden), E. Sechaud (France), E. Skale (Austria), J. Välimäki (Finland)

often more than once. They found that analysands wanted to renew the contact not because the analysis was incomplete but to 1) reactivate their self-analytical function; 2) complete the de-idealization process and 3) restructure their inner self and object representations by telling the former analyst about the important progress they had made in their development.

I do agree with the statement that it is extremely important to give termination its own place and to be able to contain the loss of the eternity perspective. For both analysand and analyst this means being able to accept limitations of the analyst and in the analyst. Nevertheless, a careful follow-up, checking the validity of treatment or reviewing the correctness of treatment models should be of primary interest to analysts, given the small number of patients they can treat in their lives. We have to broaden the scope of our work as psychoanalysts and confront us again and again with the question: how can we recognize and single out what is specific for psychoanalytical treatment, what kinds of intervention produce what kinds of change under what kinds of circumstances? We have to observe the work of psychoanalysis systematically, observe it during the treatment itself and follow it up after its termination. We have to learn more about what is specific for psychoanalytic treatment also from the perspective of our patients.

Follow up studies do not only provide external legitimation of psychoanalysis, but also represent a fruitful method of studying psychoanalytic change. But as a discussant pointed to*: what about internal validity, the scientific rigour, that ensures the assessment of the intervention (the treatment) to be precise enough, so that not extraneous influences account for changes observed? Choosing to do a katamnestic study the researchers accepted obvious drawbacks like selective recall, inaccurate recall and recall biased by the outcome, a real threat to internal validity."* He, as well as others, questioned the statement that "*simultaneous observation of the treatment process will disturb it"*. Despite of strong opposition and resistance from the analytic community, more and more analyses are recorded and transcripts are used for research purposes like: a) the Praxisstudie analytischer Langzeittherapien (PAL) of the Heidelberg Study Group (Rudolf, Grande, Oberbracht), where patients are interviewed during the ongoing process every three months; b) the Stockholm Outcome of Psychotherapy and Psychoanalysis Project (STOPP), where the research group measured outcome with questionnaires sent to the patients during the treatment every year; c) and the Munich Psychotherapy Study (MPS).

I do also wish to refer to the study of Morton Gill and co-workers (1968[7]). They wanted to find out whether the recorded therapy possesses the essential ingredients of an analysis and to study the nature of the influence of recording upon the two analytic participants. *"Our experience leads us to believe that the difficulties of a recorded research analysis have been overblown and are not of a different order than the problems of an ordinary analysis. As with so many other things, once we become convinced that the endeavour is worthwhile and bring ourselves to face and deal with specific problems, they are not nearly the bugaboos that they had seemed to be when they were in the realm of the useable and the unspeakable"*.

An other obstacle to study the psychoanalytic process in the presence of a "third" is opposed because it will compromise and brake confidentiality. Here I refer again to Gill, "*that confidentiality is meaningful only in terms of what it means to the two participants. The working alliance is ultimately based upon trust, and trust is ultimately based—assuming the patient is not one who is incapable of trust—upon the analyst's demonstration to the patient in the course of their work together that he is in fact trustworthy. That is to say the analyst has both the capacity and the intent to put the patient's welfare foremost. Trust is neither guaranteed by the formal criterion of confidentiality, nor destroyed by its absence, any more than an analytic situation is guaranteed by the formal criteria of frequency of interviews, recumbent posture, etc., nor destroyed by their absence"*.

Nonetheless – the discussion did not stop with this. The question was raised repeatedly: Does research interfere with psychoanalysis? Some thought that the PPRS questionnaires could be experienced as a straight jacket, as an intrusion by a third, monitoring once work, and could resemble a metronome dictating the artistic performance of a professional pianist. According to the Dutch colleagues, the researchers were vied as mentors, and the feedback they received was mainly experienced as a useful supervision. On the other hand as one discussant emphasized: *"We know that not only the measured object changes, the measuring object changes as well. Within the context of the modern theories of inter-subjectivity, it can be worthwhile to study the interactivity between analysand*

[7] J. Amer. Psychoanal. Assn., 16:230-244 (APA)

*and analyst as a function of the discussion in a peer-group, as the PPRS-research seems to do. We all know, how the bare notion that we are going to present some case-material in whatsoever context, influences our mental disposition behind the couch. The more it will be the case in an situation where reporting and answering standardized questions are part of the continuing programme of the ongoing psychoanalysis. Not to mention the influence, if such questioning is realized and systematically discussed within the bureaucratic peer-group of an institute. What plays maybe a still more difficult detectable role is the conditioning effect that repetitive* questionnaires have on our 'free floating attention', an elementary aspect of our work.

All in all, it was great pleasure to be present and chair this workshop. The papers presented, the prepared as well as spontaneous discussions were deeply engaging and interesting. As I sincerely wished and hoped our dialogue would not stop when the workshop ended, but will continue and deepen. Over and above what Meltzer stated, viz. about our capacity to have an adult appreciation of the beauty of the analytical process, we need to study it systematically.

The **second workshop** was organised **2003 in Sorrento**.

Dieter Bürgin as co-chair introduced the workshop. He started with a number of quotations –of which I repeat the first two: *"No, our science is no illusion. But an illusion it would be to suppose that what science cannot give us we can get elsewhere*". [Freud S.: Vol. 21, S. 55-56: The future of an illusion]. *".. there are no sources of knowledge of the universe other than the intel1ectual working-over of careful1y scrutinized observations - in other words, what we call research - and along-side of it no knowledge derived from revelation, intuition or divination."* [Freud S.: Vol. 22, S. 158-159: New introductory lectures on Psychoanalysis].

Professor Burgin pointed out three major forms of research in Psychoanalysis: clinical, conceptual and empirical research. a) *Clinical psychoanalytical research* mainly generates hypotheses and develops preliminary concepts out of the individual cure. They then have to be tested empirically or experimentally in order to gain a more scientific quality. b) *Psychoanalytic concept research* investigates systematically the meanings and uses of psychoanalytic concepts, including their changes over time. c) *Empirical psychoanalytic research* examines analytical findings in a quantitative statistical manner. He emphasised *"Clinicians have to think systematically and self-critically about their clinical observations, testing them again and again in new clinical situations and then trying to generalize them successively. Hypotheses, first collected in the individual psychoanalytical situation, can later become the subject of clinical or extra-clinical research. The steps from clinical psychoanalysis to research lead therefore from observation to theorizing and finally to systematic testing of hypotheses. The extra-clinical researcher has to use criteria from empirical research in order to test these hypotheses in a systematic manner"*.

The first paper **"Psychoanalysis and research - two conflicting positions? Conclusions from the Heidelberg-Berlin project studying structural changes in psychoanalytic therapies".** [8], [9] was presented by Tilman Grande and Gerd Rudolf (Heidelberg). Central for their investigation is the question of the specific quality of therapeutic changes, which take place in intensive psychoanalytic treatment on the one hand, and in low-frequency psychodynamic therapies on the other. Their working hypothesis is that there are qualitatively distinct forms of change that can be designated as "structural change " in the one instance and "coping" in the other. They assume that "structural changes" are more likely to occur in psychoanalyses, whereas in low-frequency therapies the probability is higher of encountering changes of a "coping" kind. To investigate this they had an elaborate design – and they attempted also to supply a better understanding of the way in which various different procedures

[8] Authored by G. Rudolf, T. Grande, C. Oberbracht, W. Keller, R.Dilg, and T. Jakobsen. (Heidelberg)

[9] Rudolf, G.; Grande, T.; Oberbracht, C. (2000): *Die Heidelberger Umstrukturierungsskala. Ein Modell der Veränderung in psychoanalytischen Therapien und seine Operationalisierung in einer Schätzskala. Psychotherapeut* 45. 237-246. Rudolf, G., Grande, T., Dilg, R., Jakobsen, Th., Keller, W., Oberbracht, C., Pauli-Magnus, C., Stehle, S., Wilke, St. (2002): *Structural Changes in Psychoanalytic Therapies - The Heidelberg-Berlin Study on Long-Term Psychoanalytic Therapies (PAL).* In: Leuzinger-Bohleber, M., Target, M. (Eds.): Outcomes of Psychoanalytic Treatment - Perspectives for Therapists and Researchers. Whurr: London, pp. 201-222.
Grande, T., Rudolf, G., Oberbracht, C., Jakobsen, Th., Keller, E. (2004). *Investigating structural change in the process and outcome of psychoanalytic treatment. The Heidelberg-Berlin Study*. In: Richardson, Ph. , Kächele, H., Renlund, C. (Eds.) Research on psychoanalytic psychotherapy with adults. Karnac, London, pp. 35-61.

achieve their effect of the processes they set in train – from good outcome also of the risks of standstill and failure. Using the *Operationalised Psychodynamic Diagnosis system (OPD)* they focus on the ways the patients/analysand mental structure changes in three areas: on the relationship axis, conflict axis and structure axis. The *Structural Change Scale* can enable external observers (aided by the data the patient and analyst give through self rating questionnaires and protocols) to qualitatively follow the changes – presumably "produced". Each stage of the scale marks a therapeutically significant step, beginning with the increasing awareness of a problem area not perceived as such until then, extending through to the therapeutic working-through of the aspects and experiences associated with it, and from there to more basic changes resulting from it both in the patient's experience and in his/her concrete external behaviour. With the aid of the scale patients are assessed as to the degree of structural change they have achieved at a given point in their treatment. A separate assessment is made on the scale for each of the five foci defined.

The diagnostic formulation of problem focus and therapy goals which are observed during therapy can be rated concerning structural change at different times including the end of therapy and the follow-up. Under the legal impact of quality assurance in the German health system this model has been applied as a project for a number of psychoanalytic practices because its design and the instruments are more related to psychoanalytic thinking than any others do.

The ambition of the researchers was and is that their approach will do more than merely furnish global evidence for the superiority of one therapy form over another. It can support the development of a therapeutic modification concerning structural personality development problems (like internalisation deficit, problems of regulating impulses, affects and self-value, difficulties of differentiating own affects or being empathic to others, etc) as well as treatment of adolescent and young adults in in-patient treatment. They do expect it to supply a better understanding of the way in which various different processes achieve their effects; of the processes they set in train, the likelihood not only of a good sustainable therapy outcome but also of the risks of standstill and failure.

In their paper **Investigating implicit theories of change in analysands and their analysts** Andrzej Werbart and Sonja Levander (Stockholm) presented some preliminary findings from a project investigating the analysands' and the analysts' preconscious, private, or implicit theories of pathogenesis and cure, how they develop during the psychoanalytic process, and how the theories of the two participants relate to each other. As they emphasised in their introduction, the private theories of analysts are the object of study of the EPF Working Party on Theoretical Issues. (Canestri et al., 2002[10]). However, the private theories of the analysand, as well as their relation to the analyst's private theories, were still an unexplored area. These implicit theories use material from fantasies, popular ideas, and available pieces of real or distorted information. Also we as analysts make our own attempts to understand and interpret "what it is all about?" and "how it can actually be remedied". They trust, that a systematic explication of this implicit knowledge will lead to recognition of the need for questioning and modifying existing, theoretically derived theories of change, which can contribute to a more solid ground for our clinical practice and for our theoretical models. Following an account of the background, aim and method of the study, including a short summary of their previous work in the area, a theoretical model of private theories was outlined.

The analysands and the analysts were interviewed at repeated points of time: at the start of analysis, 6, 18 and 36 months later, at termination, and the analysands also at a 1.5 year follow-up. The Private Theories Interview (PTI) focuses on four questions: (1) Problem formulations: What are the difficulties and problems that brought you to analysis? (2) Theories of pathogenesis: How did the problems and difficulties arise? (3) Theories of cure: What would be the best help for your problems and difficulties? (4) Positive and negative changes (at termination and follow-up). With two cases they wished to illustrate the co-existence of two irreconcilable, implicit theories of change, held by the analysand and by the analyst. The two

[10] Canestri, J., Bohleber, W., Diatkine, G., & Fonagy, P. (2002). *Mapping private theories in clinical practice.* Paper presented at the EPF Conference in Prague, April 2002.

cases illustrate the parallel existence, both in the analysands and the analysts, of a wish for and fear of profound transformation of the personality by ways of deep regression, and an idea of more limited change in ways of coping with old problems. Both types of theories of expected changes or therapeutic goals existed at the start of analyses and were still present at the follow-ups as ideas of utopian versus obtained changes.

The discussion[11] was lively and despite of great differences in viewing them it never became polemic. To quote some of the comments*: "The Heidelberg Structural Change Scale permits to follow the therapeutic process and the evaluation of the patient's progress. The structuring of specific psychoanalytic parameters into operationalised dimensions may help to add new answers to an old question, namely ‚how psychoanalysis works' - by constructive change of conflicts - by modification of central relationship themes, which loose their compulsive character or - by integration of vulnerabilities into the structure".* It does not present the `essence of psychoanalysis', but may serve as useful tools in training and evaluation – even if this can be seen by some as an attack on the analyst's creativity and unique relation to his patient. Some cautioned against the exclusive preoccupation with effectiveness, which is a must in the race of the sciences and health services. At first sight this reduces the psychoanalytic encounter to a healing relationship with a medical concept of illness in the background. The cost-effectiveness mentality, the cult of optimisation and the idea of evidence based medicine force psychoanalysis into the realm of the monological discourse. Although the production and distribution of knowledge in society are highly political, power-dependent and success-driven processes, there are many possible ways to produce and distribute psychoanalytic ideas, viewpoints and knowledge. The psychoanalyst, as a tender clinician should maintain a firm position on the margins of the clinical world while retaining his/her basic methodological commitments. But again: *among the efforts for understanding and investigating at an empirical level what we experience at a clinical level, i. e. a deep, stable change in our patients, the Heidelberg-Berlin Study is a remarkable example. It tries to define and assess "structural change".* Their study was compared with the STOPP-Project, which also considered the definition and the assessment of "structural change", but only a posteriori and not directly. Whereas the STOPP-Project was originally not intended to study *"structural change or something of that sort"*, one of the important results of the STOPP-Project was that *"psychoanalysis may be expected to produce stable change, that is, structural, change"* (Sandell 2003, p. 5-6[12]). From the point of view of clinicians there remains the curiosity and the need to put together such impressive empirical findings, which are achieved, from quite different positions and expressed hope to have a continuous discussion about them.

So was also Werbart and Levander´s paper highly valued. To systematically study the psychoanalytic process, how change does come about as well as the necessity for the analyst to increase his/her awareness about the working models and preconscious private theories they use was strongly endorsed by all. *"Largely unconscious values strongly influence the analyst's choices in the areas of clinical theory and metapsychology alike. Such unconscious commitments involve profound aspects of the analyst's core identity; hence his ideological positions on seemingly objective matters tend to assume the narcissistic flavour",* and were looking forward to the further results of this interesting research, which may be of special meaning for the clinicians. A discussant stressed: "*Today could be considered more optimistically as a time of pluralism or more pessimistically as a time of splitting psychoanalytic theories. Within this frame, the proposal of the authors to investigate implicit, private, "preconscious" theories of change seems to me to be very useful because of the common tendency to multiplicate the private psychoanalytic theories ad infinitum. This project also seems to me particularly interesting in order to collect significant material about the First-person perspective of both the analyst and the patient. Explorations in this domain will be really important if we consider psychoanalysis as the only scientific discipline which integrates the subjective First-person dimension in a science"*[13].

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[11] Discussants: G. Amadei (Italy), K. Bell (Germany), G. Bodin (Danemark), G. Bögels (Netherlands); M-F Diaspaux (Belgium); E Gattig (Germany), P. Giampieri-Deutsch (Austria), I. Lust (Hungary), R. Sandell (Sweden), J. Schachter (Great Brittan), J. Stoker (Netherlands), M. Utrilla (Spain).

[12] Sandell, R. (in press). Structural change and its assessment. Experiences from the Stockholm Outcome or Psychoanalysis and Psychotherapy Project (STOPPP). In P. Giampieri-Deutsch (Ed.), *Psychoanalysis as an empirical, interdisciplinary science. Collected Papers on Contemporary Psychoanalytic Research* (pp. 269-284). Vienna: Austrian Academy of Sciences Press.

[13] *Psychoanalyse im Dialog der Wissenschaften. Europäische Perspektiven, ed. P. Giampieri-Deutsch, (2002) Vol.1. Stuttgart: Kohlhammer*

While an other discussant was grateful *"for having pushed me to deepen my personal considerations on some important issues, peculiar to the relationship between analyst and analysand, such as: But I do not think, for instance, that researchers can explore implicit (that is both conscious and unconscious) knowledge of patients about the functioning of the cure in a more profound way than clinicians could do. The exploration, elaboration and interpretation of so called "private theories" have always been the core and the essential aim of any analytic work"*

Once more did the presence of the third open an old controversy; to involve external observers seems to be irreconcilable for many psychoanalyst. Can we ever deepen the dialogue and understanding between those who advocate the necessity of using the perspective of the external observer/ researcher to approach the questions: how does psychoanalysis/psychotherapy work and those who find the presence of the third as incompatible, destructive and unnecessary. "*What did they expect from participating in the project? How did the analyst feel about participating? How did the presence of at third (the interviewer) effect the process? Did they genuinely feel it as help, and an opportunity to think? Or did the rather feel it like being controlled and having somebody looking over your shoulder? Could the interviewer effect the analyst in such a way that became more critical of herself? How did the analysand experiences being interviewed about her/his own analysis? Could it disturb the attachment to the analyst? Could it create uncertainty and disbelief about the analyst and him/her think that it was necessary to control the analysis? Or was it felt like security? Did it felt safe to have somebody keeping a watching eye on the treatment?"*

My own deep conviction is, that we need to study how psychoanalysis and psychoanalysts work: what kinds of intervention produce what kinds of change under what kinds of circumstances? This we have to do in all the three ways Professor Bürgin mentioned in his introduction. We have to foster in our institutes and societies a more scholarly atmosphere in which members, faculty and candidates can work together in understanding, challenging, and extending psychoanalytic method and theory. This is how I understand Michel's accent that *"we should disapprove of analysts who have no analytic interest other than the analysis of their analysands. They are practitioners, but not professionals, since they fail to contribute to their colleagues or to future patients.[14]"*

The **third workshop** on ***What can clinicians gain from research in psychoanalysis***? was held at the Annual Conference of the EPF in **Helsinki** April 18, **2004**.

Encouraged by the achievements of the previous workshops, I attempted to widen the focus of the third one. The two papers presented by Marco Chiesa and Rudi Vermote did not stay within the frames of the psychoanalytic situation, but did show how psychoanalytic thinking and dialogue can be used with severely disturbed patients in hospital settings. Marco Chiesas (England) paper had the title: ***"When less is more: reflection from the findings of a prospective study of psychoanalytically informed treatment for severe personality disorder"***, and Rudi Vermote (Belgium): ***"The psychoanalytic process with moderate and severe personality disorders in psychoanalytically oriented hospitalisation and its influence on outcome".***

We can define psychoanalysis as a meeting between two unique individuals, who become engaged in an intersubjective dialogue, in which each of them is experienced as parts of the world of one and other. This dialogue takes form within the frames of the psychoanalytic situation, and is influenced by how the analysts does relate to and uses psychoanalytic theorising. This theorising shall be a disciplined speculation about the fundamental structures of our psyche, with an openness to question ones hypotheses and confront them with the theorising of other disciplines. We should be open to be surprised all the time, as well as be able to rely on empeiria, which means to be able to use experience that is based on observation and not on theory. To maintain psychoanalysis as a discipline, as a theoretical system and as a treatment method we have to have a commitment to the reflection of its own nature and structure and we have to be continuously interested in trying to study these questions.

We have also to acknowledge that we are already framed by the frame that we try to establish for the psychoanalytic interaction. We are bound up with a social reality and must clarify and explain that which happens within the analytic frame to the world around us – thus, also to the larger community that accepts or rejects psychoanalysis; a society that protects the social fabric, or tears it to shreds; where solidarity and long-term planning is encouraged, or where planning is viewed as a game

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[14] Michel R. (2000) The case history *JAPA 42*

of win-or-lose all. In order to do both, to affirm and retain our working space as well as examine how we use it, we need research. We have to be continuously interested in trying to take part in the development of the *"virtuous cycle of theoretical development leading to increased refined observations and data collection, which in turn produces findings that raise the theoretical questions, that in turn lead to further scientific hypotheses of increased specificity"* quoting Peter Fonagy from his foreword to the recent publication of Research on Psychoanalytic Psychotherapy with Adults[15]

In his paper Marco Chiesa argued that *"scientific research in psychoanalysis and applied disciplines has beneficial effects for psychoanalysis and its clinical practitioners. Systematic collection of relevant data yields comprehensive information about several key aspects of clinical practice that would otherwise evade awareness. Second, well-conducted studies may increase our knowledge concerning the effectiveness of psychoanalytic therapy, which is more than ever in urgent need of validation. There is still grave uncertainty and disagreement as to which components of the psychoanalytic encounter are responsible for structural change. Reliance on clinical case studies has not advanced our ability to generalise findings and find consensus".* In order to exemplify some of the points made above the main findings of a prospective study based at the Cassel Hospital, a center dedicated to the psychoanalytically informed residential treatment of severe personality disorders, were presented and discussed. Comprehensive data was collected and analysed for 143 patients, evenly divided amongst three groups: one-phase in-patient group, step-down in-patient/out-patient group, general psychiatric treatment as usual. Patients were evaluated at intake, 6 months, 12 months and 24 months on a number of clinically meaningful dimensions to ascertain their progress into treatment and at follow-up. Several dimensions of functioning were assessed through the use of standardised instruments and systematic collection of clinical outcome variables in the areas of symptom distress, social adaptation, global functioning, self-harm, readmission rates and health service utilisation patterns.

The study revealed important results, which on the one hand contributed to the validation of the psychoanalytically informed approach to these disorders, but on the other did challenge widely held assumptions of most clinical staff within the institution. Concerning outcome they found that overall psychoanalytically informed treatment yielded better results than routine general psychiatric treatment in several key dimensions, such as psychiatric morbidity- , social adjustment and global assessment of functioning. The results have also shown that a reduction of the duration of inpatient stay not only did not have adverse effects, but also led to a better outcome when it was coupled with continuation treatment after discharge. In addition it had to be recognised that the research programme did not have adverse effects on patients´ mental state or level of engagement in the clinical programme, and the feared split between research and the clinical teams was a rare event.

The difficulties of carrying out a major research project have highlighted the importance of establishing a research culture within the institution, which can only be achieved through a painful but necessary process of working through of the dynamics and transferences that the research endeavour evokes. The introduction of practices values and ideas inherent in research projects can be at first experienced as alien and threatening to established practices and dominant culture, as disrupting and threatening the clinically based, familiar philosophy upon which psychoanalytically derived treatments are based. As such it evokes primitive transferences not exactly favourable to the development of psychoanalysis, characterised by a mixture of suspicion and persecution that in turn may mobilise hostile reactions. Chiesa concluded: *"Without wanting to deny the difficulties inherent in setting up research projects within a psychoanalytic framework, we need to acknowledge the importance of research and be aware of the risks of not engaging it in the present cultural and economic climate".*

The second paper: **"The psychoanalytic process with moderate and severe personality disorders in psychoanalytically oriented hospitalisation and its influence on outcome"** was presented by Rudi Vermote[16]. He emphasized: "*As analysts we focus on the psychoanalytic process. However the relationship between outcome and process is not so clear as we should*

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[15] 7th volume of EFPP series Ed: Phil Richardson, Horst Kächele & Camilla Renlund

[16] Vermote, R., Vertommen, H., Verhaest, Y., Stroobants, R., Corveleyn J., Peuskens, J. (2004). The Kortenberg-Louvain Process-Outcome Study. *Poster, Working at the Frontiers, IPA 43RD Congress, 10-14 March 2004.*

*hope. While 80 % of psychoanalyses have a good outcome, only in 40 % of the cases a psychoanalytic process is considered to have been developed. This relationship between outcome and process is even less evident with personality disorders, where most therapeutic approaches show to have a good outcome at least in the short term. This raises many questions: i) How to define the psychoanalytic process in personality disorders? Is it possible to operationalise this for empirical research ii) what is the difference between a patient report, an analyst report and a report by an external researcher of the same psychoanalytic process? iii) How do the different dimensions of the process influence each other during the process? iv) what is the relationship between clinical outcome and the psychoanalytic process?"*

To study these questions, Vermote and co-workers use a sample of patients with personality disorders who are consecutively admitted for psychoanalytically oriented in patient treatment at the University Center St. Joseph, Kortenberg, Belgium. In trying to understand their patients and their psychoanalytic processes, they made a three dimensional model based on a theoretical-clinical integration of the common psychoanalytic theories on personality. According to this model, one can see the psychic functioning of patients as happening in three dimensions. These three dimensions are felt safety, mentalization and objectrelational patterns. The first two dimensions: felt safety and mentalization are silently and non-problematically present in neurotic patients, but failing in personality disorders. This failing is manifested clinically, in the sensibility of these patients to changes of the analytic frame, in the acting out of affects in the here and now instead of psychic processing, in the lack of an as-if transference and so forth. From this model follows the common idea that in personality disorders the major work to be done is to contain and to help symbolizing experiences and feelings, while in neurotic patients one should work with lowering their neurotic defences in a psychoanalytic regression, so that the basic layers may play their vitalising role again.

The three dimensions of the psychoanalytic process were measured each three months during 15 months on 44 patients. Besides of this assessment of the three dimensions of the process by external researchers (with the Object Relation Inventory),
there was an assessment by the patients themselves as well on a self-report scale (the Louvain Psychotherapy Scale) and by the psychotherapists on the Psychoanalytic Process Rating Scale (Beenen & Stoker, 2001). To correlate the changes of the process over time with outcome, the outcome was measured at several levels (diagnostical, symptom, interpersonal) on admission, discharge and three months after discharge by several scales.

Summary of the results: at the outcome level symptom changes are manifest with a large effect size after six months of therapy. At the process level, an inner process is manifest and it is possible to assess it from a therapist's, a patient's and an external researcher's point of view. The interactions between the three measured dimensions of the psychoanalytic process show that felt safety and self-objectrelations gradually increase after a period of regression during the first period of the therapy. The pattern of change in mentalization suggests that a controlled regression maybe a decisive factor for a good outcome also in personality disorders. This result is somewhat unexpected from theory but it is recognisable in clinical practice. It is common in in-patient treatment that patients with personality disorders may have a good outcome, even when first lessening their control and go worse in the beginning. This may correspond to what Balint calls ' a new beginning'. Making this 'controlled' regression possible may be an advantage of in-patient treatment of personality disorder

As was pointed out in the discussion [17], the workshop seemed to have too many aims: 1.To discuss the rationale and the results of the outcome of PDs patients in two different studies. 2. To discuss the quality of different methods to evaluate the process (scales, inventories and so on). 3. To discuss the political reasons- in addition to the scientific ones -of doing such types of researches- political reasons, which are, different in the different states. 4. To assess the consequences that doing research had on the clinical work of the researchers 5. To imagine which consequences these researches could have on psychoanalytic theories and technique.

17 Discussants: G. Berti-Ceroni (Italy) C. Renlund (Finland) B. Salomonsson (Sweden) U. Schultz-Venrath (Germany) and Jan Stoker (Netherlands)

Nonetheless the importance of defying resistance within the psychoanalytic community against empirical psychotherapy research was stressed, and "*to increase our efforts to save psychoanalysis as a discipline in the competitive world of science and far more, that it is accepted and valued as a therapeutic tool!"* Even if the use of the psychoanalytic method is carried out in a frame of mind very much like that of the researcher's, with an inquisitiveness, a thirst for knowledge, and an openness of mind as crucial elements, the importance of projects of research being formalized and structuralized was stressed, with careful attention to the definition of concepts, methods, and the objects of study, irrespective of whether the research in question is e.g. empirical or conceptual. The study at the Cassel Hospital was seen as *"an example of meticulous, well-conducted research informing the staff and clinicians of the effect of what they are doing, of informing them of the comparative merits of two alternative treatment programmes they are offering, of giving information about the soundness of the theoretical basis for the programmes, of providing information that may be the basis for future changes in the treatment programmes, and, in the long run, of possibly providing information for future treatment policy decisions on a larger scale*". The Belgian study was also prized and discussants did find the 3-dimensionel model as overwhelmingly convincing; as it did focus on **"***what lies behind the credible changes in clinical outcome measures? what are the intrapsychic changes or the psychoanalytic processes happening during the psychoanalysis or psychoanalytic therapy with these PD-patients?* One suggested, that it would be important to enlarge the field of research to study the mutual influences of leadership-style and the phenomena of the group-matrix of the therapeutic teams, treating PD-patients with the question: *"Does the leader (and his or her team) function as a holding environment. I could observe that, if the leader or leader-team is more phobic-anxious, one could often find a dependent team, which emphasizes exclusively the "felt safety"-concept, even theoretically, which seems more to prevent than to challenge mentalising of the patients and of themselves".*

It was also emphasized, that the three dimensional model could also be seen as a test, a verification as well as an extension of the dual mental process model, developed by Fonagy and others. A dual mental process includes the coupling between two modes of psychic functioning, the equivalent and pretend mode, by enhancing the blocked or inhibited pretend mode and by resolving conflicts between mental self- and object representational processing. The results confirm that the dual mental process model is valid for ALL psychoanalytic treatments. One can learn from the study the indispensability of Felt Safety, delivered by the interpersonal communications of the clinical setting, as mediator of the dual mental processing. With other words*: "Without Felt Safety no Mentalising. The meanings based on the integrated equivalent and pretend mode of psychic functioning are not only in the head as merely mental processing, but they appear to be interpersonally based. We shall not confuse mental processing - which is interpersonally based - with brain processes that are in the head". "Meanings are created, not by inner subsystems within each individual, but discursively, by communication between people. So, we can add to the definition of the psychoanalytic process as a dual mental processing, mediated by a good enough secure attachment relationship, which is verified by this study."*

Professor Dieter Bürgin closed the discussion by emphasizing that in contrast to a unity of science, there exists a variety and diversity of psychoanalytic research cultures in different centres. Following the 'Zeitgeist', the health care systems in many countries put pressure on psychoanalysis to show in an objective way that psychoanalysis or psychoanalytic psychotherapy works effectively and efficiently. This may on one hand lead to an over-adjustment to the 'Zeitgeist' but on the other also to a rethinking of how psychoanalysis can remain in contact with other forms of science. Psychoanalysis can not escape from proving its efficiency, but it should do it without sacrifying its autonomy as a scientific discipline. The retreat to an ivory tower - refusing a scientific discourse - leads to a drying out of creativity. May be that we have to separate psychoanalytic therapy and research. But a therapeutic attitude cannot be separated form the desire to discover new insights. Scientific experience however is not simply an increase of therapeutic experience. It has to be more precise, complete and generalisable. Continuous critical reflection on the methods by which psychoanalytic knowledge has been acquired and on its limitations is combined with an objectivation of subjective experiences. If psychoanalytic research makes its theories, values and methods explicit and transparent, we might not only tolerate differences between different psychoanalytic approaches, but even be able to enjoy these, because they put in question our basic clinical beliefs or give them at least a better basis and transmit a

personal gain to our everyday identity as analysts. Psychoanalytic research, be it conflicting or complementary to the clinical practice of every day, reconfigures our system of thinking, conceptualising, feeling, intervening and brings about a deepening of the understanding of what happens intersubjectivly between analysands and analysts in the protected setting of the analytic cure[18].

***The forth workshop was held March 20, 2005 at the Annual Conference of the EPF in Vilamoura.***

To continue with a dialogue between clinicians and researcher about the" impact of research on psychoana-lysts", Rainer Krause (Saarbrücken) [19], Björn Salomonsson (Stockholm), Rolf Sandell (Stockholm/Linköping) , Jan Stoker (Amsterdam) and Sverre Varvin (Oslo) were invited to the fourth workshop – to give shorter introductions from their projects, focusing on how research does/did influence those analyst who are/were participating in a study (doing it or exposed to it so to speak - being interviewed before - during or after as in a katamnestic study, their analysands being interviewed, having sessions tape-recorded, etc.).

**Rainer Krause** and his group are (since 30 years) investigating un- and preconscious micro affective behaviour, predominantly in the face but also in the whole body of two persons and language in a pragmatic sense and how this micro interactive behaviour is related to mental disturbances and curative factors in treatment. Besides many other things the variability and richness of affective exchange processes are related to higher levels of mentalisation indicating that the expressive part of affect is tied to thinking and not directly to the interaction. Success of treatment is related to the specific forms of such unconscious exchange processes from the very beginning of the first meeting, in so far as complementary affective exchange patterns are related to better results whereas reciprocal patterns are doomed to fail. The latter means that the therapist remains in the same affective frame as the patient ( Mutual happiness f.e.) They have developed expert knowledge and can code affective behaviour of patients and therapists. They use this knowledge for selection of cases, to teach candidates to differentiate their own observable behaviour from their countertransferential feelings which might be very far apart in cases of countertransference defense. To help them overcome mistakes (such as taking their internal feelings as equivalent to what they do or what they express) he tries in the work of supervision to rely on the emotional procedure memory of the therapist and to link their narratives with their emotional procedural memory. This can be done by focusing on significant affective moments, where the candidate talks about some counter-transferential event, "microscoping" protocognitive structures of the experience, with a structured and disciplined observation of ones own emotional handling of the experience with the patient. Whenever possible, they recommend to use videotapes to understand the candidates emotional style and communication with the patient.

In his project **Björn Salomonsson** does investigate how mothers experience their infants' developmental problems. Mothers and infants will be interviewed and allotted to psychoanalytic treatment or treatment as usual. Results will be compared and followed up. A few treatments will be qualitatively analysed in a close-up study[20]. The sample consists of mothers experiencing their infants' problems with sleep, food, contact etc. They are mothers who are seeking help at (a) a specialist unit for nursing problems; or (b) at Child Welfare Centres. All children are under 18 months. During a video-taped interview, mothers talks about their infant's situation. If mother and infant are seen to be reasonable cases for psychoanalysis, they will be informed about it. Next day, a lot will be cast deciding whether analysis or TAT at the Child Welfare Centre will be suggested. Mothers will be guided as to whom to go for treatment. This, and several other steps in the procedure, will guarantee an ethically correct procedure. Systematic data will be a video-taped sequence of mother-infant-interaction, a Bayley test, a diagnostic classification DC 0-3 and questionnaires on infant symptoms, maternal health and experience of parenthood. Data pre- and post- treatment will be compared. The

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[18] Leuzinger-Bohleber M., Bürgin D.: Pluralism and unity in psychoanalytic research: some introductory remarks. In: Leuzinger-Bohleber M., Dreher A., Canestri J.: Pluralism and Unity? Methods of research in psychoanalysis. International Psychoanalysis Library, London 2003

[19] Due to his new position as Dean of the faculty of social science at the University of Sarrland, Rainer Krause could not come to Vilamoura, but did send his introduction on a DVD

[20] Several steps in the study will be done in cooperation with Anna Sylvén, a clinical psychologist and a candidate of the Swedish Psychoanalytical Association.

close-up study will focus on qualitative aspects of treatment processes, the theories behind treatments and how they relate to execution and results.

Björn Salomonsson closed his presentation with emphasizing: *"Discussions with my infant-analyst colleagues have focused on how to provide analytic treatment within a research framework as un-intrusive as possible and how I shall get relevant research data from their treatments. Questions whether the instruments yield psychoanalytically valid information and how analyst-researcher feedback should be organized have also been on the agenda. These questions reflect apprehensions that research might interfere in the analytic process and that quantitative findings might not be so relevant for an analyst. Here, information and dialogue is crucial. The attitudes towards systematic research, especially randomised controlled studies, have sometimes been cautious. However, the conviction is quickly spreading that the scientific and political community demands this kind of proof if they be willing to subsidize these treatments".*

**Rolf Sandell** made an interesting summary of the research studies he and his group are conducting in the Stockholm Outcome of Psychoanalysis and Psychotherapy Project (STOPPP). Using Power Point subtitles, he presented the audience with a number of interesting findings. 1. Psychoanalysis is an effective treatment, in absolute terms and relatively. 2. The positive outcome continues to develop after termination. Thus, analysis does not end when the analyst and the analysand stop seeing each other. Outcome is a *process.* 3. According to qualitative analyses of a series of post-termination interviews this post-treatment process seems to be influenced, not as much by intentional self-analysis, but by various self-managing and self-soothing strategies under the influence of the introjected good analyst. 4. Long-term treatment is not necessarily better than short-term treatment and more frequent sessions are not necessarily better than less frequent ones. Different combinations of duration and session frequency produce different outcomes post-termination. Thus, for example, brief treatments (less than 2 years) with more than 2 sessions per week tended to produce negative development post-termination, at an average, whereas 1 session per week for the same duration and more than 2 sessions per week in treatments longer than 4 years generated gradually improving outcomes post-termination. 5. Money does not buy good outcomedirectly. It buys time. There was no direct effects of financial variables, like amount of subsidization or amount paid by the patient, on post-treatment outcome. 6. Symptoms respond more easily to psychoanalysis than do social relations. Several self-rating scales indicate that patient response to psychoanalysis or psychoanalytic therapy was not as strong in terms of social relations or social adjustment as on the severity of psychological problems. 7. Effects on well-being do not necessarily generalize to health care utilization. Most psychoanalytic patients were light consumers to begin with and stayed on that low level throughout the entire treatment. 8. Psychodynamic psychotherapy is not a special case of psychoanalysis (or vice versa). Findings on the influence of the analyst's or therapist's attitudes in therapeutic matters indicate that attitudes that matter in psychotherapy do not in psychoanalysis. Further, therapists' long training analyses are very negative for their patients in psychoanalyses" quite ineffective, in fact negative. There seems to be a negative transfer from psychoanalysis to psychotherapy that make "as-if "psychotherapy.. The main source of variation in psychological treatment outcome is not different types of treatments but different treatment providers. Thus, differences between good and not-so-good analysts or therapists produce outcomes among patients that differ much more than the average differences between various types of psychological treatments. 10. The therapist is "the dark continent" in psychotherapy (research). Therapist must participate in research. Especially the last finding makes it important that analysts and therapists lend themselves to studies and evaluations of their performance.

How this is already realised at the Netherlands Psychoanalytic Institute was presented by Jan Stoker in his his paper: "**How do therapists use feedback from a quality monitoring system?"** The Institute is not a part of the Psychoanalytic Society as in other countries. In contrary, it is a mental health institution, confining itself to psychoanalytic treatments payed by national health insurances and have to deal with social-political representatives. The psychoanalytic clinicians working at the Institute are recruited from members and candidates from both [IPA certified] psychoanalytic societies that operate in the Netherlands as well as from the psychoanalytic psychotherapy society. The increasing attention for research issues already started around the beginning of the nineties A quality committee was set up (199?) and the quality monitoring system was introduced in daily clinical practice . Patients at registration fill out a number of scales, and a selected group of patients who might

be eligible for psychonalysis or psychoanalytic psychotherapy receive a second assessment. This assessment consists of interviews, among them the AAI [Adult Attachment Interview], and several psychological tests. The therapists fill out, every two weeks during treatment, the Psychoanalytic Process Rating Scale, PPRS[21], with 44 statements about the actual behaviour, action and interaction of the therapist and patient; and than completes these data with three monthly written reports. Statistical processing results in five output scales: "tension", "cooperation", "contentment", "making explicit" & "disillusion". By assessing the degree of the presence and the mutual relationship of these factors & of their underlying items, visualized by graphs, the researchers try to give a provisional interpretive comment on the course [for better or worse] of the psychoanalytic contact. Once a year the output of the scale as graphs and the written reports are presented for and discussed with the therapist.

Working with AAI - and moreover - applying the Reflective Functioning Scale [RFS] had to be introduced by theoretical and technical seminars to give familiarity with the theories of the mental process- and mental representational model and their important links with the technique of [mentalization based] psychoanalytic interventions. They became aware lately, how thoroughly the mental change of the staff members of the Institute has been. It snowballed other developments, such as the start of a new department for *"knowledge and training"* that organizes, among many other happenings, monthly presentations and discussions about ongoing projects. It is remarkable how psychoanalytic theories are becoming more or less accessible to question what works in psychoanalytic treatments linked with what kind of outcomes. This turn also had its renewing effects on the teaching [on theoretical issues] and the training [technical seminars & supervision] by those staff members of the Institute who also participate in the education of candidates under the auspices of the three societies.

Stoker summarized the experience with the monitoring system: a) looking at the graphs as the processed end result of the sessions, the therapists are sometimes surprised when looking in their own mirror, b) the graphs & reports from the collected data during the year seem rather to facilitate the development of new ideas about the facts instead of conclusions based on pre-established theoretical opinions on reports made at the end of the year, c) the atmosphere of the yearly discussion groups changed from authoritarian to a discussion between worthy egalitarian discussants on equal terms. d) colleagues express "it gave me new ideas about the treatment"; "the advantage is that the mutual relationship of the subscales gives you an idea about a pattern in the psychoanalytic encounter, so you are able to start thinking about the pattern of interventions and responses. But, at the same time it makes me feel hesitant and somewhat scared about being so explicitly and consciously thinking about such a pattern, because it mirrors your own way of handling the patient during the session, it mirrors too your functioning as a professional"

As a conclusion Jan Stoker underlined that research does set in motion an irreversible change from believing to questioning. By introducing research into daily practice may stimulate 1) an important revision of the assessment procedures "what kind of treatment is suitable for the patient?" 2. the use of a system that monitores the treatment 3. during discussions psychoanalytic interventions will be scrutinized in the light of testable models 4. monitoring of the outcome and systematic follow up during treatment.

**Sverre Varvin** called attention to in his presentation: *There is an inner "clinical triangle" where the school of thought and the community of colleagues represents, apart from ones own analytical experience, the third in the relationship to ones patients and ones clinical practice: a necessary third without which our thinking and functioning would tend to deteriorate and open for possible enactments in clinical practice. Research activities in a community of practitioners is thus situated in a subjective dimension, a relational field where the understanding of transference is central both on a symbolic and an imaginary level".*

Within psychoanalysis, ambivalent, if not outright antagonistic, attitudes towards formal empirical research have been the tradition. Identifying strongly with psychoanalysis as a distinctive discipline the findings of formal research seem irrelevant to the practicing clinician. Or, even when research is viewed as a base for knowledge and of possibilities for (often painful) change, it can be feared as a source of rejection and devaluation. The problem of validation is important in

[21] which is a translation and a processing of the Anna Freud Centre Session Rating Scale for children and adolescents and the Anna Freud Centre Young Adult Weekly Rating Scale

this context. In formal empirical research validation is supposed to be a “built-in” quality of the research design. Generalisations in qualitative research aim, then, at showing which phenomena and meaning-structures exist in a group in a given historical situation. There is thus a strong emphasis on *pragmatic validation* in qualitative research. Results from psychoanalytic research are heavily connected with the subjective factor and the evaluation of research findings will also be situated in a transferential field where dependence on theoretical fractions, authorities will be important. The historical and context-boundedness are built into the method, and it is made explicit that the empirical facts are interpreted from certain points of view and interests. The aim is not to find general laws but patterns and regularities (Varvin 2003[22]).

After Harald Schelderup pioneering follow-up study in the 1950ies (the Oslo I Study) the presently ongoing ***Oslo II Study (***a prospective process-outcome research) started in the mid 90-ies.. The specific aim of the project is, through intensive, detailed study of a small number of completed, tape-recorded psychoanalyses, to identify and describe process factors and interventions contributing to positive outcome. Therapeutic outcome is assessed through a variety of dimensions, including symptomatic improvement, modification of personality structure and changes in subjectively experienced self states. A diversity of methods are applied, among them AAI (Crittenden 2000[23]).

There has been a rather positive development in the Society, such as: a) Activation of members both as participants and as supporters and possible users of research. b) Training in research methods and interests among younger colleagues; c) They have developed a project that potentially will give interesting results; d) They have now a research fellow who will make a doctoral thesis on the postanalytic process ; e) Research is established as a institutionalized activity at the institute; f) They are now making a research fund with around 50.000 NoK (approximately 75 000 Euro) g) They are planning a prospective study with the aim that every member should “offer” one analysis for research. One amazing thing has been the willingness among some clinicians to do tape-recording and also the general acceptance by members in the Society for this procedure. “One main aim, however, with bringing research into a psychoanalytic society is to foster a research culture where questions can be posed, positions can be criticized and, most important, ones work can be evaluated both by formal research and in the daily clinical work without prejudices. In the daily clinical work one would moreover hope that a culture of research will influence our private theories and models and open for better psychoanalytic work”.

In the discussion –ending the workshop - Henk-Jan Dalewijk referred to the 1996 report of the IPA's House of Delegates, which emphasised the crucial importance to deal with the crisis that psychoanalysis as a treatment method was facing. To conduct research was one of the central remedies the committee suggested, despite the well-known ambiguity and even resistance that existed against research in most psychoanalytic Institutes. In his paper *Institutional Problems of Psychoanalytic Education.* (Kernberg 1986 pp 833) emphasized, *“*P*sychoanalytic education is all too often conducted in an atmosphere of indoctrination rather than of open scientific exploration”.* In their memorandum about a reform of psychoanalytic training, submitted to the Executive Council of the IPA (1999 published in the IPA Newsletter) Thomä and Kächele still had to stress that – “*to keep psychoanalysis alive for the future - we should build our psychoanalytic education on the teaching, research and treatment triad* “. Nevertheless, there are also some important events that can increase our hope for the future. In 1997 the IPA has installed a research fund that received many applications. There are ongoing studies on the efficacy of psychoanalysis; on the specificity of the psychoanalytic process and its effect; on comparing the process and effect of psychoanalytic therapy of different frequencies, where the same therapist is conducting treatments 4-5 times and 1-2 times a week; on how training does influence the candidates; on how can supervision be used by fax, internet, video compared to face-to-face supervision. Under the presidency of David Tuckett the European Psychoanalytic Federation has formed so-called Working Parties on Clinical and Theoretical Issues, as well as on Psychoanalytic Education. They have the task to “describe the types of working psychoanalytically”, “assessing the effectiveness of working psycho-analytically” and “ creating transparent means to assess training outcomes, and publishing studies of the effectiveness of different educational systems”.

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[22] Varvin S (2003). *Mental survival strategies after extreme traumatisation*. Copenhagen, Multivers.
[23] Crittenden PM (2000). Dynamic-maturational approach to attachment theory.

At IPA congresses research does receive more and more space, and at the last four EFP congresses workshops were organised on the theme: *How can clinicians use psychoanalytic research?* with the ambition and hope to encourage dialogue between clinicians and researchers; to exchange ideas, discuss problems, and present results to the broader public. We should be thankfull to the EPF for encouragement and to Imre Szecsödy for organising them. Thanks to his enthusiasm, stimulating capacities, and pushing power, every year again, these workshops are a success.

The fifth **workshop** was held at the Annual Conference of the EPF in **Athens** Sunday April 9 2006

The first paper was given by ***Anssi Peräkylä*** *(Finland)**:** Patients responses to interpretations: a dialogue between Conversaion Analysis and psychoanalytic theory*. He reported from a conversation analytical study of the patients' responses to interpretations in psychoanalysis. The data came from 27 tape recorded and transcribed psychoanalytic sessions involving three analyst-patient dyads. The study seeks to facilitate dialogue between conversation analytical findings and psychoanalytic theory, by using CA to describe the practices in and through which the psychoanalytic theory concerning interpretation is realized in actual interactions.

**Patrizia Giampieri Deutsch** (Vienna) *"Does the clinician's knowledge of psychoanalytic assessment instruments improve her/his everyday analytical work?"* She started expressing her hope, that the long-standing tradition in clinical psychoanalysis, that theoretical thinking may impair the capacity of the analyst (and of the candidate) to carry out sound clinical work is changing. The presentation focused on how the knowledge of psychoanalytic measures [like Sidney Blatt's Object Relations Inventory (ORI) and Peter Fonagy's Reflective Functioning (RF)], which are a concentrate and distillate of the clinical psychoanalytic experiences, helps to improve the clinician's perception and are sharpening the psychoanalytic work of the clinician.

**Gabor Szönyi** (Budapest) *How to be a lay researcher in and of psychoanalysis* gave very interesting descriptions about and reflection to a number of studies ha was engaged in, about psychoanalytic competencies, shuttle analysis and supervision.

**Beatriz Priel** (Israel) **The relevance of psychoanalytic research for analytic training**

The relevance of psychoanalytic research for analytic training She emphasized in her paper the relevance of psychoanalytic research for analytic training. In her experience, clinical training and a close acquaintance with the contents and methods of psychoanalytical research are dialectical partners in the formation of future analysts. The integration of psychoanalytic research early in the analytic training should be a crucial step towards the creation of a psychoanalytical culture open to questioning, exploration and collaboration.

**APPENDIX**

**Saturday, April 6, 2002. Prague**

**Workshop 09.00 – 17.30** *What* **can clinicians gain from research in psychoanalysis.**

1) Introduction Chair I Szecsödy, co.chair P Fonagy

***2) How to study the quality of psychoanalytic treatments? Report from the DPV katamnestic study*** **MarianneLeuzinger-Bohleber, Bernhard Rüger, Ulrich Stuhr, Manfred Beutel**

*This is a presentation of the project, its development, what was learned and gained. Detailed clinical descriptions will be given about how the follow up interviews with former analysands were used in a psychoanalytic way, to gain a deeper perspective in how these individuals experienced and used analysis.*

*Discussion with participation by* G Bodin, G Bögels, K Ditrich, E Gattig, G. Klug, A Kluzer Usuelli, S Lagerlöf, I Lust, R Perron, R Sandell, E Sechaud

3) Chair: I Szecsödy, co-chair R Krause

**U*sing the Psychoanalytic Process Rating Scale (PPRS) as a tool for research as well as quality assurance in clinical work* Jolien Zevalkink and Jan Stoker**

*The time series of this data will be presented to show how therapists receive feedback about the psychoanalytic process, how the research data look like in terms of process material, as well as the way the discussion about the results with colleagues influences the way the therapist proceeds with the psychoanalytic process in any particular case.*

*Discussion with participation by* G Bodin, G Bögels, K Ditrich, E Gattig, S Lagerlöf, R Perron, R Sandell, E Skale, J Välimäki

4) Chair: I Szecsödy, co-chair HJ Dalewijk *General discussion with all partticipants*

**Saturday April 26, 2003 Sorrento**

**Workshop 09.00 – 17.30 What can clinicians gain from research in psychoanalysis.**

**1) Introduction** by *Dieter Bürgin* (Basel) . *Chair I Szecsödy, co-chair D Bürgin*

**2) "Psychoanalysis and research - two conflicting positions? Conclusions from the Heidelberg-Berlin project studying structural changes in psychoanalytic therapies**". *Gerd Rudolf, Tilman Grande, Wolfram Keller, Reiner Dilg, Thorsten Jakobse*n. (Heidelberg)

*Conclusions are presented from a prospective study on the process and out-come of psychoanalytic long-term treatment and time-limited psychodynamic therapy. The focal point of the study was the investigation of structural changes as a hypothetically specific effect of analytic long-term therapies. Some of the core concepts derived from this study were implemented in studies on psycho-therapeutic practice and quality management concerning psychodynamic treatment.*

Discussants: Amadei, Gherardo (Milan) Bell, Karin (Köln) Bodin, Gudrun (Copen-hagen) Gertie Bögels (Amsterdam) Diaspaux Marie-France (Bruxelles ) Giampieri-Deutsch, Patrizia (Vienna) Lust, Ivan (Budapest) Schachter, Joan (London)Utrilla, Manuela (Madrid)

3) Chair Imre Szecsödy, co-chair Dieter Bürgin

**Investigating implicit theories of change in analysands and their analysts**

*Andrzej Werbart and Sonja Levander* (Stockholm)

*This is a presentation from a project, investigating the analysand's and the analyst's preconscious, private, or implicit theories of pathogenesis and cure, how they develop during the psychoanalytic process, and how the theories of the two participants are related to each other. The analysands and the analysts were interviewed at repeated points of time: at the start of analysis, 6, 18 and 36 months later, at termination, and the analysands also at a 1.5 year follow-up*

Discussants*: Amadei, Gherardo* (Milan) *Bell, Karin* (Köln) *Bodin, Gudrun* (Copen-hagen), *Gattig, Ekkehard* (Bremen*) Giampieri-Deutsch, Patrizia* (Vienna) *Kluzer, Giampaulo (*Milano) *Sandell, Rolf* (Stockholm) *Schachter, Joan* (London) *Stoker, Jan* (Amsterdam)

**Sunday, April 18 2004 Helsinki**

**Workshop 08.45 - 12.30 What can clinicians gain from research in psychoanalysis.**

***1 )Introduction by the chair Imre Szecsödy***

**"When less is more: reflection from the findings of a prospective study of psychoanalytically informed treatment for severe personality disorder***".* *Marco Chiesa (England)*

*This paper argues that scientific research has beneficial effects for psychoanalysis, applied disciplines and their clinical practitioners. Reliance on data generated from clinical case studies, is not considered as an accepted method of scientific scrutiny and alternative, extra-clinical ways of studying psychoanalytic claims are needed to integrate clinical findings. The study presented shows how systematic collection of data yielded comprehensive information about several key aspects of clinical practice that would have otherwise evaded awareness. The findings from research have a potential for informing the practicing clinician and lead to beneficial modifications and developments in the approach to emotional disorders, as shown in our study*

Discussion started by Professor Giuseppe Berti Ceroni (Italy) and Camilla Renlund (Finland)

**2) The psychoanalytic process with moderate and severe personalit disorders in psychoanalytically oriented hospitalisation and its influence on outcome. "** *Vermote R. , (Vertommen H., Corveleyn J. , Verhaest Y.) Belgium*

*The relationship between outcome and process is not so clear as we should hope. While 80 % of psychoanalyses have a good outcome, only in 40 % of the cases a psychoanalytic process is considered to have been developed. This relationship between outcome and process is even less evident with personality disorders, where most therapeutic approaches show to have a good outcome at least in the short term. For the study of this problem we relied on a three-dimensional model of the psycho-analytic process in personality disorders, that is, felt safety, object relations and mentalization and will present its operationalization for research. We will discuss the preliminary results of a process-outcome study based on this model, for 70 patients with personality disorders consecutively admitted in an in-patient and day treatment on psychoanalytic lines.*

Discussion will be started by Professor Schultz-Venrath (Germany) and Jan Stoker (Netherlands)

*3) General discussion* ***"Psychoanalysis and research - two conflicting or complementary positions? "*** *led by professor Dieter Bürgin (Switzerland)*

**Sunday , March 20 2005, Vilamoura**

**Workshop 08.45 - 12.30** **What can clinicians gain from research in psychoanalysis.**

**Moderator: Imre Szecsödy** (Sweden)

**Rainer Krause** (Germany) ***Implications of research work on the process of upervision***

R Krause will focus on an altered understanding of countertransference separating between the internal mental representation of feelings and the very often un- or preconscious counter-transference behaviour as it is depicted in the micro momentary affective behaviour. Depending on the research results they train people in tolerating incoherence in them selves as a major possibility to understand the unconscious part of their one enactments.

**Björn Salomonsson** *(Sweden)* ***Infant Developmental Problems - a treatment study. Doing research on analytic colleagues' work - thoughts and reactions***

After a brief outline of his research project, which evaluates psychoanalytic treatments of infants and mothers in Stockholm and treatments conducted at child guidance centers, B Salomonsson will expound on his own and his colleagues thoughts and reactions when their psychoanalytic work is subjected to quantitative and qualitative research.

**Rolf Sandell** (Sweden): ***Learning from the patients through research.***

In this paper R Sandell will consider how even large-scale outcome research may force the researcher/analyst to reconsider old assumptions and alleged truths about the workings of psychoanalysis..

**Jan Stoker** (Netherlands) ***Do therapists use feedback from a quality monitoring system?***

J Stoker will comment on the use that therapists make of the feedback from outcome and process measures from the quality monitoring system at the Netherlands Psychoanalytic Institute.

**Sverre Varvin:** (Norway) ***Can a psychoanalytic community identify with research on process and outcome in psychoanalysis?***

The Oslo II study is a prospective process outcome study that started in 1997, gathering data before and after analysis, at follow-up and during the process. 11 analyses are included in the project. S Varvin will present a reflection on the potentiality of such an endeavor in a psychoanalytic society and discuss where they succeeded and where they have failed in involving members in this process.

After these introductory presentations an open discussion will follow inviting all workshop participants - presenters and audience.

**Sunday April 9 2006 Athens**

**Workshop 08.45 - 11.00** **What can clinicians gain from research in psychoanalysis.**

**1) Imre Szecsödy**(Sweden)**: Introduction**

2) **Anssi Peräkylä**(Finland)**: Patients responses to interpretations: a dialogue between CA and psychoanalytic theory**

The paper reports a conversation analytical study of the patients' responses to interpretations in psychoanalysis. The data come from 27 tape recorded and transcribed psychoanalytic sessions involving three analyst-patient dyads.

3) **Patrizia Giampieri-Deutch**(Austria): **"Does the clinician's knowledge of psychoanalytic assessment instruments improve her/his everyday analytical work?"** Psychoanalytic assessment instruments try to convert authentic psychoanalytic knowledge into reliable measurement techniques. This brief paper would like to suggest, that the knowledge of psychoanalytic measures, a concentrate and distillate of the clinical psychoanalytic experiences, helps to improve the clinician's perception.

4) **Gabor Szönyi**(Hungary): **How to be a lay researcher in and of psychoanalysis. A personal view**

Reflection to organising and conducting a number of studies about psychoanalytic competencies, shuttle analysis and supervision.

5) **Beatriz Priel** (Israel): **The relevance of psychoanalytic research for analytic training**

The clinical training and a close acquaintance with the contents and methods of psychoanalytical research are seen as dialectical partners in the formation of future analysts. The integration of psychoanalytic research early in the analytic training is a crucial step towards the creation of a psychoanalytical culture open to questioning, exploration and collaboration.

**Discussion**