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Re-parenting Your Elders? Transference from Older Patients

José Luis Hernández Rodríguez

Sonja Embree, PhD, Directora de Trabajo de Titulación

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José Hernández

Sonja Embree, PhD.,

Directora del Trabajo de Titulación _____

Teresa Borja, PhD.,

Directora del Programa _____

Carmen Fernández-Salvador, PhD.,

Decana del colegio de Ciencias

Sociales y Humanidades _____

Quito, 16 de julio de 2015

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Firma del estudiante: _____

Nombres y apellidos: José Luis Hernández Rodríguez

Código: 00103463

Cédula de Identidad: 171592170-4

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DEDICATORIA

A mis profesores, mis pacientes, y las futuras generaciones de terapeutas.

AGRADECIMIENTOS

Quiero expresar mi profundo agradecimiento hacia la voluntad que tengo de conocerme a mí mismo, pese al temor de lo que pueda encontrar. Esa voluntad me ha permitido entender que ese agradecimiento va también para la suma de las consciencias que han topado mi vida de alguna manera u otra. Es decir, al fin y al cabo, que estoy agradecido con la vida misma.

RESUMEN

La transferencia es un fenómeno de importancia capital en la terapia psicoanalítica y psicodinámica. Cuando un terapeuta joven trata un paciente de mediana o avanzada edad, sin embargo, se puede esperar la ocurrencia de un tipo de transferencia especial. La transferencia que ocurre entre un paciente y su terapeuta, más joven que él, podría tener implicaciones particulares para la terapia. Un grupo focal conformado por cinco integrantes de las perspectivas psicológicas psicoanalítica y psicodinámica que han tenido pacientes de mayor edad que ellos fue realizado con el objetivo de entender estas particularidades y cómo podrían informar la terapia. Los resultados, aun cuando siguen siendo preliminares, parecen indicar la existencia de un tipo de transferencia con figuras del pasado más jóvenes que convendría explorar más a fondo. Esta transferencia parece ofrecer valiosas ventajas al proceso terapéutico con pacientes de este grupo de edad. Estas ventajas son la posibilidad de realizar análisis de la transferencia en pacientes cuyo pasado traumático ha activado defensas que es mejor no cuestionar puesto que la personalidad podría desestructurarse; y la posibilidad de que los pacientes aprendan, a través de la neurosis de transferencia, a relacionarse mejor con las personas jóvenes que hay en su vida.

Palabras clave: psicoanálisis, psicología psicodinámica, psicoterapia, transferencia, paciente de mediana edad, paciente de edad avanzada, terapeuta joven.

ABSTRACT

Transference is a phenomenon of paramount importance in psychodynamic and psychoanalytic therapy. However, when a young therapist treats a middle-aged or elderly patient, a distinct kind of transference can be expected to occur. Transference that occurs between a patient and his/her younger therapist could have particular implications for therapy. A focus group of clinicians from these perspectives who have treated patients older than themselves was formed in the aim of understanding these particularities and the way they could inform therapy. Results, although still preliminary, appear to indicate the existence of a type of transference from younger past figures that ought to be explored in more depth. This type of transference appears to offer valuable advantages to the therapeutic process of patients from that age group. These advantages consist of the possibility of performing transference analysis on patients whose traumatic past has put in place defenses that are best not questioned because their personality could deconstruct; and the possibility of the patients learning, through the resolution of transference-neurosis, to better relate to the younger people in their lives.

Key words: psychoanalysis, psychodynamic psychology, psychotherapy, transference, middle-aged patient, elderly patient, young therapist.

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INTRODUCTION

Psychological theory, especially within the theories usually referred to as “depth psychology”, has had one of its main applications in the therapeutic context. Clinical psychology possesses an incredible amount of theoretic perspectives and an even greater number of possible therapeutic techniques to be applied. The focus of this study comes from one of the oldest assumptions to inform clinical work with mental patients. I refer to the notion that aspects of past relationships can emerge in new relationships, and cause one to feel, think and behave with a new person as if they were the past relationship. This notion gave birth to the term “transference” and became one of the main phenomena to be worked with in psychoanalytic therapy (Freud S. , 1912/1958).

Antecedents

Literature on the concept of transference is overwhelmingly abundant. Freud not only first discovered the existence of this phenomenon, but also revised and modified it, together with its clinical implications, constantly. First, he observed a particular kind of transference, the erotic transference (Freud & Breuer, 1885/1996). Then, he foresaw the possibility of transference to be ubiquitous in normal people, which would make the transference with the therapist a simple exacerbation of a naturally occurring phenomenon. Finally, he understood transference to be a gateway to the cure of the patient if it is properly analyzed (Freud, 1914).

From this point forward, virtually every therapeutic approach has included its own variation of transference into the list of concepts to be observed and understood by therapists, or to be used as a therapeutic tool. Staying in the realm of depth psychology, noteworthy variations of transference and its uses were made by Jung and later followers of the analytical

psychology tradition (Wiener & Rosen, 2009); by Lacan and his separation of symbolic and imaginary transference (Lucchelli, 2009); and by Melanie Klein and other object-relations theorists such as Otto Kernberg, especially on the role countertransference has in helping the therapist analyze the patient's transference (see Kernberg, 1987).

The problem

Extensive as this literature may be, it fails to focus on particular therapeutic contexts that might require special attention. This is the case of the context in which the patient is older than the therapist. Most theorists and researchers have focused on transference that is made from past parent figures. The reasons why this type of transference is of utter importance are clear to anyone with a basic understanding of psychoanalytic or psychodynamic theories. However, the real characteristics of the therapist facilitate the appearance of past relational patterns (Gabbard, 2014). This means that the difference of ages between therapist and patients that favors this type of transference, and that is therefore favored by the amount of literature dedicated to it, is the one where the with the patient is younger than the therapist. This causes little attention to be paid to the rather frequent setting of a young therapist treating an older patient.

Hypothesis

From what precedes, it is possible that the literature has missed an important place of research within psychoanalytic and psychodynamic clinical theories. I, therefore, hypothesize that transference coming from an older patient towards a younger therapist can have particularities, different from other kinds of transference, worthy of being theorized about and used as a therapeutic technique in their own right.

Research question

How can transference be used as a therapeutic tool when the patient is older than the therapist?

Context and theoretical frame

This study will be conducted within the theoretical frame of both psychoanalysis and psychodynamic psychology. This is due to the fact that these two theories are the ones, within the realm of clinical psychology, that make the strongest emphasis on the use of transference as a therapeutic technique. Moreover, they are also the ones that possess the largest amount of literature dedicated to this concept. Finally, they have traditionally been the main ones (if not the only ones) in which therapists are specifically trained to pay attention and understand the therapist-patient relationship in such a deep level.

Purpose of the study

It is expected to find data that shows that transference coming from an older patient is substantially different from the traditional parent-figure transference. Furthermore, this data is expected to be sufficient enough to start formulating a theory on this particular transference and especially the way it can be used to treat, or aid or inform treatment.

Significance of the study

Should this study reach significant conclusions, the repercussions outside of my personal context will be immediate. This is, after all, a study aimed at generating knowledge that will inform clinical decisions. This study could be of great importance to a large body of young therapists who are entering the professional field and treating patients older than

themselves. Moreover, it would be the first time, to the best of my knowledge, that a focus group is conducted on this subject.

Definition of terms

Given the incredibly vast nature of the term "transference" in the literature, and all the variants it has from theory to theory, a simple, unified definition is proposed for the aim of this study. Transference is to be regarded as the unconscious re-emergence in a present relationship of patterns of mental organization, relations, affects, expectations, conflicts and traumas originated in past situations and relationships.

Presumptions of the author

The conduction of this study is based on two assumptions for which I do not possess evidence, but are nonetheless reasonable. First, it is assumed that, given the unconscious nature of the phenomena that will be researched, they are global and minimally or not at all influenced by culture. Therefore, studies conducted in cultures significantly different from the Ecuadorian culture in which the study is taking place can serve as fundament for the study. Second, it is assumed that the level of expertise of Ecuadorean psychodynamic psychologists and psychoanalysts is not significantly different from that of the professionals from other countries and cultures. Thus, the findings that are made by means of the cases they present and the discussion that ensues can be generalized.

Summary

Transference is a concept that has been intensively theorized about for more than a century now. It has focused mainly, for clinical purposes, on the displacement of the parent-

figure. Literature on transference from older patients is scarce, but not absent, as I will present in the next section. The following literature review presents some knowledge on the main topics that will be covered by this study.

LITERATURE REVIEW

Literature genres included in the review

Sources.

The information gathered in this literature review comes from several peer reviewed journals, specialized books, and a videotaped interview.

Steps in the process of literature review

An initial idea of the literature that would best serve the purpose of this study was obtained through the syllabus of a class on geriatric therapy in a Masters in Social Work program. Subsequently, several literature searches were performed in on-line databases such as EBSCO, Ebrary, and JSTOR.

Literature review format

Literature will be revised and organized according to the subjects that must be covered.

Transference nowadays.

Besides what has already been stated about transference, a couple of points are still worthy of mention. In the first place, it is necessary to understand how is it that transference is nowadays used as a therapeutic tool by analysts and psychodynamic therapists. Freud (1914) was the first to realize, as previously seen, that transference provides a unique setting for treatment. Specifically, in his paper *Remembering, Repeating and Working Through*, he refers to a particular state of mental organization the patient enters once the transference with the analyst has brought from the past important traumas or conflicts. He coined a term for this

state: transference-neurosis. It is a particular state of psychic conflict in which the patient is unable to remember at the psychic level the contents that have been repressed, but is still able to remember them at the motor level. That is, the patient repeats or acts out these contents without realizing that he is doing so. This new situation repeats all the features of the illness, but is an artificial illness created by the therapeutic context and within transference. Therefore, these features are now open for analysis and intervention.

In relation to this, countertransference has received an increasing amount of attention since the days of Freud. Countertransference was regarded at first as the analyst's transference to the patient or the analyst's reaction to the transference from a patient, but it was assumed that it emerged from unresolved conflicts in the therapist's unconscious (Freud, 1912/1958). The concept has undergone important modifications, and it is now widely accepted that countertransference can either come from the therapist's unresolved conflicts or from a natural reaction to the patient's transference that supposes no harm for therapy (Gabbard, 2014). Actually, it is now viewed as a therapeutic tool that aids the process of transference analysis, given that the affective content of the therapist's countertransference is a direct response to the affects perceived in the patient's transference (Kernberg, s.f.).

Finally, it is worth to state that transference has now been operationalized in terms of theories that can be quantitavely researched. Social constructivism theory, particularly, is gathering a large amount of empirical data on transference that seems to be aligned with previous psychoanalytic and psychodynamic views. In a review of literature aimed at testing psychodynamic hypothesis empirically, Andersen (1992) explains transference from this information-processing theoretical viewpoint as the assimilation of a new person to the

representation of a significant-other, which in turn leads one to respond to the new person as if they were this person, to assume the new person to have qualities they do not have, and to evaluate them in a similar way as they would with their significant-other. She uses purely idiographic data to come to these conclusions. In the studies she reviews, participants are asked to give information about a significant-other, a non-significant-other, a stereotype, and simple traits, in a previous condition. Then, participants are given the description of a new person, with similar characteristics to those of the participant's significant other in the experimental condition, and with similar characteristics to someone else's significant-other in the control condition. The hypothesis was a false-positive recollection of memories of the new person in the experimental condition. As expected, the participants did remember information they were not given about the new person. The main conclusion to be drawn from this revision is that transference is not particular to therapeutic settings but rather occurs in everyday life. Another important conclusion is that this research informs the clinical assumption that much of human suffering comes from inappropriate superimposition of old relational patterns learned with significant-others.

Using this very same study design in a slightly more contemporary manner, Andersen and Berk (1998) operationalize transference in a mixture of idiographic and nomothetic data analysis methods. Moreover, they theorize that some of these constructs are more readily activated because of chronicity, that is they have been more frequently activated, and thus are most accessible in the person's memory; and others are transiently activated, meaning they activate because the new person possesses characteristics that remind the person of their significant-other. Besides these slight modifications and additions, the study design remains unchanged from the previous articled that was reviewed (Andersen, 1992). This methodology

is used across the many studies revised in this present article, therefore many conclusions are drawn. The main ones, besides confirming the conclusions already drawn from the previous article, are that the new person's resemblance to the significant other is important in triggering particular transference schemas in the perceiver, reflected in "inference and memory, evaluation, affect, motivation, and expectancy effects, as well as effects associated with the activation of interpersonal roles and with changes in self-definition in relation to the new person" (p. 114).

The position of the young clinician.

The thought of a therapist becoming better with time seems a matter more of common sense than of scientific research. However, the fact that experience helps therapists become wiser, thus better at their professions, does not help define the position in which the young therapist finds himself. Counselor age has been found by some not to have significant impact on therapy outcome (Beck, 1988). Others, on the contrary, believe that the difficulties encountered by beginning clinicians with their older clients are due to the fact that training programs do not fully address the obstacles arisen by the conflict of roles that the age difference creates, mainly because this conflict is not fully understood (Carkhuff, Feldman, & Truax, 1964).

By interviewing two directors of training programs in counselling and therapy, Pointon (2007) reports some of the characteristics that young trainees need to present in order to be deemed ready to receive patients. In the first place, self-awareness and self-confidence are paramount for young therapists. A good sense of their core self will help young clinicians to contain and accompany a patient in distress without having a similar life experience to reflect

on. Therefore, older clients will still feel that their therapist is, even if unexperienced about some of the things that will appear in therapy, able to provide them help in critical moments. Moreover, Pamela Atkinson, one of the interviewees for this article, even discusses the issue of transference, although briefly. She states that transference does not only rely on concrete factors like age or gender, but also on the function, need and feeling it might be providing in the therapeutic setting. Thus, a younger therapist, by containing, understanding and relating to his patients in an attuned way can create the needed experience for the patient, regardless of the age difference. Finally, one last characteristic discussed in the article that I consider worth mentioning is the firmness to hold an authority. This is necessary in the therapeutic setting because, regardless of the age difference once again, the therapist has to be the one to provide limits and boundaries for the patient. This, again, might be a difficulty for a beginning clinician that needs to be an authority figure to somebody older.

Analysis and psychodynamic psychotherapy of the older patient.

The treatment, or rather the literature on the treatment of middle-aged and elderly patients from psychodynamic and psychoanalytic perspectives is relatively recent. Erik Erikson's (1998) seminal work on the impact of the life cycle on the psychic processes fueled a new viewpoint from which to consider middle-aged and older adults vis-à-vis therapy. Changes in the social, biological and psychic spheres started to be paid attention to in the older adult, and that has helped inform treatment with this population. The major concerns that appear to be sources of anxiety in this second half of the life cycle, and thus have received special attention from analysts, are the diminution of sexual potency, the fear of work loss and ensuing loss of worth or identity, the marital problems that appear when children leave home,

the awareness of the fragility that comes with ageing, the loneliness that comes from losing love-objects, and the confrontation with inevitable death (King, 1980; Cohen, 2006).

Cohen (2006) further expands on yet annother complication of therapy with older patients when he discusses the situation in which these patients usually find themselves when they decide to come to therapy. There is, of course, the possible situation in which the neurosis presents at this late age due to context. However, it is also common, acording to Cohen, that analysts receive very narcissistic elderly patients because the nature of their difficulty prevented them from seeking help earlier, mainly through primitive defenses. This causes them to have none of the main features that would be needed to cope with ageing problems, such as the ability to mourn, to accept dependency, to part from loved ones, and to accept death. Thus, when they finally come to therapy, they have already attempted for quite some time to, quite superficially, reach a sense of equilibrium, and have failed at it. They come with the urgency that accompanies the thought of this surely being their last chance to find peace, and probably with a deep sense of failure from their attempts to self cure.

Transference from regression.

Transference from an older patient can actually be directed at the parent-qualities of the therapist. Pearl King (1980) states that middle-aged and elderly patients could be operating from different time-scales: the chronological one, the psychological one, the biological one, and the one of the unconscious. This last one is timeless. This means that transference can come from any significant figure of the elderly patient's past. Although the therapist can be experienced by the patient as a child or a grandchild, it is accepted that more often the transference will come from the family of origin (Nemiroff & Colarusso, 1985). In fact, this

transference is what causes the role reversal that was mentioned earlier. Carkhuff, Feldman and Truax (1964) discuss the clinical implications of the role reversal in therapy when the patient is older than the clinician by exemplifying with vignettes some of the situations often encountered by beginning therapists with older clients. The main source of insecurity, for both therapist and client, is that the older person is used to having the young one come looking for help, and the young person is used to look the older person for help as well; but, in this clinical setting, it is the parent that is looking at the child for help. King (1974) also mentions the difficulty arising from the countertransference on the part of the therapist, attributing the difficulty of treating someone much older than oneself to the fact that they could be one's parents, which would mean that one needs to have come to terms with the ambiguity towards them first.

Apparently, the most frequent solution to this uncomfortable and very seldom discussed situation is the patient's experience of a regression, which allows the transference to be of parent-figures. Once again, King (1980) is the one to have the courage to make insightful conclusions about the analysis of such patients. She conjectures, through observations of her analytic process with several patients of this age group, that there is an important parallelism between this stage of life and that of adolescence. This translates, in therapy, as the need to work through the developmental phase of puberty and the traumas experienced then through transference, the therapist being experienced as significant adults from the patient's adolescence. She finally illustrates this with case examples of middle aged patients from both genders that regressed and worked through their traumas from early life stages in the transference.

Transference from regression can also be found in a case study by Blum (2001). He depicts a patient who received previous psychoanalytic therapy in her young adulthood due to constipation problems. By the end of the process, she was not constipated anymore, and her personality had also modified from being eager to please, controlled, and afraid of losing control and loved objects, to being able to challenge, disagree, joke, and criticize. She re-entered therapy in her sixties due to her symptoms presenting once again, and this time in a more intense manner. Her constipation symbolized her difficulty in letting go, and she was now confronted with a stage of life in which loss of loved ones is more commonplace. She experienced the death of her parents, leaving her vulnerable and unprotected, followed by the departure of her daughter to form her own family. To cope with the situation, she regressed to an anal stage, longing for a nurturing mother figure. This gave way to a "transference split between her comforting, consoling mother and the disappointing, rejecting, envious mother-figure" (p. 119). Thus, she felt resentful at the therapist whenever the end of session approached in a similar way in which she felt towards her husband giving attention to her child, or her daughter giving more attention to her own children than to her. This, alongside countertransference from the therapist to his own ageing, and ageing love objects, was said by Blum to be important in order to help the patient to have a more meaningful life. The recapitulation of unconscious conflict and trauma, facilitated by transference analysis, might be one of the most direct ways for this endeavor.

METHODOLOGY AND STUDY DESIGN

Justification of selected methodology

As the literature review section of the introduction pointed out, transference is a highly specific, complex, and elusive construct within psychology. The first factor to consider is the nature of the data that will be gathered. As previously shown, although psychodynamic concepts can be researched in a quantitative way, operationalizing them as such would mean to switch perspectives to a more "nomothetic-friendly" theoretical perspective, which in turn would be psychodynamically informed (Andersen, 1992). Given that this study is to remain within the boundaries of psychoanalysis and psychodynamic psychology, the data will have to be qualitative.

The other important factor is participant selection. It would be unwise to assume that patients can understand, identify, and explain their transference to a researcher because of two reasons: they are not trained to do so, and the unconscious nature of transference prevents them from doing so. Therapists from psychodynamic perspectives and analysts, on the other hand, are trained to identify, understand and, whenever pertinent, explain transference phenomena. The participants of the study are therefore the therapists and analysts who are in the best position to provide the data that is relevant to answer the research question. Criteria for eligibility would be: (1) to be a therapist trained in the psychodynamic or psychoanalytic perspectives, and (2) to have completed an entire therapeutic process with at least one older patient. This ensures that participants had to analyze transference from an older patient at some point in therapy.

Given the relative scarcity of psychodynamic therapists and analysts, the methodology used will be a focus group. A possible alternative to this would be a case study, especially given the high prevalence this method has in the psychoanalytic tradition. A case study might nonetheless pose some drawbacks. First, I have not had the experience of analyzing the transference from an older patient myself. This means that I would have to interview a psychodynamic therapist or an analyst about a case they have had, and then analyze the data. The indirect nature of such a design would make the internal validity of the study very objectionable. Second, the opinion of a single therapist describing a single case might be far too subjective for appropriate generalizability.

A focus group, on the other hand, possesses several advantages. The most obvious ones are the advantages the method has by itself. Morgan & Krueger (1993) affirm this method's strengths are to explore a specific issue in depth, as well as to provide understanding of the origins of complex behaviors and motivations. This falls right into the scope of this study. Moreover, Morgan (1996) also states that the discussion of a group is more valuable than the addition of individual interviews because the group provides the chance for members to query each other and to explain their views to each other. This provides the researcher with the opportunity to analyze a direct comparison among the participants' experiences and views instead of speculating about why their opinions differ.

Research tool

Design issues should not be based on past tradition, but should instead address the goals of the study they are created for. In focus groups, these issues concern standardization of questions, sampling, number of groups, selection of the moderator, level of moderator

involvement, group size, and ethical standards. This study, as evidenced by the literature review section, is not preceded by a large amount of literature. It is therefore mainly exploratory in nature. However, should I or the scientific community find it pertinent to follow it up with further qualitative research, some of it needs be replicable. This calls, in matters of standardization, for a design that has some "emergence", meaning the allowance of procedures to shift from group to group according to the most interesting topics to address given each context (Morgan, 1996), as well as a core set of standard questions. Morgan (1996) proposes, for this type of studies, a "funnel" pattern in which the beginning of the group conversation is led by a fixed set of questions and then proceeds to a variable set of specific issues. Thus, there is comparability between groups for the first part of each discussion, but also room for variation according to the emergent topics of conversation and/or needs of the research.

Sampling, for the best possible data collection in regard to the research question, should be segmented into several groups that address the same issue. The segmentation criterion would be theoretical affinity, making the participants in each group homogeneous in their clinical perspective. However, given the size of the current study in terms of personnel, several groups are impossible to conduct. Instead, a single group formed of participants from different perspectives will be conducted. This entails sacrificing theoretical specificity and depth in order to gain the diversity needed for the generalizability of the findings.

Selecting the moderator is an important factor for the completion of the study's goals. In order for the basic validity criteria in qualitative research proposed by Whittemore, Chase & Mandle (2001) to be met, the moderator will have to be someone different than the researcher, but well versed in psychodynamic and psychoanalytic theories, as well as the

literature already addressing transference with older patients. This prevents one of the major threats for this study, which is researcher bias, while it ensures integrity, authenticity, credibility, and criticality. However, if the study aims at informing clinical practice, it should have high standards for thoroughness and congruence too, meaning that data should be comprehensively and exhaustively analyzed, and that there should be a connectedness within the study and with external sources of information so that the findings can fit into contexts outside of the study situation (Whittemore, Chase, & Mandle, 2001).

The level of involvement from the moderator has two aspects. It can be more structured about asking questions, so that the moderator controls the topics that are discussed; and it can be more structured in terms of group dynamics, so that the moderator controls the way in which the participants interact (in the aim of having everyone participate equally in the discussion) (Morgan, 1996). The "funnel" pattern previously described already sets a high level of moderator involvement in questioning in the first part of the discussion, and a low level in the last part of it. Given that the goal of the study is to generate new knowledge for peer reviewers, the involvement of the moderator on group dynamics is set to be as low as possible, according to Morgan's (1996) recommendations.

Provided the group is expected to discuss very specific, highly emotionally charged topics, group size is determined to be small (Morgan, 1996). This will also allow participants to fully present their cases, express their views, and discuss about their experiences. The group size is therefore set at five participants.

Ethical standards for this study do not appear to be difficult to apply. First, it would be reasonable to expect that mental health professionals are able to discuss highly emotionally

charged topics without being emotionally harmed themselves. However, a debrief session is planned in an individual way after completion of the focus group. Second, confidentiality is ensured from the moderator, but the researcher cannot account for what other group members will or will not say outside of the group. Therefore, participants will be instructed to guard their patient's confidentiality as they would in any other case presentation or supervision session. Should any participant refuse to answer a question from the moderator or other group member, a single inquiry is to be made about the reason for the refusal, but the question itself is not to be insisted upon. Finally, should a participant wish to receive a copy of the study upon completion, he/she will receive the electronic version via e-mail.

Participant description

Recruitment of participants.

Participants will be sought, as previously stated, with consideration to their theoretical orientations, in order to have a diverse group. This means that their recruitment will be made through an e-mail invitation. The e-mail states the criteria for eligibility and the time and place of the focus group, and asks participants to confirm their participation as soon as possible (see Appendix A). The first five responders will form the group, unless there is a clear theoretical homogeneity among participants.

Number.

As previously stated, five participants will conform the focus group.

Theoretical orientation.

Two of the participants come from the lacanian psychoanalytic tradition. One participant was trained in an eclectic psychodynamic perspective. One participant identifies as neo-freudian. One participant was trained in the object relations tradition

Data collection and analysis

The group interaction will be recorded in video. A complete transcription of the video will be made. Content analysis will be performed on the data by research assistants.

ANTICIPATED RESULTS

It is expected that the focus group will develop rather uneventfully, with all of the participants contributing more or less to the discussion.

Details of the analysis

I estimate that the content analysis will gather significant data in the following categories: activity, process, situation, respondent perspective on transference from middle-aged and elderly patients, and strategy for transference use.

Activity.

I think that all of the participants will be willing to actively engage in the conversation. Given that the participants would have decided to participate voluntarily in a study that offers no monetary retribution, it can be assumed that they feel interested in the subject that is to be discussed. Naturally, as in all discussions that develop in a mid-sized group of people, there will be some participants that will expand and elaborate on their opinions, and others that will prefer to stay relatively quiet and speak their mind in a short and concise way. I expect activity to spike in moments poignant emotional content and/or moments of theoretical controversy. I also expect activity will decrease when the participants attempt to view a familiar phenomenon in a new light.

Process.

I expect participants to start the discussion in a rather cold and technical way, exposing, as they are asked, their cases and elaborating on the theory. However, as the group feels more comfortable with each other (which should happen rather quickly given their

profession), I expect them to become slightly more interactive. Still, this will be a group of professional listeners and interpreters, which means that the conversation will develop in a very respectful way, without many interruptions or heated arguments. I estimate that, once the focus group is in its second half, the discussion will be self-sustained and the moderator will not have a significant role in it anymore.

Situation.

I expect a majority of the participants to have been, at least minimally, in a situation in which transference could have been interpreted as coming from a younger figure of the patient's past. That is, they will have been experienced as a younger significant other by the patient. It is reasonable to assume that some participants may never have been in this situation (which would mean the transference always came from an older figure from the past of their patients), or that some participants could have been in this situation but, because of their theoretical mindset, interpreted the transference as coming from an older figure from the patient's past. However, I also expect a majority of the participants to have been experienced by their patients as older figures when their patients were experiencing a regression. In fact, I anticipate that this situation will be favored in amount of discussion time over the other situation. The moderator is expected to stir the focus back to the former situation.

Respondent perspective on transference from middle-aged and elderly patients.

I expect this particular category of content to be the subject of the most significant controversy in the discussion. Ideally, this will cause the discussion to self-sustain. I can reasonably anticipate that the group will become polarized between two opinions. The first one would be that age differences between therapist and patient have no effect on transference

analysis. This would mean that transference analysis is performed in the same way with an older patient experiencing the therapist as a younger past figure as it would be if the transference came from an older past figure. The second opinion will be that these two kinds of transference have, in fact, some important features that make them different from each other enough to consider changing the way in which the therapist works with transference.

Respondent strategy for transference use.

This category is the logical continuation of the last one. Thus, each opinion previously described has a consequent position on the strategy for transference use. On one hand, participants that believe analysis of transference is to be done the same way no matter the type of transference are expected to prefer to be experienced as parent/older figures by their patients, so that they can re-parent the patients and the transference-neurosis can ultimately lead to a cure. These participants are also expected no to perform significant work on transference when they are experienced as being a younger significant other by their patient. Alternatively, they are expected to interpret that the roles in transference have been reverted (so the patient is acting towards the therapist as he felt his parents acted towards him). On the other hand, participants that believe these transferences should be acted upon differently are expected to embrace being experienced as younger past figures and work from there, so that through the resolution of this particular transference-neurosis patients can learn to better relate to the younger people in their lives.

DISCUSSION

Answer to the research question

The first observation on the data that I want to make is about the current state of the art of psychoanalytic and psychodynamic therapies vis-à-vis older patients. Within these psychological perspectives the literature, perhaps due to it being relatively old-dated, has a common factor of concern on whether therapy is suitable for older patients or not. Due to the natural way with which the discussion on this subject occurred among the participants of this study, I must say, rather pleased, that this doubt appears no longer to affect clinicians' willingness to accept middle-aged or elderly adults into their offices, or discuss about their cases for that matter. The level of activity, dynamics of the process, and readiness to discuss this situation all suggest that treatment of middle-aged and elderly patients from these perspectives is now widely accepted.

It was observable, from these results, that the literature has indeed covered very well one of the main phenomena to commonly arise in therapy with older patients. I refer of course to the transference from regression. All of the participants vividly recalled episodes in which their patients became helpless and quite little, and experienced the therapist directly as a parent figure. The amount of times the moderator had to redirect conversation from this type of transference to the type where the therapist is experienced as a younger past figure, although not very large, is still significant. This suggests the participants appeared to be more inclined to discuss that kind of transference. This was also made evident by a slight decrease in the activity of several participants when considering the possibility and outcomes of performing transference analysis on the younger past figure instead of tracing that back to the

family of origin. Thus, this study paralleled harmoniously with several of the case studies reviewed from the literature. The results appear to show that therapists can understand or analyze the classic transference from parent figures far better, or far more comfortably, than is the case for transference from young past figures.

The split of opinions with regard to the point of view of transference from middle-aged and elderly patients, alongside with the rise in activity when discussing this subject that further polarized the two opinions instead of bridging the gap suggest several conclusions. First, a consensus on a particular technique and its mode of employ is most difficult in these psychological perspectives. This would favor a case by case analysis of how the transference ought to be used. However, such a subjective approach to treatment would leave no room to create a theory that can inform clinical practice. This leads to the second conclusion that indeed, this kind of transference was an important topic that has remained overlooked and that has served some clinicians well when analyzing an older patient.

The respondents' strategy when discussing the utilization of such transference suggests that the possible particularities of transference of this kind could serve therapeutic processes in two ways. The first one is to still perform transference analysis on a patient whose traumatic past is too defended against, and whose entire personality may unbalance or crumble down if those defenses are taken away. The analysis of transference from, for example, their children or grandchildren does not directly question the solid and distant defenses developed in their relationship with their parents, and therefore does not attack their personality. However, and this is the second particularity, this transference neurosis small or indirect as it may be, could

serve the therapy of the middle-aged or elderly patient by showing them how they are relating to the younger people in their lives who are important to them.

Limitations

Several factors limit the applicability that these findings may have in the clinical setting of peer reviewers. In the first place, although it was heavily guarded against, researcher bias may have been present in this study in a larger proportion than could normally be expected. This was due mainly to the lack of personnel to derive functions to. Therefore, it is I who chose the participants and derived conclusions from the analyzed data. Second, the abovementioned split of opinions among participants does question the generalizability of the findings on the particularities of this kind of transference. If there is no consensus among five professionals on this subject, it might be unadvised to attempt to look for a new subdivision of transference to theorize. Third, the study design formed a single focus group to research a subject that would benefit the most by being researched by several, parallel focus groups whose participants are divided by theoretical affinity. This again undermines generalizability. Finally, the cultural characteristics of the Ecuadorean population are to be taken into account. This I mention because, this being a very collective and family oriented culture, middle-aged and elderly patients may have family ties, and therefore conflicts, that are not similar to those of the same population from other cultures.

Recommendations for future research

Future research should attempt to create several focus groups that are conducted in the same way, but are sampled by theoretical orientation. The results from such studies could shed light into the still dark corners left by the present study. Namely, the main issue of whether

this kind of transference is negligible in terms of theorizing and should be looked at on a case by case basis, or is it important enough to start paying attention to it when considering theories, treatment training programs and therapeutic settings.

Summary

At present, psychodynamic and psychoanalytic therapy with middle-aged and elderly patients appears to have been completely accepted as a viable endeavor. When considering this therapy, the emergence of transference is of paramount importance. A clear understanding has been achieved on the dynamics of this phenomenon when the patient is in regression and the therapist is experienced as a parent figure. However, not much is known, partly because not much is done, when the therapist is experienced as a younger figure from the patient's past. This, nevertheless, could be a valuable addition to the therapist's tools since it can promote cure through transference analysis as well.

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APPENDIX A: ADVERTISEMENT E-MAIL

Subject Line: Seeking Psychoanalysts and Psychodynamic Psychologists for a research study

Dear Dr. XXXX,

My name is Jose Hernandez and I am currently enrolled in the Clinical Psychology undergraduate program at Universidad San Francisco de Quito completing my last semester. I have contacted you today regarding a study I am conducting for my thesis. My research is entitled "Re-parenting your elders? Transference from older patients" and I am looking for participants. Its focus is the way in which young therapists can use transference from older patients to treat.

The study's results have the potential to inform clinical practice among young and/or beginning clinicians who find themselves in difficult therapeutic settings. They could possibly even inform clinical training programs at universities. Thus, this could be a major advantage for us young and inexperienced clinicians.

Criteria for eligibility are (1) to be a therapist trained in either a psychodynamic or a psychoanalytic perspective, (2) to have completed at least one therapeutic process with a patient that was older than you, and (3) to possess records or be able to remember this case sufficiently enough so that you can discuss the transference phenomena that occurred in it. If you meet criteria and are interested, participation would entail meeting on 20/11 of the present year at 16:00 for an introduction session, a focus group, and a debriefing session. The introduction should take 5 minutes with each participant, making it a total of 25 minutes, during which you will be asked to sign an informed consent addressing ethical concerns and your rights as a participant. The focus group will take an hour and a half, during which a moderator would lead a discussion between you and colleagues of yours that have also met the eligibility criteria around the topic of transference from older patients. Finally, the debriefing session should take between 5 and 10 minutes with each participant in order to make sure that you won't be experiencing emotional or psychological harm from the discussion of the focus group.

Following the conclusion of the study an electronic version of the results will be made available to you via e-mail.

In order to confirm your participation, or if you have any further questions, please contact me at XXXX@estud.usfq.edu.ec, or call me at 099 XXXXXXX.

Thank you in advance for your time.

Jose Hernandez

APPENDIX B: ETHICS

Research approval solicitude form

Comité de Bioética, Universidad San Francisco de Quito
El Comité de Revisión Institucional de la USFQ
The Institutional Review Board of the USFQ

SOLICITUD PARA APROBACION DE UN ESTUDIO DE INVESTIGACION

INSTRUCCIONES:

1. Antes de remitir este formulario al CBE, se debe solicitar vía electrónica un código para incluirlo, a comitebioetica@usfq.edu.ec
2. Enviar solo archivos digitales. Esta solicitud será firmada en su versión final, sea de manera presencial o enviando un documento escaneado.
3. Este documento debe completarse con la información del protocolo del estudio que debe servir al investigador como respaldo.
4. Favor leer cada uno de los parámetros verificando que se ha completado toda la información que se solicita antes de enviarla.

DATOS DE IDENTIFICACIÓN
Título de la Investigación
Re-parenting your elders: Transference from older patients.
Investigador Principal *Nombre completo, afiliación institucional y dirección electrónica*
José Hernández. Universidad San Francisco de Quito. E-mail: XXXX@estud.usfq.edu.ec
Co-investigadores *Nombres completos, afiliación institucional y dirección electrónica. Especificar si no lo hubiera*

Pedro Pérez. Universidad San Francisco de Quito. E-mail: XXXX@estud.usfq.edu.ec Juan Ortiz. Universidad San Francisco de Quito. E-mail. XXXX@estud.usfq.edu.ec
Persona de contacto *Nombre y datos de contacto incluyendo teléfonos fijo, celular y dirección electrónica*
José Hernández. Tlf: XXXX. Celular: 099 895 XXXX. E-mail: XXXX@estud.usfq.edu.ec
Nombre de director de tesis y correo electrónico *Solo si es que aplica*
Sonja Embree. E-mail: sembree@usfq.edu.ec
Fecha de inicio de la investigación *No puede ser anterior a la aprobación del estudio*
30/10/2015
Fecha de término de la investigación *Fecha estimada*
30/11/2015
Financiamiento *Datos completos del auspiciante o indicar "personal"*
Personal

DESCRIPCIÓN DEL ESTUDIO
Objetivo General *Se debe responder tres preguntas: qué? cómo? y para qué?*
Se busca comprender si existen particularidades en la transferencia de pacientes que tienen mayor edad que sus terapeutas. Se hará esto mediante un grupo focal de terapeutas psicoanalíticos y psicodinámicos que ya hayan completado un proceso terapéutico con pacientes mayores a ellos. El fin del estudio es informar la práctica clínica de jóvenes terapeutas que reciben pacientes mayores a ellos mismos, para que puedan contar con una nueva e importante herramienta terapéutica.
Objetivos Específicos
Identificar, si las hubiere, las particularidades de la transferencia de un paciente mayor hacia un terapeuta más joven. Entender de qué manera un terapeuta puede utilizar estas particularidades en terapia para facilitar la exploración o el cambio del paciente. Extrapolar los conceptos generalizables para informar la práctica de terapeutas jóvenes.

Diseño y Metodología del estudio *Explicar el tipo de estudio (por ejemplo cualitativo, cuantitativo, con enfoque experimental, cuasi-experimental, pre-experimental; estudio descriptivo, transversal, de caso, in-vitro…) Explicar además el universo, la muestra, cómo se la calculó y un breve resumen de cómo se realizará el análisis de los datos, incluyendo las variables primarias y secundarias..*

El estudio será cualitativo. Se realizará un grupo focal. El universo que se investiga es el de los terapeutas psicodinámicos y psicoanalíticos. La muestra estará conformada por terapeutas de esas ramas que cumplan con el criterio de admisión de haber ya terminado por lo menos un proceso terapéutico con un paciente mayor que ellos. Cinco participantes de diferentes perspectivas dentro de las tradiciones psicoanalítica y psicodinámica conformarán el grupo. Los datos serán analizados mediante análisis de contenido con énfasis especial en los diferentes tipos de transferencia que surjan en la discusión.

Procedimientos *Los pasos a seguir desde el primer contacto con los sujetos participantes, su reclutamiento o contacto con la muestra/datos.*

Envío de e-mail a varios terapeutas psicodinámicos y psicoanalíticos con la invitación para participar en el grupo focal, la fecha y hora del grupo, y los criterios de admisión. Elección de los participantes entre los terapeutas que hayan respondido al e-mail con el fin de tener un grupo focal tan teóricamente diverso como sea posible. De haber varios terapeutas pertenecientes a un mismo enfoque teórico se elegirá al participante de ese enfoque de manera aleatoria. Envío de e-mail de confirmación de participación a los integrantes seleccionados. Realización del grupo focal.

Recolección y almacenamiento de los datos *Para garantizar la confidencialidad y privacidad, de quién y donde se recolectarán datos; almacenamiento de datos—donde y por cuánto tiempo; quienes tendrán acceso a los datos, qué se hará con los datos cuando termine la investigación*

No se recolectará ningún dato demográfico de los participantes. Se especificará únicamente su enfoque dentro de la psicología. La recolección de datos de la discusión del grupo focal se hará primeramente en video, con el fin de realizar una transcripción por escrito de las réplicas y expresiones de los integrantes. Posteriormente el video se eliminará y la transcripción se usará para el análisis de contenido. Los datos surgidos de este análisis se guardarán bajo llave y únicamente José Hernández y Sonja Embree tendrán acceso a ellos. Una vez que se termine la investigación, los datos serán conservados en una versión electrónica por José Hernández para futuras referencias o investigación.

Herramientas y equipos *Incluyendo cuestionarios y bases de datos, descripción de equipos*

Una cámara digital de baja resolución integrada en una computadora para la filmación del grupo. Un cuestionario semi-estructurado en posesión del moderador del grupo para conducir la discusión

JUSTIFICACIÓN CIENTÍFICA DEL ESTUDIO

Se debe demostrar con suficiente evidencia por qué es importante este estudio y qué tipo de aporte ofrecerá a la comunidad científica.

Este estudio puede, potencialmente, proveer información de enorme importancia para la práctica clínica de los terapeutas jóvenes. La literatura es escasa en cuanto al fenómeno de transferencia que puede surgir entre un paciente mayor y un terapeuta que tiene la edad para ser su nieto, así como la atención que la ciencia ha decidido poner en dicho contexto terapéutico (King, 1980). En consecuencia, los terapeutas jóvenes, especialmente aquellos que se encuentran empezando su carrera profesional, se encuentran a menudo en situaciones en las cuales les es particularmente difícil asumir el rol del terapeuta (Carkhuff, Feldman & Truax, 1964). Este estudio podría ayudar a llenar ese vacío en la literatura, y de esta manera facilitar la práctica de los terapeutas jóvenes.

Referencias bibliográficas completas en formato APA

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DESCRIPCIÓN DE LOS ASPECTOS ÉTICOS DEL ESTUDIO

Criterios para la selección de los participantes *Tomando en cuenta los principios de beneficencia, equidad, justicia y respeto*

1. Ser terapeutas entrenados en la perspectiva psicoanalítica o la perspectiva psicodinámica.
2. Haber completado por lo menos un proceso terapéutico con un paciente mayor a ellos.
3. No se hará distinción en cuanto a variables demográficas.

Riesgos *Describir los riesgos para los participantes en el estudio, incluyendo riesgos físico, emocionales y psicológicos aunque sean mínimos y cómo se los minimizará*

Se espera que los participantes, al ser profesionales de la salud mental, puedan razonablemente manejar temas sensibles. Siendo la transferencia un tópico emocionalmente cargado, es posible, sin embargo, que los participantes puedan sentir malestar emocional o psicológico. Se planifica una sesión de chequeo individual con cada participante, posterior al grupo, para ayudarles a minimizar cualquier

posible malestar.
Beneficios para los participantes *Incluyendo resultados de exámenes y otros; solo de este estudio y cómo los recibirán*
Una copia electrónica del artículo finalizado.
Ventajas potenciales a la sociedad *Incluir solo ventajas que puedan medirse o a lo que se pueda tener acceso*
Ofrecer una herramienta terapéutica más para los terapeutas iniciantes y/o jóvenes.
Derechos y opciones de los participantes del estudio *Incluyendo la opción de no participar o retirarse del estudio a pesar de haber aceptado participar en un inicio.*
Los participantes pueden decidir no participar en el estudio, pese a haber aceptado participar en un inicio, hasta el momento de la introducción al grupo focal. En esta introducción, se les explicará más en detalle los temas sobre los cuales el grupo discutirá, para que puedan decidir por última vez si participarán o no, y se les pedirá firmar el consentimiento informado. Una vez iniciado el grupo, se les pedirá permanecer en él hasta el final de la discusión. En el grupo, los participantes tienen el derecho a no responder preguntas y a permanecer en silencio si así lo desean.
Seguridad y Confidencialidad de los datos *Describir de manera detallada y explícita como va a proteger los derechos de participantes*
Como fue dicho, los datos serán guardados bajo llave durante la realización del estudio, y en versión electrónica en posesión de José Hernández una vez que el estudio haya concluido. La identidad de los participantes estará protegida en todo momento por los realizadores del estudio. Sin embargo, se especificará que los realizadores del estudio no pueden controlar lo que otros miembros del grupo focal digan o no digan una vez que el grupo haya concluido. Por ende, los participantes deberán decidir si quieren participar pese a este riesgo. Las identidades de los pacientes de los participantes del grupo deberán ser protegidas por los participantes mismos, de la manera en la que lo han aprendido para hacer presentaciones de casos o sesiones de supervisión.
Consentimiento informado *Quién, cómo y dónde se explicará el formulario/estudio. Ajuntar el formulario o en su defecto el formulario de no aplicación o modificación del formulario*
El moderador del grupo tendrá una sesión individual previa al grupo con cada participante en la cual explicará el consentimiento informado y lo hará firmar.
Responsabilidades del investigador y co-investigadores dentro de este estudio.
La responsabilidad del investigador será asegurarse de que los derechos de los participantes estén

siendo respetados en todo momento, y asegurar que se respete la confidencialidad. El moderador deberá guardar absoluta confidencialidad sobre la identidad de los participantes. La persona que realiza el análisis de contenido deberá omitir, en el caso en el que la hubiere, cualquier información que surja en la conversación que pueda identificar a los participantes.

Documentos que se adjuntan a esta solicitud ***(ponga una X junto a los documentos que se adjuntan)***

Nombre del documento	Adjunto	Idioma	
		Inglés	Español
PARA TODO ESTUDIO			
1. Formulario de Consentimiento Informado (FCI) y/o Solicitud de no aplicación o modificación del FCI *	x		x
2. Formulario de Asentimiento (FAI) *(si aplica y se va a incluir menores de 17 años)*			
3. Herramientas a utilizar *(Título de:: entrevistas, cuestionarios, guías de preg., hojas de recolección de datos, etc)*	x		x
4. Hoja de vida (CV) del investigador principal (IP)			
SOLO PARA ESTUDIOS DE ENSAYO CLÍNICO			
5. Manual del investigador			
6. Brochures			
7. Seguros			
8. Información sobre el patrocinador			
9. Acuerdos de confidencialidad			
10. Otra información relevante al estudio (especificar)			

(*) La solicitud de no aplicación o modificación del FCI por escrito debe estar bien justificada.

CRONOGRAMA DE ACTIVIDADES

Descripción de la Actividad (pasos a seguir dentro del proceso de investigación, comenzando por el contacto inicial, reclutamiento de participantes, intervención y/o recolección de datos, análisis, publicación…)	**Fechas**		
	1	**2**	**3**
Contacto inicial: envío de e-mail	30/10		
Reclutamiento de participantes	15/11		
Grupo focal	20/11		
Transcripción del video	21/11		
Análisis de contenido	22/11	23/11	24/11
Publicación	30/11		

CERTIFICACIÓN:

1. Certifico no haber recolectado ningún dato ni haber realizado ninguna intervención con sujetos humanos, muestras o datos. Sí (x) No ( )
2. Certifico que los documentos adjuntos a esta solicitud han sido revisados y aprobados por mi director de tesis. Sí (x) No ( )
   No Aplica ( )

Firma del investigador: _____ (con tinta azul)

Fecha de envío al Comité de Bioética de la USFQ: _____

Informed consent

Comité de Bioética, Universidad San Francisco de Quito

El Comité de Revisión Institucional de la USFQ
The Institutional Review Board of the USFQ

Formulario Consentimiento Informado

Título de la investigación: Re-parenting your elders: transference from older patients.
Organización del investigador: Universidad San Francisco de Quito
Nombre del investigador principal: José Hernández
Datos de localización del investigador principal: Tlf: 289 XXXX. Celular: 099 895 XXXX. E-mail: XXXX@estud.usfq.edu.ec
Co-investigadores: Pedro Pérez, Juan Ortiz

DESCRIPCIÓN DEL ESTUDIO
Introducción *(Se incluye un ejemplo de texto. Debe tomarse en cuenta que el lenguaje que se utilice en este documento no puede ser subjetivo; debe ser lo más claro, conciso y sencillo posible; deben evitarse términos técnicos y en lo posible se los debe reemplazar con una explicación)*
Este estudio busca extender nuestra comprensión sobre el fenómeno de transferencia en un contexto terapéutico en el que el terapeuta es más joven que su paciente. Usted puede hacer todas las preguntas que quiera para entender claramente su participación y despejar sus dudas. Usted ha sido invitado a participar en esta investigación porque ha sido entrenado como terapeuta en la tradición psicoanalítica/psicodinámica, y porque ha completado un proceso terapéutico con un paciente mayor a usted.
Propósito del estudio (incluir una breve descripción del estudio, incluyendo el número de participantes, evitando términos técnicos e incluyendo solo información que el participante necesita conocer para decidirse a participar o no en el estudio)
Este estudio busca aumentar el conocimiento sobre la transferencia mediante un grupo focal conformado por cinco miembros que cumplan los criterios de admisión previamente mencionados. Un moderador conducirá la discusión en un inicio, para posteriormente permitir que los miembros del grupo deliberen sobre el tema.

Descripción de los procedimientos (breve descripción de los pasos a seguir en cada etapa y el tiempo que tomará cada intervención en que participará el sujeto)

Una vez que todos los participantes hayan firmado el consentimiento informado, se procederá a realizar el grupo focal. Éste tendrá una duración de una hora y media. Posteriormente, habrá una sesión individual de chequeo con cada participante, con el fin de minimizar cualquier malestar emocional o psicológico que pueda haber surgido durante la discusión.

Riesgos y beneficios (explicar los riesgos para los participantes en detalle, aunque sean mínimos, incluyendo riesgos físicos, emocionales y/o sicológicos a corto y/o largo plazo, detallando cómo el investigador minimizará estos riesgos; incluir además los beneficios tanto para los participantes como para la sociedad, siendo explícito en cuanto a cómo y cuándo recibirán estos beneficios)

Dado que la transferencia es un fenómeno emocionalmente cargado por definición, es posible que la discusión exalte emociones en los participantes. Esto conlleva un riesgo, aunque relativamente pequeño siendo usted un profesional de la salud mental, de que usted experimente malestar o incluso daño emocional y/o psicológico. Estos riesgos serán minimizados mediante la sesión de chequeo posterior al grupo que se mencionó anteriormente.

Por otro lado, los posibles beneficios de este estudio para la comunidad terapéutica son grandes. La información recolectada gracias a este estudio podría servir para informar la práctica clínica de terapeutas jóvenes e incluso los programas de entrenamiento de nuevos terapeutas. Un beneficio personal de participar en este estudio es que usted puede recibir, si así lo quisiera, una copia electrónica de este estudio una vez que haya sido completado.

Confidencialidad de los datos *(se incluyen algunos ejemplos de texto)*

Para nosotros es muy importante mantener su privacidad, por lo cual aplicaremos las medidas necesarias para que nadie conozca su identidad ni tenga acceso a sus datos personales:

1. Se filmará el grupo focal con el objetivo de transcribir las réplicas y lenguaje corporal de los participantes. Posteriormente, se destruirá esta filmación y se conservará la transcripción.
2. Dentro de esta transcripción, la información que nos proporcione se identificará con un código que reemplazará su nombre y se guardará en un lugar seguro donde solo el investigador y su directora de tesis, Sonja Embree, tendrán acceso.
3. Su nombre no será mencionado en los reportes o publicaciones.
4. El Comité de Bioética de la USFQ podrá tener acceso a sus datos en caso de que surgieran

problemas en cuando a la seguridad y confidencialidad de la información o de la ética en el estudio.

Derechos y opciones del participante (se incluye un ejemplo de texto)

Usted puede decidir no participar y si decide no participar solo debe decírselo al investigador principal o a la persona que le explica este documento. Sin embargo, una vez que decida formar parte del grupo focal y firma este consentimiento, se le pedirá permanecer en el grupo hasta que éste concluya. Dentro del grupo, usted puede decidir no contestar preguntas y permanecer en silencio. Si usted se rehúsa a contestar una pregunta directa del moderador o de otro participante, el moderador del grupo tiene la indicación de preguntarle por qué ha decidido no hacerlo, pero no se insistirá sobre la pregunta en cuestión. Se le pide mantener una actitud de completo respeto con los demás participantes del grupo, y, si se presenta un tema delicado, mantener una actitud de sensibilidad.

Usted no recibirá ningún pago ni tendrá que pagar absolutamente nada por participar en este estudio.

Información de contacto

Si usted tiene alguna pregunta sobre el estudio por favor llame al siguiente teléfono 099 895 XXXX que pertenece a José Hernández, o envíe un correo electrónico a XXXX@estud.usfq.edu.ec

Si usted tiene preguntas sobre este formulario puede contactar al Dr. William F. Waters, Presidente del Comité de Bioética de la USFQ, al siguiente correo electrónico: comitebioetica@usfq.edu.ec

Consentimiento informado *(Es responsabilidad del investigador verificar que los participantes tengan un nivel de comprensión lectora adecuado para entender este documento. En caso de que no lo tuvieren el documento debe ser leído y explicado frente a un testigo, que corroborará con su firma que lo que se dice de manera oral es lo mismo que dice el documento escrito)*	
Comprendo mi participación en este estudio. Me han explicado los riesgos y beneficios de participar en un lenguaje claro y sencillo. Todas mis preguntas fueron contestadas. Me permitieron contar con tiempo suficiente para tomar la decisión de participar y me entregaron una copia de este formulario de consentimiento informado. Acepto voluntariamente participar en esta investigación.	
Firma del participante	Fecha
Firma del testigo *(si aplica)*	Fecha
Nombre del investigador que obtiene el consentimiento informado	
Firma del investigador	Fecha

APPENDIX C: FOCUS GROUP QUESTIONS

When discussing the transference of your patient.

Q1: Was any of you ever experienced by your patient as a child, a grandchild or another younger figure from the patient's past?

Q2: If "Yes", did transference-neurosis generate from that transference?

Q3: If "Yes", was this resolved through transference analysis

Q4: Do you think transference analysis should be different depending on which figure of the patient's past it comes from?

Q5: Did transference from a younger figure of the patient's past ever lead directly to a parent/older figure?

Q6: Did it ever happen the other way around?

Q7: Do you think transference analysis should always lead back to the family of origin in order to be effective as a therapeutic tool?