The Effect of Frequency and Duration on Psychoanalytic Outcome: A Moment in Time

Allan Frosch, PhD, FIPA

"The stuff of the world is mind-stuff"

(Eddington, A.S., 1928).

Introduction:

History is shaped by politics, and this is certainly true for the history of psychoanalysis. Theoretical and organizational schisms have led to heated debate about what psychoanalysis is, the "best" way to practice it and the exclusion of those who do not do it the "right" way (cf. Perron, 2002). These issues are particularly important in a paper on session frequency and duration and their relation to outcome. For many of us this topic has a very visceral or "in your face quality". My institutional affiliations and experience from both sides of the couch, as well as my own research on frequency/duration and outcome (see Freedman, et al, below), lead me to believe that the combination of high frequency and longer duration (open-ended) treatment is the most effective form of psychoanalysis. My gathering together of 'facts' in this paper is always embedded in this subjective context. This threatens to politicize a topic that is difficult enough in its own right.

In recent years there has been a veritable avalanche of psychoanalytic outcome research (Fonagy, 2002). To approach a paper on session frequency/duration and outcome feels quite overwhelming – even without the ever present "political issues". On an organizational level my task in writing this paper was made easier because I had access to George Frank's excellent paper (this issue). I am happy to use his general organization – 1) What is psychoanalysis, 2) The resolution of the transference and its effect on

our thinking about session frequency (and duration), and 3) The inconclusiveness of outcome research - as a basis for developing my ideas about psychoanalytic outcome research.

What is psychoanalysis?

In this paper psychoanalysis refers to a therapeutic process conducted by someone who has formal training in psychoanalysis and understands and attends to the notion of a dynamic unconscious, transference, countertransference, and resistance[1] and, as George Frank notes, takes into account the goals of psychoanalysis which are different from those of other treatments. A psychoanalytic treatment, said Freud, "is not undertaken for the purpose of getting rid of a single symptom. Its aim is the refashioning and re-education of the entire person…" (cited by Fichtner, 2008, p. 841). I view frequency and duration in the context of determining the optimal psychoanalytic treatment, rather than defining characteristics of the process itself. From this perspective psychoanalysis is seen along a continuum (Rothstein, Arden, 2010), and rather than making a distinction between psychoanalysis and psychoanalytic psychotherapy, which is characteristic for psychoanalytic outcome research, I will refer to more intense and less intense forms of psychoanalysis.[2] 'More intense' refers to a frequency of 3-5 times per week and a duration that is open-ended and measured in years.

Resolution of the Transference:

In her book 'The Analyst's Analyst Within' (2003) Laura Tessman takes a close look at the fate of the transference in the internalization of the analytic process. In the chapter on analysis ending and unending Tessman asks: what happens when the analysis "the carrier of extraordinary intimacy" ends; how does the "actuality of the analyst infuse the after experience" (p. 223)? In talking about the analysis as an extraordinarily intimate experience and the actuality of the analyst, who the analyst is and what she/he brings to the analytic situation, Tessman is beginning to highlight some of the differences between open

and closed systems. I believe that psychoanalysis has evolved from the model of a (relatively) closed to an open system. The shift in emphasis from a closed to an open system is at the heart of Hans Loewald's seminal paper on the therapeutic action of psychoanalysis (1960). It is a shift that has a profound effect on how we understand the resolution of the transference, and how we understand the research on frequency and duration.

Closed and Open Systems: Description, Evolution and Implications for the Fate of the Analyst

A closed system is one that is isolated from its surrounding environment. The term often refers to an idealized system in which closure is perfect. In reality no system can be completely closed; there are only varying degrees of closure (see Web definitions of Closed systems, en.wikipedia.org/wiki/Closed_systems). In contrast to closed systems which have relatively "hard boundaries through which little information is exchanged," open systems have "porous boundaries" with ongoing feedback (Field Guide to Consulting and Organizational development, authenticity consulting.com). Working from the model of a closed system the analyst's instrumentality is emphasized. That is to say, transference is seen as a fantasy laden distortion of reality and the analyst, like a surgeon extirpating a tumor, reaches into the system (i.e., the patient's mind) and corrects these distortions via interpretations. In a closed system the analyst's availability "is seen in terms of his being a screen or mirror onto which the patient projects his transferences, and which reflects them back to him in the form of interpretations. In this view, at the ideal termination point of the analysis no further transference occurs, no projections are thrown on the mirror; the mirror, having nothing now to reflect, can be discarded" (Loewald, p.18). This point of view can be traced back to Freud's proclamation that at the end of an analysis we must "dissect" the transference "in all the shapes in which it appears" (1917, p.453).

It is worth mentioning, of course, that Freud never advocated dissecting the positive transference or, what he called the unobjectionable positive transference. Since transference was so closely related to

suggestion, Freud's rather absolute statement is best understood as a political statement designed to differentiate psychoanalysis from the "demon of suggestion" (Levy and Inderbitzin, 2000, p. 839) inherent in hypnosis. Under the rigid orthodoxy of psychoanalysis in this country (cf. Smith, 2007, p. 1050) during the first half of the 20th century Freud's hyperbole became established fact. The analyst was situated outside the patient's world and acted as a mirror reflecting the patient's unconscious. When the patient's fantasy-laden constructions of the analyst were rectified via interpretations, the analyst could be discarded, "like a piece of shit" (Lacan, 1959, cited by Tessman, 2003, p. 224). The patient was expected to identify with an 'analytic function' (i.e., self-analytic function/self-reflection). This identification with a part object was the compromise in a closed system.

In contrast to closed systems where the analyst is not seen as an integral part of the patient's world, in an open system "transference wishes… are already altered by the particular *affective* (emphasis added) presence of the analyst … the analyst in his or her reality is positioned differently in the transference and at termination" (Tessman, p. 224). "What we need to aim at, (said Martin Bergmann), is not to resolve the transference neurosis but to make sure that it forms a productive inner structure in the life of the former analysand" (Bergmann, 1988, p. 151). In an open system the analyst is an actor on the stage of transference (Loewald, 1960); and in a successful analysis the analyst continues to play a role in the patient's internal world that is qualitatively different from the identification with an analytic function.

For Hans Loewald (1960) "…the 'resolution of the transference' at the termination of an analysis means resolution of the transference neurosis,…(and) this includes the recognition of the limited nature of any human relationship and of the specific limitations of the patient-analyst relationship. But the new object-relationship with the analyst, *which is gradually built in the course of the analysis* (emphasis added) and constitutes the real relationship between patient and analyst, and which serves as a focal point for the establishment of healthier object-relations in the patient's 'real' life, is not devoid of transference …

to the extent to which the patient develops a "positive transference" (not in the sense of transference as resistance, but in the sense of that "transference" which carries the whole process of an analysis) he keeps this potentiality of a new object-relationship alive through all the various stages of resistance. This meaning of positive transference tends to be discredited in modern analytic writing and teaching, although not in treatment itself" (p.32).[3]

For Loewald, it is the patient's *"internalization of a longed for integrative experience*" (emphasis added, p.26) that is necessary for the resumption of structural changes (or ego development). In this context it is important to note that Loewald is referring to the internalization of the interaction – process, not simply the internalization of an object (p.30). And it is a process that takes place in the emotional context of the analyst's love and respect for the patient. "This love and respect represent that counterpart in 'reality', in interaction with which the organization and reorganization of ego and psychic apparatus take place" (p. 20). In other words, the analyst's love and respect for the patient is the necessary emotional context that allows for meaningful interpretations of the patient's regressive longings vis-a-vie the analyst. For Loewald the internalization of the analytic interaction always refers to an interaction with a differentiated other so that insight (an- *other* way of looking at things) in the context of an emotional relationship is internalized by the patient. Although the term internalization is used differently in the various studies that will be discussed I believe Loewald's approach provides a common denominator.[4] (This is particularly clear in the Falkenstrom study (see below) where the internalization of insight and self-soothing aspects of the analytic relationship are spelled out by the authors.) From a 'Loewaldian' perspective in order to help the patient achieve this internalization of an integrative experience "The analyst must be in tune with the patient's productions, that is, he must be able to regress within himself to the level of organization on which the patient is stuck…a regression against which there is resistance in

the analyst as well as in the patient" (p.26). In talking about the analyst's resistance Loewald exemplifies the idea of the reciprocity ("porous boundaries") of an open system.

I think these comments about the resolution of the transference highlight George Frank's reading of Freud's movement from identifying the transference, to the analyst and analysand working on it in the treatment: "…resolving transference is inherently difficult, and, hence, is done *in vivo*, that is, in an analysis of the relationship with the analyst (as opposed to talking about these issues in an intellectual manner…) [and this] make(s) the case for psychoanalytic treatment necessitating frequent sessions per week" (p. 11). I also believe that the "working through" of transference fantasies (along with the analyst's attention to his/her countertransference fantasies) in the "heat of the moment" can provide a theoretical basis for more intense treatment. It brings to mind Charlotte Schwartz's emphasis on frequency as necessary to establish "the coordinates whereby it is possible to gain access to unconscious material more consistently and in greater depth" (2003, p. 182). I think we can add to this that high intensity treatment can also help the analyst know herself (e.g., the resistance to regress) that is necessary for a successful 'resolution' of the transference.

Introduction to "formal" research:

In his paper on session frequency George Frank argues that research on the effect of frequency of sessions is inconclusive (p. 14). This is a reasonable interpretation of the outcome research. I would add, however, that any notion that our research efforts should be conclusive falls into an idealization of science where conclusiveness is equated with certainty and truth.

The idea that research is decisive and studies are routinely replicated is part of a fantasy that defends against the uncomfortable fact that we live in a world of uncertainty. The world is an open system where boundaries are porous and variables are constantly interacting. Small differences, or

"small" perturbations, can have very large effects. This is true for psychoanalytic research as well as research in the "hard sciences" (Leuzinger-Bohleber and Burgin, 2003, p. 9). In my opinion, however, there is a clear pattern of meaning that has emerged from our psychoanalytic outcome research. I say "pattern of meaning" because I believe 21st century ("postmodern") science has moved away from the idealized notion of linear cause and effect relationships (or absolute truth) promised by logical positivism with its reliance on the deification of numbers (see Faber,1999a, 1999b; see also Kelley, 2009). In attempting to understand the general features of a system, we are trying to discern (i.e. to come to know or recognize mentally) patterns of meaning (impressions, trends) in the global system of outcome research. And we do this by looking at data from the different components of the system, or different levels of observation.

In any complex system, like the global system of psychoanalytic outcome research, we would expect variability on a "local level", i.e., between individual studies, as well as variability on a "micro level", e.g., differences in quantitative and qualitative findings in the same study (Leuzinger-Bohleber, Stuhrast, Rüger, and Beute, 2003, see especially p. 270). Over time, however, and with enough observations, we would also expect to be able to describe an evolving pattern of meaning that characterizes the global system of psychoanalytic research *at a particular point in time*. In other words, the pattern of meaning is not static. Its "shape" is dependent on input from the various levels of observation which constitute the components of the system. In this paper the different levels of observation, the components in the overall system of outcome research, are input from 1) quantitative research – particularly large scale studies; 2) qualitative research – clinical case studies or variations on this theme; 3) theoretical research in the form of ideas on the resolution of the transference; and 4) the individual research that each analyst does in his/her practice daily. And the researcher's task is the same as the individual analyst's task as she or he is involved in clinical psychoanalysis. It is one of pattern

recognition. Can we recognize, i.e., construct a pattern that emerges from the variable nature of the data? To extend the analogy between research and treatment further, I would say that research is always an interpretive process; and just as we embrace pluralism in clinical work, we do the same in our research efforts. There are many ways of generating data and many potential interpretations of the data. My interpretation of the data from these different levels of observation is, to use Irwin Hoffman's language, an attempt "to make something" … to construct a way of thinking about the data that is "in the ballpark in terms of plausibility" (2009, p 1048). It is a given, therefore, that the notion of an 'emergent pattern of meaning' is embedded in a context of subjectivity. This is as true for research as it is for clinical psychoanalysis.

Overview:

An emergent pattern of meaning from outcome research is that for most people in psychoanalysis high intensity treatment leads to a better outcome compared to low intensity treatment. Sometimes the difference between the two groups increases dramatically following termination of treatment (Sandell, Bloomberg, Lazar, Carlsson, Broberg, Schubert, 2000). An important difference between the two groups seems to be the internalization of the therapeutic relationship that is experienced as a soothing and helpful inner presence (Freedman, Hoffenberg, Vorus, and Frosch, 1999; Falkenstrom, Grant, Broberg, Sandell, 2007). This is also a finding associated with more successful analyses (Tessman, 2003). Some investigators relate this process of internalization to the duration of treatment, i.e., longer duration leads to a greater chance of internalizing the analyst in a way that is helpful well after the analysis ends (Freedman, et al). Others, however, (including Freedman et al) see the *interaction* of frequency and duration as a more powerful variable affecting outcome, including the internalization of this helpful and soothing inner presence (Sandell, et al; Falkenstrom, et al). Differences in results between studies are influenced by differences in research methodology (e.g., outcome measures, time interval between measurements), the

treating clinician, the patient population, as well as cultural differences where the same or similar measure in different countries can lead to very different results (Judson, 2010; see also, http://www.wired.com/medtech/drugs/magazine/17-09/ff_placebo_effect?currentPage=all).[5]

I would reiterate, however, that once we move toward a "theory of hypercomplexity" (Green, 2003, p. 43) variability is expected. Certainty or conclusive results should not be considered the sine qua non of outcome research. The findings that the internalization of the analyst is more likely to occur in high intensity treatment has come about through a shift in our research paradigm from an emphasis on quantitative research to qualitative research, and from a shift in our theory about the resolution of the transference (see above). In addition to the more general arguments against the absolute truth value of quantitative studies there are a growing number of analysts/ analyst researchers who question whether the measures used in large scale studies can do justice to psychoanalytic outcome research. Analysts like Leuzinger-Bohleber, et al (2003) consider such measures non-analytic and place qualitative measures at the heart of their research designs. Other investigators (e.g., Sandell, et al) use qualitative measures to shed light on their quantitative data. A third group of analysts (e.g., Green, 2003; Perron, 2002) view large scale quantitative studies as peripheral, at best, to psychoanalytic research (see also, Hoffman, 2009). I do not think it makes sense to throw out data from large scale quantitative studies any more then the methodological issues (see Fonagy, 2002, pp. 22 and 283) rule out case studies as a legitimate source of psychoanalytic data.

In the next section a number of research studies bearing on frequency/duration and outcome will be discussed. . The studies are, from my subjective position, the major studies on frequency/duration and outcome of psychoanalysis. A more inclusive review and discussion of this area of research can be found in Fonagy (2002) and in Levy and Ablon (2009). In keeping with Jonathan .Shedler's (2010) very important comment about the difficulties in understanding research, even for experienced researchers, a

narrative rather than a quantitative approach is used. In addition, an overview is provided at the beginning of each study.

The Effectiveness of Psychoanalytic Psychotherapy: The Role of Treatment Duration, Frequency of Sessions, and the Therapeutic Relationship (1999). Freedman, N., Hoffenberg, J.D., Vorus, N., and Frosch, A.

> Increased frequency and duration is positively related to outcome. High intensity psychoanalysis contributes to greater affective intensity in treatment and facilitates the internalization of the supportive and growth-enhancing aspects of the therapist. This process continues post-termination and makes a significant contribution to a positive treatment outcome.

In this study patient self reports of how treatment affected them (Effectiveness Score) were used to measure outcome. The authors report increasing outcome scores with increasing duration; and this reached significance at six plus months. The same was true for session frequency where the difference in outcome was significant between one and two sessions per week and between one and three sessions per week. The difference between two and three sessions per week was not statistically significant but continued the trend in the direction of a positive relationship between outcome and session frequency. Once again, the 'critical time period' was a treatment duration of seven months: "…after seven months the treatment relationship tends to become more stable" and, at this point, "frequency of sessions makes a difference" (p. 757). In this regard it is noteworthy that in a recent article Sidney Blatt and his colleagues (Blatt, Zuroff, and Hawley, 2009) argue that the establishment early on in the treatment process of a positive therapeutic relationship is a very strong predictor of positive outcome (p. 394).

Freedman et al go on to say that the *combined predictive power* (emphasis added) of frequency and duration was "quite significant" and, in addition, that each of the variables contributes to outcome in

"qualitatively different ways" (p. 758). Frequency was related to symptomatic gains (how much the treatment helped with the problem that led the patient to therapy) and global improvement (how respondents felt at the time of the survey compared to when they began treatment). Duration, with its strong association to the Positive Relationship Index (see p. 753 for details of this index), was more related to the patient's satisfaction with the therapist; and Freedman, et al see this as an indicator for the potential internalization of the therapeutic relationship.

The statistical teasing out of the role(s) of frequency and duration is a valuable contribution to our understanding of the psychoanalytic process. It is worth asking, however, if the differential effect of frequency and duration is an iteration of the historical tension between insight vs. the therapeutic relationship as the mutative factor in psychoanalysis (Schlesinger, 1988; Gray, 1988) That is to say, since increased frequency is associated with alleviation of symptomatic behavior and global improvement (e.g., "I have no serious complaints," p. 751) it seems reasonable that the changes can be related to new ideas in the form of the analyst's interventions that lead to new ways of constructing the world (i.e., the world of self and object representations). But new ways of constructing the world, even if they lead to changes that are objectively beneficial to a person's life, do not necessarily translate into a basic alteration in the essence of how one feels. 'I have no serious complaints' is not the same as 'I feel secure, comfortable, life is really worth living'. This may be another permutation of Herbert Schlesinger's prescient statement about the "untidy fact" that insight does not always lead to change (1988, p. 19). I think we can add to this that insight that leads to actual change in one's life does not necessarily translate into a more positive (and more profound) internal state. A shift in one's internal state seems more closely related to the patient's satisfaction with the therapist's treatment of his/her problems (p. 758).

Freedman et al argue that increased therapeutic exposure (frequency and duration) "contributes to the experience of greater affective intensity in treatment, and that such intensity facilitates a perception

of the therapist as optimally responsive to the patient. Further, we believe these conditions to be particularly important because of their role in facilitating a process of internalization that in turn supports the development of a relatively enduring internal relationship with the supportive and growth-enhancing aspects of the therapist" (p. 760). It is the patient's exposure to "a sustained therapeutic presence (that) has an incremental impact on his or her "*experience* (emphasis added) of clinical improvement" (p. 758). This was clearly the case in the two patients who were interviewed post-termination where high frequency in the context of a positive treatment relationship was most predictive of therapeutic success:

Ms. A came two and three times a week for approximately two years. During the post-termination interview Ms. A made the paradoxical statement that she does not think about her therapist but at the same time her therapist is not someone she does not think about. From a psychoanalytic perspective the paradox is transparent: I do not think about my therapist on a conscious level because she is available to me on an unconscious level. Ms. A's capacity to feel good, happy, and productive about her life seemed directly related to the internalization of her therapist who was experienced as an understanding inner voice that has helped her have different expectations about herself and the world (p. 767).

In contrast to Ms. A, Ms. B came once a week for nearly two years. She seemed to be doing better in her life in terms of how she related to others, or functioned at work, and was experienced as less depressed by her friends. And Ms. B thought there was something about the treatment that was helpful but she could not say how talking with her therapist helped. In the post-termination interview she did not say much about her therapist and when she did it was in terms of a distance she experienced between them. The therapeutic relationship lacked emotional intensity and evidence of internalization. Ms. B was "objectively" better following her treatment but did not seem to feel very different about herself. The words of the therapist did not feel like they had "healing power" (p. 768). The development of a relatively

enduring internal relationship with the supportive and growth-enhancing aspects of the therapist was not present with Ms. B. as it was for Ms. A.

The interview data is consistent with the findings from the quantitative aspect of this study, as well as the theoretical ideas presented earlier about the resolution of the transference. From the point of view of attachment theory Morris Eagle's (2003) ideas provide an excellent fit with the Freedman et al data as well. From Eagle's perspective what changes a person's experience of the world is the internalization of the therapist "as a secure base" and this, he argues, is related to frequency and duration (p.28). In Eagle's scenario self-understanding (insight) leads to better ego functioning, one index of which is self-reflection. Feeling understood by the analyst is the pathway for an alteration of procedural rules, i.e., our basic emotional sense of self in the world. Of course, an accurate, well-timed, tactful, and well-phrased interpretation, particularly in the context of a good therapeutic relationship, can contribute both to self-understanding and feeling understood (p. 45n). This is a point that is essential to our understanding of the concept of internalization. In this context I would like to cite Schlesinger (1988) to the effect that it "is difficult, and perhaps impossible, to distinguish the effects of correct interpretation from the effects of a good therapeutic relationship, for they are not separable in practice, and it is questionable if they are even separable in contemporary analytic theory" (1988, p. 17).

How we understand the fate of the analyst post-termination is very much related to the resolution of the transference. If we understand the resolution of the transference from the perspective of a closed system the remains of the analytic relationship are to be found in an identification with a function of the analyst, e.g., a self-reflective/self-analytical function. From the perspective of an open system it is the internalization of the relationship with the analyst that is emphasized. It is a shift in emphasis that has a profound effect on how we understand psychoanalysis and how we understand the research on frequency and duration.

Varieties of Long-Term Outcome Among Patients in Psychoanalysis and Long-Term Psychotherapy: A Review of Findings in the Stockholm Outcome of Psychoanalysis and Psychotherapy Project (Stoppp). (2000). Sandell, R., Blomberg, J., Lazar, A., Carlsson, J., Broberg, J., Schubert, J

> Increased frequency and duration was associated with positive outcome, and the difference between high and low intensity groups became significant three years post-termination

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The authors found that increasing frequency depended on duration, and vice versa. Increasing frequency had a negative effect in therapies of short duration, and increasing duration had a negative effect in low-frequency therapies. There was, however, an increasingly positive effect of increasing frequency the longer the duration or of increasing duration the higher the session frequency. Thus, long durations and high frequencies, *in conjunction*, were associated with the most benign treatment outcomes on the SCL-90, a widely used quantitative measure in outcome research (p. 932).

A significant part of the outcome differences between patients in high intensity treatment and low intensity treatment could be explained by the adoption, in a large group of therapists, of "orthodox psychoanalytic attitudes" that seemed to be counterproductive in the practice of low intensity treatment but not so in high intensity work (p. 921). Sandell et al suggest that this effect may be a negative transfer of the psychoanalytic stance into less intensive (what they refer to as psychotherapy) practice and that this may be especially pronounced when the attitudes are not backed up by psychoanalytic training. Another way of looking at this is that something went wrong in the relationship between analyst and patient. This is certainly what George Frank suggests and it is a position that Rolf Sandell very much moves toward in a recent article (Sandell, 2009) where he argues that "researchers - and therapists - so far have tended to

underestimate the accountability of the therapist factor" (p.361). To my way of thinking this is a movement away from technique (instrumentation) toward who the analyst is and how this affects the analytic dyad. It seems clear that the person of the analyst is very much part of how he/she uses psychoanalytic concepts and technique (Frosch, 2006; Wilson, 2003).

The unintended contribution of therapist variables to outcome highlights how 'context dependent' (Hoffman, 2009) psychoanalytic research is: we cannot control for all the variables that impact on outcome. Psychoanalytic research is "messy." In any given population of therapist-patient dyads some people "get better", some don't and some may get worse (Sandell, 2009). The ambiguity of these terms takes us well off the mark of certainty. As Freedman, et al note, some people may 'get better' in terms of functioning, but do not feel much better at all. And, we can add, some people may get better by not getting worse. This messiness should not cast a pejorative shade to research efforts, nor should it stop us from coming up with some plausible reflections on what might be going on. Sandell, et al go on to say that what they call dosage factors (high/low intensity) does account for a proportion of the outcome difference between the groups: Of particular interest was the finding that "these effects became visible and significant only at the third follow-up, that is, about three years after termination: Before that there were no significant effects at all" (p. 932). They speculate that something is occurring during the more high intensity treatment that leads to a different post-termination outcome: "When the specific issue of the between-treatments differentiation is concerned, what will be particularly interesting is of course the patients' accounts of the post-treatment process". They put forward the idea that patients in the high intensity group may have developed a stronger self-analytic attitude than patients in the less intense form of treatment. "Whatever one's expectations, however, an open mind is the best instrument for discoveries in texts like these" (p. 938).

How to Study the 'Quality of Psychoanalytic Treatments' and their Long-Term Effects on Patients' Well-Being: A Representative, Multi-Perspective Follow-Up Study. (2003). Leuzinger-Bohleber, M., Stuhrast, U., Rüger, B., and Beute, M.

When patients in high intensity and low intensity psychoanalysis were interviewed six years post-termination the patients in the high intensity group had internalized the analyst in more extensive and more intensive ways than those of the low intensity group. The study represents an important shift in emphasis between quantitative and qualitative methods with precedence going to the latter.

The major aim of the project was to study patients' retrospective (six years post-termination) views of their treatment. Using questionnaires the investigators found that approximately 70-80% of all the patients who responded reported positive changes. Based on the quantitative data, (questionnaires) however, there was no statistically significant difference between the high intensity and low intensity groups regarding their retrospective assessment of impairment before and after treatment (p. 270). The author's argue that a lack of difference in outcome between the groups based *on the quantitative measures* does not mean that such a difference does not exist. In point of fact, when the patients in both groups were interviewed there was a clear difference between the groups: the high intensity group with "good enough" treatment outcomes "had internalized the analytic function in a more extensive and intensive way". Therefore their self-reflective functions were rated as "deeper", "more elaborated" and "more differentiated" than those of the low intensity patients with similar outcomes (p. 282).

There are a number of important points that I would like to highlight in this study: This is a retrospective study where quantitative (Questionnaire) and qualitative (Interviews) methods were used. The differential findings between the two sets of measures attests to the complexity of the data and, while inconclusive in the sense that we cannot make absolute statements that the high intensity group did

"better" than the low intensity group, the investigators' focus on internalization allows us to look at the fate of the analyst post-termination across groups.

The authors argue that the former high intensity patients had developed a creative 'inner analyst' and were thus able to continue with the analytic process more effectively in the post-analytic phase than patients in the less intensive treatment (p. 283). The notion of an inner analyst could refer to what has often been called an identification with an analytic function, i.e., a self-analytical attitude. But there is another way of understanding the 'inner analyst' that Bohleber et al may also allude to when they talk about the analyst and patient need for an 'inner, resonant' dialogue. In "good enough" treatments the clinician was particularly successful in showing empathy and adapting flexibly, openly and professionally to their patients special traits and idiosyncrasies; their technique was orientated towards the patient's needs, not primarily towards their own convictions or beliefs (p 282). In less successful treatments in the high and low intensity groups some of the clinicians described their painful memory that they were not able to enter into an 'inner, resonant' dialogue with the patient over a long period of treatment. Some of the former patients complained about an analogous perception (p. 282). Here I am building a case, so to speak, to interpret the data from the perspective of an internalization of the analyst, rather than an identification with a function of the analyst. This, of course, is my interpretation of the findings, not Bohleber et al. It seems clear that the investigators in this study viewed the interview data along the lines of an identification with the self-analytical function of the analyst. And this finding, they argue, may "correspond to the results of the Stockholm Study" (p. 283). In other words, the hypothesized difference between the groups in the Sandell et al study would lead to the expectation (prediction) that the post-termination difference between the groups would be in the greater identification of the high intensity patients with the self- analytic function of the analyst in comparison to low intensity patients.

The next two studies that I will discuss do not support this hypothesis at all. What turns out to be an (perhaps the) most important difference between high intensity and low intensity groups in the Falkenstrom, Grant, Broberg, and Sandell study is that the high intensity group has internalized the analyst as a source of insight and a self-soothing presence, and this is not the case with the low intensity group where there was an identification only with the self-analytic function of the analyst. In Laura Tessman's work the difference is not between high intensity and low intensity groups but between successful and unsuccessful analyses – all at high intensity. The findings in this study consist of lengthy reports by former analysands and are quite dramatic and clear: The people from the more successful analyses had internalized the analyst as a self-soothing presence; and those from less successful analyses did not, or certainly not to the same degree. In my opinion these findings on the 'fate of the analyst' post-termination are a very strong indication of an emergent pattern from our psychoanalytic outcome research that is consistent with current theoretical ideas about the resolution of the transference.

Self-Analysis and Post-Termination Improvement After Psychoanalysis and Long-Term Psychotherapy. Falkenstrom, F., Grant, J., Broberg, J., Sandell, R. (2007).

High intensity patients interviewed from the Sandell et al study spontaneously mentioned various self-supporting strategies such as the internal presence of the analyst and self-calming strategies associated with insightful moments in the analysis. This was not the case with patients from the low intensity group. The development of a self-analytic function was the same for both groups.

This study was the qualitative follow up to the Sandell, et al study. In the latter study high intensity and low intensity patients continued to improve on quantitative measures post-termination. There was a tendency, however, for the high intensity group to improve more than the low intensity group and this

reached statistical significance in the third year post-termination (p. 630). The basic research question for the Falkenstrom team was to see if they could discern what might have been going on with the high intensity group that would account for the greater post-termination improvement in comparison to the low intensity group. The working hypothesis was that the difference between groups was to be found in the self-analytic function. To explore this the investigators interviewed ten patients from the high intensity group and ten patients from the low intensity group. The patients were matched along a number of dimensions including psychological health at termination. Each participant in the study was interviewed twice: "The interviews were studied qualitatively using a multiple case study design, and categories of different types of post-treatment development were created from these case studies" (p. 629). The expectation that the differentiating factor between the two groups would be along the dimension of a self-analytic function was not, in fact, the case at all. There was no difference in self-analytic function between the two groups (p. 665). Falkenstrom et al did find that "the most striking" difference between the groups was in various self-supporting strategies described by members of the high intensity group but not the low intensity group. 'Self-supporting' strategies were further broken down into 1) use of the analyst as an internal supporting presence, e.g., "being able to recall the voice of the analyst as a soothing presence in times of stress or to recall the analyst's office as an inner source of support and containment – (p. 644) and 2) Self-calming strategies, e.g., recalling meaningful insights from the analysis during difficult times of stress (p. 645). "Most patients (seven out of ten) in the high intensity group spontaneously described such strategies, while none of the low intensity patients did so" (p. 665). The authors note that the self-supportive category seems related to introjection and internalization. In this context I would like to mention again Sidney Blatt's work (Blatt, Zuroff, and Hawley, 2009) where he argues that what is crucial to the outcome process is a reduction in the patient's vulnerabilities so as to prevent relapse after the termination of treatment. Central to Blatt's argument is the quality of the

therapeutic relationship and its eventual internalization by the patient (pp. 280-281). Blatt et al take the position that "the quality of the therapeutic alliance significantly predicted the reduction in personality vulnerability that in turn significantly predicted symptom reduction" (p. 292). This formulation is consistent with the Freedman et al study as well as Eagle's work (see above). It highlights the crucial role of internalization in a patient's overall improvement. In the Falkenstrom study we can see the internalization of a soothing presence coupled with insight as part and parcel of the process of the internalization of the relationship with the analyst.

My own impression is that concepts like internalization and introjection connate an unconscious process that in this context refers to a sense of the inner presence of the other. This is in contrast to the self-analytic function which Falkenstrom et al regard "as an identification more or less conscious" (p 666) with the clinician. Of particular importance in thinking about this study is the 'counterintuitive' finding about the internalization of the analyst as a self-soothing presence that characterizes the high intensity but not the low intensity groups. I say counterintuitive because this study was a follow-up of the Sandell et al study where the authors' expectation of an 'analytic function' - the self-analytic function – as a differentiating factor between the high intensity and low intensity groups was not supported. Sandell and Broberg, of course, are part of the Falkenstrom study; and their caution about keeping an open mind to what we might consider an internal differentiating factor between high intensity and low intensity treatment (see above) is very relevant to the Falkenstrom et al study and to research in general.

The Analyst's Analyst Within. (2003). Laura Heims Tessman.

Patients who have had a successful analysis internalize the positive presence of their analyst to a far greater extent than patients who have had less successful analyses.

In her book Laura Tessman explores how the analyst is experienced by the analysand "post-termination". I put this in quotes because of the mistaken idea that the analysis ends when the analytic dyad stops meeting. It is clear from the studies reviewed that this is not the case at all. Tessman highlights the importance of studying the post-termination phase because, as she puts it, "postanalytic [sic] developments occur in the wake of what the analysis started" (p. 6). Tessman interviewed analysts at the Boston Psychoanalytic Institute about their own analyses and found dramatic differences between those people who experienced their analysis as positive ("deeply satisfying") and those who did not. "Taken in aggregate, the narratives of Participants suggest that the optimal use of the inner presence of the analyst to further positive development after termination is preceded by satisfaction with the analysis" (p. 18). One participant in the deeply satisfying group said that it was a pleasure to have his analyst in his mind: "He's with me every day. …My analysis continues to grow" (p. 41). In contrast to more satisfying analyses, analysands who experienced their analyses as unsatisfying more typically described the absence of an affective presence of their analyst: Tessman – "As you practice analysis, where is he in your inner life? Analysand – Nothing of him. I can't think of any ways that I operate similarly except that I'm prompt and he was prompt. I give people the bill and things like that. Tessman – So just the frame remains. Analysand - Just the frame" (p. 59).

I have outlined some of Laura Tessman's theoretical ideas about the resolution of the transference in an earlier section of this paper; and her findings are consistent with these ideas. An obvious criticism of Tessman's work, therefore, is that of bias. The same "criticism" can be made about everyone's work to a greater or lesser extent. The concern about bias is that it will interfere with discovering something 'out there'. The idea that there is something out there – an absolute, certain and infallible truth that we can discover to conclusively answer our questions about frequency/duration and outcome is a particular way of thinking about research. Another way of thinking about research, and also about bias, is that there is

not something out there but something we construct, and our constructions will always be influenced by our subjectivity. This is the position I have taken throughout this paper and it is why I believe the most powerful influence upon the meaning we give to outcome research comes from the people who practice clinical psychoanalysis on a daily basis. If the stuff of the world is mind-stuff then the stuff of our outcome research is also mind-stuff. And the way each of us thinks about psychoanalysis will shape how we view important dimensions of the psychoanalytic process and how we think about the relationship between frequency/duration and outcome. I believe this to be the case whether the analyst actually does formal research or whether the analyst contributes to the theoretical/clinical literature.

Analysts and butterflies:

> In 1961 the physicist Edward Lorenz was using a computer program to create weather patterns. At one point he rounded off a six place number to three places: "Lorenz had entered the shorter, rounded off numbers, assuming that the difference - one part in a thousand – was inconsequential" (Gleick, 1988, p. 16). To his astonishment, however, the new computer generated weather pattern was vastly different from the pattern using the six place number. Lorenz's accidental discovery came to be known as the "butterfly effect" so that small differences or perturbations in a complex system could lead to enormous consequences, e.g., the beating of butterflies' wings in one part of the world can influence the weather in a very different part of the world.

It seems that many analysts do not believe that they can do psychoanalysis at a high intensity. There are simply not enough people around who want to be in this form of treatment, insurance companies make it difficult, the competing therapies promise more in a shorter amount of time. And the list goes on. It is important to view these 'reality factors' in the context of analysts' long standing resistance to doing psychoanalysis at a high intensity. In more formal (pseudo) 'scientific' terms we have cloaked our discomfort around the concept of analyzability. Analyzability is the analog of the researcher's quest (i.e.,

fantasy) for certainty. From a so called objective perspective it is a judgment about whether someone is healthy enough to be in psychoanalysis. On a narcissistic level to say someone is analyzable probably reflects the clinician's belief that he or she will be successful in analyzing *this particular person* (the myth of the "good" analytic patient) without moving too far out of the comfort zone of his/her own emotional state. In other words, 'I am not too frightened to work with this person and I may even be comfortable enough to work at a high intensity'. Major steps away from this approach were taken by Leo Stone (1954) in his widening scope paper and in the work of Arnold Rothstein (1998, 2006) and others (e.g., Grusky, 1999). All of these authors highlight the analyst's discomfort with the intensity of the analytic situation and, especially, how uncomfortable analysts get with certain so called "disturbed patients". Rothstein in particular makes the point that when we are uncomfortable with a patient we tend to diagnose the patient as disturbed and argue that we can not work with such a person at a high intensity (1999).

In a paper written nearly seventy years ago Harold Kelman (1945) argued that high frequency analysis is necessary "in most cases" with the exception of those situations "in which the analyst feels that the limitation of the analysis to once a week is indicated" (p. 18). Kelman goes on to say that once a week analysis is indicated with patients who are very detached and need distance from others: "One should remember that with such patients, your genuine interest and desire to be helpful may not be so regarded, but may be viewed rather as an intrusion and your desire to clutch, involve, and tie them down" (p. 22). Another kind of patient that Kelman feels is more suitable for low frequency psychoanalysis is the highly aggressive patient who causes the analyst "to defend himself rather than to analyze the patient" (p. 24). Kelman argues that high intensity psychoanalysis allows such patients to "waste your time and theirs (and) only incurs increasing their contempt" (p. 24). When there is a reduction in the aggression and the patient's attempts to sabotage the analysis "the number of hours can be increased" (p. 25).

Kelman's ruling out of certain patients for more intense work is no different than what we do today. Sometimes we do it under the artificial guise of analyzability potentiated in most cases by our uncomfortable reaction to the patient. It seems reasonable, therefore, that the category of "most people" is indexed by the level of comfort/discomfort in the transference/countertransference matrix. If we have the idea that discomfort is something to be analyzed, then the category of most people will be expanded.

Of course, another way of thinking about Kelman's paper is in terms of a collaboration between analyst and patient with the ultimate goal of higher frequency sessions. This is certainly a point of view that is very much part of the current literature (see Rothstein, 2010b; Carrere 2010). And it is a point of view consistent with the idea of psychoanalysis along a continuum. My emphasis on the analyst's uncertainty or discomfort in recommending high intensity treatment stems from my belief that the crisis in psychoanalysis today is that analysts are not "armed with the conviction" (Rothstein, 1998, p. xviii) that high intensity psychoanalysis is the treatment of choice for most people.

Psychoanalysis is difficult work. We are barraged with feelings triggered by our own unconscious and the unconscious of the people we work with. And in undertaking a high intensity psychoanalysis we are taking on a huge responsibility for the life of another person. There is an ever growing literature on the analyst's uncertainty in taking on this work (Panel, 2002; Ehrlich, 2004, 2010); and it seems more than reasonable that in the face of this uncertainty we have to have a passionate belief in what we do. It is only too easy to rule out patients for high intensity work. Kelman's paper in many ways was ahead of its time. He worked from the model of an open system and saw psychoanalysis along a continuum. And like all of the people I have read who support less intensive psychoanalysis (e.g., Greenberg, 1986; Coopersmith, 2005) Kelman believed in high intensity psychoanalysis. Consider, for example, Hyman Spotnitz's position.

Spotnitz (Meadow, 1999) was very clear about the "job" of the analyst: "…to stay in touch with the unconscious of the patient and with our own unconscious. It's a very difficult job" (p.12). And he was also quite clear about how we accomplish this. Analysts, he said, "…should go to five- or six-year, four or five times a week analysis like I did" (p. 12). Spotnitz spoke quite poignantly about his own psychoanalysis and its relation to Modern Psychoanalysis: "I saw her (his analyst) five and six times a week for five years. She helped me develop Modern Psychoanalysis" (p. 7). I know that followers of Modern Psychoanalysis, (including, and perhaps especially, Spotnitz himself), also argue for less frequent sessions – sometimes less than once a week (see Meadow and Spotnitz, 1976, p. 13; Spotnitz, 1997, p. 39). Support for less frequent sessions, however, takes place in the context of a belief in high intensity work. And this is also true today. Even those colleagues who are more favorably disposed to less intense work are not, to cite Stern (2009), "after all, recommending abandoning more intensive analysis" (p. 650). In his discussion of Stern's paper Lewis Aron makes a similar point: "Frequency in fact can matter a great deal. No one here is arguing against the advantages of frequency in our clinical work" (p. 666). I would say that analysts who were trained in the context of high intensity work, *including and especially their own analyses*, are quite supportive of high intensity work. But what about the next generation of analysts many of whom are not being trained or analyzed in the context of high intensity psychoanalysis? In New York State the new licensing law for psychoanalysis does not require high intensity analysis for control cases or for the prospective analyst's own analysis. This is, to use the language of systems for a moment, a "perturbation" to the overall system of psychoanalysis. And any perturbation in a complex system will cascade through the system (Moran, 1991). And we cannot predict the ultimate impact on the system, except to say that there will be an impact.

<u>Conclusion</u>:

In this paper I have attempted to synthesize input from various components in the overall system of outcome research. I have emphasized that changes within and between the components influences how we view research on frequency/duration and outcome. When we view the internalization of the positive relationship with the analyst as a crucial aspect of the resolution of the transference we, quite naturally, begin to look for this in our research. This shift in the theory of transference is influenced by (and influences) a shift toward qualitative research, particularly the follow-up of patients post-termination. And this has radically changed our view of psychoanalysis to one where we consider that the analysis does not end when it ends!

Analysts in their daily work come up with new and often innovative ways of thinking about what we do and how to do it. These changes in how analysts think perturb the system. As expected, in an open system every part of the system is affected by every other part. The next generation of analysts who are not trained or analyzed in the context of high intensity psychoanalysis will influence the overall system of psychoanalysis including how we view, conduct, and understand outcome research. At the moment, however, from my subjective perspective and using the research described throughout this paper, the most plausible construction that I come up with is that high intensity psychoanalysis is the optimal treatment with patients that I feel I can work with at that intensity, and who feel they can work with me. I believe that high intensity psychoanalysis increases the probabilities for therapeutic success, but I do not believe that less intensive psychoanalysis precludes therapeutic success.

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Footnotes

1 It is understood that these concepts have different meanings, both theoretically and clinically, depending on the training model and philosophy of the particular analytic institute.

2 Not all the studies that I will discuss can make the claim that treatment was done by people with formal analytic training. This was one of the 'confounding variables' in the Sandell et al study. We can view this as interfering with the so called conclusiveness of the work or, as I prefer to see it, as highlighting the importance of who the analyst is and what she/he brings to the analysis.

3 I would add that the attempt to discredit positive transference is a remnant of our adherence to a closed system and a more linear view of the world where the elimination of our subjectivity is associated with an increased ability to view a 'reality' that exists independent of the analyst.

4 It is in this sense that I am using 'internalization' throughout this paper.

5 My thanks to Jonathan Hale for bringing this site to my attention

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