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PSYCHOANALYSIS CONDUCTED AT REDUCED FREQUENCIES

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This paper explores the clinical indications for an optimal psychoanalysis conducted at reduced frequencies. Among other purposes psychoanalysis is an engagement that serves to demystify experience. The structure of multiple session frequency applied a priori and in the absence of other considerations may contribute to mystification of the analytic process itself. Particularly for those patients presenting with limited ego-capacity for reflection, impulsive or compulsive behaviors, inhibition of thinking processes, blunting of emotions, and rudimentary capacity for therapeutic cooperation, analyses of multiple frequencies can contribute to false compliance or resistance.

Clinically the frequency of sessions can be determined on an empirical basis. An analysand's ability to self-reflect occurs in the same measure as one's tolerance for emotional contact with the analyst and the unconscious. An optimal psychoanalysis understood as a maturational process is conducted initially for some clinical varieties of transference at reduced frequency, which is then expanded over time as the person's capacity for thoughtful self-reflection and interpersonal contact with the analyst develops. In this way actual unconscious processes are privileged over taken-for-granted therapeutics and addressed as an empirical reality.

Keywords: frequency of psychoanalysis, psychoanalytic psychotherapy, psychoanalytic frame, mystification, adaptation, countertransference

Can a psychoanalysis conducted at frequencies fewer than three to five times weekly be considered optimal? At what frequency should an optimal psychoanalysis be initiated?

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These questions have been given scant consideration, except in discussion of training analyses (Kernberg, 2001b). This is notable, for the institutionalization of analytic frequency and duration began with the advent of training analyses as a gate-keeping function, as recently as the 1930s and 40s in this country (Lipton, 1988).

The matter of frequency has not been thoroughly studied, for historically we have used it to define what it is that we do in distinction to what it is others do. The depth and intensity of psychoanalysis over that of psychotherapy is attributed to a frequency of multiple sessions. Along with the couch, it is a key feature constituting the analytic frame by convention, used to define what is true psychoanalysis, and is considered indispensable for analysis proper. As an analytic ideal, frequency is one of the pillars of psychoanalysis that has served us much as an article of faith, something not to be questioned but adhered to if I am to consider myself an "uber" analyst. And if we do alter the frequency in any given treatment situation, we may do so with feelings of shame, guilt, anxiety, and being fraudulent, accompanied by desperate rationalization.

Freud Does the Math

By 1921, Freud's analytic frame included a six session per week frequency and a therapeutic duration of 6 months, which he announced to his analysands at the start by letter (Kardiner, 1977). Before his summer vacation of that year, Freud invited five Americans and a Swiss to Vienna to begin analysis on October 1st. His invitation was consistent with his intention to spread the practice of psychoanalysis to other countries, now that the Great War had been concluded. As they had all arrived in September, a month earlier at his request, he called them together upon his return from vacation to discuss a dilemma that had arisen. He told them, "I had normally expected, under conditions like this, that at least one of you would drop out. I know that you have all changed lives in order to come here, but I have only 30 hours for all of you." While he was willing to take on another hour of work, he informed them that his wife and daughter would not hear of it. He told them to meet to decide among themselves who would forgo psychoanalysis with him, for he would highly recommend to them Karl Abraham in Berlin, Otto Rank or Sandor Ferenczi in Budapest adding, "All of them are great at their craft." But as Abram Kardiner, one of the five Americans, noted, Freud was the only analyst foreigners wanted to see.

The next day when they met with the Professor, they informed him that none wanted to drop out. "Well, gentlemen," Freud replied, "my daughter, my wife, and I have reached a conclusion, which I hope will suit all of you." He told them that everything had been worked out in his mind, as during last evening's consultation from his family, it was his daughter, quite an expert at mathematical calculations, who had informed him that $5 \times 6 = 6 \times 5$. So if they were willing to come in 5 days each week versus 6, it was agreeable to him. Kardiner's formulation of the shift from six- to five-times-weekly analysis was that "Tradition yielded to expediency. Yet this expediency in its turn became a tradition."

I believe that it is time for us to study the matter of frequency and to consider for each of our patients what might be the optimal initial contact with an analyst as well as optimal ongoing contact. In raising the question of frequency, my intent is for us to consider two matters. First, what is our essential contribution to the psychotherapeutic change process? Second, how might reduced frequencies better serve an analysis compared to conventional frequencies?

What Is Our Essential Contribution to Therapeutic Change?

There has existed a tension within psychoanalysis, with Freud himself, between a psychoanalytic approach that is essentially objectivist and cognitive relying on interpretation and reconstruction and leading to insight and mastery (Kernberg, 2001b; Sternbach, 1990; Wallerstein, 1968) and another that gave greater emphasis to analytic process as "a struggle played out between the doctor and the patient, between intellectual life and instinctual life, played out in the phenomena of transference" (Sternbach, 1990, p. 153).

Historically the objectivist approach led us to define dogmatically what is the "pure gold of analysis" (Freud, 1912a), and we debated topics such as analytic parameters, analyzability, the superiority of psychoanalysis to psychotherapy as a thorough-going reconstructive therapy, and psychotherapy as a trial or preparation for psychoanalysis (Lipton, 1988). The hegemony of the objectivist approach which became classical led us to reject shibboleths such as countertransference, suggestion, corrective emotional experience, and subjectivity which was reduced to an epiphenomenon, that is a derivative of the drives. The technique included: (1) "the establishment of a full-fledged regressive transference neurosis" and (2) "resolution through a centrally thorough interpretation leading to insight and mastery" (Wallerstein, 1986, p. 54).

But there have always been those voices of dissent, including Freud's, calling us back to a consideration of transference and the tension between persons in the analytic dyad. This approach placed greater emphasis on analytic process, the personality of the analyst and the subjectivity of both participants, but it failed to achieve a privileged position.[1]

The objectivist approach just about crashed and burned in the Menninger Research Project reported by Wallerstein (1986) which found a "greater-than-expected success" of supportive psychotherapeutic approaches, conducted by analytically informed therapists, and a "lesser-than-expected success" of psychoanalysis. That is, the outcomes of each therapeutic approach (supportive, expressive, and psychoanalytic) converged significantly rendering many of our cherished ideals little more than bias.

This comparative research found, for example, that change occurred equally with and without insight; structural changes occurred in supportive and expressive psychotherapies; psychoanalysis failed to demonstrate superiority as a change process; and suggestion appeared in all treatments. In short Wallerstein concluded:

> in almost every instance (the psychoanalyses included), the treatment carried more supportive elements than originally intended, and these supportive elements accounted for more of the changes achieved than had been originally anticipated (p. 730).

As we know, Freud's conduct of analysis was not classical in style, made use of suggestion which he defended on numerous occasions in opposition to the use of direct suggestion (Freud, 1912a 1912b), and resembled contemporary approaches that place greater emphasis on the subjective factors operating in the dyad.

Freud lamented that our reluctance to work with transference in the early days slowed the progress of psychoanalysis by a decade. Little (1951) described how in similar fashion our reluctance to include countertransference in our analytic work constituted a similar

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[1] Relational psychoanalysis probably represents the most thorough-going articulation of this approach to date, although I believe that with this metapsychology we may be idealizing subjectivity at the expense of objectivity.

obstacle. For half a century countertransference was, as Racker (1968) called it, the "Cinderella of psychoanalysis."

Like transference and countertransference before it, session frequency has been neglected in a similar fashion overlooked by our institutionalization of it, and allowed to lie obscure and unnoticed as a tool of our analytic engagement. However with analytic frequencies established empirically[2] rather than by convention, might we not discover that we have at our disposal yet another essential and indispensable tool for working with a variety of transference states?

For Freud, the crucial distinction in what constitutes psychoanalysis lies in the therapist's assiduous attention to transference and resistance. Now we include countertransference as the third axis of focus. Our essential contribution to the change process lies in making ourselves available to our patients to work through their deepest conflicts and problems in vivo. It is intimate, and it is challenging for both persons. As Freud (1912a) sagely noted, "For when all is said and done, it is impossible to destroy anyone in absentia or in effigie" (p. 108). Bird (1972) described working in the transference as "the hardest part of analysis," for it is the medium through which we bring unconscious conflicts into the consultation room and through our empathic participation transform them into lived experiences with us.

Our willingness and skill at living into the transference (Carrere, 2008) makes a psychotherapy psychoanalysis. This is essentially the position that Gill (1979, 1988) reached in his consideration of the essential factor distinguishing psychoanalysis from psychoanalytic psychotherapy. The functioning of the therapist. The conversion of psychotherapy to psychoanalysis accrues through an *internal* shift in the analyst. "One simply set(s) to work in an analytic way (p. 271)," that is, the therapist analyzes the transference and facilitates the patient's clarity about the therapist's contribution to the transference. In this way psychoanalysis, for Gill, is the conduct of a unique process that occurs regardless of the external conditions of frequency and position, regardless of whether or not optimal conditions obtain, and irrespective of a particular end point (e.g., resolution of a regressive transference neurosis). He notes:

> Some patients may be so unwilling or unable to collaborate in the analysis of the transference for at least some periods of time that the analyst will do well to postpone transference interpretation, conceivably even interpretations of the patient's aversion to dealing with the transference. If the analyst is firm in his conviction about the importance of the transference and its interpretation in

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[2] Empirical in the original sense of the Greek *empeira* means experience, and this sense is retained today in the idea of empirical as guided by practical experience rather than theory. Within psychology the dominant natural scientific approach has narrowed our understanding of empirical to that which is observed and assessed through experimentation and quantitative methodologies. A humanistic scientific approach, however, retains that more inclusive sense of the empirical as experience and allows for both approach and research methodology that feature a disciplined consideration of subjectivity (Giorgi, 1970). I endorse quantitative research of psychoanalytic practice, for example, the quantitative assessment of the effect of various frequencies. My use of the term empirical might be idiosyncratic, yet I find that I have to think my own way into things in a manner that is psychoanalytically meaningful. My intention as far as I know, is not to stand in opposition to common usage but to revive our collective memory of where we might have lost something of significance (Carrere & Weiss, 1988; see also Zimiles, 2009). Psychoanalytic process and descriptive research share a sensibility of approach in that both seek fidelity to subjectivity as it is lived even though unconscious. The sort of practical assessments that psychoanalysts perform in their consultation rooms approximates more closely a humanistic scientific approach to the empirical than a natural science approach.

> the long run and works with that end in view the therapy in my formulation qualifies as psychoanalysis, not psychoanalytic psychotherapy (pp. 271–271).

Transference work demands that we bear all of our feelings complementary to the transference needs of our patients. Even the most experienced of us would flee if we allowed ourselves our raw feelings expressed without the benefit of reflection. But when functioning at our best, we subject our countertransference states to reflection, and through thoughtful identifications with one another, Freud, our basic sense of humanity, and many other figures conscious and unconscious, we remain in the room to *be* with our patients. What occurs next varies because we all have our preferences in theory and technique that will uniquely shape each analyst's psychoanalysis. But there is more than one way to conduct an effective psychoanalysis. Although we traverse different routes, we arrive at a similar outcome: the transformation of a raw emotional encounter into a human exchange structured through meaning and understanding. It is more important that we feel and bear the awareness of feelings for both persons until such time that the patient may do likewise in a mutual collaboration. But at the start of an analysis we may be working with someone who exhibits at best rudimentary cooperation (Spotnitz, 1969) and a minimal capacity for mutuality.

Clinical Varieties of Transference

I am thinking here, in particular, of those individuals who present with immature, highly defended egos, accompanied by primitive emotional states. These pathological ego capacities organize to a considerable extent around dissociation or evacuation of unconscious feelings, thoughts, and conflicts that threaten awareness, and what is passive and internal typically becomes enacted and interpersonal. The individual presents with a host of problems: a limited repertoire of defenses that are rigidly maintained; an ego weakened and depleted by an internal persecutory world—brutish, mean, and psychically ensconced; traumatic memories of parental impingements sometimes glossed over through idyllic dissociation of dysphoric affects; poorly established mentalized subjectivity; and the omnipotent projection of these pathological intrapersonal relationships onto one's interpersonal relationships.

These unbidden, unconscious aspects of self and their correlates are objectively induced in us by virtue of our empathic engagements, if we are available and have not emotionally abandoned the person. And here lies the rub. We are recruited to bear corresponding dysphoric self-states and possibly to enact with our patients those very painful situations they wish to avoid, flee, or dissociate. However, the degree of defense, resistance, and ego deficits are frequently not recognized from the start of an analysis only to emerge abruptly much later (Deutsch, 1942).

In these clinical moments, we meet an individual functioning with a pathologically compromised ego unconsciously defended against and resistant to both self-reflection and interpersonal contact. In short, the patient is not yet ready to use the analyst's mind fully or his own. It is these clinical varieties of transference needs that require analytic adaptation. When I say transference *needs* I am referring to the patient's need for us throughout the analysis to meet the development of one's mind and whatever limitations in talking and self-reflection that exist. As in the past when we debate the analyzability of certain individuals or character pathologies, we are asking the wrong question. Rather, the question is: am I willing to bear all the countertransference states that I am likely to have with a given individual. I may not have the emotional resources to treat each person who

comes for consultation, but one among us may very well have the necessary affective capacity, resilience, and sensitivity to do so. The question of analyzability rests with the countertransference capacities of the analyst in reaction to the patient's transference needs (Epstein, 1981; Fromm-Reichmann, 1950).

Analysis with such individuals approaches an optimal state if I can allow the person to have his or her own mind met by my adaptive functioning. By *adaptation* I have in mind what Winnicott (1955/1958) considers the primary analytic task with patients presenting a compromised ego structure: "we must allow the patient's past to *be* the present" (p. 297). Of course despite any good enough adaptations I may make, I can fail the patient in some manner, and it is these failures in adaptation that allows for the ego to mature through various expressions of aggression: dissatisfaction, disappointment, aggravation, irritation, upset, anger, spite, rage, withdrawal, retreat, and so forth. My effort, as for all of us, is to help the person remain in the analysis and put all these feelings into words instead of action.

When engaging such patients, we all experience the same clinical phenomenon. We all go through an expected range of emotional and interpersonal pressures whether we understand these mental states to be preoedipal conditions, paranoid-schizoid modes of functioning, narcissistic self-states exhibiting omnipotent strivings, mentalization capacities limited to an imposition of psychic equivalence upon reality, ruthlessness prior to the development of a capacity for concern, or other privileged formulations. In everyday life, people will react to such an individual with raw feelings including counter-exasperation, -anger, -frustration, -hatred, -rage, -fear, the whole gamut of feelings. No less so in the psychoanalytic relationship. The countertransference complements to these transference needs are typically dysphoric and accrue in what Epstein (1987, 1999) terms "bad analyst feelings."

Self-Reflection and Interpersonal Contact

The matter of contact frequency can be utilized analytically and empirically if we consider it another transference need that represents both a desire for and resistance to contact. It is another interpersonal dimension of the patient's unconscious. The intrapsychic is the private aspect of one's interpersonal functioning, and the interpersonal is the public aspect of one's capacity for reflection, how one has a mind and a character structure, how one organizes internal life and the development of a capacity for mentalization (Fonagy, Gurgely, Jurist, & Target, 2002), bears and enacts fantasies, in short, allows some thoughts and feelings into awareness and disallows others in defensively compromised way. The very character of one's capacity for experience, as well as one's defense and resistance against experience (the unconscious) will be expressed in the language of the body until such time as the analyst and patient learn to talk with one another. Then it will be expressed in the language of words, the first and most crucial step to intrapsychic and functional change.

In initiating a psychoanalysis at a reduced frequency I am interested in being of no more use to the patient than the patient consciously expects until such time as the defenses and resistances against contact and self-reflection are resolved and the patient can demonstrate greater interest in both the analyst's and one's own mind. I think of this approach as being unconscious near (Carrere, 2008), and I want to position my analytic mind just so at the edge of the patient's awareness and thus at the edge of the unconscious.