Therapists' Experience with Patients who are Reluctant to Increase the Frequency of their Weekly Psychotherapy Sessions

Terese G. Schulman

THERAPISTS' EXPERIENCE WITH PATIENTS WHO ARE RELUCTANT TO INCREASE THE FREQUENCY OF THEIR WEEKLY PSYCHOTHERAPY SESSIONS

A dissertation submitted to the
California Institute for Clinical Social Work
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
in Clinical Social Work

By

Terese G. Schulman

June 26, 1999

CALIFORNIA INSTITUTE FOR CLINICAL SOCIAL WORK

DISSERTATION APPROVAL PAGE

We hereby approve the dissertation

THERAPIST'S EXPERIENCE WITH PATIENTS WHO ARE RELUCTANT TO INCREASE THE FREQUENCY OF THEIR WEEKLY PSYCHOTHERAPY SESSIONS

By

Terese G. Schulman

Candidate for the degree of

Doctor of Philosophy in Clinical Social Work

Doctoral Committee

Sylvia Sussman, Ph.D.
Chairperson

Signature 6/24/99 Date

Samoan Barish, Ph.D.
Committee Member

Signature 6/24/99 Date

Zonya Johnson, Ph.D.
External Member

Signature 6/24/99 Date

ABSTRACT

THERAPISTS' EXPERIENCE WITH PATIENTS WHO ARE RELUCTANT TO INCREASE THE FREQUENCY OF THEIR WEEKLY PSYCHOTHERAPY SESSIONS

By

Terese G. Schulman

This qualitative study explored the experiences of psychotherapists who recommended increased frequency of sessions to patients who were reluctant to accept the recommendation. The study looked at how therapists decided to suggest increased session frequency, how they understood their patient's reluctance and how they worked with the patient.

The questions that the study addressed were: 1) What makes a therapist think that a particular patient might benefit from being seen in psychotherapy more that once per week? When do they ask the patient about making the change? 2) How do therapists understand what impedes a patient from increasing the frequency of their sessions and how do therapists work with that reluctance? Do therapists gain additional information about the patient's hesitation by examining their own emotional reactions to the patient?

Semi-structured interviews were conducted with nine purposefully selected, senior psychotherapists in private practice. Data from the interviews were content analyzed according to Glaser and Strauss' (1967) method of constant comparative analysis.

Results indicated that psychotherapists in this study felt that increased frequency could help patients become more engaged with themselves and in the therapy relationship. They often used cues of a subjective nature connected to the relational context to decide whether a patient seemed suitable for increased frequency. The client's needs as perceived by the therapist were seen as a priority, but were weighed with respect to various dimensions of client and therapist readiness.

The findings of this study suggest that experienced therapists pay as much attention to the subjective reactions that are evoked from their interaction with their reluctant patients, as they pay attention to isolated patient criteria.

ACKNOWLEDGEMENTS

I am enormously grateful to my committee chairman, Sylvia Sussman. Her faith in my ability to solve problems increased my confidence that I could arrive at creative solutions and have fun doing so. She was a superb teacher and her enthusiasm was a great inspiration.

I have been lucky to have Samoan Barish on my committee. It has been a treat to discuss clinical issues with her and weave them into the research context. I have always felt her support for my work and her belief in my ability to do clinically meaningful research.

Zonya Johnson, my external committee member, was a model of clear thinking. Her good sense and her great sense of humor helped me keep things in perspective.

I am very appreciative of the eight therapists who were generous with their time and were very responsive to my inquiry.

I am very grateful to my husband Saul for his unswerving faith in my ability. He was unfailingly enthusiastic about my topic, and was always ready to talk about the ideas I was exploring as well as to give me comfort during the inevitable low points in doing this work. In addition to his emotional support, he provided invaluable practical help in the form of references, library pick-up service, computer consultation, editing and childcare.

I am very grateful to my parents, Eli and Enid Galford, who have rooted for me all through the dissertation process. They instilled in me the value and pleasures to be found in education.

I also want to thank my son Max. His cheerful and loving personality have brought me tremendous pleasure and helped leaven the serious side of this work. Being his mother has also made me understand more fully how deep the connection between two people can be, a topic that is so much a part of the material discussed in this study.

TABLE OF CONTENTS

THERAPISTS' EXPERIENCE WITH PATIENTS WHO ARE RELUCTANT TO INCREASE THE FREQUENCY OF THEIR WEEKLY PSYCHOTHERAPY SESSIONS

CHAPTER ONE: INTRODUCTION

This study explored therapists' experience working with patients who are reluctant to shift from one time per week therapy to more frequent sessions. Therapists' decision-making process was addressed, as well as their perceptions of the nature of this reluctance and their modes of addressing it. Grounded theory, a qualitative research approach, was used to analyze the data.

Statement of the Problem and Background

There is consensus among psychoanalytic psychotherapists that in a well-conducted expressive therapy, more than once-weekly sessions contribute to the patient achieving the structural psychic modifications that are necessary for lasting change to occur. This consensus is based on a vast amount of clinical experience that is reported in the psychoanalytic literature, (such as Dewald, 1972; Menninger, 1958). However, some patients whom the therapist feels would benefit from more than once-weekly sessions are reluctant to increase their session frequency. This creates a dilemma for the therapist who, on the one hand, believes the likelihood of a good therapy outcome would be strengthened if frequency were increased. On the other hand, many therapists feel the patient's reluctance has important meaning and would not want their patient to simply comply, in spite of their hesitance, by meeting more frequently. Because there is so little written about helping reluctant patients make this shift, therapists are left with few guidelines as to how to handle this frequently complex process.

The patient's reluctance to increase session frequency is intimately connected to what precedes it - the therapist having arrived at the recommendation - and to what follows it - the way the therapist deals with the patient's refusal. What criteria do therapists use to decide a patient would do better at more than once-per-week? Are there

aspects of a patient, or of the interaction in the therapeutic couple, or the problem that brought the patient into therapy that result in the invitation? Do therapists assign meaning to their reactions about the patient that relates to themselves or to the therapy interaction? Does this affect the way they act toward the patient?

It is only in the literature that discusses the conversion of psychotherapy to psychoanalysis that technical aspects of working with the patient who is reluctant to come to therapy more frequently is addressed, (for example, Bassen, 1989; Bernstein, 1983; Skolnikoff, 1990). This literature discusses the anxieties that a patient may have about himself that he is reluctant to reveal, as well as the often interrelated anxieties that can be stirred up at the prospect of having a more intimate relationship with the therapist. Because conversion from psychotherapy to psychoanalysis was disapproved by psychoanalytic institutes until recently, issues involved with increasing frequency remain understudied. However, the conversion literature does not focus on the therapist's subjective experience in helping patients to understand their reluctance, which is the subject of the present research. Furthermore, the conversion literature concerns itself with the field of psychoanalysis, while my study focuses on the domain of psychotherapy. In the literature review (Chapter 2), I will examine the conversion literature where it is relevant to the therapist's process and technique when working with the problem of transition to greater frequency in psychotherapy.

The therapist's criteria for seeing patients more than once-weekly after treatment has already begun has not been researched. This lack of discussion about criteria is illustrated in the treatment planning literature. The general aim of this literature is to call attention to the need to plan carefully and individually for each patient's therapy. However, this literature ignores the therapist's experience when discussing the factors used by clinicians to choose the kind of treatment that is offered to the patient. Though there is some mention that the therapist's past clinical experience must necessarily be brought to bear on decisions about therapy (Perry, 1987), the overall tone of the literature moves away from an appreciation of the therapist's subjective experience. Even when clinical case studies are presented to exemplify the considerations regarding the form of treatment appropriate to a patient, the literature does not attend to the rich mix of feelings, attitudes, thoughts and theories that any one therapist might bring to thinking

about a particular patient. Nor does it address how the therapist's thinking is influenced by the interaction in the patient/therapist dyad. The therapist's internal process and the way it is influenced by the therapy interaction is the arena of my study.

Another gap in the clinical literature, with the exception of the conversion literature, is that it barely mentions frequency. Discussion of reluctance is absent. The large body of literature based on several national and international psychoanalytic conferences concerning the differences and similarities between psychoanalysis and psychoanalytic psychotherapy, (such as, Wallerstein, 1969; Rangell, 1954a) focuses primarily on differences in techniques, material elicited from the patient and expectable goals given appropriate patients. Textbooks covering the technique of psychotherapy make little mention of frequency (for example, Blanck and Blanck, 1974; Basch, 1988).

An assumption of this study is that more than once-weekly sessions are desirable when doing exploratory psychotherapy. More frequent sessions per week can provide the therapist and patient increased access to the internal experiences of the patient and the meaning of these experiences. Cohler and Gedo (1992) state that increased frequency produces "... a qualitative change in the data obtained and the way in which each participant-observer is able to use this material" (p.246). These authors point out that patients inevitably talk about external life events; in a more than once-weekly therapy there is more time to go beyond the life circumstances and to understand what repetitions are being enacted by the patient during these events. Increased sessions mean more time to become aware of repetitions in the therapeutic dyad and provide rich introspective opportunities for both parties that can be used to clarify the meanings of these repetitions. Whether thinking about external events or those in the hour, there is less pressure on the therapist to intervene prematurely.

The Study Question

This exploratory study of the experience senior therapists have working with patients whom they think would benefit from more than once-weekly sessions but who are reluctant to do so addresses a lacunae in the literature. The questions addressed in this study are 1. What makes a therapist think that a particular patient might benefit from being seen in psychotherapy more that once-per-week? When and how do they ask the

patient about making this change? 2. How do therapists understand what impedes a patient from increasing their weekly session frequency and how do therapists work with that reluctance? Do therapists gain additional information about the patient's hesitation by examining their own emotional reactions? The study includes instances of therapist-initiated recommendation of frequency change only and discussion of patients who are reluctant to accept the recommendation.

A number of recent articles (such as, Bassen, 1989; Bernstein, 1985; Stolorow, 1990) (reviewed in Chapter 2) provide case examples dealing with the increase of sessions through conversion of a psychotherapy to a psychoanalysis. My data provides an elaboration of therapists' thinking about their own process that is not available in the majority of the case studies already in the literature. I hope to provide other clinicians with information about the way the study participants think about themselves and their patients and what they actually do in the clinical hour. What do they notice in the process that made them think of increasing frequency? What does it mean to them to wish for more contact with the patient, and what meaning do they feel this wish might have for the patient? What role does the therapist's tact and timing have in issuing the invitation? When a patient refuses the recommendation, what personal and theoretical meaning do therapists assign to the patient's reluctance? What do they struggle with when working to understand their patient's reluctance?

In this study, the word "reluctance" is being used in preference to "resistance". "Resistance" is a technical term with a specific meaning in psychoanalytic theory. "Reluctance" has the advantage of being a colloquial term that, while perhaps sharing some of the meaning associated with resistance, remains open to the possibility of additional meanings.

For the purpose of this study, the "therapists" studied are those who are psychoanalytically-oriented. Having a similar theoretical background increases the likelihood that data useful to psychoanalytic clinicians will emerge. This homogenous group of therapists is of particular interest to me because my theoretical orientation is psychoanalytic. My bias is that individuals who share this orientation are more apt to be introspective in their efforts to understand how human beings develop and change.

However, there are many schools of thought in contemporary psychoanalysis. The participants in this study were not limited to any one school of thought for a couple of reasons. I believe few therapists practice using purely one model in psychoanalysis, so that it would be an unrealistic (and unsuccessful) categorizing. Further narrowing of the sample within psychoanalysis might limit the richness of the ideas and practices presented.

The "experienced" therapists in this study were therapists with at least ten years experience doing individual psychotherapy in a setting that allows open-ended therapies to be conducted. In addition, they should have at least five years of experience seeing patients on a more than once-weekly basis.

This study focuses on patients whom the therapist is seeing in a predominantly expressive or insight-oriented psychoanalytically-based psychotherapy. The two types of therapies, expressive and supportive, are conceptualized differently. Because therapies are never a pure example of either supportive or exploratory work, I specified that therapists speak with me about therapies that they feel are predominantly expressive ones.

A qualitative design was chosen as appropriate for the study of subjective experience. Semi-structured interviews were conducted with nine experienced, autonomously practicing therapists. Data from the interviews was analyzed according to Glaser and Strauss' (1967) method of constant comparative analysis.

Significance

Psychotherapy is an undertaking that asks a lot of each participant. The patient comes for help with problems that have caused much pain in his life and yet have not given way to logic or conscious efforts at change. Major needs have not been met; powerful unconscious forces are in conflict and need to be accessed. Therapists must work hard to remain in touch with themselves and their own reactions as part of their effort to help the patient. The psychoanalytic literature supports the idea that frequency, while not a sufficient factor in the success or failure of a therapy, can play an important role by providing time for the necessary elements of a successful therapy to grow and take root. Studying the problem of patients' hesitance to increase their session frequency

can shed light on how therapists can help patients make this transition. It addresses an aspect of making certain therapies more successful.

The results of the study can provide avenues for further research as well as provide information about this understudied issue for graduate and professional training and clinical supervision.

CHAPTER 2: LITERATURE REVIEW

In this chapter I will review literature on session frequency, the criteria therapists' use to invite patients to increase their session frequency, relevant aspects of the conversion of psychotherapy to psychoanalysis literature and the role fees play in increased frequency and reluctance.

There is a limited amount written on the subject of session frequency and even less on client's reluctance; the present research will attempt to add to that literature. There is no literature specifically detailing criteria for seeing patients more frequently; however, the expressive psychotherapy literature contains discussion of the kinds of patients and goals appropriate for this type of therapy. Since frequency is given value in expressive therapy, this literature is relevant to the subject of criteria and will be reviewed.

Aspects of the literature on conversion of psychotherapy to psychoanalysis that relate to the reluctance of psychotherapy patients to increase session frequency will be discussed. The results of the present study may inform the conversion literature. Finally, the issue of fees will be considered in light of the literature on money in psychotherapy.

Frequency

The psychoanalytic literature concurs with the assumption of the present research that in predominantly expressive psychotherapies more than once-weekly sessions can be a factor in enabling the patient to make more of the long lasting personality changes they need in order to enrich their lives.

However, there is little mention of frequency in textbooks on psychotherapy technique and no discussion of patient's reluctance to increase sessions. The following references, taken out of psychotherapy textbooks, and which represent the only mention of session frequency in each book, illustrate this scarcity: "My clinical experience has been that the optimal beginning frequency of intensive psychotherapy sessions is twice per week, though some patients require three times a week. ... the major factor in this decision should not be the economics but the anxiety level of the patient" (Chessick, 1974, p. 116). Paolini (1981) mentions frequency of sessions only in the context of

reminding the reader that techniques don't make a treatment psychoanalytic; rather, it is the goals of the therapy that emerge out of the understanding of psychic functioning that define the treatment. Reid (1980) concedes that some insight-oriented therapy can be conducted on a once-weekly basis, but believes that to maintain the momentum, and fully develop the therapeutic alliance, sessions twice per week or more is best.

Cohler and Gedo (1992) discuss frequency more fully, although there is no discussion about reluctance. They point out that there is a current emphasis on the importance of understanding the patient's pre-oedipal experience. Getting to this pre-oedipal material requires a "holding environment" that feels secure to both parties and can be related to frequency of sessions. Moreover, given the difficulty of getting to this more archaic material, the frequency of sessions may be crucial. In addition, it is increasingly felt that patients, even those considered classically analyzable, have focal needs for an empathic partner which "reflects expectable developmental vicissitudes" (p.247) and that frequency of meeting may be a critical factor in developing this kind of partnership. These points represent an argument for increased frequency of sessions based upon the belief that it will lead to deeper, longer lasting change, with all the implications that holds for a better life for the patient.

Oremland (1991) supports frequency in expressive therapy as an important factor when he states that the shift from once to twice-weekly sessions is larger than that between any other incremental increase. He characterizes this shift as one that allows the patient to begin a process of introspection as opposed to the process in a once-weekly therapy which is often "...a request to bear witness to or to correct the events of his or her life..." (p.115). In Oremland's (personal communication) opinion, once-weekly therapy often becomes interactive in spite of the orientation of the therapist or the interventions that are offered. This he ascribes to a covert message, "Tell me what happened", that he feels is communicated to the patient in once-weekly therapy. He contrasts this to the covert message communicated in twice weekly therapy: "Let's look beyond what has happened."

Because of the many difficulties in doing outcome research, there is little reliable data delineating the factors that predict successful outcomes between different kinds of dynamic therapies (Perry et al, 1983). When they do mention frequency in exploratory

therapy, these authors, as does much of the treatment planning literature, resort to loose rules of thumb based upon the opinions found in the psychoanalytic literature. An example from the treatment planning literature follows:

> The large commitment of time is necessary for the patient to develop a deeply emotional relationship with the therapist and to recall and re-experience in regard to him [or her] the repressed wishes, fears, fantasies, attitudes, and conflicts that originated in childhood and that continue to influence current behavior. ... Sessions must be relatively frequent to allow for transference regression and so that a "crust" of resistance and forgetting does not again settle over the recalled, anxiety-laden material.... In general, the more ambitious and global the treatment goals, the more the duration and frequency are increased (Frances, Clarkin, and Perry, 1984, p.161).

Luborsky (1988), an authority on research into psychotherapy outcomes, discusses the dearth of empirical research on how frequency of sessions affects the outcome of the psychotherapy. He lists six studies that look at the number of sessions and outcomes. Luborsky states that the results of these studies are inconclusive as to the value of frequent sessions, due to the many problems in setting up good outcome studies in psychotherapy. Garfield and Bergin (1986) cite eighteen findings from eleven studies that show no significant difference in outcome when session frequency is varied. It is not clear how many of these studies involved psychoanalytic psychotherapy, the focus of this study. The populations of these studies ranged from neurotic adults to schizophrenic children. Great variation could also be found in the number and length of sessions compared in the studies, with the range spanning once versus twice weekly sessions and five minute sessions five times per week versus one twenty-five minute session. Given the inconclusive findings and the difficulties of using the extant empirical research model to look at this subject, Garfield and Bergin caution about the difficulty of testing variation in session frequency because all aspects of scheduling, i.e. frequency, length of session, number of sessions and calendar length of treatment cannot all be controlled simultaneously. The assumption that frequency is useful remains a qualitative clinical observation by experienced clinicians.

Criteria Therapists Use to Decide Increased Frequency Would Be Beneficial

In general, there is little in the literature about criteria therapists use to assess whether or not a patient might benefit from increasing their weekly session frequency. Wolberg (1988) lists reasons for increasing the number of sessions which apply to expressive therapy, such as the wish on the therapist's part to stimulate the development of the transference, or to work more intensely with severe resistance. Other reasons he cites for increasing session frequency, such as the threat of the ego shattering if support isn't given, don't usually apply to the situation in which a therapist is thinking about increasing the number of sessions per week in an expressive therapy (p.1301).

In the expressive psychotherapy literature, discussions are found regarding the kinds of patient characteristics and circumstances that through clinical experience seem most often to be linked with successful clinical outcomes. This literature, and the value frequency is given in the wider psychoanalytic literature, forms the context in which many psychoanalytic therapists have been trained to evaluate whether or not a particular patient might benefit from a more than once-weekly psychotherapy.

Traditionally, expressive therapy is thought to be closer to psychoanalysis than supportive therapy in the kinds of techniques used and the goals that might be attained. Character changes are felt to result from the resolution of conflict, the growth of previously non-existent or underdeveloped capacities, and new or modified ways of using defenses. The patient develops, to whatever degree possible for him/her, a greater ability to be effective in the external environment through having greater internal freedom to choose how to behave. Interpretation, especially of the transference relationship, was traditionally thought to be the major technique through which change occurs (Bibring, 1954; Malan, 1979; Greenson, 1967). While the therapeutic action of interpretation is still felt to be important, there is question about its centrality in all cases as an agent of change (Wallerstein, 1989) as well as disparate views about what it is in the interpretative process that allows change to take place (Mitchell, 1988).

Factors thought to enable a patient to use expressive therapy include: a capacity for self-object differentiation and reality testing, tolerance for anxiety and depression, impulse control, capacity for introspection, intelligence and ability to abstract, ability to form emotionally meaningful and reciprocal relationships, capacity to tolerate therapeutic

regression and to use it by experiencing and observing oneself, internal object constancy, evidence of successful social, vocational and leisure time functioning, ability to communicate through speech, and having current and prospective life situations that provides for the possibilities for change (Perry et al, 1983). This is a formidable list of capacities. Patients may possess only some of them without it excluding them as a candidate for a predominantly expressive therapy. It is part of the art of psychotherapy for the therapist to discover what assets a patient has that might enable them to use a predominantly expressive therapy even when many of the capacities cited are poorly developed.

Conversion of Psychotherapy to Psychoanalysis

The conversion literature has appeared in the last decade and was written in order to address the question of whether or not a patient's therapy can be converted to psychoanalysis with the same therapist. In the past, the practice of an analyst seeing a patient in psychoanalysis that had begun as psychotherapy was frowned upon. It was believed that in doing psychotherapy the transference relationship was contaminated to such a degree that a full transference neurosis, felt to be a necessary condition for a successful analysis, could not develop. This cautious approach was begun in Freud's day (Freud, 1913) and continued until recently (Malin, 1990; Pigman III, 1990). The development of psychoanalytic psychotherapy which was not available in Freud's day (Horwitz, 1990), the questioning of the conclusion that the transference relationship in psychotherapy is always contaminated, brought on by the debate about the similarities and differences between psychoanalytic psychotherapy and psychoanalysis (Wallerstein, 1969, Alexander, 1954; Rangell, 1954a) and the recent lack of patients applying for psychoanalysis brought about a change in attitude about this practice. Psychoanalytic institutes no longer categorically bar candidates from converting psychotherapies to analysis (Pigman III, 1990). In addition, there is a general agreement that a broader spectrum of patients (pre-oedipal) is analyzable. These patients sometimes benefit from a period of psychotherapy that helps build certain capacities that will permit them to enter a formal analysis. There are many good reasons why people begin psychotherapy and then

shift to psychoanalysis; they benefit both from the treatment and from being able to continue with the same therapist.

The conversion literature addresses several issues relevant to the present study. Of importance is the therapist's part in the invitation to enter analysis and thus increase session frequency. The nature of the therapist's motivation in issuing such an invitation is discussed in six of the thirteen conversion articles (Bassen 1989, Skolnikoff 1990, Bernstein 1983, Bernstein 1985, Stolorow 1990, and Joseph 1990). The writers emphasize how powerfully the therapist's motivations can operate in the treatment and how powerfully the patient can influence them. Bernstein (1990) discusses the ambivalence a therapist may feel about making the recommendation for analysis; he cites the example of a therapist with an unconscious fear that he needs his patient too much. The therapist, caught in his own unconscious conflict, may not offer follow-up interpretations of the way in which he understands the patient's resistance to mirror the conflicts the patient may have outside of therapy.

Oremland (personal communication) stated that one reason that there is so little written about frequency in the psychotherapy literature is that there is often hesitance both to ask patients to come more frequently and to explore their reluctance. He believes that the therapist may fear angering and then losing the patient. Therapists who have had poor training or a poor experience in a personal therapy may also be ambivalent about what they, or therapy in general, can offer and so hesitate to recommend more.

Skolnikoff (1990) suggests that the recommendation for analysis might be motivated by the analyst's own wish to control or redress intense feelings within himself [the analyst] that he/she may be reluctant to experience:

> We should remember that when we say we can't analyze something in a patient, we are simultaneously speaking about our own incapacity as well as the patient's. That incapacity is often in the direction of a fantasy that might occur in the analyst, one that might arouse too much anxiety (p. 115).

He also suggests that therapists are often struggling with grandiose fantasies about what can be accomplished and suggests that this might account for the length of many analyses. On the other hand, he points out, it may be the patient's fears or grandiose fantasies that are influencing the therapist in ways that are not initially clear to the

therapist. Bernstein (1985) also discusses the therapist's acting on countertransference feelings. He gives examples of the invitation to enter analysis as being aimed at undoing feelings of impotence or incompetence in the analyst that the patient is inducing.

Bassen (1989) states that the recommendation of psychoanalysis to a psychotherapy patient has received little scrutiny aside from the acknowledgement that such a recommendation will have transference meaning to the patient that needs to be analyzed. Its meaning to the analyst is her concern:

> Viewing a recommendation for analysis made in the course of psychotherapy however, omits the therapist's responsiveness to the patient's attempts at actualizing transference wishes -- as if the therapist came to the recommendation independently of the interaction with the patient, as he does in deciding on when to take a vacation. Yet, clearly this is not the case (p. 87).

Bassen tells us that her invitation to two of her patients to enter analysis was an enactment of each patient's inability to take the initiative in their treatment as well as in their lives.

These articles contain very useful discussions of countertransference. In addition, authors often mention factors that led them to think about analysis for a particular patient that they discuss. However, it is only in Bassen's (1989) article that a detailed discussion of her subjective experience leading up to her invitation and the subsequent work with her patients can be found. This gap in the conversion literature and as it relates to psychotherapy will be addressed by the present research.

The present study addresses the question of how therapists understand their patient's reluctance and how, given the reluctance, they deal with their patients. While this study is not concerned with analysis per se, it does concern the deepening of the work in psychotherapy, and these authors do suggest a general list of reasons for a patient's reluctance as well as the outline for a useful therapeutic stance.

Bernstein (1990) states that the recommendation for analysis provokes pre-existing conflicts related to a "...loss of control, isolation, deprivation or object loss..." (page 22). Other repetitive conflicts that may be aroused are those regarding commitments, fears of intimacy, sexual and aggressive impulses. Beginning with a less intense therapy can provide a setting in which fears about dependency or being overwhelmed by anxiety can be ameliorated.

Bernstein (1983), Stolorow (1990), and Skolnikoff (1990) remind the reader that the therapist must keep in touch with their own motives for making the recommendation to increase frequency. Therapists need to remain alert to the possibility that the patient is merely complying with their recommendation. They also need to be open to the possibility that that in some cases the increased frequency is truly not in the patient's best interest.

The overwhelming majority of writers on the subject advocate beginning therapy at a reduced frequency with a reluctant patient and working to understand the hesitance instead of insisting on analysis or referring the patient to someone else. Not only does this work allow patient and therapist the time to clarify and help understand some of the fears that make analysis untenable initially, but it can serve several other purposes as well. An initial psychotherapy can help a patient build the structure and gain the capacities, such as curiosity and the ability for self-observation that are needed in an analysis. Psychotherapy can help the patient develop trust in the therapist (Levine, 1985). The patient may receive help with external stressors that seem so overwhelming that the patient is hard pressed to do much introspection. More distance and a sense of control can be established over these situations. Finally, this work may provide the patient with a new perspective on what he/she thought were only external stressors (Bernstein, 1985).

The conversion literature does address issues that might be expected in a discussion about increasing a psychotherapy from once-per-week, such as how therapists understand patient reluctance and the importance of countertransference issues surrounding the wish to see a patient more frequently. Most of the articles contain a clinical example. However, with the exception of the Bassen (1989) article, the conversion literature does not speak to the subjective experience of the therapist in making the decision about who might benefit from increased sessions. In addition, what the therapist actually does in the office is often not clear.

Conclusions are arrived at in a way that is also not clearly spelled out. For instance, suitability for analysis of the patient or patients being discussed (in the articles here reviewed) is treated as a foregone conclusion. Bernstein (1983) states that the patients he is describing are,

> "... by all criteria analyzable, and the preparatory treatment serves not to "build ego" but to explore resistances, thereby allowing for their attenuation and enabling the treatment to progress to psychoanalysis. ...I shall focus specifically on a group of patients for whom such resistances are less concealed by reality factors, lack of a psychoanalytic context, acute problems, or lack of acknowledgement of the life restrictions caused by their psychopathology. Instead, these patients' resistances are related to the meaning of analysis as it represents the facilitator of a feared regression and the rekindling and reactivation of warded-off libidinal and aggressive impulses and wishes, which are experienced as more controllable in psychotherapy" (pp.365-6).

As helpful as it is to have the author define his population, no detail is given that allows the reader to understand how conclusions about the nature of the resistance are arrived at for this group of patients.

Fees

Patients often cite lack of money as the reason for refusing to increase the frequency of their sessions. Money is acknowledged to be a strong carrier of metaphorical meaning; "...only food and sex are its close competitors as common carriers of such strong and diverse feelings, significance, and strivings" (Krueger, 1986, p.3). Because this is true, inquiries into a patient's relationship with money can be a valuable part of any therapy; it is certainly so if increased frequency is being considered and money is cited as an obstacle. More frequent sessions are economically impossible for some patients if the therapist cannot afford to lower their fee. If a therapist too readily interprets the patient's citing inadequate finances as a signal of the patient's lack of readiness to consider more frequent sessions, it does a disservice to the patient and to the therapy. However, it is also important for the therapist to feel able to explore the issue as thoroughly as one might do with any reason given for declining the option of coming more frequently. There appear to be two groups of patients with whom the symbolic meaning of "not being able to afford" more frequent sessions is worth exploring: those who have the ability to pay for more sessions, but seem reluctant, and those whose ability to afford more frequent sessions is unclear.

Freud counseled analysts to be direct and frank with patients about money matters. He stated: "Money questions will be treated by cultured people in the same

manner as sexual matters, with the same inconsistency, prudishness, and hypocrisy" (Freud, 1913, p.351). Within a two-person psychology, the therapist's relationship with money, as well as the patient's, must be the focus of examination. The more alert a therapist is to personal character traits and reactions to the patient and how these are experienced and *enacted* in the dyad, the less risk there is of either overly influencing the patient with the analyst's own psychology, or repeating, without resolving, the patient's old and internalized interactional patterns (Aron and Hirsch, 1992).

Aron and Hirsch discuss therapists' discomfort with the many meanings money might have to them, but particularly emphasize the therapist's wish to avoid exposing their own greed and/or dependence on the patient. Therapists can act in order to avoid conflicted wishes for more money by not even discussing their idea that increased sessions would be beneficial. They may fear angering and then losing the patient and so never make the recommendation. Alternatively, they may press the patient to increase session frequency because of their wish for increased income. Not acknowledging their own greed and/or dependence can result in transference allusions that are not explored to clarify what the patient is noticing about the therapist and how real or distorted the patient's interpretations about the therapist are. A patient's reluctance to increase session frequency may be a way of flagging their concern about the therapist's greed or dependency.

All of the articles in this review represent a strong beginning for the present study which will collect more experiences of therapists doing expressive psychotherapy in order to continue to study the full range of issues involved in this important process.

CHAPTER 3: METHODS AND PROCEDURES

Design

The questions addressed by this study are 1. What makes a therapist think that a particular patient might benefit from being seen in psychotherapy more than once-per-week? When and how do they ask the patient about making this change? 2. How do therapists understand what impedes a patient from increasing their weekly session frequency and how do therapists work with that reluctance? Do therapists gain additional information about the patient's hesitation by examining their own emotional reactions to the patient's reluctance?

As the goal of the study is to develop new hypotheses rather than to confirm or test pre-existing ideas, a qualitative research design was considered most appropriate to explore therapists' subjective experiences. The Grounded Theory Method developed by Glaser and Strauss (1967) was used to analyze the data. In this approach, theory is developed from patterns of relationships that emerge directly from the data. I began with knowledge gained from my own clinical experience and the literature, but remained open to the data, which in this study was from semi-structured interviews. Pre-structured categories were not imposed either in the data gathering or analysis phase. This qualitative approach allowed for the collection of data from a group of articulate therapists that would best help me capture their "... depth of emotion, the ways they have organized their world, their thoughts about what is happening, their experiences, and their basic perceptions." (Patton, 1990, p.24)

Using the "constant comparative method" (Glaser and Strauss, 1967; Strauss and Corbin, 1990) data collection and analysis were conducted in tandem, each interview being informed by an understanding of the previous interviews. It is of primary importance to analyze each participant's experience, building the findings from each into an integrated whole. The method allowed me to compare incidents and concepts across the experiences that each of the participants report.

The constant comparative method is particularly well suited to projects in the social and behavioral sciences which have to do with how people perceive themselves and others, and how they process and give meaning to what they have experienced

(Mischler, 1986). The constant comparative method is also well suited for study of an area about which little has been written. Using this method, the researcher can generate "...categories, dimensions and interrelationships..." from which a picture of the complexities of the phenomenon can be described (Patton, 1990, p.40).

Reliability and Validity

In quantitative research, reliability is demonstrated when the findings are replicable. In qualitative research, where an interviewing method that does not rely on standardized questions is used, these criteria are not applicable. Reliability in qualitative research refers to the trustworthiness of the data rather than the replicability of observations. It is assumed that a participant will, after understanding the purpose of the study and its confidential nature, be an accurate and trustworthy source of information about their personal and professional experiences in the arena into which the study is inquiring.

Traditional quantitative research has used a definition of validity that is not applicable to qualitative research. In quantitative research, an attempt is made to find a cause and effect mechanism by the manipulation and control of variables. Initially qualitative research designs were criticized because their methods did not match the standards of quantitative research. However, different ways of thinking about validity have become more widely accepted as the inadequacy of strictly defined quantitative methodological solutions and hypothesis testing has been more widely recognized. Witness the fact that much psychotherapy research is never applied. Mischler, in a discussion of internal validity, quotes Campbell's reference to validity as "the best available approximation to the truth or falsity of propositions, including propositions about cause... we should always use the modifier "approximately" when referring to validity, since one can never know what is true" (Mischler, (1986) p.111-112; Cook and Campbell, (1979) p.37). An alternative to "ultimate truth" is that the plausibility of the interpretation and how it compares to alternative interpretations becomes a criterion for validity. Thus, a research conclusion becomes more valid when it withstands the competition from plausible alternatives.

In the present study, the therapists were interviewed once and it was assumed that each accurately reported their experience given the assurance of confidentiality. Interviews between the participant and me were tape recorded and accurately transcribed. My analytic steps are carefully laid out in the description of the findings; data excerpts illustrate descriptive categories. The interpretation of data refers to these descriptions such that the plausibility of my argument may be scrutinized. Mischler argues for a constant sifting and comparing of interpretations on research done in specific areas (Mischler, 1986, p.115). Use of the constant comparative method stresses the careful consideration of each participant's responses. Validity is sought through the cross-comparing of the participant's responses. Patton (1990) indicates his belief that the interview process has within it the possibility of both discovery and confirmation. Ultimately the best measure of validity is the skill of the analyst to represent the data fairly and to come up with the most plausible explanations possible given the patterns and their variations that emerge.

Participants

Nature of the Sample

The sample of therapists used in this study will be purposeful rather than random. In purposeful sampling, the participants are chosen for their ability to provide information-rich data so that an in-depth study of the phenomena can be made. The researcher is not concerned with generalizing to the population of therapists as a whole. Rather the purpose of this study is to learn more about the experiences of therapists who are dealing with patients' reluctance in order to shed as much light as possible on the subject under investigation (Patton, 1990).

The participants for this study were an "exemplar" sample of experienced therapists who use psychoanalytic theory in their clinical work, and in addition, have substantial experience working with patients around the issue of increasing session frequency. These criteria were used to insure that the participating therapists were experienced in working with the clinical problem about which this study proposes to gain more information. For the purposes of this study, I sought participants who focus on therapies that are predominantly expressive because of my interest in the analysis of the

transference/countertransference. Specifically, eight experienced psychotherapists who are psychoanalytically-oriented were interviewed for this study. This number of therapists was used because according to Renie, Phillips and Quartaro, (1988) saturation of categories usually occurs somewhere between five and ten participants.

The "experienced" therapists in this study are therapists with at least ten years experience doing individual psychotherapy in a setting that allows open-ended therapies to be conducted. Therapists of both genders and whose professional disciplines vary were the study participants.

The original criteria for the percentage of patients presently being seen more than once-per-week had been set at thirty percent. The practice of four of the therapists was made up of over thirty percent of patients being seen more than once-per-week; the range was from thirty-eight to fifty-nine percent. The range in the other four therapists' practice was fifteen to twenty percent.

I decided to include the four therapists whose practices did not meet the thirty-percent mark because all of the therapists in this second group were much more experienced in the area this study explored than had been originally required. I decided that their overall experience rose to the level required to act as informants who could provide rich description of their experiences with patients reluctant to shift to more frequent sessions. This rationale also applied to my decision to include the one therapist in the group who had not been in a personal therapy of more than once-per-week.

Because this is a study of how therapists deal with the reluctant patient, the researcher also asked that each therapist have substantial experience working with once-weekly therapy patients around the issue of increasing the frequency of their sessions. "Substantial experience" in this study meant asking at least two to three patients a year about increasing the frequency of their weekly therapy sessions.

Recruitment

The participants were selected from a pool of therapists that I contacted through my own network or on the recommendation of colleagues. A letter (see Appendix A) describing the general purpose of the study, the time required to complete the study and the interview method the researcher was using was sent to prospective participants. If

interested in participating in this study, therapists were then be asked to complete a brief questionnaire (Appendix B) to ascertain that they were qualified to participate in the study. In addition, a copy of the informed consent statement (Appendix C) was enclosed with the questionnaire for the potential participant to review so that they were informed about the study procedures. They were asked to indicate on the questionnaire whether or not they would be willing to sign the consent statement at the time of the interview.

A self-addressed stamped envelope was provided to return the questionnaire to me. After I received the questionnaire, prospective candidates were contacted to clarify any information on their forms that was unclear. The participant was also asked if they would be willing to be recontacted by me by telephone after the interview to clarify material from the interview if necessary. An interview was then scheduled.

Data Collection: The Interview

Data was collected from the participating psychotherapists by means of a face-to-face semi-structured interview that was audio-taped. These interviews lasted for about fifty minutes. The interviews were carried out in a setting that provided the assurance of confidentiality and no distractions.

An open-ended approach was used in order to discover new phenomena by giving each psychotherapist the maximum range in which to respond. The rationale for choosing this interview format was that in trying to gather information about this under-researched subject area, I wanted to cast my net as widely as possible. This method provides a framework in which each participant can speak freely using their own terms to express their point of view. Establishing an open dialogue would not be possible if a survey or questionnaire was used.

The data consisted of the spontaneous narrative descriptions of the psychotherapist/participants' experiences as well as their responses to open ended questions. My goal was to elicit a narrative from the therapists about their internal processes and what occurs between themselves and their patients, so the interview guide avoided questions that imposed my ideas on them. Mischler (1986) supports the view that narratives are "...one of the natural cognitive and linguistic forms through which individuals attempt to order, organize, and express meaning" (p.106).

My role in these interviews was as a participant observer. This means that I took an active part in forming the discourse between herself and the person interviewed. Mischler (1986) is critical of efforts to standardize questions and interviewer behavior because, he argues, these attempts are made under the false assumption that then each interviewee is receiving the same stimuli and thus responses can be more objectively coded and statistically analyzed. He gives convincing arguments that this is not the case. Mischler describes the form of interview to be conducted in this study as an interactional event, the structure and meaning of which is jointly constructed by the interviewer and interviewee. This is analogous to the trend in psychoanalysis from a "one person" to a "two person" psychology; in a two person psychology, each person in the therapy dyad is seen to influence and be influenced by the other. The interactive nature of the interview allowed me to question and draw out the participant's answers further in order to discover their point of view. Patton states, "Qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable, and able to be made explicit (p.278)".

The Interview Guide

The interview guide (Appendix D) is made up of Topic areas and open-ended probe questions that served as a reminder to me so that each interview could cover the same basic subject areas. Though I had a list of questions, they were not asked in any particular order, and sometimes were not asked at all. The participant's responses served as a starting point for a discourse in which I felt free to pursue relevant themes or points expressed in the respondents' narrative.

At the beginning of each interview, I provided an explanation of the purpose of the study, (see Appendix D) as well as an assurance to the participants that their anonymity and the confidentiality of the material given would be maintained. It was explained to each participant that the tape recording of their voice would be destroyed after the data analysis was completed. Identifying information about them in the verbatim transcripts would be deleted.

After the introduction, the initial open-ended question was posed to get the dialogue started. The questions of the interview guide were derived from my experience

in this area as well as her review of the literature. As subsequent interviews were done, the questions changed as a result of my use of the method of constant comparison in which new material may be explored in subsequent interviews. In summary, the emphasis was on covering similar ground with each therapist but doing it in such a way that allowed for maximum spontaneity and breadth for the participant and for follow-up by me. The goal was to achieve as clear a representation of the therapists' perspective on themselves and their patients as possible.

Interview Guide Topics

The following topics were used to guide the interview, discussion and elaboration process:

I. Indications the Therapist Uses for Considering Increasing Session Frequency

This topic begins the discussion about the choice of frequency for particular patients. I was interested in what the therapists notice about their inner processes, the qualities about the patient and their interactions with a patient that leads them to think an increase in frequency would be advisable. There is literature that suggests a variety of personality and diagnostic factors have been used to infer a patient could benefit from expressive therapy at a greater frequency than once-per-week (Perry et al, 1983; Oremland, 1991; Gill, 1988; Bassen, 1989; Skolnikoff, 1990; Lichtenberg and Levi, 1990). I also wanted to discover whether these therapists thought about the meaning of their wish for increased frequency as being connected to, or induced by the patient's dynamics. Bassen (1989) and Skolnikoff (1990) have suggested that therapists may be responding to a patient's attempt to actualize a transference wish. The therapist was asked to address these issues by talking about a specific patient focusing on her reactions, impressions and feelings prior to making the invitation.

II. Inviting the Patient to Increase the Frequency of Sessions

In this topic, I was interested in how the therapist translates her impressions about a beneficial increase in frequency into addressing the patient about the issue. I was interested in what conflicts a therapist might experience about inviting the patient to increase frequency. Hesitation to recommend increased frequency is mentioned in the literature in two ways: as a strategy recognizing the disruptive influence a premature

invitation could have (Lichtenberg and Levi, 1990), and as a product of the countertransference (Bernstein, 1990). Specific examples from the therapist's work were sought in order to elicit memories that were more vivid.

III. Internal Processes the Therapist Uses to Understand the Patient's Reluctance

In this section, I wanted to explore the therapist's reactions to a patient expressing reluctance after an explicit invitation to increase the frequency of sessions had been made. There is literature to suggest that a patient's reluctance is based on fears about what increased frequency represents. (Rothstein, 1995; Bassen, 1989; Levine, 1985; Bernstein, 1983). I was interested in knowing what considerations the therapists uses about him or herself, the patient and the preceding work to help understand the patient's reluctance. In addition, I was interested in knowing if further discussion about frequency takes place after the refusal. If so, what is it about the patient's manner or what is said that therapists use to help them gain further understanding about the reluctance and the meaning of the invitation to the patient? Hesitation on the therapist's part to follow-up with discussion after a referral has been connected to a countertransference inhibition (Bernstein, 1990). Again, a more detailed view about the way the therapist thinks was sought.

IV. The Therapist's Personal Feelings

This topic covers how a therapist's personal sensitivities affect the way they intervene with a reluctant patient. This topic overlaps with discussion about the therapist's responsiveness to patient wishes, but I believed there was an advantage to conceptualizing it separately. Discussion of the therapist's personal vulnerability in regard to a particular patient's reluctance was requested.

V. Working with the Reluctant Patient

Here I was interested in whether the therapist's experiences dealing with reluctant patients had evolved into a general method of intervention with a patient regarding increased frequency. If it had, then the nature of those experiences that led to the adoption of that method was discussed. I was also interested in knowing what remains difficult for these therapists either in recommending increased frequency and/or in working with their reluctant patients. Individual examples in regard to specific patients were sought in order to obtain the best descriptions possible. The literature offers many examples of therapists who suggest agreeing to work with the patient at the original

frequency, but who also request that trying to understand the patient's reluctance become part of the work in therapy (Rothstein, 1995; Levine, 1985; Bernstein, 1990).

VI. Closure

I was interested in how the therapists experienced telling me about their clinical experiences. I assumed that unresolved questions, new perspectives or some integration of ideas would emerge as a result of the interview.

Data Analysis

The constant comparative method of data analysis was used to analyze the content of the interviews (Glaser & Strauss, 1967; Strauss & Corbin, 1990). This method is a process of data analysis in which theory is first generated inductively and then refined through interplay of inductive and deductive thinking. The theory that is developed should be consistent, plausible and close to the data.

The data analysis took place in two phases. Each interview was analyzed for content. The analysis consisted of first dividing the narrative data into the topic areas, assigning the data meanings that expressed as psychological and phenomenological concepts and then weaving these concepts together into a general description or summary of the participant's experience. Secondly, data which resulted from the analysis of each individual interview was compared and contrasted across interviews in order to examine common patterns and variations in the responses among all of the subjects (Strauss & Corbin, 1990).

Procedure for the Data Analysis

The topics of the Interview Guide (Appendix D) were used to begin collection of data. As each interview was completed, it was transcribed, summarized and emergent themes and concepts were noted. This summary material from each interview was reviewed prior to subsequent interviews. This enabled me to stay in touch with the data and provide continuity between interviews. The Interview Guide (Appendix D) was revised to incorporate new ideas and concepts that were not immediately apparent.

Conceptualization was based on the topic areas of the Interview Guide and from the meaning of categories which emerged from the interview through a process of "open

coding" (Patton, 1990; Glaser & Strauss, 1967). Comparison of data from different therapists underscored similarities and differences in their experience and in this way new categories were formed or redefined. Returning to the data tested initial categories. The comparative process, with its search for common features and variations was key. Categories were collapsed, expanded and revised in a process that moved back and forth between categories and the data (Glaser & Strauss, 1967; Strauss & Corbin, 1990).

New data was collected until categories become saturated, i.e., no new information was found in the incidents that were coded. Then the relationship among the categories was defined; the major thematic categories, sub-categories and their properties were drawn and the criteria for classification were detailed. Variations were noted as variant themes or as dimensions of a category or its properties (axial coding, Strauss and Corbin, 1990). The individual interviews were reviewed in terms of the categories that evolved through this constant comparative process. In this way, the fit of the categories to the data was reassessed and could be revised (Glaser & Strauss, 1967; Strauss & Corbin, 1990).

Presentation of the Data

First, a descriptive summary of the characteristics of the group of psychotherapists will be presented. Precautions were used to protect their anonymity. Then the common thematic categories and sub-categories will be discussed, using illustrative excerpts from the interviews. Individual variations will be addressed. In the final chapter, theory will be developed through establishing the nature of the relationships among the primary thematic categories developed from the comparative process ("selective coding", Strauss and Corbin, 1990). The hypotheses formed will address the study questions. The research study's significance for clinical practice, clinical research and training will be discussed. Limitations of this study will be addressed.

CHAPTER 4: RESULTS

This study explored the experiences psychotherapists have when working with patients who are reluctant to increase the frequency of their therapy sessions to more than once-per-week. The experiences that the psychotherapists related demonstrated that they place the problem of patient reluctance in regard to session frequency into an understanding of the context and issues of the patient's therapy as a whole. The therapy context included the therapist's wish to see a patient more frequently, and having to balance that against a sense at times that the patient was not ready to do so. This left the therapist with a decision about whether to proceed with the invitation or discussion of the patient's reluctance or not. The decision depended on how the therapist assessed the nature of the patient's lack of readiness. One of the therapists who, overall, worked with a more disturbed population, illuminated through dramatic observations and examples the kinds of fears that motivate patients to keep their distance, and the respect that he gives this strategy to avoid being hurt. The data shows in general how carefully the therapists think about their next step when they either sense or are given direct evidence of a patient's reluctance, in an attempt to keep their patient's welfare as primary.

Therapists in the study also focused attention on their own readiness or lack of readiness to notice patients as candidates for more frequent sessions, to invite them, or to pursue the issue with them once the patient had "declared" their reluctance. Some therapists struggled to understand the meaning of their own hesitation at various points in the process, and identified patterns of personal countertransference as well as reactions they identified as being evoked in the therapy of a particular patient.

Concern about maintaining and developing the therapeutic relationship ran throughout the discussion about balancing both therapist and patient needs and readiness. All therapists saw the development of this relationship as a major means of helping patients both become more engaged with themselves and become successful in having other satisfying relationships.

Data was collected through a fifty-minute interview with each of eight psychotherapists (See Interview Guide Appendix A). The major findings of this study are

grouped according to categories and the dimensions that arose out of the analysis of the interview protocols. These categories are:

1. Arriving at a Decision
2. The Invitation
3. Strategies Therapists Use When Working With Reluctant Patients
4. The Meaning of Frequency

Prior to presenting these findings, a description of the participants will be given.

Description of the Psychotherapists

The eight licensed psychotherapists who were interviewed represented a multi-disciplinary group. Two were social workers, two were psychologists and four were marriage child and family therapists. This group was comprised of four men and four women. All of them were Caucasian. They ranged in age from between forty-one to sixty-three, with six of them clustered between forty-six and fifty-four years of age.

The therapists chosen for this study were recruited through my personal networking but were not close professional associates of mine. All of the therapists spent one hundred percent of their time in private psychotherapy practice with the exception of one person who taught ten percent of the time.

All of the therapists had a psychoanalytic orientation. Under that basic theoretical umbrella they further described their theoretical orientation in the following ways: four used an eclectic psychoanalytic approach, one used a control mastery model, one an interpersonal model and two described using an object relations model. One of the two people using an object relations model combined it with a Jungian orientation.

Each therapist had over ten years of experience doing psychotherapy; in this group, the average was seventeen years. Everyone had been practicing in a setting that allowed them to see patients in an open-ended manner for at least five years, and had been seeing patients in therapies of more that once-per-week for at least five years. The range of years actually reported for the practice setting and the time they had been seeing patients in therapies of more than once-per-week was between twelve and twenty years. The participants reported discussing the issue of increasing frequency with at least three patients per year.

The practice of four of the therapists was made up of over thirty percent of patients being seen more than once-per-week; the range was from thirty-eight to fifty-nine percent. The other four therapists' practices ranged from fifteen to twenty percent of their patients being seen more than once-weekly. All of the therapists with the exception of one had been in a personal therapy of more than once-per-week.

It was my impression that all of the therapist's were very engaged in the interview and gave open and thoughtful responses to the questions. I appreciate their willingness to participate in this study and for what I learned through their participation.

All of the participants were interviewed in their office or home. The interview began with the question, "What do you notice about your thoughts, feelings or interactions with a patient that makes you think that an increase from once-weekly sessions would be beneficial?" After that, I tried to follow the participant's lead while keeping in mind the areas of the interview guide. When another area of inquiry came up in the discussion, I tried to ask about it in a way that avoided forcing the material in any particular direction. Thus, in no interview were all of the areas in the guide covered.

Arriving at a Decision

Therapists' readiness to invite patients to increase the frequency of sessions involves attending to cues about their own sense of willingness to take on more intense work with a particular patient. Therapists feel they could do the work better if they see the client more often but they are concerned about imposing their needs on the client.

Client readiness is also discussed by the therapists in regard to the various cues they use in perceiving the client to be ready or not. The client's needs, as perceived by the therapist, were seen as a priority but are also weighed with respect to the various dimensions of readiness of client and therapist. Therapists showed sensitivity to not pushing their own needs upon a client and expressed the need to be ready themselves. These dimensions and their interplay are described below.

Many of the therapists expressed both their love of working at a greater frequency than once-per-week and their wish to see more people in their practice in this way. One therapist described those patients he sees more frequently as, "... people that I like, people

that stimulate me, I look forward to those hours. I mean there's definitely something going on there."

In addition, many of the participants expressed the belief that, in general, "more is better". As one therapist expressed it:

> I really like doing more than once a week. ... I like doing deeper work and I think that there is a depth that you can do generally with more frequent sessions. ... the work really changes when people come more than once a week. I often think an increase is helpful across the board.

Only one of the therapists in the group acted on this belief by actually inviting most of his patients to come more than once-per-week. He expressed his thinking about frequency in this straightforward way,

> In my experience, more is always better.... The more often I see somebody the better the work. It's easier for me. Because it makes my work easier. The stories they tell. Their personality. It's... [fresher] in my mind if I see them a couple times a week. They're easier to understand. The more you see somebody the more you know them.

In studying the interviews, it is apparent that a lot of the work therapists do in regard to increasing the frequency of their patient's therapy sessions occurs before the invitation is issued. The process of thinking about a particular patient and an appraisal of the frequency at which they were being seen, proceeded from the therapist noticing clues that led them to think about inviting the patient to an additional weekly session. Then the therapist evaluated the entire situation to see whether there was anything that would be a contraindication to the invitation. An invitation was issued or not. The first two steps in this process could happen in sequence or there could be a flow back and forth as the therapist noticed their interest in seeing the patient more, but then noticed a certain hesitance which might be given further thought or not. If more thought was given to the hesitance, the therapist gathered "evidence" in an effort to resolve the conflict.

A number of indicators from two different sources alert the therapists in this study to think about the decision to invite a patient to come more frequently. The first source of clues therapists use to decide about an invitation is gained from external information; the second source of clues comes from the way the therapist processes information that has a more internal origin. It would be an oversimplification to say that these are entirely

independent categories; there is some interpenetration. The external information has to be processed and organized by the therapist to give it meaning in relation to the decision about an invitation to increase frequency. In addition, although the origin of the second source of clues is internal, the patient's communications, both conscious and unconscious, are contributing to what sensations and thoughts arise for the therapist. It can be a complex decision for the therapist to determine the origin and meaning of certain feelings that they experience, or conclusions that seem inevitable. However, it is a necessity in order that the therapist does not feel stopped from exploring external matters, such as when a patient claims to be unable to afford another session, that may be motivated by internal reluctance.

External Clues

Therapists described the patient's diagnosis and the problems of fees and scheduling as indicators of whether or not frequency might be appropriate to bring up.

Diagnostic Considerations

Most therapists in this study spoke of diagnostic categories that once assigned to the patient, either always or often brought up consideration of more than once-weekly psychotherapy sessions. Depression and crisis were the diagnoses mentioned most often. Other diagnostic categories were mentioned but not brought up by more than one therapist; some of them might be applied to people who were depressed or in crisis, but were mentioned separately. These include: lower functioning people, borderlines, adolescents, recovering addicts, people who had suffered a lot of neglect in their pasts, and people whose lives were not going well in many areas.

One therapist spoke about telling patients who are in crisis that once-weekly sessions won't be adequate: "... you've got big problems right now. Once a week, fifty minutes a week, is just not going to be enough to get you through this right now." He also believes that limiting the therapy to once-per-week for some people who are lower functioning or severely depressed would handicap the treatment so much that to see them at that frequency would be negligent on his part.

Another therapist discussed how he envisions work with people in crisis:

> The bulk of the people that I think about going more often with are in some overwhelmed state emotionally.... they don't have enough in the environment to support them. So, in order to do the work, I think about them needing a little bolstering in order to help support and to hold ego strengths with them so that they can get clear enough to do the insight-oriented work.

His evaluation that someone is in crisis can be accompanied by a persistent feeling that the patient is at risk, which illustrates the way in which external and internal clues can overlap.

One therapist spoke about what alerts him to the need for more frequent sessions after a patient has cut back to less than once-per-week sessions:

> He is getting more depressed. So I think he might have interpreted my letting him do it, as my not caring, my letting him go astray the way his family did. And in those cases, you either have to interpret it or else say it doesn't make sense, it was a mistake.

Fees and Scheduling

After an invitation to increase session frequency had been issued, five therapists mentioned that fee and scheduling issues affected their ability to see some patients more frequently. All five of these therapists had a sliding fee scale. One of the therapists, when asked how often the need for a sliding scale came into his discussions of frequency with patients said, "Almost always... I see many people that don't have a lot of money and so I negotiate that. I try to figure out a fee that's fair for the two of us." Another therapist said he negotiated his fee about two-thirds of the time.

The findings contain very little data on the question of whether or not a therapist's initial decision to invite a patient for more frequent sessions is affected by their sense that a patient could afford another hour or that a schedule fit would be possible. Four of the five of the therapists mentioned that their ability to see a patient more frequently sometimes depended on the fit between the patient's schedule and theirs. Two therapists spoke about a conflict between two, sometimes contradictory, wishes. On the one hand, both of them wanted to keep their fee high enough to earn a living, and to have the increased enjoyment of seeing patients more frequently. On the other hand, charging a

high enough fee to make a living could mean the patient couldn't afford an optimal frequency.

The way these two therapists practice shows that their readiness to lower their fee varies according to their own circumstances, including their financial position, their wish to work more in depth, and their appraisal about who the patient is. One therapist initially stated that when she was discussing the possibility of another session with a patient she was open to lowering her fee by a maximum of ten dollars. She explained that the limit was ten dollars, "Because I'm still here. Even though I value working more often, I still need to make a certain amount an hour. I'd never halve it.... It means more hours to work." However, she later mentioned lowering the fee of a patient she was seeing three times per week by twenty dollars a session, and stated that it was more interesting to her to see the patient at a greater frequency because that it made the work of the therapy easier. Here, the wish to make money was offset by her wish to do interesting work.

The second therapist spoke about his conflict between his love of doing more frequent therapy, the appropriateness of it for certain patients and the limits he has imposed both because of his four day work schedule and because of the amounts by which he is willing to reduce his fee. (This therapist, before having a family, used to see more low fee, disturbed patients who could call on him at night and on weekends.)

He expressed discomfort over the enjoyment he gains when seeing patients more than once-per-week:

> I find myself thinking more and possibly putting more energy outside the hours into my multiple times a week patients. They're more in my life. I dream more about them. They're more important characters in my own drama. So, in that respect they get more of me.... Does that mean that the once a week clients are being penalized or getting second rate therapy?

The discomfort he feels is compounded by the worry that he is participating in a system in which people with less money are less likely to be offered multiple times a week therapy. This therapist manages the issue in several ways. First, he doesn't ask certain patients when he believes he won't be able to offer a fee low enough to accommodate them, or an hour that will work. However, if he feels a patient would be "dedicated" and very interesting, he will occasionally offer a much lower fee than usual. At times he will mention his idea that another session per week would be helpful to a

patient he feels would be unlikely to accept. If they indicate that they are interested, they are the one to make the accommodation in terms of their fee or schedule, or they wait until something changes in his schedule. Finally, if increased frequency is an immediate necessity, he refers people to interns he is supervising if the patient is unable to see him because of fee or scheduling problems.

Internal Clues

Therapists in the study begin to think about seeing a patient more frequently from signals that arise from their own reactions to how the patient is presenting himself verbally and non-verbally, consciously and unconsciously. "... When you're thinking about increasing the time, it has to do with a curious mixture of who they are and who I am" was how one therapist expressed her sense of the process. While all of the data could be called countertransference, I chose, for heuristic purposes, to present the data in a less global way. The data about internal clues clustered into three other categories in addition to countertransference reactions. These subcategories are the therapist's perception of not enough time, the therapist's perceptions of the interaction and the therapist's intuition about aspects of the relationship.

The Therapist's Perception of Not Enough Time

Therapists reported frustration with the time constraints imposed by the hour's end. For some therapists, the experience that there is a lack of time develops gradually. One therapist noted that her wish to see a patient more frequently:

> kind of evolves in a session or over a period of sessions where it becomes clear, every time this person leaves, this person is saying, `I don't want to leave', and `a week seems such a long time', and `I had so much more to tell you, where did the time go'.... I'm really getting it from that - they're wanting more and not saying it.

This therapist's sense that her desire is linked to a desire in the patient, that they connect through overlapping subjectivities, is a common theme among the therapists in this study.

> I become aware of a desire in myself to see the person more often", says another therapist. " Which usually is totally subjective.... it often just comes to me.... then I think about why that might be. Sometimes that comes to me in the hour; sometimes it comes to me outside of the hour. And then I... look for themes that might [be]... derivatives of that material.

Derivatives can include the patient saying that there hasn't been enough time to say everything they wanted her to know. This therapist described what happened with one patient:

> It just felt like there wasn't enough time.... So you know sometimes we would go over a few minutes.... that would fit in... like the "cues" for me, where we go over a few minutes and it still feels like we could have another session. It's not like a few minutes is really about finishing some little piece off...I was feeling like we really needed to have more contact.

A different therapist also spoke about the sense that a week "... seems like an eternity to the person or to me..." and that there was material in the hour indicating that more deeply felt material is readily available. She described a patient of hers who decided to come to therapy more frequently in this way:

> Just more and more was coming up. He was having dreams; he was engaged with himself.... for him there was an excitement or an energy, a sense of revelation about the things he was saying. It was like he was ripe.... it was the right ambiance between us for him to do what he needed to do. So, the timing was right. It was just happening. And it just needed a place to happen.

Therapist's Perception of the Interaction

Here again, developing a sense that a patient would benefit from more frequent sessions may take some time. One therapist enumerated aspects she notices about the material in the hour as well as some strong, unpleasant affect.

> With a particular patient, I guess there are several things that will alert me. One would be the difficulty in getting away from the storytelling. Repeating the events of the week or filling me in somehow.... there isn't enough time to let the material develop. Or that the person is reporting increased distress from our talks. Which I often see... as... [not] going into... enough.... I can find myself feeling frustrated. Trying to find enough ... input for me to listen to. Enough of the experience of being with this person to inform me about what it is I need, where I need to go next. It's though I'm not really actually getting enough of an experience with the person.... I can't quite know enough inside myself to know what to say to move forward.

A different affect is evident in the general description another therapist gives about what he senses in the interaction with certain patients whom he at first describes as high functioning.

> But maybe [they] don't have to be so high functioning but [have] a great capacity to do the work. So those clients that are voracious and compelled or they just are quick learners... I think of ... [them] as star clients.

This therapist gives an example of the process he experienced with one of his "star clients". The process occurred over some time and started after the patient had been in therapy for over a year. It began with the patient asking for some reading material and borrowing some books from the therapist. Then the therapist received a couple of telephone calls regarding scheduling matters that this client would normally have taken up in the hour. He said, "I remember thinking ... why are you calling? And... I started thinking about, what does he want? And we were talking about the transference.... [and we were] talking about what he wanted from his dad, from me."

The client mentioned analysis and asked for a referral to marital therapy. The therapist continued:

> A lot of it was talked about in terms of him allowing himself to... unbind himself, to be able to think more powerfully about what he wanted. And go after it.... And I know I ended up wondering with him about the calls....

Because of those discussions the therapist invited the patient to come to therapy for a second hour and the patient accepted.

For the therapist in the preceding example, the clues indicated the patient's readiness to increase the frequency of his therapy. However, there are times when there are clues to the patient's unreadiness to increase their session frequency. One therapist, in response to my asking about clients with whom he thought an invitation to increase session frequency wouldn't work, mentioned a client he'd seen three or four times and whom he wasn't sure wanted to continue in therapy. This is how he described the client in terms of his unreadiness:

> He's intrigued. However, his idea... [is] five or six sessions. And he had a list [of things he wants to work on]. He's got a book and... He's nowhere near the stage yet where I'm going to interpret or ask him about that... in terms of... a way to keep my influence somewhat diffused, so he's got this book on his lap. And he wants... [to] make a plan, and... [to] check things off. How are we going to do that here?

However, the therapist also noticed that the patient seemed pleased when he is shown the lack of logic in his thinking. He has also asked the therapist about the minimum number of sessions per month that are needed to make the therapy useful. The therapist calls him "a treat" and thinks this patient may yet become invested in his therapy.

Sometimes a patient's lack of readiness to use more frequent sessions becomes known only after discussion about the change has begun or after the change has been made. One therapist described patients who emerge in his mind as candidates for increased session frequency as those who begin to "... get excited, or break through or pick up some momentum", or those who are struggling with some of what is coming up in the therapy. Sometimes the increase in frequency works. Sometimes though, "As we start to talk about going twice per week, the feeling is that they can't tolerate it because it brings too much... intensity in terms of looking at their issues. Somehow it's too much in too short a time span..." and the decision is made not to increase the frequency.

The Therapist's Intuition about the Relationship

For the therapists in this study, development of the relationship between themselves and the patient was crucial to the success of the therapy. As one therapist put it, "I really do feel that the relationship is ultimately the primary healing factor in any psychotherapy."

Three therapists reported feeling that a complaint about the therapy could actually be a signal that the patient wanted or needed "more". One therapist stated that in such a case, contrary to sharing his patient's feelings of discouragement about the therapy:

> I think the therapy is working. I think that in fact that's a sign that the therapy is working in some way that they're willing... [to say] how discouraged they really are, that they've been keeping it at bay and... [defending against feeling discouraged] - and so I may be the first person that they can let those defenses down with and make a different kind of connection with.

Letting down defenses to allow the wish for more contact to emerge is an idea that is echoed in the example of another therapist whose patient often said she didn't think therapy was doing much good and who was rather distrustful. One day the therapist, in trying to reassure the patient, said something that sounded rather dismissive. The patient

came in the next hour wanting to quit. As they talked, the therapist realized the nature of her mistake and acknowledged it to the patient. She also said that she didn't think quitting was going to be helpful, but understood that the patient wanted to prevent getting hurt again. What the patient really needed was:

> to feel more like I was here and reliable and that if there was a misstep on my part, that we in fact could figure it out and work it through. It's not that you shouldn't be seeing me. However, in fact we should meet even more frequently. At which point she [the patient] burst into tears. And she said, `I think the only thing that would make me feel better is to meet every day'.

Another patient's complaint about her therapy stagnating and her thoughts about leaving helped focus her therapist's attention on previously vague thoughts of her own that she and the patient weren't talking enough about their relationship and that the patient wasn't making enough use of her. She describes what happened:

> In this particular interaction... it just became clear to me that what really needed to happen was she needed to come more than once a week... And when I said it, I thought it was a crazy thing that I was saying. I thought she was going to think it was the most ludicrous thing I had ever said to her. And she was really intrigued by it...and then, she decided that she would like to do that. And then the work... deepened.

In this example, the therapist's ability to translate the patient's complaint into a clue signifying the patient needing or wishing for more was muffled at first, but emerged strongly and suddenly, facilitated by an unarticulated inner process. The therapist then felt ready to invite the patient to more frequent sessions. Sometimes though, the therapist feels very clearly that the patient is not ready to be invited to more frequent sessions. This perceived lack of readiness is the result of the way the patient already experiences the relationship with the therapist or because of the way the therapist fears the patient will experience the relationship if the invitation is issued. One therapist spoke of her hesitation to invite her patient to increase her session frequency because she wanted to preserve the relationship:

> Sometimes I don't ask them because I think they will experience it as an injury, or they'll see it as I must think that they're really sick to bring it up.... or it will trigger them to start feeling like I want too much from them. But that doesn't mean that I think if they come in more often, it might not be a good thing for

> them. It means that I don't think our relationship is at a point where they could really make that jump or tolerate me introducing the subject.

Another therapist describes a patient of hers as someone who is "chatty", who has trouble speaking about herself and feels very undeserving of her therapy time. The patient has made important gains in coming to therapy and is someone the therapist envisions seeing for many years. However, she knows the woman feels being in therapy is a weakness, an attitude which the therapist understands as an identification with her mother who was not attuned to the patient's emotional needs. "I don't think she feels she needs me more than once a week" is the way she describes the patient's wish to curtail their involvement. "I think she would feel very ashamed to make me too important." Therefore, the therapist will not invite her to more frequent sessions.

Of course, all decisions are not so clear-cut. In some instances, the therapist considers factors that seem to indicate opposite courses of action. A therapist described a patient who had been quite depressed, was being seen twice weekly and was on medication. She had improved, but her mood was still fragile. The therapist felt intuitively that it would not be a good time to raise the issue of a third session to her patient:

> There's something about what she's dealing with in her life where she's trying to carve out an autonomous part of herself, away from the wife and mother role and being in... school again... just finding herself through her interests. And while this is a tremendous interest of hers that she comes to the therapy, I don't know that it wouldn't feel like it was for me... [that it would] tip the balance too much towards something involving another person as opposed to the... academic pursuits.... Would another hour support that interest or would I become too much in her psyche that would take her away from her own relationship... [of] dealing with herself?"

The therapist decided to monitor the situation and offer a third session only if the patient's depression increased or if the relationship between them developed to the point that the offer could be considered by the patient as something that she could feel free to either refuse or accept.

At times, the assessment has to be about the <u>therapist's</u> readiness or ability to tolerate what she senses will develop between herself and the patient if the frequency of their meetings increases. One therapist spoke of seeing a woman whom she knew needed

to do an intensive piece of work "...but that it was going to turn out to be extraordinarily volatile. Perhaps even to the extent of where we would have to be talking about her physical violence against me. And I knew I could not do that." In this instance, the therapist referred the patient to someone who would see her more intensively.

This therapist described another situation in which she had to evaluate her own readiness to see someone more frequently. She was seeing an impulsive man in treatment who wanted to be seen in a double session. She said:

> My worry was, can I do this? Can I personally tolerate this? Will this make it easier for him but too hard for me? I had some sense... [that] I had to think about my own tolerance for what I'm going to undertake." She feared the longer session would, "... instead of having him... think more, and use a little more insight, build a few more... defenses around his behavior, that in fact I could really undermine something. I worried that we'd just get in some kind of brawl, horrible brawl.

After several months of discussing it with the patient, the therapist decided to try his plan and felt the new arrangement had a positive influence on their work.

Countertransference Reactions

The findings about therapist's intuitions and their thoughts and feelings about their relationship with their patients make it evident just how deeply involved they are in the therapeutic dyad. Countertransference reactions in this context are those reactions of the therapist that they are unaware of, or unaware of the meaning of, but that influence their judgement and the way they act with the patient with regard to the issue of increasing frequency. Several therapists expressed concern that because of their wish to see patients more frequently than once-per-week, they would impose this on patients who were inappropriate for this kind of work or at least not ready to work at a more frequent pace.

One therapist stated it this way:

> Therapy is not... for my needs. It's for the patient's needs. Although of course I'm in there, and there is a relationship happening. I think I have to be really careful not to push somebody to do something because I want it.... I tend, almost always at the beginning, not to invite people to come more than once. Unless it's really clear either that they need it or they want it. Because I check myself a lot about, is this for me or is this for them?

Another therapist remembers being influenced by working in a setting where, because patients could only be seen for a brief period, a process of assessment was set in place in order to prevent therapists from routinely transferring patients who needed to continue into their private practices. Some patients clearly needed to continue with the same therapist, but she came to feel that it was not devastating for all patients to continue their therapy with a new therapist. "... I saw the wisdom in the idea of the policy that there was a potential conflict of interest. That's with me a lot when I think about having somebody come more than once-per-week. Especially pushing it. "

This therapist preferred having a patient quickly agree to increase the frequency of their sessions in order to avoid a struggle in which the patient could project "... that somehow I was trying to get something from them, which I'm really sensitive to". She felt this sensitivity to having things pushed on her had surfaced in her own therapy where she had been reluctant to increase her sessions from two to three times per week. She felt that this personal sensitivity could make her "skittish about raising the issue and pushing the issue" about increasing frequency with her patients.

This reluctance about pushing or being pushed was echoed by one therapist who explained how he could feel "crowded" when patients asked him about being seen more frequently, even when he knew that it was clinically appropriate. "Just because somebody is asking doesn't mean they're crowding me, but I experience it that way."

These therapists thought that their personal sensitivities made them slower to invite appropriate patients to come to more sessions each week. Each expressed some regret about this, perhaps because they were disappointed with themselves in the way another therapist said she would assess herself if she thought she hadn't brought up the issue with an appropriate patient. This therapist couldn't think of a case where that had happened:

> But if I [did] do that, it's... a failure of courage. ... a failure to move forward into whatever it is you know you'll be getting into. Or to have the courage to really confront someone's resistances. And to hang in there talking about something when it makes your patient very uncomfortable or very fearful, very dismissive.

This then, illustrates the beginning of a process that continues between the therapist and patient when the therapist decides to ask the patient to consider more

sessions per week. The next section will contain a summary of the findings about the way therapists think about and issue the invitation to their patients.

The Invitation

Once therapists become aware of feeling that increased frequency could be beneficial to a patient, they prepare carefully. Often, the timing of the invitation coincides with signals they perceive to be coming from the patient, indicating to the therapist that the patient is ready and emotionally open to the invitation. At other times, in spite of the patient's perceived lack of readiness to welcome the invitation, the therapist proceeds to issue it. The therapists think of the invitation as an intervention in the therapy whether the patient ultimately accepts it or not.

Laying the Groundwork

Earlier, many of the therapists had expressed concern about imposing their preference for working more frequently on their patients. One therapist, in order to check whether her wish to see a patient more frequently was for the patient's benefit or for hers, didn't even mention greater than once-per-week frequency initially. In contrast, there were two therapists who might ask a patient near the end of the first hour, "when would you like to come back?" or, "how often would you like to come in?" This question was used to introduce the idea that greater frequency was possible, and to move away from the commonly held assumption that once-per-week sessions was the treatment of choice. As one of the therapists explained:

> People will sometimes be kind of startled.... And I'll say, `well I often work with people more frequently than [once-per-week].' I will sometimes explain what I... think is the substantial difference between meeting once a week and meeting twice a week.... then later in the treatment, if I... begin to see there's reasons [to see someone more frequently], I'll bring it up.

The other therapist explained that the purpose of his question was to elicit a patient's wishes about when they would <u>really</u> like to come back, which might be quite different than the once-weekly sessions they had consciously planned. Through their answers, it was possible to begin engaging more deeply with the patient.

> Often times you'll get two or three different things. You'll get either directly or... [the] easily translatable... wish not to leave, the wish to come back tomorrow. You know it's more the wish. And then you get the... reality, what I can afford, what I can do.

The Timing of the Invitation

Most of the therapists try to issue their invitations to increase frequency when something about the patient or an issue under discussion becomes clear enough to provide a bridge to, or justification for the invitation. Examples of the way this is done are captured in the following quotes from one therapist:

> [Increased frequency would be helpful because] we get caught here". "I think we're in this... kind of difficulty... because in fact we're not meeting enough". "I think you get left in this kind of distress and then there's... all this time before we speak again.... it doesn't allow me to be as helpful to you as I could be".

The most frequently mentioned aspect of a patient's psychology that was linked to the invitation to increase frequency was the therapist's perception that the patient wanted more contact. The patient's wish could be expressed indirectly, or stated in words that the therapist felt were easily translatable into the wish for something more. Speaking of the directly stated wishes one therapist said:

> People start telling me it's not enough in various ways.... 'I really missed you this week', or 'it seems so long since we've met', or they're walking out the door and they're saying, 'gee, I wish we didn't have to end because there's so much more to talk about'.... practically that's... where I will jump in at some point and say 'maybe this isn't enough.'

Her invitation comes, as another therapist put it, when... "You get a little bit of feedback that they themselves are noticing [the] constraint."

The first therapist provided an example from her practice of how the work can proceed when she perceives an indirectly stated wish for more contact and then couches the invitation in terms of a central theme of the therapy. She described a patient whose hours were filled with the theme of neglect and lack of attention.

> I started thinking that it might be helpful for her to come twice a week. And I framed it in terms of attention. That there was a kind of attention I felt she needed that she wasn't getting from once a week therapy. And had never gotten.... she just jumped at it.

The therapist felt that she was responding to the patient's wish for a richer relationship to which the patient felt unentitled. "... it... never occurred to her that she could have something like that. It was really okay to have something like that."

Another therapist spoke of how she often notices her own wish to see a patient more frequently and then thinks:

> Why is that?... what's been going on between us? Is there something that I can point to and raise with them, or is it more... my feeling that there's just so much going on here? And if I can't connect it to something that they've been telling me... directly or indirectly, I generally will wait until I can do that.

She illustrated the approach of pacing things in order to keep in maximum psychological contact with her patients by discussing one of her patients who was very distrustful of therapists, but who had a tremendous number of things she needed to explore.

> So I raised... the idea that it just didn't seem like we had enough time. She... agreed with that, and... felt that it was her experience too.... I don't think I jumped to that next place. I think I just sat with... the dilemma with her because I know that... it's very easy for her to feel manipulated.

In this last example, the therapist's assessment of the disruptive effect on the patient because she would be deeply afraid if invited to more frequent sessions, resulted in her not issuing the invitation at that time. However, a therapist's assessment of whether or not a patient is ready to hear the invitation is not always based on whether or not it will be welcomed. Sometimes the therapist feels something "... deeply imbedded in that particular therapy" must be confronted and hopes that the patient can eventually make use of it.

One therapist discussed just such a case. Her patient was also someone who had had many experiences of being exploited by others. "This made her intensely suspicious of my motives and of what I wanted and why I thought this [increased frequency] was going to be of use of her." The invitation had come because the therapist noticed that the

patient was doing all she could to distance herself from the therapist, and yet, "... she was having a tremendously dependent relationship with her partner where she was always in the needy position, wanting more affection, contact, sex.... she was living out with each of us different parts of her." The therapist felt that although the patient reacted to the invitation with distaste, it was one way of addressing, "her attachment to making her partner be who she wanted her to be and her resistance to getting more involved in her relationship with me." In addition, the therapist felt that the complexity of this patient's issues required more frequent contact,

> She was in this repetitive, neurotic, suffering-based [relationship], beating her head against the wall trying to get her partner to be more sexual with her. And that was just backfiring. And it felt like I was pushing on her resistance to being more vulnerable [with me].

The timing of the invitation was based on the therapist's judgement that her patient's fears about their relationship needed to be addressed. The therapist hoped the nature of those fears might become clearer to them both through discussion of her objections to increasing the frequency of their meetings.

The Invitation as an Intervention

All of the therapists see the invitation as an intervention that can have great significance to the patient and may alter the course of the work, whether the patient makes the change or not. Several therapists who discuss their experiences inviting patients to consider more frequent sessions further illustrate this idea.

The first therapist's example concerned a patient with whom she felt irritated and whose issues she could not grasp. Her invitation to increase their session frequency felt like:

> A foreign idea to him.... in suggesting it, I'm making ... an intervention about how much he distances people. And how worried he is about... revealing more or getting emotionally involved with someone. So that the actual discussion about frequency is in and of itself an interpretation.

Therapists are very interested in the different ways patients hear the invitation. Two other therapists discussed how they felt the invitation to increase session frequency

could provoke reactions in the patient that lead to an increased understanding of their dynamics.

The one therapist in the study who routinely invited his patients to come more frequently and who stated that he didn't tend to discuss it much if people refused his invitation, did watch his patient's reactions beyond their saying "no", indicating his knowledge that this can be an important interaction. His invitation is quite personal, " 'I would like to see you more'. In that way, I'm either caring about them or I'm trying to control them." He looks for patient's reactions after they refuse his invitation,

> And I find out, either [in] that hour or in subsequent sessions. I listen carefully [to see] whether that was the right thing to do or not. I can sometimes tell.... if I make a bid for them to come a couple of times a week and they say no, and as a result of the sessions, they're making statements to indicate they're bolder... - it was the right thing to let them [turn me down]. If they really wanted me to insist, [and] I realize [it], then I go [make the] bid again.

The second therapist discussed a patient whom she saw in her practice during several periods. The patient had quite a traumatic history and had recently moved back to the area in order to see the therapist. About a month after the latest group of sessions began, the therapist raised the possibility of them seeing each other more often. "And she said yeah and then she didn't come the next week. And she was furious with me. And she let me know that she would be the one to decide when a question like that should be offered." This reaction began what became a valuable discussion about the meaning the offer had to this patient.

The timing of the invitation is often carefully considered because the offer of more sessions is acknowledged to carry psychological significance for the patient. This is how one therapist expresses it:

> When I bring it up with patients, it is often a rather powerful intervention. People... hear it in many different ways. But... it's an indication of one's involvement with them and one's willingness and interest in going ... farther with them.

The idea that the offer of more sessions carries meaning for the patient and the therapist will continue to appear in the next section as I discuss how therapists work with patients who are reluctant to increase their session frequency.

Strategies Therapists Use When Working With Reluctant Patients

Once the invitation has been issued and the patient has made clear that he is reluctant, the therapist is faced with knowing how to pursue, or if to pursue, discussion of the issue. In this section, the two primary strategies that emerged as the therapists spoke about their work with reluctant patients will be presented. The first one is understanding the patient's dynamics; in this strategy the therapist understands that the reluctance exists in a context in regard to fears and conflicts that have already been recognized or developed as themes in the therapy. Then the therapist decides, depending on a judgement of what the decision might mean in light of the patient's dynamics, whether or not to try and explore the reluctance further.

In some cases, the therapist's readiness to explore the patient's reluctance is in question. This is a matter for the second strategy, therapist's work with their own hesitance. Therapists discuss how they work to understand why they don't pursue discussion with a patient when they consciously feel it would be beneficial to do so.

Understanding the Patient's Dynamics

To understand the meaning an invitation to increase session frequency has for a particular patient, all of the therapists stress the importance of understanding the patient's dynamics. Often, because the treatment had been going on for some time, the therapist is familiar with the patient's view of himself and others. And, from having discussed current and past problem areas, a template of the patient's psychology emerges for the therapist that is useful in understanding the meaning of the patient's reluctance and then in what way - or whether - to pursue exploration of the reluctance.

Understanding a patient's psychodynamics and linking that to a decision about how, or whether, to pursue exploring the reluctance can be difficult work. One therapist spoke about the difficulty when she described a "decision tree" she faced after a patient expressed reluctance:

> The decision to me is... which of the objections are actually real? You know whether it be money or time and space. And which of the objections are born of the conflicts they've come in about. And then which are the ones where you just

> get a compliant response where you don't actually get someone engaged in talking about, what would that [coming more frequently] be like.

Another of the therapists mentioned earlier, who often quickly invited his patients to come more frequently, described actively gathering information about the patient's history in the first hour. He did this to get a "snapshot" of the person's dynamics in order to have an idea about how the patient would react to the invitation. He too emphasized the uncertainty he faced in knowing what course of action to pursue in face of the patient's reluctance:

> It's really a difficult task to know what to do about that. Sometimes you might want to explore why. But the trick is you really have to know what the psychodynamics are of the client to know how they're going to respond. You know they may want you to insist. They may want you not to. They may want to desist. Depending on how they're raised. They many want you to up the ante and indicate that you really are concerned about them. They may not want you [to] do that if they think you're just trying to control them.

This therapist again alludes to the difficulty in knowing whether to pursue the issue or not. These dimensions, pursuing the discussion of frequency or not, are discussed in the following sections. First, therapists discuss how their intellectual ideas about theory or themselves can help motivate them to carry a discussion forward with the patient. Several examples are given showing how therapists, depending on what they know about their patient's dynamics, speak with them about increasing frequency. The discussion will then turn to why the therapists decide not to pursue further discussion of the reluctance. Fee and scheduling negotiations, both successful and unsuccessful, can limit further discussion of the frequency issue. Second, the therapist can decide that the most important issue at hand is allowing the patient to regulate themselves in regard to their degree of involvement in the therapy.

Pursuing Discussion of the Patient's Reluctance

In spite of the uncertainties, a majority of the therapists felt they pursued the issue with appropriate patients most of the time. Two of the therapists spoke explicitly about an image of themselves that helped guide them in their continued efforts to explore the patient's reluctance. The first therapist said, "... they're paying me because I have some

expertise. And I, in fact, am making a professional judgement and a professional recommendation, and pushing my point of view."

The second therapist spoke early in the interview hour about the difficulty he expressed at times pursuing a satisfactory discussion with some of his adult patients. Later, he evaluated his performance with his adolescent patients much more positively:

> Adolescents have [a] certain kind of resistance to anything in life... So that I'm much more geared up I think to expecting a 'no' to things. It's a very formal and structural kind of thinking about adolescents.... I know it's going to be a back and forward. I've got to get ready to reach further out to them, and sort of push that.... that's how I conceptualize... the developmental stage. And so I... [have] a very clear stance in my mind [of how I have to act].

What follows is an example of how one therapist understood the connection between her patient's dynamics and her reluctance to increase the frequency of their meetings. The therapist began by acknowledging the reality of some life circumstances that made it difficult for her patient to increase the session frequency; she lived at some distance from the therapist, and was a working mother.

> But she also had both a former therapist and mother who... needed her to service them emotionally through her attendance.... She also had a father who was sexually... inappropriate with her... so all of these things made her intensely suspicious of my motives and of what I wanted and why I thought this was going to be of use to her.... and she has never done it.... not coming more often is just one version of her needing to keep me in a certain safe position. And not wanting more from me, because then it will open a floodgate in me or in her. We talk about this stuff.

Sometimes, a therapist communicates with his patient using less complex ideas, but still intervenes in a meaningful way. One therapist described his idea that reluctance to increase frequency for patients who had been quite neglected as children might be an unconscious test by the patient to see whether the therapist would do the same. "If I know somebody has had tons of neglect, I continue to remind them that I'd like to see them more often as proof that I'm not going to reject them. Some clients require tons... of proof."

When this therapist thought about the issue of frequency, he also considered patients who wanted to decrease their session frequency or terminate prematurely. He described what he might do in this case with a patient who had been neglected. "...

periodically they're always wanting to leave therapy... and I will say, `you aren't ready yet. You haven't finished yet.' It settles them down. Without any interpretation. I'll say I don't think its a good idea."

This therapist says explicitly that his behavior in response to the patient's reluctance has meaning to the patient; other therapists imply this understanding. He explained the response I just quoted by saying, "... my behavior means... I have to take care of him. I have to make sure he stays here and gets as much help as he needs without fleeing -- he just left home, his parents neglected tons of his problems." Therapists can unwittingly convey a message of rejection if they don't understand their patient's psychodynamics, he continued. "... too many therapists operate under this autonomy model that they're not supposed to tell the client what they want. So the poor patient feels that the therapist doesn't care about them. This so-called neutrality thing is actually wrong."

Not Pursuing Discussion of the Patient's Reluctance

Two reasons emerged that explained why there might be little or no discussion of the patient's objections to the invitation to increase session frequency. The first had to do with the way a therapist evaluated a patient's saying that they either couldn't afford another session or couldn't arrange the time. Further discussion of increasing frequency might also end if the therapist felt that, given the patient's dynamics, it would be in the best interest of the patient to allow their decision not to increase to stand.

Fees and scheduling issues. Earlier, I quoted one therapist who said that part of her "decision tree" had to do with knowing whether the patient's objections relating to a lack of time and money reflected the whole reality or concealed other issues that would be important to pursue. If a therapist felt that the fee or time issue reflected the whole or a significant portion of what impeded the patient's agreeing to increase the frequency, two things might happen. Sometimes a fee or scheduling change couldn't be negotiated successfully and the matter of increasing frequency was dropped or tabled with no more discussion.

At other times, an adjustment to the fee, a practice that was frequently used among this group of therapists, was negotiated. (This common practice was discussed earlier in the section on how a therapist arrives at a decision to invite a patient.) Similarly, at times, although it is problematic at first, another hour was negotiated. Sometimes rescheduling is done in an untraditional manner. This was the case with one patient who the therapist described as someone under a lot of pressure from her work and the fact that she was in the midst of a divorce. She lived in a community that required a one-way commute of between forty-five minutes to an hour to get to the therapist's office.

> She suggested coming to a double session. And I agreed to experiment with her. And in fact, I see her for ninety minutes a week.... And it works beautifully for her. [She was] exactly right. She knew what would work for her. She comes up once a week. She doesn't have to deal with the commute. So that's the twice a week therapy that happens once a week.

Patient's self-regulation of their session frequency. Therapists felt that it was vital for certain patients, given what was known about their dynamics, to be able to regulate their own degree of involvement in the therapy. An expression of this self-regulation of involvement was to allow the patient, with little or no further discussion, to refuse consideration of increased session frequency.

> One therapist expressed the idea in the following manner and gave an example:
>
> Some people actually may not be ready... the intensity of a relationship being too difficult for them. And they need to monitor, they need to regulate the degree of involvement in life for themselves. So you do that.... if... some woman comes in and tells you how she slept with her father for a number of years, and she's constantly being exploited or [having] to be submissive to men, you almost can be sure that they'll freak out if you ask them to come more... And more than likely they'll want to be able to say no to somebody. That being the work of therapy.... It bothers them but I help them oppose me.

Another therapist described a patient who never increased her frequency. She lived frugally on a trust fund and was thus able to continue her work that was important to her, but that was mostly unpaid work in the arts. Increasing her therapy fees for another therapy session would have meant finding paid work. The therapist explained:

> And the feeling of hoarding and needing to not give herself away, in the form of money, was very much a psychological issue. And we could disentangle those

> over time. And she managed to do a truly depth therapy - we're in termination - and without coming more often. Although it took her longer.

When asked how she adjusted to this, given her wish to see the patient more frequently, the therapist replied:

> She made other sacrifices in life to not spend money, not just therapy. Therapy was something she was giving herself -- so I had to keep that perspective.... I just think this was her way, she needed to be in control in this way. I've been doing it long enough and I've had the experience of people really [being] able to change through therapy. I don't think it happens in less than a decade.... It wouldn't work for me [personally]. It works for her... so I guess that satisfies me.

A third therapist (mentioned earlier in the section on how therapists arrives at a decision to invite patients to more frequency) described the process he undergoes at times, which results in his no longer pursuing increased frequency. He spoke of patients who:

> Start to get excited or break through, or pick up some momentum and I start to think about them going twice weekly to help push them along... As we start to talk about going twice weekly, the feeling is that they can't tolerate it.... And then I become empathic with that, so I tend to back off. And often times, they'll state that out loud.... I know I tend to move away from that [more frequency] to try to go at their own pace.

The patient signals his distress, and in these cases the therapist decides that pursuing the issue of more frequent meetings is not in the patient's best interest.

Therapists Work With Their Own Hesitation

In this section, another strategy used by therapists in their work with reluctant patients will be described. Examples from the interviews of four therapists will illustrate how they work to understand the part their own thoughts and feelings played in delaying the process of pursuing discussion with reluctant patients. A sizeable majority of the group spoke at some point of their concern about the way in which their reactions could, or had, affected the patient's progress. In the examples that follow, two of the four therapists view their thoughts and feelings as counter-transference reactions emanating from their own conflicts. The other two view their reactions in the examples that they give as having been shaped from their work with the conflicts of a specific patient.

Two of the therapists used the research interview itself as a place to review the way they work with their own hesitation when dealing with reluctant patients. One therapist, midway in the interview, spoke about noticing what he had been saying about his reaction to patients who expressed reluctance to increase their frequency. He put it this way:

> I back off a little more quickly than I might.... my thoughts tend to go with the same theme of my... countertransference - my issues.... some sort of fragility issue.... it's not so much that I feel rebuffed... it's more like feeling, 'uh oh, don't hurt them. They can't do this. Back off. Real quick. Don't intrude in their space.' I wondered how it might impact my work. And god knows how they [patients] pick that up, if they do.... it will be interesting to see if I can do something with this.... whether it shifts... [my] work in some way.

The second therapist has been mentioned previously because he speaks about the issue of frequency as running along a continuum that includes both increasing frequency and terminating prematurely. In the segment of the interview highlighted here, he talks both about people who have been neglected and who are reluctant to increase their frequency of visits, as well as those who want to drop out of therapy. Depending on the patient, he begins by proposing the increase in frequency or that they remain in therapy, allows them to oppose him without rejecting them, and may interpret their characteristic pattern of giving up things that are of value to them. Sometimes though:

> You can say things that are correct in a stupid way and it doesn't make sense to them. It isn't a matter of timing; it's usually my own confidence [in] what I'm doing. And how to handle it. They're very difficult things. And sometimes I just don't want to work that hard. So if they want to leave, okay.... It's too difficult to try to keep them. Some patients are more... wearing than others.... And you can't be perfect all the time.

He continues his characterization of a certain kind of patient that can't really get into therapy, whose life is chaotic and who can't form an attachment to him. He becomes responsible for caring for the patient and the relationship and says "his batteries" just aren't up to it at times. He denies that the patient's manner is responsible for his feeling drained, and attributes it to events in his own life. He describes how he can feel:

> I realize I'm getting really annoyed with a person, they [start] making me feel crappy, they're ignoring every damn thing I say. Then I catch myself, `okay, this is what's going on.' Then I pull back for a second or two. Or a day or two. You

> know you have sessions, and then all of a sudden you realize there's terrible sessions. And you realize you've missed the boat.... You feel like killing them -- you realize you've done something wrong.

When I questioned his sense of having done something wrong, he conceded that the patient might be contributing to his reactions, but then returned to the claim that his own life difficulties or his inability to understand the manifestations of alternating internal representational shifts in the patient, are responsible. A main concern of his is not blaming the patient, "Because they're always blaming themselves. Try to take some of the blame off their shoulders." He seems to be both trying to account for his patient's actions by understanding their psychodynamics, and his own reactions, without unduly blaming himself.

In the next two examples concerning the way therapists work with their own hesitation regarding patient reluctance, the therapists explain their reactions as being interwoven with the psychodynamics of the specific patient. In the first example, the therapist realized in our interview that she was hesitant to pursue the issue. She was describing a patient whose abrupt refusal to increase the frequency of his sessions had led her to believe that he just couldn't engage around the issue. As she continued to speak she said, "I'm actually thinking as we're talking about this that I may back off too quickly too.... Because he so quickly says... no." And, "Well, it may be more about me than about him." As she continued to explore her own reactions and what she knew about the patient, she became able to understand her countertransference reaction. She feared that if she continued to discuss his refusal she was going to feel too rejected and ashamed for wishing to have more contact with him, the very concerns the patient had been discussing in relation to himself.

The final example is one in which the therapist understood her own hesitation to issue an invitation to increase session frequency only after her patient had accepted the invitation. It pertains to a case in which the hesitation occurred before the invitation rather than after it. However, it is being included in this section because it is a good illustration of how therapists can continue to think and review their own reactions in order to understand and be helpful to their patients.

The patient, previously mentioned, had been complaining about her therapy stagnating and had been thinking about stopping. The therapist had explained to me that, in an unexpected moment of clarity, she realized that the patient needed more contact with her, not less, and invited her to come to therapy more frequently. When I asked her what she thought might have prevented her from becoming aware of her patient's need before, since the patient had complained several times about the process feeling stagnant, she replied:

> I think my counter-transference was that I just wasn't that important. And so I don't think I ever really allowed myself to give in to consider the fact that she would be interested in having more of me.... [what] got enacted in some way between us [was something] where I think I felt... not good enough... and that's really an issue that she struggles with a lot. Not being good enough. Not being strong enough emotionally.

This therapist's realization has the potential to inform other aspects of her work with this patient and so improves their chances of continuing to work productively together. Both understanding the patient's dynamics and therapist's work with their own hesitation, are strategies therapists use to try and reduce the patient's reluctance and/or maintain an ongoing therapy.

The Meaning of Frequency

In the previous sections, the therapists illustrated the careful thought they put into considering which patients to invite to increase their session frequency and how to understand the reluctance patients had to increased frequency of sessions. In this section, therapists discuss their perception of the value more frequent sessions can add to a patient's course of therapy. This value is what makes therapists pursue the issue so vigorously at times. Two factors, perceived by the therapists to be beneficial to the development of the therapy, emerged: development of the therapy material and making an intimate connection with the therapist. The therapists felt that both of these factors were more likely to develop with more frequent sessions than they were with just more time. In addition, these factors were perceived as being linked with each other, one promoting the development of the other. They will also be discussed in regard to

therapist's perceptions of why patients might choose to either leave treatment or choose less frequent sessions.

Before discussing the development of the material or making an intimate connection, I want to re-quote one of the therapists who speaks in simple, common-sense terms about why increased frequency works:

> The more often I see somebody the better the work. It's easier for me.... The stories they tell. Their personality. It's... [fresher] in my mind if I see them a couple of times a week. They're easier to understand. The more you see somebody the more you know them.... It's like... [any] close relationship.... if you see somebody once a year... you forget what they're like. And the client probably also forgets what you're like too.

Development of the Material

In every good psychoanalytic therapy the patient gains better self-understanding from the clarification of the troubling conflicts and difficulties that bring them to treatment. Increased frequency is valuable because the extra sessions allow more to be said. One therapist, in describing the sense she and her patient had of there not being enough time, listed all of the things about which her patient wanted to speak:

> She had earlier life issues.... She had a very complicated relationship... [that] she was still very enmeshed in... And then there's so much to talk about with us and then she had a lot to talk about in terms of her feelings of abandonment from the previous therapist.... she also had a lot going on internally... where she describes having these different parts of herself.

Earlier, another therapist had talked about things in the hour she uses as indicators of the need to increase frequency:

> One would be the difficulty in getting away from the storytelling. Repeating the events of the week or filling me in somehow.... there isn't enough time to let the material develop. Or that the person is reporting increased distress from our talks. Which I often see... as... there is a stirring up of a lot of material and then not having enough time to talk about it.

The implication is that she believes increased frequency of sessions can address these problems.

Two of the therapists spoke about the increased accessibility of the material that more frequent sessions allow the patient to have. One therapist spoke of a depressed

patient who began coming to therapy more frequently because the sessions "... were enlivening to her.... they were beginning to engage a part of her that had been asleep for a long time.... And the material began to happen. She began to have more dreams and more transference of her responses." This therapist felt dreams were an important indicator that the person was connecting with themselves. They "... indicate that something... has been engaged in the psyche and needs work."

The second therapist described ongoing therapies which "catch fire" and a decision to increase frequency is made. Sometimes many meaningful dreams come up and there doesn't seem to be enough time to work with the emerging material. Here is the way he may talk to a patient about why he feels an increase in sessions would be helpful:

> There are certain moments in a person's life where the psyche, the unconscious is very close to the surface. And ready and willing and begging to be engaged.... this is one of those transitional moments where clearly this material is right at the surface... let's go for it. Let's avail ourselves of this.

A third therapist views increased session frequency as a means by which the patient engages in the difficult task of becoming conscious of deeply ingrained patterns of thoughts and ways of doing things:

> For a lot of people that I see, making intimate connections is very difficult. *Relying on others is really difficult* [italics added].... the idea that when we're so helpless,... [and] dependent... [in] our early years, twenty-four hours a day... what goes on in our families is just so powerful. And to begin to get some consciousness of that... to get out of the consciousness that we were trained in is, I think, a lifetime struggle.

Deep engagement with the self and the development of themes in the material is linked to making intimate connections with another person, the subject of the next section.

Making an Intimate Connection to the Therapist

The development of a deeper, more complex and intimate tie between the patient and therapist often occurs in a more than once-weekly therapy and can facilitate the material of the therapy developing. The articulation of what is wished for but also feared between the patient and the therapist, can play a crucial part in clarifying some of the patient's difficulties. Although the development of an intimate connection can be part of

the material of the therapy, its contribution to making a therapy successful would be diminished if it were viewed only as an aspect of the development of the therapy material. First, the work in the arena of the therapeutic relationship often frees the patient to have relationships that are more intimate with other important figures in addition to the therapist. Second, the development of some intimacy and feeling of safety with the therapist very often influences the patient's ability to go further in exploring areas of their internal world to which they had no previous access. For these reasons, the development of an intimate connection with the therapist merits a separate discussion. Material from one therapist's discussion of why patients might choose either less frequent sessions or to leave treatment prematurely will be presented to illustrate the extreme difficulty some patients have making this connection, thus underscoring the contribution being able to do so can have to the success of the therapy.

In the examples that follow, the therapist's thoughts illustrate how interdependent they feel the concepts of development of the material and contact in the relationship are. The first therapist described one of her patients and her role with him. She perceived him as being quite:

> Engaged with himself.... for him there was an excitement or an energy, a sense of revelation about the things he was saying. It was like he was ripe.... it was the right ambiance between us for him to do what he needed to do.... *I feel like I'm...a vehicle and he's providing all the fuel* [italics added].

She sees herself as an essential component in the patient's material being available to work with "... because I need to be more of a figure or presence for them [patients] to be able to go into whatever we're talking about."

The idea that the therapist's presence is essential is also captured in the example, previously described, of the therapist who felt that a mistake made by her resulted in her patient wanting to quit therapy. She explained what she felt had happened to the patient and added that she felt quitting was the patient's attempt to avoid further hurt, when what the patient really needed was, "To feel more like I was *here and reliable*...[italics added] so that missteps could be worked through." Her patient responded to her invitation to come to therapy more frequently by saying tearfully, "I think the only thing that would make me feel better is to meet every day."

The next therapist spoke about patients in crisis. He feels his presence supports these patients so that they are capable of doing the necessary work. Crisis patients are "... in some overwhelmed state emotionally.... And I think about their needing more emotional support.... In order to do the insight-oriented work, they need more shoring up." This is what increased frequency provides.

This same therapist had previously described a male patient, in whose therapy the theme of wanting to "be able to think more powerfully about what he wanted" was being developed. Part of what the patient wanted was a more intimate relationship with the therapist:

> It came around clinical material where he's starting to get to talking about his father. And they had a very distant relationship. And his father... [had been] very unsupportive.... this is a guy who never really had any man close to him. And in the context of the material... [there was] an intensity on his part to want to connect with me.

The therapist invited the patient to increase the frequency of his sessions because he felt that the increased time and continuity to talk would allow the patient's thoughts to develop and take shape more clearly.

Here, as in the second example, the development of the material is specifically about a better connection with the therapist; the other two examples illustrate the therapist's conceptualization that increased contact with them is a way in which the patient's engagement with themselves can be nurtured.

Why Patients Choose Less Frequent Sessions

Material from interviews in which infrequent sessions of less than once-per-week were discussed enlightened the analysis of the data concerning the establishment of an intimate connection between patient and therapist. The data on infrequency underscores the importance of the connection to the therapist. The lack of contact makes intimacy, which not all patients want, more difficult, and affects what help the therapist can offer the patient.

Most of the data on infrequency comes from the one therapist in the study who considered increasing frequency to be on a continuum that included terminating therapy, (no therapy), and infrequent (less than once-per-week) therapy. He said that the difficulty

in knowing how to help a patient increase frequency, "... also occurs when somebody wants to stop or claims they want to stop or wants to reduce the number of sessions. It all has some kind of meaning. And you have to... think real carefully [about] what the right thing to do [is]...."

Another therapist contrasted his experience in a more frequent therapy with his experience in a less frequent one. In a more frequent therapy:

> I'm more engaged.... I'm more in relationship with them. I know more about them.... the work can proceed more quickly, more deeply.... I see some people once every two weeks. Those are the most difficult therapies for me to really maintain a level of serious engagement on the deeper levels.

The first therapist shared his observations about the characteristics of the patients who want less frequency. He felt that they were people who, "May find ... the intensity of a relationship... [is] too difficult for them." One sub-group was described as,

> patients who have really crazy backgrounds. They sometimes stop and start therapy several times over the course of the years.... they stay for a few months, they stop, they stay. There's nothing you can do about it. All the interpretations in the world won't make any difference. They [have] just simply had such chaotic upbringings with parents who beat them, or neglected them, [that] they're almost borderline psychotic people.... you'll never feel like you're ever connected.... They never get that involved. They can't allow it because it's so scary for them.... their lives are such chaos there's never a moment for reflection. Because they're in survival mode.

Safety for these patients consists of keeping a distance between themselves and others; an intimate attachment, in which they come to depend upon the therapist to be a good, reliable figure, carries with it the threat of being hurt again. Because of their backgrounds, they are not self-reflective people. Their capacity to become more self-reflective is hindered from developing in therapy because, after the poor treatment they received as children, they are terrified of attachment. These patients contrast sharply with the examples of those people who, with the help of their therapist, "begin the discussion about dependency and making me too important in their lives and the fears around dependency. And not wanting therapy or the therapist to become too important."

A patient who was always ashamed to be in therapy exemplifies a description of this more frightened kind of patient. He came in because of marital trouble and used the

therapy to become clearer about a pattern of feeling overly responsible for his wife's difficulties. The patient had a mother, who had always been afraid to leave the house and who made the patient feel guilty for growing up and leaving home. The therapist was therefore aware of what difficulty this patient had in leaving relationships. One day, the patient abruptly announced that he was ending his therapy sessions. The therapist was not surprised:

> I could tell by the way he made sure... he didn't talk about him and me.... some clients will want to have a relationship with you.... He was just the opposite. He did not relate to me as another man, as a buddy or something like that.... he was probably not wanting to make me too important. Some people ...can't let the therapy become important because if they get attached they'll never be able to leave.... I predict he might be back.

This therapist strongly believes that more frequent sessions are usually the best option and is the only therapist in the study who extends the invitation to increase frequency to most of his patients. However, he also believes that infrequent sessions have to be an acceptable option because for some very frightened patients this is the only way to maintain a relationship, which is his primary concern. Being in even a "diluted" relationship with them at least allows him to offer some help and support. He also believes that for patients who want to terminate prematurely, like the one in the example, the best treatment is to state his disagreement with them clearly, but in an unrejecting manner, and let them leave. He believes this is what allows patients to return when they are ready. Keeping in contact, even if temporarily it is only as a presence in the patient's mind, is of primary importance.

CHAPTER 5: DISCUSSION

After reviewing the study questions and results, I will discuss the implications of the findings. The questions addressed in this study were 1) What makes a therapist think that a particular patient might benefit from being seen in psychotherapy more than once- per-week? When and how do they ask the patient about making this change? 2) How do therapists understand what impedes a patient from increasing their weekly session frequency and how do therapists work with that reluctance? Do therapists gain additional information about their patient's psychology by examining their own emotional reactions to the patient's reluctance?

Therapists used two different types of clues to suggest increased frequency. The first was related to the patient's problems or diagnosis. The second set of criteria were interactional and intersubjective in nature. Many therapists considered patients who were in a crisis, who were depressed, or who were functioning poorly as appropriate candidates for increased frequency. Therapist's feelings about insufficient time and their impressions about the interaction between themselves and a particular patient were important to their thinking that an increase in session frequency would be beneficial. These subjective criteria were as important in indicating to them that the patient needed more frequent sessions as the patient being depressed or in crisis. Therapists in the study felt that the chances for a successful therapy were greater the more deeply involved a patient became in thinking and experiencing a variety of feelings about himself and others, including the therapist. They believed that increasing the frequency of sessions to more than once-per-week provided a better environment in which the patient and the therapist could understand the patient's unconscious material. When patients got a chance to talk about their relationships, their needs and their inner life with therapists , the patients came to know themselves better, and to understand what had made it difficult to feel and behave in a more authentic way. Therapists in the study believed that more contact through frequent sessions, rather than a longer, once-per-week session therapy, were more apt to allow these deeper connections to be made. That is why, with appropriate patients, they pursued discussion about the patient's reluctance to increase session frequency.

The study participants also emphasized the importance of the patient's experience in the relationship with the therapist. Therapists described the unconscious fears and wishes that got mobilized and then articulated in more frequent therapy. The data on therapist's observations about patients who wanted to decrease the frequency of their sessions, or leave therapy, underscored the importance of the patient's connection to the therapist. These patients were characterized as being afraid of the intensity of a relationship because of their early experiences with unreliable and hurtful caretakers. Such patients were often unable to connect with the therapist, and their capacity to understand themselves more fully was hindered from developing.

In addition to a general belief in the benefits of more frequent therapy, therapists experienced longings for more contact with the patient. Therapists were frustrated when insufficient time with the patient placed a limitation on their ability to help the patient go more deeply into conflictual or painful material. Therapists had to measure their own wishes to see patients more frequently against their own needs for income and time when patients weren't easily able to pay for or schedule another session.

Therapists also felt that, at times, their wish to increase the frequency of sessions was a response to their patient's signals about a lack of time or frustration about slow progress in the therapy. They used what they sensed was their attunement with their patient's wishes, and made the recommendation for more frequent sessions, because they believed from the patient's signals as well as their own impression, that it would be beneficial to the patient. They thought this was a time when the patient would be emotionally receptive to the idea. This proved to be a fairly successful strategy. Some of the therapists favored this strategy in regard to issuing an invitation in order not to impose their own needs on the patient. This concern about imposing one's own desires on their patients made some therapists abandon initial thoughts about whether a patient was a good candidate for increased session frequency. Other therapists, when they believed the patient would benefit from more frequent sessions, felt less concerned about imposing their needs on the patient and invited them to increase the frequency of their sessions even when the invitation was not going to be welcomed.

Once a patient expressed reluctance to increase their session frequency, therapists tried to understand in what way the patient's hesitation was a reflection of the patient's

dynamics. Then the therapist sometimes pursued a discussion with the patient about their reluctance following this understanding. Therapists reported that these discussions could clarify the patient's difficulties both inside and outside the therapeutic relationship. Thus, the invitation could be an important therapeutic intervention whether the patient decided to increase frequency or not.

At other times, the understanding that emerged about the patient's dynamics made the therapist decide not to pursue further discussion about the patient's reluctance. Settling fee and scheduling issues, or deciding there was no way to resolve them, would terminate further discussion. Therapists also dropped discussion of more frequent sessions when they understood the patient needed to regulate their own degree of engagement in the therapy.

Therapist's hesitation to consider a patient for increased frequency, to invite them, or to pursue discussion about the patient's reluctance could hamper the process of increasing session frequency. Therapists' ability to understand the nature of their own hesitance, either as a product of their own dynamics or of fears that were evoked in the relationship with a particular patient, provided them with information about how to proceed with their patient.

Implications of the Results

Balancing the needs of the therapist and the patient was a central theme contained in every category of the results. It will continue to be an important theme in the discussion that follows about whether or not therapists are anxious about issuing an invitation when they do not sense a corresponding wish on the patient's part and what's involved in suggesting more frequency when a patient is complaining about the therapy.

Therapists in the study fell into two groups in regard to their willingness to proceed with the invitation in the face of expected patient reluctance. Three of the eight therapists expressed discomfort about using any other strategy to invite a patient to increase their session frequency other than the one in which they sensed that an invitation would be welcomed by the patient. These therapists expressed the most concern about imposing their own wishes on their patient. They seemed concerned that to do otherwise would harm the patient and would be tantamount to behaving like a narcissistically vulnerable parent who is unable to act in their child's best interests. These therapists liked feeling that their desire and

their patient's desire for more contact were linked. This seemed to eliminate the anxiety and shame connected with displaying their own needs and possibly being rejected for doing so.

The other five therapists seemed less concerned about imposing their needs on their patients. When they thought that there was a need for more frequency, they did not shy away from extending the invitation. They also looked for the right moment to extend the invitation, but when using this second strategy, the moment did not necessarily have to include indications that the patient wanted more frequency. These therapists might choose a moment in the therapy hour in which the problem that the increased frequency would address was viscerally present to them. They did not see the invitation as shamefully connected to needs of their own. In fact, one therapist spoke of the shame she would feel if she did not propose the increase when she thought it was indicated. She felt that by proffering the invitation she was attending to the patient's needs.

This second group included the therapist who invited most of his patients early in treatment to come more than once-per-week. He was quite comfortable having patients refuse the invitation. He felt that the ability to refuse was an important part of the work in the therapy of patients who had often submitted to the needs of others. Another therapist in this second group illustrated her lack of anxiety about her patient's accusation that her suggestion that they meet more often was only for the therapist's benefit. She had thought carefully about and expected her patient's reluctance before issuing the invitation, and also thought about the patient's explicit objections once they were made. The therapist acknowledged without shame that increased frequency would increase her income and make it easier for her to do good work, which were both needs of hers. However, she also felt that she was addressing an important characterological issue of the patient's by extending the invitation. Thus, she felt confident that the increased sessions would hold something of value for the patient.

The second strategy is based on a different conviction about how therapists' needs dovetail with those of the patient. These five therapists noticed their thoughts about wanting increased frequency just as the other three did. However, they more readily invited patients for whom reluctance was a likely response if they believed it was in the patient's best interest. They seemed to feel sure that their boundaries were clearly enough differentiated; they did not worry about being seen as too needy or too selfish. This allowed them more

freedom to recommend increased frequency. That freedom may be particularly helpful with patients who, because of their own narcissistic sensitivities to needing others, are likely to treat with contempt someone who shows a wish for more contact. This kind of patient fears making the therapist too important, and can either accuse the therapist of acting only in their own behalf, or create an atmosphere in the therapy in which the threat of this accusation occurring is likely if the therapist is bold enough to issue the invitation. This type of situation was cited by several therapists in the first group as one in which they might hesitate to inquire about increasing frequency, even when they felt it might be to the patient's benefit.

The therapists who proposed this second approach did not discuss the possible danger associated with it. The first group of three therapists, who advocated inviting patients primarily when the patient was likely to feel a corresponding wish to make the increase, did so in order to avoid imposing their own needs on the patient and damage the therapeutic relationship. There is evidence that the second group of five therapists, while not explicitly citing this danger, did take it into account. Included in this group are therapists who carefully consider possible objections from their patients before issuing the invitation, who discuss the issue with patients who never do make the increase and who advocate self-regulation in regard to increased frequency. Such examples provide evidence that these therapists do make room for the patients' wishes and fears. The invitation seems warranted to these therapists given both their own wishes and what they think is in the patient's best interest.

A second finding of the study is connected to the fact that several therapists (from the entire group of participants) responded to vague complaints about the therapy as an indication that the patient wanted more frequency. The steps in their thinking that led them to the invitation are not spelled out. One is left to conjecture about why a situation like this does result in more frequency and more engagement. What goes wrong when it does not work to suggest more frequency in the face of vague complaints about the value of the therapy? In the cases where the invitation does not sit well, the patient feels terribly misunderstood; the therapist is suggesting more meetings when the patient is not satisfied with what is transpiring. When the invitation feels right, the patient can experience it as if an almost magical translation of their hidden wish has occurred.

When the recommendation for increased frequency does not feel right to the patient, is it because the patient's ambivalence about therapy is so profound that a suggestion of more sessions has to be refused and, in some cases sends the patient fleeing from treatment? The patient's ambivalence could stem from a variety of sources, including a need to disavow their own wishes for more contact, a fear that their autonomy will not be respected or that their own self-hood will be subordinated to the therapist's. The possibility that the therapist is making errors that the patient is trying to articulate, cannot be ignored. On the other hand, has the therapist responded to the patient's dissatisfaction and thoughts about leaving treatment with feelings of shame about his/her own adequacy and, in an effort to repair this narcissistic hurt, offered more frequent sessions? Both of these scenarios seem plausible, and both could conceivably operate in the same instance. In the former case, the patient's fears about therapy may be uppermost. However, because the nature of the fears is not clear, the suggestion of more frequent sessions does not seem helpful in allaying those fears. In the latter case, the therapist's need to avoid a disruption of their own self-esteem takes center stage, forcing them to take action, i.e., suggest increased frequency, rather than respond empathically to the patient.

It is evident that the therapists in this study were deeply involved with their patients. They thought carefully, felt strongly, and struggled intensely to stay attuned to their patients and themselves. They endured confusion, shame and frustration in the process. They reported a variety of thoughts and feelings that resulted in their either moving confidently, or hesitantly because they were feeling confused about the motives behind their interest in seeing a patient more, or unsure of the patient's interest.

As both patient and therapist balance their respective needs and fears in negotiating increased session frequency, their relationship resembles a courtship. The therapist is indicating to the patient through the invitation to increase session frequency that they want to increase their involvement and connection with them. Because the invitation to increase the session frequency is a request for increased intimacy and commitment, it carries with it, as in a courtship, similar possibilities of risk and reward for each party.

As in a romantic couple, therapists have their own needs for intimacy. The need for attachment and for relationship is engaged for the therapist as well as the patient and may bring up conflict for the therapist when that need is exposed, as it is when offering an

invitation to increase session frequency. Therapists' ability to remain empathic can be negatively affected, especially at moments when they feel more emotionally vulnerable. The invitation to increase frequency can be such a moment for some therapists all the time and for other therapists only at those times when they invite particular patients.

Therapists feel vulnerable because they, like their patients, also have accompanying fears about the effect their needs for attachment and intimacy will have on others. These needs and fears help shape the form the therapeutic relationship takes. Each relationship is unique. As in any courtship, there is no guarantee that a productive relationship will ensue with increased contact, nor is it known completely beforehand what painful material might be touched on for the therapist and patient. Acting to recommend more contact reverberates against the therapist's template of early object relationships. When it is a troublesome or hesitation-filled process, the question arises about what the therapist is responding to, given their own inner model of relationships. When the patient's anticipated response to the invitation corresponds closely to a role or affect the therapist fears, troubled feelings may emerge for the therapist.

Several therapists reported that discussion with appropriate patients about their reluctance increased the patients' engagement with themselves and deepened the therapeutic relationship. Failure to pursue the issue of frequency with appropriate patients can result in patients having less knowledge about themselves in relationships and fewer opportunities to delve deeply into other important matters in their life. This situation is not unlike what can happen when one party in a courting couple either presses for more commitment or avoids it. Fears about making the request for more commitment can lead to a relationship which stagnates, while pressing ahead with a discussion of what more commitment means for each person can lead to increased intimacy, or at least to a clearer sense of why that's not possible.

Bacal (1996) discussed how frustration of the analyst's narcissistic needs can affect the therapy. Aspects of his discussion are useful for understanding the tension that therapists experience in preparation for, or when discussing increased session frequency with a patient. Bacal states that therapists, like everyone else, have needs for "... self-restorative and self-sustaining responses" from others (p.18); when doing therapy, these responses, also known as self-object responses, are needed from their patients. Since the 1950's, there has been a growing acceptance of the idea that a therapist's emotional

responses to the patient are an inevitable and useful means by which to understand the patient's unconscious needs. Bacal believes that practically speaking, the therapist's emotional responses are still often considered shameful and something from which the analyst must recover, an attitude that he feels block therapists from being maximally effective.

He argues that, "the analyst's self is ordinarily sustained in his work by ongoing self-object responses of the analysand" (p.22). These patient responses to the therapist's needs can be the almost unnoticeable transactions in an ongoing therapy and can include the patient coming regularly, paying a fee, using interpretations, and supplying associative material. When these needs for affirmation are frustrated, the therapist's ability to function analytically may diminish, and a disruption may occur in the therapeutic work. Bacal feels a disruption is especially likely to happen if therapists are ashamed of their needs and of the dysphoric and sometimes ego-dystonic emotions such as hatred, boredom, and contempt, that can accompany their frustration. The therapist acts out, rather than using the frustration as an opportunity to notice a disturbance within the relationship and the way a patient may be disavowing their own needs. The belief that an intensifying need for affirmation experienced by the therapist can be used as a signal to investigate rather than, at the extreme, serve as shameful evidence of a therapist's lack of fitness, corresponds to Sandler's (1976) view that important unconscious experiences of the patient can be understood through the roles they induce in the therapist.

Bacal's specificity about what therapists need in the therapy situation sheds light on the successes and difficulties they can have in dealing with the fantasized or stated reluctance of patients whom they would like to see more frequently. Therapists, Bacal writes, need to have affirmation that they are good therapists in whatever way they conceptualize that function, so that they feel effective and special to their patients. Their need to give, their need to be seen as having a special capacity to be understanding and their need to be seen as people whose motivations are primarily caring and humanistic are important, and perhaps universal ways in which therapists wish to conceptualize themselves. When these needs and expectations of the therapist are met by the patient, Bacal describes "... a situation of mutual regulation - a kind of harmony...- [that] prevails in the analytic ambience" (p.25).

This "mutual harmony" is the situation the therapists in the study describe when they feel that their desires and that of their patients' are linked by the wish to have more contact. The therapist's desires may represent a controlled regression that the therapist undergoes in an effort to remain attuned to the patient (Bacal, 1996). The therapist's own needs are also met in this transaction. First, the therapist is experienced by the patient as being understanding and caring, which fits the way that therapists need to feel. The patient's wish to be seen more frequently can be evidence of their commitment to the treatment, another affirmation of the therapist's specialness which "... also meets the [therapist's] need for attachment to a significant other..." (p.29). An intimate atmosphere between the therapeutic couple is produced.

No wonder some therapists prefer to feel there is a match between their desire and the patients'! They seemed aware of the power their needs for affirmation had and worry about the damage it might do. This damage ranges from the pain of their own fragmentation (due to those needs being frustrated beyond a containable point), to acting out, which can hurt their patient. Hurting the patient can result in further damage to the therapist's wish to see himself or herself as a good therapist. Seen in this light, their strategy of primarily inviting patients to come to more frequent sessions after receiving some sign that the patient wished for more contact, appears justified. The question of whether there are patients for whom this strategy is unnecessary did not get raised by this group of therapists. The heart of the dilemma in inviting patients who will probably be reluctant to increase their frequency, can be found in the therapist's own difficulty in recognizing and giving the appropriate weight to their wishes.

Bacal's concepts of "signal disruption in the analyst" and countertransference are useful in explaining why there can be so much hesitation before inviting the patient to more frequent sessions after patients have made their reluctance known. "Signal disruption" is the term used when therapists note that their needs for affirmation are not being met, and yet they are able to maintain a stable sense of self and to continue to function analytically. When therapists hesitate to act after thinking about inviting a patient for more sessions, or reluctance arises in the patient after the invitation for more sessions has been given, these therapists maintain their ability to think about their patients needs and objections. They do not become overly uncomfortable about wishing to, or having expressed their own wishes.

This is where the value of the two strategies, understanding the patient's dynamics and working with their own hesitance, described in the results section, becomes germane.

One of the therapists in the study spoke about how after inviting her patient to come to another session each week, the patient accused her of thinking only of her own needs. The therapist reviewed her understanding of the important issue that she thought increasing the frequency might address, and then spoke about the way in which she hesitated and thought about the patient's accusation to deal with some of the discomfort she experienced.

> You know there's always a grain of truth [in the patient's accusation]. So that's the part for any of these people that I could respond to. You know when she says, 'you just want me for your own needs, financial and otherwise `... on one level she's right unless I didn't have an opening.... I would rather see people more often.... And there was some feeling... about how it wasn't okay to want more contact in the message from her that I reacted to.... she would say all therapists want this.... she's not wrong. At least for my kind of therapist. So I had to check my motives. ... and say is this really the right clinical recommendation or does it come from some other [motivation] or is it both and, ... is that bad? So I felt a bit pierced in private. Sort of exposed... once I could check in with myself about it, I could own [it] -- yeah, I thought the work would be more beneficial, which I could say to her.

The ability to think about themselves and their patient's dynamics allows the therapist to minimize the effect that having their need for affirmation frustrated has on them and their work with the patient. These strategies can help the therapist try to make conscious sense out the patient's reactions and to their own discomfort.

Bacal defines countertransference as a reaction which occurs when the disruption caused by the frustration of the analyst's needs for affirmation affects his or her ability to stay attuned to the patient and to respond optimally. The results of this study contain several vignettes that may be examples of this kind of reaction. One therapist, who because it never occurred to her that her patient "... would ever want more of me", hesitated for over a year before inviting her patient to increase the session frequency. Another therapist, who until she was describing her patient to me, had not been aware of either the shame she had felt in wanting to see him more frequently, or her lack of ability to pursue the issue of his reluctance after his abrupt refusal of her invitation. The final example that illustrates Bacal's concept of countertransference can be found in the vignette of the therapist who felt that he had let a patient leave therapy prematurely because his own "batteries" were worn down. Of these three examples, the first two proved to be countertransference reactions from which

the therapists were able to recover and become attuned to their patient and themselves. These examples illustrate both how good therapists work with themselves all the time and the growth enhancing possibilities of these often difficult situations regarding increasing session frequency.

In the third situation, the therapist attributed his failure to maintain the relationship with the patient to his weariness due to personal difficulties that coincided with the patient's insistence about leaving, which the therapist felt was connected to the man's fears about having a relationship. It exemplifies the limits every therapist-patient dyad potentially has, and sounded a note of caution to therapists not to expect too much of themselves. As the therapist in this case noted, "You can't be perfect in all these things." Therapists can make recommendations, and try to be as responsive as possible to what the patient wants and is afraid of. Working with this material can shape the therapy in a way that can be quite effective and helpful. However, it is not always possible to do so. Therapists' ability to withstand these disappointments can be found in their realistic view of their adequacy, and acknowledgement of imperfection.

Bacal's ideas regarding the role the therapist's frustrated narcissistic needs play in a therapy also have some application to the success some therapists had in "treating" patient's vaguely worded complaints about the therapy with an invitation to increase session frequency. These experiences can be contrasted to instances when suggesting increased frequency to patients who feel dissatisfied with something in the therapy process leave them feeling very misunderstood. Bacal's concept of countertransference fits these instances where a therapist's need to feel affirmed for their ability to understand and be empathic is being frustrated. The frustration at not understanding more about their dissatisfied patient could culminate in the therapist acting to stave off feelings of failure and anxiety about the situation by inviting the patient to more frequent sessions. The invitation would represent a failure of the therapist to continue trying to understand the meaning of both the patient's complaints and their own sense that something the patient was doing was contributing to the unsatisfactory experience.

These experiences differ from the reports two therapists give regarding the impact of these kinds of cases. One therapist presented his idea that the patient's complaints represented progress for people who had never let down much with anyone and spoken

about their disappointments. The attunement this therapist feels is supported by his idea, in which he feels important and special to the patient, i.e. the patient is allowing him to be privy to previously undisclosed sorrow and disappointment. In the second example the therapist, who had been unable to understand her patient's complaints about stagnation in the therapy, suddenly became able to focus on past thoughts of her own about how much more the relationship between she and the patient could be developed and on a new idea that the patient might want to "have more of her". This resulted in an invitation to the patient to meet more frequently, which took place as the patient was complaining about feeling stagnant. The invitation was accepted with an alacrity that surprised the therapist. Before her moment of clarity, the therapist could be said to be having a reaction in which her ability to feel important to the patient was blocked. She had not been able to discuss the relationship more fully because it would have placed her in danger of feeling humiliated if the patient's expected response of a lack of equal interest in her had materialized. Although she didn't take any precipitous actions, her lack of action, due to the partial frustration of her need to be affirmed, was affecting the development of important material in the therapy.

Considerations About Session Frequency With Respect to the Literature

It was reported earlier that although there is a dearth of information about frequency in textbooks on psychotherapy technique, the psychoanalytic literature concurs with the assumption of this study that more than once-weekly sessions in an expressive therapy can be a factor leading to a more successful outcome. The results of this study showed that the therapists also agreed with this assumption. They believed a connection existed between session frequency and the deepening of the relationship between the therapist and patient, as well as between increased frequency and the development of a greater understanding of the issues that brought the patient to therapy.

The psychoanalytic literature about expressive therapy is usually being written with an eye to differentiating it from supportive therapy. As such, it often contains discussion about the psychological capacities that enable patients to use this approach. Perry et al (1983) included indications for expressive therapy such as a capacity for self-object differentiation and reality testing, tolerance for anxiety and depression, impulse control,

capacity for introspection, ability to form emotionally meaningful and reciprocal relationships and internal object constancy.

The therapists in the study spoke about the way they come to think of a patient as a candidate for more frequency in very different terms. Although depressed and crisis patients were mentioned by the therapists, the majority of their energy was spent describing a more subjective experience that brought them to think about the frequency issue for a particular patient. They were aware of the longing for more time, or of feeling that they could not read a patient, or that an eager patient needed more time with them to increase their self-engagement. In contrast to the expressive therapy literature, the therapists in this study seemed more focused on their subjective reactions to the patient rather than whether the patient met a specific requirement, such as being psychological minded. I am not suggesting that the therapists don't use these criteria - they may provide an almost unconscious background against which the therapist's subjective experiences are played out. In fact, when discussing patients who want to cut back on session frequency or leave therapy, the gist of what the therapists spoke about was the limited capacity of these patients to form mutual and reciprocal relationships. However, their subjective experience is what makes them start thinking about increased frequency for a particular patient. The expressive therapy literature ignores the current emphasis on the intersubjective field of the patient and therapist when it focuses on patient characteristics in isolation as criteria for increased frequency.

In the literature on the conversion of psychotherapy to psychoanalysis, both the therapist's and the patient's motivation and fears are given equal emphasis (Horwitz 1995; Bernstein 1983,1995), and the way in which the therapist and patient influence each other, consciously and unconsciously, is felt to be quite important (Stolorow, 1995; Skolnikoff, 1995; Bassen, 1988). The therapist's ambivalence about recommending psychoanalysis, or concern about what is motivating the recommendation may manifest itself in many ways, from having anxiety about being manipulative and seductive, or offering a tentative invitation, to failing to continue discussion about the patient's reluctance (Bernstein, 1995). The invitation itself may be an effort by the analyst to conquer feelings of hopelessness, impotence, urgency, and incompetence that arise either from stimulation and frustration of his or her own needs for narcissistic supplies or omniscience, or in response to the patient's

unconscious struggles (Bernstein 1983,1995; Skolnikoff 1995). The patient may have fears that increased frequency will lead to a loss of control, result in the emotional hurts that are imagined to come when one is intimate or dependent on another, as well as stir up conflicts about sexual and aggressive impulses (Bernstein, 1990).

The conversion literature and the therapists' descriptions of both how they arrive at considering a patient for more frequency and what strategies they use to understand the patient's reluctance complement each other in a couple of ways. The strategies of understanding the patient's dynamics and therapists' work with their own reluctance bolster the assumption found in the conversion literature that both patients' and therapists' needs play a part in the invitation to increase sessions. There is also concurrence from both camps about the advisability of self-regulation for patients in regard to frequency.

Only Bassen (1988) articulated her subjective experience clearly in her clinical case descriptions of the transference-countertransference enactments that can occur around the recommendation for increasing session frequency. As an analytic candidate she both wanted and needed to do analytic work. She was also able to see the strong feelings she experienced with two of her patients as being both her own wish for more to happen in the therapy, as well as a response to her patients' wish to have someone else take the initiative in matters of increasing commitment.

Bassen agrees with the study therapists about the need to be aware of the power of their own motivations for wanting the increased frequency and the dynamics that can lie behind a patient's reluctance. Her case examples demonstrated the complexity involved in understanding how intertwined patient and therapist fears and motivations could be. Both of her patients seemed to want more from the treatment. However Bassen's recommendation for psychoanalysis (an increase of two more sessions per week) proved to be the impetus for each patient to express much of the negative transference that had been covert. Bassen's impression was that she had been "invited" by the patient to pursue them, only to be the target of the intense emotions associated with each of her patient's fears of being controlled or abandoned once she invited them to consider analysis. Bassen's examples bear considerable resemblance to cases discussed earlier where an invitation to increase frequency was extended to patients who had vague complaints about their progress, and who seemed to want more from their therapy.

Because money carries powerful symbolic meaning, authors have emphasized how difficult a subject it can be for both therapist and patient. The notable absence of much data in this study regarding fees as it relates to the issue of increasing session frequency may reflect this difficulty in discussing money. The data from the study that is available is, in contrast with discussion about other aspects of the work with reluctant patients, remarkably bland. Most of the therapists stated that they had a sliding scale of fees and that financial issues were often a part of discussions involving increased frequency. Only two of the therapists expressed some conflict between achieving a beneficial frequency and the need to have a fee high enough for them to meet their financial needs. One of these two also expressed some discomfort about participating in a system in which a patient's financial means could dictate what form of treatment they would get. While this lack of discussion could mean that this group of therapists was comfortable with their needs for money, this seems an unlikely conclusion. Most of the conflict that therapists in the study expressed had to do with the concern about imposing their own wish to work at a greater frequency on the patient.

Money can symbolize many things; Kreuger (1988) suggested that money might be connected with dependence and greed - issues about which therapists are often uncomfortable. There may be other needs to feel special that money fulfills and ways in which it may therefore be difficult to ask for more money, such as when the invitation for increased frequency is being made to redress the therapist's feelings of incompetence. It may be that the therapists in the study found it more ego-syntonic to express their worry about wanting too much from their patients in terms of wanting more contact rather than in revealing their wish for money. These difficulties in discussing money issues may extend to reticence about having full discussions with patients who state that they "can't afford" more sessions, the meaning of which for some patients can be quite complex.

Limitations of the Study and Implications for Future Research

The study participants were all experienced, psychoanalytically oriented psychotherapists. The sample was small and while themes and findings from this study might emerge in a study with a different group of psychoanalytic therapists, it is unlikely that this study has represented the entire breadth of themes and dynamics possible. It is

possible that with another group of experienced, psychoanalytic therapists and a different interviewer other findings would be produced. This is both because of the limited sample size and the unique intersubjective fields which would be created by different therapists and a different interviewer.

As noted earlier, there was limited discussion of money in this study. Both my lack of asking more questions about money and the lack of information offered by the therapists reflect a discomfort with the subject. Money is an important issue. It is one that has clear social implications for people in regard to being able to obtain the mental health treatment that would be most beneficial. It also can be an especially confusing issue for the therapist since this is an area in which their own needs can so clearly diverge from their patients' and the reality issues can hide the myriad of psychological meanings money can have for each participant in the therapeutic dyad.

Several of the therapists in this study spontaneously commented on how helpful talking about the issue of increasing frequency was, and wondered what effect the thinking they did in the interviews about themselves and certain patients would have on their practice in regard to this issue. It may be that the findings from this study will provide material for both seasoned and beginning professionals to review on this understudied subject.

A study using a larger sample of therapists, and a lengthier interview might be helpful in looking at different aspects of this problem. Particular areas that were neglected in this study could be taken into account. It would be interesting and helpful to focus on the timing of the invitation, since the consideration of a patient for more frequent sessions seems to be a time when issues that are often difficult to articulate may be affecting the therapeutic couple.

Focusing on the reluctance of patients to increase session frequency served as a point of entry into how therapists think patients become more engaged in – or retreat from – the therapeutic process. Patient and therapist anxieties about intimacy emerged as a crucial issue that affected when and how increased frequency was discussed. As in a couple, patient and therapist needs were sometimes complementary and at other times were in conflict. How these needs were addressed and negotiated had a decisive impact on the engagement of both parties.

APPENDIX A

LETTER TO PROSPECTIVE SUBJECTS

Terese G. Schulman, LCSW
5625 College Ave., Suite 208
Oakland, CA 94610
(510) 444-2602

Dear ,

I am writing in order to invite you to participate in a study about how therapists understand and work with patients who are reluctant to increase the frequency of their therapy from once to two or more sessions per week. Some patients, despite being suitable for intensive treatment, are reluctant to come to therapy more frequently. The professional literature contains very little about this topic. This study, which I am conducting as part of the requirement for my doctoral degree at the California Institute for Clinical Social Work, is intended to fill the gap in the literature. Everyone who participates in my study will get a summary of the results.

If you agree to participate in the study, I would interview you for about 50 minutes at a location and time that is convenient to you. The interview would be tape-recorded; the information will be kept confidential and your anonymity will be protected. It is possible that, in order to clarify something from our interview, I would have to contact you for a few minutes by phone. I hope that you are interested and available to participate.

If you are able to participate in this research project, please complete the enclosed Information Form (which will take less than 10 minutes) and return it in the enclosed self-addressed envelope as soon as possible. I will then be in touch with you regarding your potential participation in this project.

Please feel free to contact me at the above number if you have any questions. Thank you.

Sincerely,

Terese Schulman, LCSW

Encl.

APPENDIX B

PERSONAL INFORMATION FORM

Please return this form in the enclosed SASE. Thank you.

NAME_____ AGE

ADDRESS

_____

PHONE (day) _____ (evening)

PROFESSIONAL DISCIPLINE AND LICENSE: Year acquired _____

Social Worker___ Psychologist

Psychiatrist ___ MFCC

CURRENT PRACTICE SETTING:

Private practice_____% Educational institution _____%

Agency_____% Other (specify) _____%

THEORETICAL ORIENTATION

Ego Psychological ____ Control-mastery _____

Eclectic psychoanalytic___ Object-relations _____

Self-psychology___ Other (specify) _____

AVERAGE NUMBER OF PATIENTS SEEN PER WEEK

Number of patients seen once/per week

Number of patients seen twice

Number of patients seen three

" " " " four/five

WHAT PERCENTAGE OF PATIENTS THAT YOU ARE CURRENTLY SEEING MORE THAN ONCE-WEEKLY BEGAN THERAPY ON A ONCE-WEEKLY THERAPY?

Estimated percentage: _____%

What percentage of these therapies is predominantly insight-oriented? _____%

WITH APPROXIMATELY HOW MANY PATIENTS PER YEAR IS INCREASING SESSION FREQUENCY AN ISSUE? _____

LENGTH OF TIME IN PRACTICE SEEING PATIENTS MORE THAN ONCE/WEEK

Less than five years _____ Ten to twelve years ____

Over twelve years _____ Five to ten years

PERSONAL THERAPY Have you been in, or are you currently in a therapy of more than once-per-week? Yes___ No___

CONSENT FORM I have enclosed an example of a consent form. Would you be willing to sign it prior to an interview if you participate in this study? Yes __ No___

APPENDIX C

INFORMED CONSENT STATEMENT

Terese Schulman, L.C.S.W.
5625 College Ave., Suite 208
Oakland, CA 94610
(510) 444-2602

I,_____, willingly consent to participate in a research project on therapists' views on dealing with patients who are reluctant to increase the frequency of their therapy conducted by Terese G. Schulman, L.C.S.W under the direction of Sylvia Sussman, Ph.D., faculty member at the California Institute for Clinical Social Work. This research will examine the experiences of psychotherapists in treating patients who could benefit from more frequent psychotherapy sessions but are reluctant to do so.

I understand the procedure as follows:

1) A 50 minute audio-taped interview will be conducted in a confidential setting to be arranged between me and the researcher. I will be talking about my thoughts and feelings about working with patients who are reluctant to increase the frequency of their sessions.

2) I am aware that there is little potential risk for emotional discomfort involved in participating in this study. Benefits that may accrue to me would be clarifying my thoughts about working with reluctant patients and receiving a summary of the study results.

3) I understand that I may withdraw from the study at any time. If this study is published, all identifying information will be eliminated and my identity will be protected. No names or identifying information will be used in any oral or written materials. The audio tape will be erased at the completion of data analysis.

4) I understand that I have the option to receive a copy of the results of the study. Send me a summary of the results. Yes_No

Signature_____ Date_____

APPENDIX D

PRELIMINARY INTERVIEW GUIDE

Introduction

First, I want to thank you for helping me with my research. I hope that our discussion will be illuminating for both of us.

As I explained to you earlier, the purpose of my study is to clarify how therapists understand and deal with the reluctance of patients to increase the frequency of their psychotherapy sessions to more than once-per-week. There is very little written about this particular clinical problem. The patients I would like to discuss with you are those whom you would work with in a predominantly insight-oriented manner. My hope is that my discussion with you about your thoughts, feelings and ways of working will help shed some light on this area.

You have already signed the Informed Consent Statement so that you are aware that all your answers will be kept confidential. You have the right not to answer any of my questions or to end your participation at any time.

Do you have any questions before we begin?
Let's begin by having you tell me ...

Interview Guide Topics

The following topics will be used to guide the interview, discussion and elaboration process:

I. Indications the Therapist Uses for Considering Increasing Session Frequency

Therapists work with patients at a variety of frequencies.

1. What do you notice about your thoughts and feelings or your interaction with a patient that makes you think an increase in frequency from once-a-week would be desirable? Let's begin with a particular patient and then we can talk more generally. Think of a patient with whom you have increased sessions from once-per-week, or a patient with whom you would like to increase sessions, and tell me what comes to mind that made/makes you think a change in frequency was/would be desirable?

2. Why wasn't the original contract for more sessions per week; did something change?

3. Is this a typical experience? (Different experiences?)

4. Do you ever think that the wish to see a patient more frequently is related to their dynamics? (Example?)

II. Inviting the Patient to Increase Session Frequency

Therapists have different styles of speaking with patients about increasing their frequency. Some therapists wait for the patient to indicate their interest; others recommend increasing frequency.

1. If you don't recommend it, how did you arrive at this way of working?
2. If you do recommend, let's discuss a specific patient, either the one you just told me about or another one who is more vivid in your mind. (How addressed the issue with them?)
(Was this typical of the way you begin the discussion of increasing frequency?)
3. Does the way in which you discuss increasing frequency change if the recommendation comes early in the treatment rather than if you have been seeing the patient for a while?
4. Ever hesitate to make the recommendation?
(If so, what do you make of that phenomenon?)

III. Internal Processes the Therapist Uses to Understand the Patient's Reluctance

When a patient either refuses the recommendation for increased frequency or expresses reluctance and uncertainty, therapists can experience strong reactions.

1. In thinking about a specific patient or two, what considerations about yourself, the patient and your work together do you draw on to help you understand why your patient turned down your recommendation or is hesitant to increase session frequency?
(Are these considerations typical of the way you work with your private reactions?)
(Does the patient's manner of refusal affect your way of thinking about what it means?)
2. Is it important to you that you understand the meaning your invitation had to the patient?
(If so, can you give me an example of the understanding you reached about a particular patient regarding the meaning and timing of your invitation?)
3. Do you ever feel some hesitation to follow up discussion of the refusal?
(If so, can you tell me how you understand that?)

IV. The Therapist's Personal Feelings

Most therapists have, in addition to the countertransference feelings elicited by the patient, a response to being turned down that is typical for them and related to their own psychology.

1. Do you have such a response?
(Would you be willing to share something about it with me?)
(Give an example of how this worked with a particular patient?)
(Other experiences that are different?)

V. Working with the Reluctant Patient

1. Do you have a general way that you work with a patient who is reluctant to increase their session frequency from more than once-per-week?
(How did you arrive at that method?)
2. Do you lower your fee at all to accommodate a patient's financial or emotional need?
3. Can you give me an example, using a particular patient or two, of the most difficult aspects for you about the work around a patient's reluctance?
(Are other aspects of the work around a patient's reluctance difficult or awkward for you?)
4. Do you ever find yourself questioning your motives for recommending increased sessions to a patient? (How do you understand this?)
5. What are the rewarding aspects of working on the issue of increasing frequency with a patient?

VI. Closure

1. Is there anything else about this topic you would like to add?
2. Would you like to say anything about your experience of this interview?

BIBLIOGRAPHY

Alexander, F. (1954). Psychoanalysis and psychotherapy. Journal of the American Psychoanalytic Association, 2, 722-733.

Aron, L., & Hirsch, I. (1992). Money matters in psychoanalysis. In Skolnick, N. & Warshaw, S. (Eds.), Relational perspectives in psychoanalysis (pp. 239-256). Hillsdale, New Jersey: The Analytic Press.

Bacal, H. & Thomson, P. (1996). The psychoanalyst's selfobject needs and the effect of their frustration on the treatment: A new view of countertransference. In basic ideas reconsidered: Progress in self psychology. Volume 12. Arnold Goldberg, (Ed.) Hillsdale, N.J.: The analytic press.

Basch, M. (1988). Understanding psychotherapy. New York: Basic Books, Inc.

Bassen, C. (1989). Transference-countertransference enactment in the recommendation to convert psychotherapy to psychoanalysis. The International Review of Psychoanalysis, 16(2), 79-92.

Bernstein, S. (1983). Treatment preparatory to psychoanalysis. Journal American Psychoanalytic Association. 31, 363-390.

Bernstein, S. (1990). Motivation for psychoanalysis and the transition from psychotherapy. Psychoanalytic Inquiry, 10(1), 21-42.

Bibring E. (1954). Psychoanalysis and the dynamic psychotherapies. Journal American Psychoanalytic Association, 2, 745-770.

Blanck, G., & Blank, R. (1974). Ego psychology: theory and practice. New York: Columbia University Press.

Chessick, R. (1974). The technique and practice of intensive psychotherapy. New York: Jason Aronson.

Cohler, B., & Gedo, P. (1992). Session frequency, regressive intensity and the psychoanalytic process. Psychoanalytic Psychology, 9(2), 245-249.

Cook, T., & Campbell, T. (1979). Quasi-experimentation: Design and analysis issues for field settings. Chicago: Rand McNally.

Dewald, P. (1972). The Psychoanalytic Process. New York: Basic Books, Inc Publishers.

Francis, A., Clarkin, J., & Perry, S. (1984). Differential therapeutics in psychiatry: The art and science of treatment selection. New York: Brunner/Mazel.

Freud, S. (1913). Further recommendations in the technique of psycho-analysis. Collected papers, 2, 344-365. New York: Basic Books, Inc.

Garfield, S., & Bergin, A. (1986). Handbook of psychotherapy and behavior change. New York: John Wiley and Sons.

Gill, M. (1988). Converting psychotherapy. Contemporary Psychoanalysis, 24(2), 262-274.

Glaser, B. & Strauss, A. (1967). The discovery of grounded theory: strategies for qualitative research. New York: Alpine Publishing Co.

Greenson, R. (1967). The technique and practice of psychoanalysis. (Vol. 1). New York: International Universities Press.

Horwitz, L. (1990). Psychotherapy as a trial for psychoanalysis. Psychoanalytic Inquiry, 10(1), 43-66.

Joseph, D. (1990). The fundamental rule: Its utilization in the conversion of psychoanalytic psychotherapy to psychoanalysis. Psychoanalytic Inquiry, 10(1), 88-106.

Krueger, D. (1986). Money, success, and success phobia. In Krueger, D. (ed.), The last taboo: Money as a symbol and reality in psychotherapy (pp. 3-16). New York: Brunner/Mazel.

Levine, H. (1985). Psychotherapy as the initial phase of a psychoanalysis. International Review of Psychoanalysis, 12, 285-297.

Lichtenberg, J., & Levi, D. (1990). Psychotherapy to psychoanalysis: A method of study. Psychoanalytic Inquiry, 10(1), 7-20.

Luborsky, L., Crits-Christoph, P., Mintz, J., & Auerback, A. (1988). Who will benefit from psychotherapy? New York: Basic Books, Inc.

Malan, D. (1979). Individual psychotherapy and the science of psychodynamics. London: Butterworth, Co.

Malin, A. (1990). Prologue. Psychoanalytic Inquiry, 10(1), 1-6.

Menninger, K. (1958). Theory of psychoanalytic technique. New York: Basic Books.

Mitchell, S. (1988). Relational concepts in psychoanalysis. Cambridge, Massachusetts: Harvard University Press.

Mischler, E. (1986). Research interviewing: Context and narrative. Cambridge, Massachusetts: Harvard University Press.

Natterson, J.M. & Friedman, R.J. (1995). A primer of clinical intersubjectivity. New York: Jason Aronson.

Oremland, J. (1991). Interpretation and interaction: Psychotherapy or psychoanalysis? Hillsdale, New Jersey: The Analytic Press.

Paolini, G. (1981). Psychoanalytic psychotherapy: Theory, technique, therapeutic relationship and treatability. New York: Brunner/Mazel.

Patton, M. (1990). Qualitative evaluation and research methods. Newberry Park, CA: Sage Publications.

Perry, S. (1987). The choice of duration and frequency for outpatient psychotherapy. American Psychiatric Association Annual Review, 6, 398-413.

Perry, S., Francis, A., Klar, H., & Clarkin, J. (1983). Selection criteria for individual dynamic psychotherapies. Psychiatric Quarterly, 55(1), 3-16.

Pigman III, G. (1990). Conversion of psychotherapy to psychoanalysis: The policies of the institutes of the American. Psychoanalytic Inquiry, 10(1), 131.

Rangell, L. (1954a). Psychoanalysis and dynamic psychotherapy - Similarities and differences. Journal of the American Psychoanalytic Association, 2, 152-66.

Reid, P. (1980). Basic Intensive Psychotherapy. New York: Brunner/Mazel.

Renie, D.L., Phillips, J.R., & Quartaro, G.K. (1988). Grounded Theory: A Promising Approach to Conceptualization in Psychology? Canadian Psychologist. 29(2). 139-50.

Rothstein, A. (1995). Psychoanalytic technique and the creation of analytic patients. New York: International Universities Press, Inc.

Skolnikoff, A. (1990). The emotional position of the analyst in the shift from psychotherapy to psychoanalysis. Psychoanalytic Inquiry, 10(1), 107-18.

Stolorow, R. (1990). Converting psychotherapy to psychoanalysis: A critique of the underlying assumptions. Psychoanalytic Inquiry, 10(1), 119-130.

Strauss, A., & Corbin, J. (1990). Basics of qualitative research. Newberry Park, CA: Sage Publications.

Wallerstein, R. (1969). Introduction to panel on psychoanalysis and psychotherapy: The relationship of psychoanalysis to psychotherapy - current issues. International Journal of Psychoanalysis, 50, 117-126.

Wallerstein, R. (1989). Forty-two lives in treatment. New York: Guilford Press.

Wolberg, L. (1988). The technique of psychotherapy. (Vol. I). New York: Harcourt Brace.