THE ANALYTIC FRAME AND BEYOND: RECONSIDERING FERENCZI'S CONTRIBUTIONS

YK Chan[1]

ABSTRACT

The concept of the analytic frame is discussed with the analogy of the frame as a tarting point. Various aspects of the concept are presented, with a particular focus on those of neutrality and abstinence, which lead to theoretical and practical problems within the analyst-patient relationship. Failure of the orthodox Freudian analysis for patients with severe character disorder indicates the need for accommodation of the analytic frame. Sandor Ferenczi's contributions are discussed in terms of his innovative and humane transcendence of the orthodox analytic frame in order to make room for the patient, as well as the analyst. Different patients and forms of treatment require different analytic frames and psychoanalysis should not focus completely on the patient to the exclusion of the analyst.

Key words: Psychoanalysis, Psychotherapy, theory

INTRODUCTION

A frame serves to distinguish one thing from another, to differentiate between inside and outside, or to contain things within. The frame itself, in contrast to its content, should be more solid, firm, and constant; for example, it would be impossible to confine water within a gaseous frame. The frame is also the limit or boundary, telling us where things end. This essay will illustrate the concept of the analytic frame with reference to this analogy. The problems of rigid adherence to this frame are presented with reference to its artificiality, practical impossibility, and the lack of human touch in the analysis. Sandor Ferenczi's contributions are discussed in terms of his innovative and humane transcendence of the orthodox analytic frame. His advocacy of the salience of the therapeutic relationship is also presented. Although psychoanalysis or psychoanalytic psychotherapy is not practiced by the majority of clinicians in Hong Kong,(1) the following discussion contains information about the intricacies of analytic therapy, some of which are common to all forms of psychotherapy.

THE ANALYTIC FRAME

The analytic situation is to be distinguished from an ordinary social situation, or any other circumstances involving two people. There is a constant physical setting, the content of which should reveal as little about the analyst's uniqueness as possible, so that the analyst's personal elements do not disturb the development of transference. This may sound rather ideal or even impossible, as the requirement suggests a vacuum when carried to the extreme. Nevertheless, the guiding principle of neutrality is to be upheld. The patient

1.- Address for correspondence: Mr YK Chan
Clinical Psychology Unit 4
Social Welfare Department
1204-06 City Landmark One
Tsuen Wan, NT
Hong Kong, China
E-mail: chanykee@hkusua.hku.hk

lies on the couch with the analyst sitting next to, but out of sight of, the patient. Although the origin of this arrangement can be traced back to Freud's famous remark of his inability to tolerate eye contact with so many patients everyday, the analytic meaning and functions has been well documented. (2) The patient is more likely to regress when lying on the couch as this resembles the posture of the baby in bed or even the fetus within the womb. In contrast to standing up or sitting straight, which entail more independence and imply facing the world and hence the reality, lying down means facing the direction of the sky, from which the source of gratification and frustration would usually come during infancy. Furthermore, by not seeing the facial expressions or outlook of the analyst, the analyst might appear more neutral and the cultivation of transference towards a supposedly neutral object is enhanced.

The setting also ensures privacy during the sessions, secluding patients from the worry of daily life. The analytic process appears to be more exclusive in terms of confidentiality and the analyst's time and attention, as well as their derivatives and internal representation in the unconscious. This exclusivity also applies to the focus on the patient's intrapsychic world and the intricacies of the transference and counter-transference within the analytic relationship.

The regular time and duration of the sessions are important for consistency and continuity, as well as the love and care of the analyst. The patient will have the anticipated the session to look forward to, or to avoid. The patient and analyst will also have pre-arranged and agreed vacation times, which represent the union and separation between the baby and caretaker. Such arrangements resemble the feeding schedules of babies to make them feel loved and worthy via actions, for example the regularity of sessions, instead of words. (2) The limited duration of each session reminds the patient that there must be an end to each journey in his internal world and depicts the finite essence of life; the analyst would then presumably be more like a real person with his own needs. The limited time also serves to distinguish the analytic hour from the other hours of the day (the inside versus the outside of the frame) in terms of the intrinsic difference in the content and process of the relationship. Hence, between-session contact is not encouraged. This implies that, other than the analytic relationship, the analyst will not have any other type of relationship with the patient.

The non-existence of indefinite sessions or sessions-on demand implies that the patient will not be infinitely gratified. The availability of the analyst's time for other patients is a reminder of the fact that the analyst is an incidentally frustrating object who is only available at the appropriate time. The omnipotence of both the patient and the analyst is therefore curbed.

The container function of the analytic frame is salient given the volatility and fluidity of the analytic process. It has to be firm enough for the patient to feel safe to explore the intrapsychic material and archaic feelings. The aim is not reassurance, but to be open to feelings and to enable them to come out. The patient will remain frustrated about most of his infantile needs and wants expressed in the analysis. This frustration is not to be confused with emotional apathy or lack of concern on the part of the analyst. The analyst is to convey his capacity for understanding and accepting the complete range of feelings expressed. The aim of understanding underscores the achievement of a more mature level of processing one's feelings. This capacity is demonstrated in perceiving the feeling behind various acts instead of trivializing them. The patient is then helped to achieve a similar level of insight via the analyst's interpretation.

Etchegoyen stated that the container function is for the evolution of therapeutic and curative regression. (3) The patient is given a chance to regress with various archaic feelings manifested and contained. Casement offered a vivid analogy of the concept of containment. (4) The difficult feelings are similar to liquid spilling over the patient's own container. Such feelings 'look for' a personal form of containment or holding instead of impersonal ones such as drugs or admission to hospital. Within this state of being held, conditions are created for the patient to discover for the first time that a capacity to manage life is possible. This is very different from past experience in which difficult feelings are to be avoided since other people also avoid a patient's feelings. To contain the feelings is to allow them into the analytic relationship. Although such feelings are intensely negative and directed at the analyst, if the analyst survives the patient's attack such new experience serves to cultivate the personality. A tendency to grow healthily would be re-established and the patient start a new in the process of development.

This capacity for containment is one of the most varying aspects amongst different analysts. Zac

differentiated between absolute and relative constants of the analytic situation in contrast to the varying process.(5) By absolute constant, this author means the elements present in every psychoanalysis with little or no variation. Relative constant, however, depends a lot on the analyst and is a function of the analyst-patient dyad. These constants, including the capacity for containment, are more likely to be breached given one's unanalyzed countertransference. Zac introduced the concept of 'analytic attitude' to help the analyst guard against the changing of the relative constants.(5) In addition, to be abstinent to the patient's desire, the analyst is also a serene, impartial, and committed observer of the analytic process. Such an attitude is taken in the sense of technical instrumentality and is used by an interested analyst to help his patient. It is both a behavioural event and a mental attitude of putting the least number of variables into the process. Such an attitude is to be maintained throughout the sessions. Although the frame is established at the beginning of the analysis, Olagaray argued that its internalization could be finished only at the end. (Olagaray J, unpublished data.)

THE ANALYTIC FRAME, ANALYTIC SITUATION AND MUTUALITY

The above depiction apparently implies the analyst's role as an analytic machine that curbs its own involvement into the relationship; the patient seems to be a mere object for analysis. Mutuality within the relationship is nearly absent. This might be the consequence of rigid adherence to the frame at the expense of the process. A frame and the content are inseparable aesthetically and even practically. Similarly, the demarcation between the analytic frame and the process would also be too artificial to be real. Taking them as a whole would be more meaningful. The combination of the 2 could be seen as the analytic situation, which Etchegoyen defined as a particular relationship between 2 persons, both abiding by rules, so as to carry out the task of exploration of the patient's unconscious with the technical participation of the analyst.3 Gitelson depicted it as the total configuration of interpersonal relationship and events developed between the analyst and the patient — the totality of the transactions between them occurred in the zone of interaction.(6)

Baranger even conceptualised the analytic situation as a dynamic field with spatial and temporal structure, oriented by lines of forces and dynamics but with its own volutionary laws and general and transient objectives.(7) He rejected the unilateral view of the analyst as a detached observer of the patient in regression. He believed that the analyst has a large part to play in the creation of the analytic situation and it is simply impossible for him to withhold any intervention in the intense analytic relationship. In essence, the analyst is simply not transparent in the field. Baranger further remarked that the analytic field is structured as an unconscious field fantasy, in which both the patient and analyst participate, both involved to a considerable degree, not simply a fantasy appearing in the field. (7) This implies that the patient and analyst are no longer separable, and nor are the analytic frame and process, as far as the analytic field is concerned. He even went further by postulating that the field is symbiotic since it reproduces the patient's regressive repetition directed towards projective identification. The analyst thus feels the patient's feeling and shares his fantasy, which are crucial to the achievement of insight via interpretation. Baranger even believed that without the analyst's shared fantasy, the interpretation would just be dry theorization about the patient instead of psychoanalysis of the patient. (7) In this sense, the analyst can no longer be a mere mirror. Such a level of involvement apparently precludes the neutral role of the analyst.

Up to this point, it seems that the analytic frame is not as clear cut and easily operationalized as initially thought. Certain elements are particularly difficult to realize. The pull towards mutuality within the analytic relationship is always strong given the intense contact. (8) The 'ideal' of the neutral and abstinent analyst apparently is not supported by analysts of recent generations, probably because of the inevitable countertransference (e.g. Schoenewolf (9)). The ideal implied an asymmetrical and even authoritarian relationship. . (8) Actually, even Freud himself did not seem to have done what he preached. For example, he analyzed Ferenczi during their walks. (10) Also, the analysts of those days were not always a neutral mirror for the patients. They had multiple relationships; they were friends, mentors, analysts, and patients of one another at the same time. Furthermore, the notion of neutrality and abstinence, when carried to the practical extreme, might result in a cool and detached analyst who might have no personal contact

whatsoever with the patient. This was exactly what Sandor Ferenczi complained about the analysts of his day — he even advocated for more passion and tenderness with patients.

FERENCZI'S CONTRIBUTION

According to Rachman (11) and Stanton, (12) Sandor Ferenczi (1873-1933) was a Hungarian psychiatrist before he met Freud. He was introduced to Freud by Carl Jung in 1908 and the 2 men soon developed an intimate friendship, which lasted until Ferenczi's death, with various turmoil along the way. Ferenczi was invited by Freud to accompany him on his historic trip to America in 1909. They also spent many vacations together. Ferenczi was one of the core members of Freud's inner circle. Freud regarded him as his 'favourite son' and even wanted his eldest daughter, Mathida, to marry him. Ferenczi provided much theoretical and technical stimulation to Freud in the latter's development of psychoanalysis as a form of psychotherapy. Ideas such as 'identification with the aggressor' and 'proper termination of an analysis' could be traced back to Ferenczi's innovation. (13) However, Ferenczi's final challenge to Freud's established views on sexual trauma heightened their discord. This placed him on the list of dissidents, who were to be purged and eventually ousted.

Ferenczi did not have the ambition to start his own school, as Adler or Jung had previously done, since he was still emotionally attached to Freud and longing for the master's recognition. Also, he did not have enough time since he died at the age of 60 years. Jones, the official biographer of Freud, even depicted Ferenczi as psychotic and deluded, and buried his views for decades. It was only recently that historians of psychoanalysis successfully disputed Jones' account, restored Ferenczi's fame, and re- discovered his contributions. (14)

Ferenczi's clinical diary, which was supposedly his own private document, shows him to be an analyst with humane and personal contact with patients. (15) He was more concerned about the suffering and cure of his patients than rules of abstinence within the analytic frame, particularly in the latter stage of his life. Ferenczi's patients were usually the most difficult cases, referred by other analysts who had failed after using orthodox Freudian techniques. (16) By today's standards, these patients' problems belong to the category of personality disorder, instead of traditional neurosis. As far as techniques were concerned, it was no wonder that Ferenczi had to try new or even drastically different ways of dealing with such disorders. Although many have speculated about the unconscious motivation behind Ferenczi's dissident view on analysis such as his truncated analysis with Freud and his unanalyzed negative transference, (16) Ferenczi's views are worth rereading for the human touch. If psychoanalysis is supposed to be a human enterprise for understanding the core of human nature, we cannot afford to dispose of Ferenczi merely as a heretic.

One of the most controversial parts of Ferenczi's technique is the supposed breaching of abstinence. According to Hoffer, in the 1920s, after repeated failures with patients with serious character pathology, Ferenczi gave up his previously subscribed active technique -during stagnant analysis, the patient's demands were prohibited even more sternly, heightening the tension within. (8) Ferenczi was convinced that the traumatized child is searching for tenderness from adults. However, adults, with unconscious guilt, consciously refuse to acknowledge the child's suffering. The child enlarges the trauma by interjecting the adult's guilt. In analysis, the analyst's rigidity and abstinence serve to reactivate and amplify the traumas, and hence the failure of analysis. Ferenczi then experimented with the use of 'relaxation technique' in 1930, in which the patient's longing was gratified. He showed unshakeable benevolence and empathy to the patient, regardless of the patient's extreme actions and language.(16) Ferenczi believed that in order to work through childhood trauma, the patient has to re- experience it, but in a completely safe, tender, and trustworthy relationship. Repetition of the conditions of the trauma is avoided. Trust is fostered and the analyst's reliability is not trimmed by professional hypocrisy. This state is similar to the ideal mother-infant relationship.

However, this technique is clearly contrary to the orthodox view that states that tension arising from the abstinence is necessary for psychoanalysis -when the patient is gratified, further regression is likely and there will be no observing ego for the establishment of the therapeutic alliance. Without this alliance, no psychoanalysis is possible. The patient would only regress in the service of nothing, or regress for the sake

of regression.

This logic seems to work well until we are reminded of the pathology of Ferenczi's patients -those with severe personality disorders and many failed analyses of orthodox Freudian orientation. We would raise the same question for these analyses: Has the therapeutic alliance ever been established in these failed analyses? If the character defects of these patients were simply different from that of neurotic patients, would abstinence also work for them, at least in the establishment of the therapeutic alliance? If their egos were far less developed because of the severe childhood trauma they have undergone, would the ego be able to withstand the [initial] requirement of psychoanalysis, the abstinence, and form a therapeutic alliance with the analyst?(17)

On the surface, these patients might simply be searching for ideal love. Psychoanalytically speaking, they may be looking for repair of the traumatized self or development of the impoverished ego. This would go back to the question of whether psychoanalysis should deal with such patients. However, the current scenario of various schools of psychoanalysis treating personality disorders seems to have answered this question. (17-19) If these patients are testing the limits of orthodox psychoanalysis, should some theoretical and technical accommodations be made?

Giampieri-Deutsch remarked that Ferenczi's experiments are research into the boundaries of the standard analytic setting. (20) Ferenczi was advocating the importance of both of the people in the analytic process, instead of total focus on and conceptualization in terms of the patient's own psychic reality. Ferenczi's belief in the reality of childhood trauma as the aetiology of adult pathology probably contributed much to his emphasis on the patient-analyst relationship as the curative factor. In Confusion of Tongue Between Adults and the Child, he strongly criticized adults' denial of the child's despair, which is parallel to the orthodox analyst's focus on the patient's psychic reality, and writing off the patient's trauma as unconscious fantasy.

Psychoanalysis, for Ferenczi, is then aiming at experience instead of mere insight into the unconscious. The analytic process is occurring between the patient and analyst, but not within the patient. The analyst is to participate emotionally into the analytic relationship; with the help of his own countertransference, he interprets the patient's transference. The analyst's own psychic process is thus a legitimate object of study as well. Ferenczi is the pioneer in advocating the therapeutic use of counter-transference.

Jacobs, in his latest review of the historical development of counter-transference as a technique, remarked that analysts in the past 2 decades increasingly recognize the salience, usefulness, and inevitability of counter-transference in the analytic process.

(21) Freud only alerted analysts to its potential harm and resistance in analysis, but did not advocate its therapeutic value in contrast to his previous historic discovery of patients' transference and its analytic significance. (22)

Winnicott proposed the revolutionary idea that analyst's negative feelings towards severely disturbed patients are inevitable but not the consequences of the analysts' pathology. (23) These feelings convey crucial meaning and information about the patients' inner world. Heinmann further argued that the totality of the analyst's emotional response to the patient constitutes an important tool, which enables the analyst to follow the patient's emotions and unconscious fantasies. (24) Little, recommended the use of 'countertransference interpretation' in which the analyst's subjective reactions are used to elucidate the transference and strengthen the therapeutic alliance (25) Jacobs concluded that the analyst's subjective responses arising in the sessions enable him to reach the troubled inner world of the patient. (21) Counter-transference is seen as a complex entity comprising the analyst's subjective responses being fused with the patient's projected parts of his inner world.

Such change of attitude towards counter-transference is parallel to the findings of psychotherapy research. Research into counter-transference concludes from decades of research that the characteristics of the therapist and the patient, as well as the relational matrix between the therapist and patient are crucial to the outcome. (26) Negative therapist attitudes can adversely influence therapist's interactions with patients. Therapist's behaviour is influenced by how the patient presents, especially with respect to hostility. In addition, the intricate interplay between the dynamics of the patient and therapist is a major determinant of

he therapy outcome.

Having further estranged from the Freudian circle after presenting his paper Confusion of Tongues at the 12th Congress of the International Psychoanalytical Association in Wiesbaden, 1932, Ferenczi carried his innovation to its irreversible extreme -mutual analysis, which goes against almost all the rules of the analytic frame.(27,28) Ferenczi was noted for his therapeutic zeal and persistence. He did not attribute analytic failure to a patient's incurability but to the analyst's own counter- transferential weakness and blind spots. He recorded this experiment in the case of RN, who was both a pupil and patient of Ferenczi and probably the initiator of mutual analysis, in his clinical diary. (27) Presented with symptoms of chronic fatigue, suicidal ideation, multiple personalities, and amnesia for the first 12 years of her life, RN underwent 8 years of analysis with Ferenczi in Budapest, before embarking on another unsuccessful treatment in the USA.

After years of stagnancy in the analysis, Ferenczi tried the relaxation technique with RN and unveiled severe early childhood abuse -RN recalled physical, emotional, and psychological abuse by her father since she was 18 months old. The treatment then intensified and occupied most of Ferenczi's time, as the sessions lasted 4 to 5 hours a day, extending to Saturdays and evenings, and even being carried out at her home. She even accompanied Ferenczi on his holidays to continue with the analysis. RN evidently developed intense positive transference to Ferenczi. She was fully convinced of her love for him. Ferenczi initially retreated from the involvement and interpreted to RN that she should now hate him. RN, on the other hand, interpreted to him that he hated her unconsciously and such hate blocked the analysis. She suggested that Ferenczi be analyzed by her. After struggling for 1 year, Ferenczi agreed to the mutual analysis, exchanging their roles. He gradually discovered his hatred underlying his benevolence. RN's symptoms subsided, with less suicidal ideation, and more patience and progress at work. Ferenczi, initially feeling humiliated for his self-exposure, did find RN less disagreeable and he was able to increase his patients' trust with deeper analysis which made him a better analyst. He was more sincere and sensitive, as well as less sleepy in the sessions.

Nevertheless, Ferenczi noted in his clinical diary that there was a risk in this experiment and he did not advocate its indiscriminate use. The danger lies in the deflection from the patient's to the analyst's problems. He treated mutual analysis as a last resort. After the mutual analysis with RN, he tried to resume the traditional analytic relationship with her in the sessions, but he failed to do this. The emotionality was gone, the analysis went stale, and the relationship became distant. (15) Ferenczi died months later in 1933. Nevertheless, Borossa documented that RN later recovered sufficiently to write articles and books, and practice psychoanalytic psychotherapy. (29)

However, this experiment, as well as Ferenczi's other innovations, seems to suggest that when everything within the analytic frame is done, and the condition of the patient still does not improve, we might have to look beyond it, instead of blaming the patient for his unanalysability or incurability.

Bokanowski concluded that mutual analysis tests the limits of the one-person analytic process, and challenges the classical Freudian blank-screen, one-way and one- person analytic process. (16) He also regarded Ferenczi as the forerunner of the object- relation theories, the American school of interpersonal psychoanalysis, self-psychology and the theory of inter-subjectivity.

CONCLUSION

The original concept of the analytic frame need not be one of exclusivity and rigidity, the extreme version of which leads to an analyst's apparent indifference. Different analytic frames would match with different patients or forms of treatment.

Analytic neutrality should be accommodated in order to make room for more severely disturbed patients. Ferenczi's emphasis on the analyst's counter-transference and humane tenderness for the patient should be recognized. However, psychoanalysis should not focus completely on the patient to the exclusion of the analyst. Neither should the analyst simply hide behind the façade of analytic neutrality and abstinence.

REFERENCES

1. Cheung F. The development of clinical psychology in Hong Kong. Bull HK Psychol Soc 1997;38/39:95-110.
2. Gray A. An introduction to the therapeutic frame. London: Routledge; 1994.
3. Etchegoyen RH. The fundamentals of psychoanalytic technique. London: Karnac; 1991.
4. Casement P. On learning from the patient. London: Routledge; 1985.
5. Zac J. Un enfoque metodologico del establishmento del encuadre. Revista de Psicoanalisis 1971;28:593-610.
6. Gitelson M. The emotional position of the analyst in the psychoanalytic situation. Int J Psychoanalysis 1952;33:1-10.
7. Baranger M. La situation analitica como campo dinamico. Revista Uruguaya de Psicoanalisis 1961-62;4:3-54.
8. Hoffer A. Asymmetry and mutuality in the analytic relationship: contemporary lessons from the Freud-Ferenczi dialogue. In: Rudnytsky PL, Bokay A, Giampieri- Deutsch P, editors. Ferenczi's turn in psychoanalysis. New York: New York University Press; 1996:107-119.
9. Schoenewolf G. Counterresistance: the therapist's interference with the therapeutic process. New Jersey: Jason Aronson Inc; 1993.
10. Haynal A. Psychoanalysis and the sciences: epistemology — history [translation by Holder E]. New York: The University of California Press; 1993.
11. Rachman AW. Sandor Ferenczi: the psychotherapist of tenderness and passion. Northvale: Jason Aronson Inc; 1997.
12. Stanton M. Sandor Ferenczi: reconsidering active intervention. Northvale: Jason Aronson;1991
13. Bergmann MS. The tragic encounter between Freud and Ferenczi and its impact on the history of psychoanalysis. In: Rudnytsky PL, Bókay A, Giampieri-Deutsch P, editors. Ferenczi's turn in psychoanalysis. New York: New York University Press; 1996: 145-159.
14. Bonomi C. Flight into sanity: Jones's allegation of Ferenczi's mental deterioration reconsidered. Int J Psychoanalysis 1999;80: 507-542.
15. Ferenczi S. In: Dupont J, editor. The clinical diary of Sandor Ferenczi (translated by M Balint and NZ Jackson). Cambridge: Harvard University Press; 1932.
16. Bokanowski TM. Sandor Ferenczi: negative transference and transference depression. In: Rudnytsky PL, Bókay A, Giampieri- Deutsch P, editors. Ferenczi's turn in psychoanalysis. New York: New York University Press; 1996:120-144.
17. Kernberg O. Borderline conditions and pathology narcissism. New York: Jason Aronson; 1975.
18. Kohut H. The analysis of the self. New York: International Universities Press; 1971.
19. Saretsky T. Resolving treatment impasses. New York: Human Sciences Press; 1981.
20. Giampieri-Deutsch P. The influence of Ferenczi's ideas on contemporary standard techniques. In: Rudnytsky PL, Bókay A, Giampieri-Deutsch P, editors. Ferenczi's turn in psychoanalysis. New York: New York University Press;1996:224-247.
21. Jacobs TJ. Countertransference past and present: a review of the concept. Int J Psychoanalysis 1999;80:575-594.
22. Freud S. The future prospects of psychoanalytic therapy. In: Strachey J, editor and translator. The standard edition of the complete psychological works of Sigmund Freud. Vol 12. London: Hogarth Press: 1910.
23. Winnicott DW. Hate in the counter-transference. Int J Psychoanalysis 1949;30:69- 74.
24. Heimann P. On counter-transference. Int J Psychoanalysis 1950;31:81-84.
25. Little M. Countertransference and the patient's response to it. Int. J Psychoanalysis 1951;32;32-40.
26. Butler SF, Flasher L, Strupp HH. Countertransference and qualities of the psychotherapist. In: Miller NE, Luborsky L, Barber JP, Docherty JP, editors. Psychodynamic treatment research: a handbook for clinical practice. New York: Basic Books; 1993:342-360.

27. Fortune, C. The case of 'RN': Sandor Ferenczi's radical experiment in psychoanalysis. In: Aron L, Harris A, editors. The legacy of Sandor Ferenczi. New Jersey: The Analytic Press; 1993: 101-120.
28. Fortune C. Mutual analysis: a logical outcome of Sándor Ferenczi's. experiments in psychoanalysis. In: Rudnytsky PL, Bókay A, Giampieri-Deutsch P, editors. Ferenczi's turn in psychoanalysis. New York: New York University Press; 1996:170-188.
29. Borossa J. Introduction. In: Borossa J, editor. Selected writings of Sándor Ferenczi. London: Penguin Books; 1999: IX-XL

http://www.hkjpsych.com/journal_file/0102_Analytic_frame_and_beyond%2027_32.pdf