ON CLAIMING A PSYCHOANALYTIC IDENTITY

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Abstract

In this paper I describe how I have struggled to find a viable identity for myself as a "psychoanalytic psychotherapist". Such clinical entities have been constructed by employing a particular logic, that of using parameters, which sets up an ideal of psychoanalytic practice from which all other forms of practice are meant to deviate. I argue, by means of a clinical example, that this way of thinking distorts our understanding of the analytic process. At an institutional level it deflects from the need to map out how we actually practice (rather than how we ought to practice), which we need to know so we can address real differences in approaches and levels of knowledge and skill.

One of the often repeated clichés I have encountered over my career as a psychoanalytic psychotherapist is that, as one develops in one's practice and experience, it is no longer our patients who are source of most of our professional troubles and grievances but our colleagues. My version of this truism is over my ambivalent and conflicted feelings about my professional identity within the analytic community as a psychoanalytic psychotherapist. The problem for me can be stated simply as this. Psychoanalysis is the conceptual framework, theory and method I use in all of my work: I see myself as practising psychoanalysis. I therefore think of myself as a psychoanalyst. But my analytic training

does not accredit me as a psychoanalyst but as something called a “psychoanalytic psychotherapist”. Despite many years of trying to figure out what “psychoanalytic psychotherapy” might be that makes it different from “psychoanalysis”, I have failed to find a meaningful or useful distinction between the two. But this leaves me in a difficult position: although in my work I count myself a psychoanalyst, in my professional dealings in the analytic world I describe myself as a psychoanalytic psychotherapist. Now I could see this mismatch as my problem, that I have not been content to accept my professional status in the analytic world. But although I recognize the powerful forces of jealousy and envy in my make up, the argument of this paper is that it is the analytic community that has activated these feelings in me for no good reason by creating and institutionalizing an arbitrary, incoherent and unnecessary entity of clinical practice called “psychoanalytic psychotherapy” as distinct from “psychoanalysis”, a division which serves no good clinical or institutional purpose.

Interestingly I have found that this question of what I call myself has never been an issue for my patients. I have never yet met a patient who seemed to care whether I was a psychoanalyst, psychotherapist or counsellor. All that matters to them is that I am good at what I do and can help them. It is only if I take on a patient who is training or wishes to train that these different analytic designations matter. And it is here, when my patient and I have to locate ourselves within the analytic community as a whole, that my malaise over trying to match my professional designation (psychoanalytic psychotherapist) with what I do (psychoanalysis) becomes evident. For instance I write books on psychoanalytic practice and publish theoretical and clinical papers in analytic journals with “psychoanalysis” or

"psychotherapy" in their title. In all of this writing I am immediately confronted by a consequence of the division of psychoanalytic practice into its various components: there is no single term which encompasses all of these so-called different practices. If I choose to adopt any one of these designations – analyst, therapist, counsellor – I am thereby positioning myself as only speaking to that particular group of analytic practitioners. However it has never made sense to me why I have to restrict my intended readership in this way. In my writing I wish to address all members of the analytic community. When I first had my work published I came up with what felt like the best solution to this problem by inserting a qualifier such as "in this paper I have used the term 'analyst' and 'therapist' interchangeably". But after a time such a form of qualification felt redundant, indeed irritating – why was I having, every time I wanted to publish something, to make this qualification which I did not believe in? So after a while I adopted the device of using the term "psychoanalytic practitioner" or "psychoanalytic clinician" to mean anyone using the psychoanalytic method.

Having to resort to these rather clumsy terms is, in truth, no more than a minor irritation. But it raises the larger question of why the psychoanalytic community has organized itself in this fashion. I cannot think of any other organized practice which would choose to present itself in this fragmented way, unwilling to create a common language to embrace all of its practitioners.

One consequence of this for all those in the analytic community who are not designated as psychoanalysts is that they have constantly to situate themselves when reading papers which have "psychoanalysis" in their title. Are such papers meant for them? A good example of this for me is when I read or refer back to one of the papers I have found most valuable and inspiring in charting my own development as a clinician, "On Becoming a Psychoanalyst" by Glenn Gabbard and Thomas Ogden (Gabbard and Ogden, 2009). In their paper the authors describe a number of key maturational experiences that mark the attainment of one's identity as a psychoanalyst, such as "daring to improvise" in their clinical work. They cite the importance of affiliation to the analytic community, for instance in presenting their clinical work to a consultant, or writing analytic papers in order to discover and refine what they are thinking. The key element for them is that of "developing a voice of one's own" (Gabbard and Ogden, 2009, p.314), which they characterize in generational terms:

> In the process of becoming an analyst , we must 'dream up' for ourselves authentic way of speaking that involves disentangling ourselves from our own analyst(s) as well as past supervisors, teachers and writers we admire, while also drawing on what we have learned from them (p. 315)

In exploring this process of becoming an analyst, they turn to a consideration of the nature of the internalization by the child of the parents in the Oedipus Complex, an identification by which the child metaphorically kills his or her parents by immortalizing them. They argue that this process is not simply about the incorporation of aspects of the parents as they are, but a far richer and potentially transformative type of internalization: "that of incorporating

into one's own identity a version of the parents that includes a conception of who they might have become, but were unable to become, as a consequence of the limitations of their own personalities and the circumstances in which they lived" (p. 315).

If there really is something called "psychoanalytic psychotherapy" which is different from "psychoanalysis", then it should be possible to construct a similar kind of developmental trajectory for the psychoanalytic psychotherapist. As the key element for Gabbard and Ogden is the capacity to acknowledge one's debt to one's tradition, as embodied in key figures such as one's teachers and key figures in the literature, while going beyond what these figures have achieved, one can wonder what would comprise the tradition of psychoanalytic psychotherapy, and who would its key figures be? I have not succeeded in identifying a tradition of thinking or practice with which I can engage which is not that of psychoanalysis. When I read Gabbard and Ogden's paper I position myself as though they are speaking directly to me, that we are colleagues working within the same tradition, using the same theories and method, and so facing the same developmental tasks in wishing to become better at what we do.

How "psychoanalysis" and "psychoanalytic psychotherapy" are defined as different from each other

But in implicitly claiming to be a psychoanalyst in this way, I am clearly transgressing the professional boundaries which have been erected by all psychoanalytic training and

accrediting bodies. Here is how my own accrediting body, the British Psychoanalytic Council, in its public register describes what the "psychoanalytic psychotherapist" does or should be doing:

> Trained to work intensively, generally with the patient lying on the couch. A lot of the work is with interpretations (making the unconscious part of the mind conscious) and often uses the relationship between patient and therapist as the focus. The theory base is wholly psychoanalytic (British Psychoanalytic Council, 2017a).

This definition of psychoanalytic psychotherapist is one of several other designations of analytic practitioners that all depend for their meaning on the definition of a "psychoanalyst":

> Trained to work very intensively (4 or 5 times weekly), generally with the patient lying on the couch. Most of the work is with interpretations (making the unconscious part of the mind conscious) and uses the relationship between patient and therapist as the focus. The theory base is wholly psychoanalytic (British Psychoanalytic Council, 2017a).

The American Psychoanalytic Association describes psychoanalytic psychotherapy on its website in a similar way, as a "less intense" form of clinical practice than psychoanalysis, one

" which is based on psychoanalytic theory and principles", and "utilizes psychoanalytic theories as the frame for formulation and understanding of the therapy process (APA 2018a)

Such descriptions present the psychoanalytic psychotherapist with an immediate problem. If he or she is described as using psychoanalytic theory in the same way as the psychoanalyst ("the theory base is wholly psychoanalytic"), or as "based" on psychoanalytic theories, and if we can assume that this psychoanalytic theory fully supports the practice of the psychoanalyst, then what is it that supports the practice of the psychoanalytic psychotherapist in the ways it differs from that of the psychoanalyst? What are the conceptual frameworks, clinical protocols or principles of practice which can account for the "less intensive" element of their practice which constitutes the difference from psychoanalysis? Is the psychoanalytic psychotherapist supposed to be doing something *different* in this part of their practice, for instance importing non-analytic ideas? Or is it what they are not doing, or doing *less* compared to the psychoanalyst? In either case, the psychoanalytic psychotherapist would need an overarching framework, something bigger than psychoanalysis, within which to locate that part of their practice which is fully psychoanalytic, and that part which is not. Furthermore, within this overarching framework, they would also need concepts or protocols which could coherently link together their "psychoanalytic" practice and their "non-analytic" or "less-than-analytic" practice. Where is this framework, and what does it consist of? It certainly does not exist in any of these definitions, which seem to rest on the assumption that what is being described is internally coherent.

Another problem with these definitions is that they discriminate between "psychoanalysis" and "psychoanalytic psychotherapy" in terms of a series of practices, such as session frequency, making use of the couch and use of interpretation. For a public register this might seem a reasonable thing to do, as these differences can be readily appreciated by someone looking for treatment. However the definitions are hedged around with a number of *caveats* about not taking them too concretely (so the BPC acknowledges "it would be overly simplistic to say that the difference between psychodynamic and psychoanalytic work is based on frequency of sessions", BPC [2018 b]) because the obvious objection to these kinds of definitions is that it is not simply *what* the psychoanalyst or psychoanalytic psychotherapist does but *how* they do it. In other words, a psychoanalytic psychotherapist who saw patients five times a week, used the couch and made a lot of interpretations could not then claim he or she was now a psychoanalyst, because, by definition, they would not be doing it in the right way – they would still be doing these things in an "intensive" rather than a "very intensive way", or in a way that was "based" on psychoanalytic theory rather than fully supported by that theory.

Without a clear specification of an overarching framework in which to locate the so-called differences between psychoanalysis and psychoanalytic psychotherapy, as well as a clear distinction of how the psychoanalyst works which is different to that of the psychoanalytic psychotherapist, the psychoanalytic psychotherapist is left with a flimsy and incoherent form of analytic professional identity. In effect by accepting this self-identity, the psychoanalytic

psychotherapist puts himself or herself in the position so despised by Freud when he writes about mixing psychoanalysis with other approaches:

> Psycho-analytic activity is arduous and exacting; it cannot well be handled like a pair of glasses that one puts on for reading and takes off when one goes for a walk. As a rule, psycho-analysis possesses a doctor either entirely or not at all. Those psychotherapists who make use of analysis among other methods, occasionally, do not to my knowledge stand on firm analytic ground; they have not accepted the whole of analysis but have watered it down – have drawn its fangs, perhaps; they cannot be counted as analysts (Freud,1932, pp. 152-3).

The logic of parameters

At various times in my career I have looked to the literature on the difference between psychoanalysis and psychoanalytic psychotherapy to help me understand the need for and logic underlying this difference. The persistent theme in this literature is the wish or need to distinguish psychoanalysis from some other form of therapy which might threaten its integrity. This stems from Freud's often stated concern to differentiate the new discipline of psychoanalysis from the existing practice of psychotherapy. By "psychotherapy" Freud meant treatments based on suggestion rather than the development and exploration of the transference as in psychoanalysis. But Freud also argued that if psychoanalysis was to become a form of treatment that was more widely available, it would need to incorporate

some features of this psychotherapeutic practice in order to do so; in his much quoted words "the large-scale application of our therapy will compel us to alloy the pure gold of analysis freely with the copper of direct suggestion" (Freud, 1919, p.168). Although it is clear that what Freud mean by psychotherapy bears little relationship to the contemporary definition of psychoanalytic psychotherapy (being more like what we might today call a non-analytic supportive counselling, based on reassurance, exhortation and normalization), this metaphor of the "purity" of psychoanalysis being contaminated by the incorporation of the base metal of psychotherapy has become the guiding image in all subsequent attempts to create a distinction between the two.

In the 1950's the question of the "widening scope" of psychoanalytic practice became prominent in the analytic literature, and brought with it, particularly in America, a renewed attempt to establish a clear difference between psychoanalysis and psychoanalytic psychotherapy (Rangell, 1954, Gorman, 2002). The aim was to make psychoanalytic practice available to a wider range of patients, particularly those suffering from narcissistic or borderline disorders, who might otherwise have been deemed unsuitable for psychoanalysis. The problem of how to preserve the purity of psychoanalysis while allowing for clinical and technical innovation to treat more disturbed patients was solved by introducing the notion of "parameters" as a way of distinguishing between different forms of psychoanalytic practice. The term "parameter" was introduced in an influential paper written in 1953 by Kurt Eissler, who used it as a way of designating deviations from a standard of ideal psychoanalytic practice. His version of this ideal standard of psychoanalysis was one in which the analyst's sole method was that of interpretation: "in the ideal case the analyst's activity is limited to

interpretation; no other tool becomes necessary" (Eissler, 1953, p.107). This method, of starting with a notion of an ideal psychoanalytic practice, could then allow for modifications to be introduced and for the work to still be counted as analytic. Furthermore it provided a way of differentiating between various different forms of analytic practice in terms of how far they deviated from this ideal - the more parameters needed, the further away a particular practice would be from that of pure psychoanalysis. This is the logic that has continued to be applied in attempts to differentiate psychoanalysis from all other forms of analytic practice.

For instance Otto Kernberg, in his 1999 paper "Psychoanalysis, Psychoanalytic Psychotherapy and Supportive Psychotherapy: Contemporary Controversies", differed from Eissler in defining the "essential features" of the psychoanalytic method as including "transference analysis" and "technical neutrality" as well as interpretation (Kernberg, 1999, p.1079). But his argument followed the same logic of defining all the other forms of analytic practice in terms of how far they deviate from this standard. Even if these deviations might be very small, so that their cumulative effect is hard to spot, the logic dictates that, over time, their effect will become evident. Kernberg puts it like this: "the *techniques* of psychoanalysis and psychoanalytic psychotherapy are essentially identical" which means that in any given session "the differentiation of psychoanalysis and psychoanalytic psychotherapy cannot be ascertained" (1999, p.1083, italics in original), but the "quantitative modifications" that occur in psychotherapy " create a different ambiance in psychoanalytic psychotherapy throughout time" (1999, p.1083).

It can indeed be very helpful in clinical discussion to differentiate between the kinds of analytic work needed by different patients. So Kernberg's claim that in psychoanalysis a different "ambiance" to that of psychotherapy is created over time rests on assumptions that are common currency in clinical discussion. A particular ambiance is created by the way the practitioner manages and conducts the session, which may not be easily translatable into the application of particular theoretical ideas or the use of specific techniques. Clinicians also know that the quality of the psychoanalytic process takes time to evolve, and that time and meaning have a complex relationship to each other, with meaning often ascribed retrospectively to events and experiences that occur in the analysis. But once a decision is taken to institutionalize these differences into descriptions of discrete practices, requiring different kinds of skills and competence and therefore different types of training, one has to turn these subtle and complex clinical processes into conceptual entities or criteria which will support a clear and coherent differentiation between these different types of analytic practice. This is a formidable task. Once stripped of clinical nuance and complexity, the actual deviations described that serve to differentiate the different forms of practice seem so small as to appear inconsequential if not trivial - for instance, in the designations of the British Psychoanalytic Council, how is one to tell the difference between "most of the work" is with interpretations as opposed to "a lot of the work" , or "uses" the patient/therapist relationship as opposed to "often uses" the relationship?

A further problem that any contemporary organization faces in giving accounts of what a psychoanalyst does as opposed to a psychoanalytic psychotherapist is that the method employed of using parameters to measure deviations from a standard can only work where

there is sufficient agreement as to what this standard is. Even in the 1950's the existence of difference analytic schools was recognized as making it more difficult to know how much common ground could be assumed between different analytic approaches. Today the recognition of the plurality of different analytic orientations across the world has inspired a number of attempts to find ways of comparing these different orientations. The findings from these comparative attempts lead to the conclusion that one cannot take for granted that there does exist a common language between psychoanalysts from different schools (Bernardi, 2002). For example the organizers of a series of clinical discussion groups involving the most senior and experienced European analysts, convened as part of the European Psychoanalytic Federation [EPF] Working Party on Comparative Methods (Tuckett, 2008) , reported the following:

> Since the group members mainly used the same technical language, it was assumed that the same terms also meant the same things to different people. It soon turned out that this was not the case. Terminology regarding transference, counter transference, interpretation, frames, setting, perversion, narcissism and so forth turned out to be differently interpreted by different individuals and nationality" (Boehm, 2008, p.63).

Alongside this "babelization" (Tuckett, 2008) of contemporary psychoanalytic language, the members of another EPF Working Party on "Theoretical Issues" found that the theoretical language analysts employed to articulate their own practice turned out not to be a good description of what they were actually doing – in the words of Jorge Canestri, "analysts do not do what they say (and believe) they do" (2012, p.157). In the light of these findings the

organizers of both Working Parties found they needed to develop their own conceptual, theoretical and clinical language in order to better describe how analysts think about their work and how they actually practice (as opposed to how they think they practice). In other words, not only can it no longer be taken for granted that there is only one form of psychoanalysis which represents the practice in its ideal or pure form, it can also no longer be assumed that the language used to describe this ideal practice does, in fact, describe what psychoanalysts actually do, as opposed to what they think they do or think they ought to be doing.

Contemporary debates on distinguishing psychoanalysis from psychoanalytic psychotherapy

How has the literature on the differentiation between psychoanalysis and psychoanalytic psychotherapy responded to these challenges? I will take as an example a recent debate conducted by the International Journal of Psychoanalysis in 2010, to which three leading analysts, Fred Busch, Daniel Widlocher and Horst Kachela, from different countries and representing different analytic schools, were invited to contribute (Blass, 2010, p.16).

For the first author, Fred Busch, the most pressing exigency for contemporary psychoanalytic practice is that psychoanalysis is in danger of becoming "a pale echo of what inspired Freud", and that "we are in danger of losing contact with the deeper motives for why people seek us out" (Busch, 2010, p.23). He sees psychoanalysis being replaced by a "psychotherapeutic culture", one "which views our patients as primarily trauma victims

rather than also *victims of their own mind". (*p.32 emphasis in original*)* . It is to preserve this radical and discomforting vision that Busch argues for the need to differentiate psychoanalysis from psychoanalytic psychotherapy. Busch writes from the perspective of someone who works both as a psychoanalyst and psychotherapist and who sees value in both (p.23). In his view they have different aims. In psychotherapy the aim is for the patient to achieve which he calls "state knowledge", a new state of knowledge about themselves which is the basis for change (p.25). By contrast in psychoanalysis a different form of knowledge is aimed at, the capacity for "self-analysis", in which it is the "process of knowing" rather than what is known that is paramount (pp. 25-27). Only through the self analysis achieved through psychoanalysis can the patient reach "the deeper levels of the unconscious, where madness exists in all of us" (p.30).

In order to reach the deeper levels of the unconscious, psychoanalysis has different aims to psychotherapy when it comes to the analysis of resistance and transference. Psychotherapy "most often leads to *identifying and overcoming* resistances rather than working them through" (p.31, italics in original). In order to work through resistances, transference interpretations in psychoanalysis "are now geared towards understanding the patient's mind in the present, leading to the past, rather than focusing primarily on the past in the present" (p.30). In short:

> In general , psychoanalysis leads one to be *intrigued by the mind* as the ongoing source and answer to fears and motivations, while psychotherapy leads one to *look to the past for answers* to the present (p.30, italics in original).

Daniel Widlocher also makes a case for distinguishing psychoanalysis from psychoanalytic psychotherapy. But rather than seeing each as having different aims, his differentiation is in terms of two different ways of listening to the patient. The wide range of patients now seeking psychoanalytic treatment has led to the development within psychoanalysis of more psychotherapeutic approaches which aim "to help the patient extricate him or herself from his or her psychic suffering". He contrasts this approach with the ideal of psychoanalysis, which he describes as "a pure associative and interpretive" listening.

> The psychoanalytic method is *per se deconstructive*, a pure discovery of the unconscious, its latent contents and process. It has no therapeutic value in itself, just knowledge of the psychic apparatus. But the major part of time during psychoanalysis is devoted to *reconstructing* the personal history of the patient, his conflicts and traumatic memories (Widlocher, 2010, p. 47, italics in original)

Unlike Busch, this does not mean an attempt "to individualize methods and forms of treatment (ranging from psychoanalysis *stricto sensu* to 'supportive' psychotherapies)", (p.59). Instead Widlocher argues that in actual psychoanalytic practice both forms of listening are needed:

> When we are faced with the actual patients we take into treatment, we must then decide about the specific dosage we propose of rigorous, associative and interpretive psychoanalytic experience on the one hand, and the analysis of conflicts and symptoms which make up the quest for care on the other (p.50).

For both Busch and Widlocher psychoanalysis is concerned with knowledge for its own sake (for Busch allowing the patient to become intrigued with his mind, for Widlocher a "pure discovery of the unconscious which has no therapeutic value") as opposed to the psychotherapeutic aim of providing cure, care or relief from suffering. By contrast Horst Kachele sees no value in this attempt to distinguish between truth and therapeutics (Kachele, 2010, p.36). He sees psychoanalysis defined not by its claim to a single kind of knowledge or truth but by its concern with a good therapeutic outcome, which in contemporary analytic practice is achieved in a multiplicity of ways. He does not start from the idea of a pure standard that has to be maintained, indeed is suspicious of any such claim: "there is no longer one bible at hand and there are many prophets promoting one or other version of psychoanalysis whether or not these claims are supported by evidence – and too often they are not" (pp.39-40). This appeal to "evidence" means a recognition of the "globalization of psychoanalysis and its treatment practices" (p.35), in which he finds that "psychoanalytic practice covers a range of instantiations with no clear default value" (p.38). In order to see what this "range of instantiations" consists of, Kachele looks not to some pre-existing standard but to "what psychoanalysts do in practice" (p.38).

> Mapping out the global field of psychoanalytic practice by agreeing to basic assumptions seems to be timely. Instead of separating entities that hardly exist in real practice we might better talk about conceptual families of psychoanalytic therapies or at least close neighbours" (p.40).

Applying this view of the psychoanalytic field to training, Kachele would "firmly reject the notion of basic, principal differences between analytic psychotherapy and psychoanalysis as not leading us where the battle really takes place", which is that of "our versatility to match patients' need and preference by applying a psychoanalytic therapy that is unabashedly therapeutic, flexible yet firm, supportive yet interpretive and deliberate yet spontaneous" (p.41).

"Psychoanalytic psychotherapy" as a lower form of psychoanalytic practice

While these three papers appears to be about the rationale for differentiating psychoanalysis from psychoanalytic psychotherapy, what I think emerges as the real debate is simply what is to count as psychoanalysis *per se* – as the editor of this collection of papers seems to recognize when she writes in her introduction that questions concerning the difference between psychoanalysis and psychotherapy "repeatedly re-emerge, as a variety of exigencies seem always to compel us to ask, not what psychoanalysis is, but how it is to be distinguished from psychotherapy" (Blass, 2010, p.16). Although there is clearly a lot of common ground between the three authors, the differences between the language they use and their conceptions of psychoanalytic practice is substantial. So, for example, when Widlocher

writes about the "reconstructive" way of listening of the "psychoanalytic psychotherapist", it is really not clear to me whether the way Busch describes his psychoanalytic (as opposed to psychotherapeutic) practice would fall into this category or not (for instance Busch writes that transference interpretations in psychoanalysis "are now geared towards understanding the patient's mind in the present, leading to the past" – this sounds to me like a reconstructive rather than deconstructive form of listening). Here I find Kachele's argument, that it is better to speak of "conceptual families of psychoanalytic therapies" rather than seek to establish global distinctions between "psychoanalysis" and "psychoanalytic psychotherapy", much more compelling, the only one that speaks to my own clinical and professional experience of the considerable and profound differences between the different analytic orientations.

The debate about what is to count as psychoanalysis in these papers is conducted alongside, indeed overlaps with another argument about how to define good analytic practice. For Kachele this is where "the real battle" needs to be, that is to try to spell out what would constitute a psychoanalytic practice that can effectively meet the needs of a diverse and challenging range of patients. But for Widlocher and Busch, the debate about what is to constitute good or excellent practice is displaced onto their formulation of a difference between "psychoanalysis" and "psychoanalytic psychotherapy", the former implicitly or explicitly described as a clinically and ethically higher form of practice.

In Widlocher's version, psychotherapy with its "reconstructive" form of listening is more concerned with offering "care" rather than the "deconstructive" form of listening in

psychoanalysis, which is described as a "rigorous, associative and interpretive psychoanalytic experience". Widlocher's deconstruction seems similar to Bion's well known description of the need for the analyst to cultivate the capacity of working without memory, desire or knowledge, which he calls it an "essential discipline" in psychoanalytic work (Bion, 1970, pp.51-52). Clearly, then, for Widlocher psychotherapeutic work is seen as less rigorous and disciplined than analytic work.

Busch is even clearer in how he sees the hierarchy of practices. He characterizes the "psychotherapeutic culture" as offering no more than a "pale imitation" of the radical nature of Freud's psychoanalysis by substituting empathy for the patient's suffering rather than helping the patient learn to become curious about the workings of their own mind. In describing himself as doing both psychotherapy and psychoanalysis, it is only in the latter that real depth is achieved. So, for instance, he describes himself as doing psychotherapy in identifying and exploring resistance, but not work through their resistances, for which psychoanalysis is needed. Busch gives an illustration of what this difference in ability might look like:

> For example, inquiry into a patient falling silent will most often lead to her telling about the thought she was avoiding, rather than *the feeling that led to the thought* being avoided, which is the necessary ingredient for working through" (Busch, 2010, p.31, italics in original)

But in making this distinction (just as he differentiates between the "aims" of "psychoanalysis" and "psychoanalytic psychotherapy" in terms of intensity of transference and the depth of self-knowledge) Busch can make an informed decision as to which kind of practice he will employ at any given time with each particular patient as he defines himself as able to do both. If I, as a psychoanalytic psychotherapist, were to think of Busch's distinction as a basis for constructing my own identity as a psychoanalytic psychotherapist, I would have to define myself as doing the things Busch attributes to the psychoanalytic psychotherapist not out of choice or the exercise of judicious knowledge, but simply because *I would not know any better.*

In defining psychoanalysis as a practice or form of listening that is interested in knowledge for its own sake, as interested in truth rather than pragmatics (a distinction that cuts no ice with Kachele), Widlocher and Busch can be seen to be drawing on a well established definition of high quality work or skilled practice. For example in his book "The Craftsman" Richard Sennett defines craft or craftsmanship as: "an enduring, basic human impulse, the desire to do a job well for its own sake" (Sennett, 2008, p.9). In constructing a form of listening or of practice and calling it "psychoanalytic psychotherapy", these authors have created a form of practice that, by definition, is disbarred from being a high quality practice, one in which both patient and practitioner arrive at an appreciation of the intrinsic value of self-knowledge and listening to the unconscious. And this is because the argument, however sophisticated it may seem, ends up being conducted in terms of the logic of parameters, which has to operate by setting up an ideal from which all other forms of practice are measured against.

Time as a super-parameter

This can be seen most clearly when we look at the way the so-called differentiation between psychoanalysis and psychoanalytic psychotherapy is usually presented, both in the literature which comprises this debate and in the public registers, which is to translate "intensity" into frequency of weekly sessions. So, for instance Busch appeals to what he takes to be a commonly accepted idea of the impact of time on experience in supporting his differentiation of psychoanalysis from psychoanalytic psychotherapy:

> Resistance analysis is possible in psychotherapy but limited, in part, by the infrequency of sessions. There is a necessary safety in coming upon a terrifying feeling, and knowing one can return the following day for further understanding. It is too much to ask of the human psyche to hold on to such feelings for a week or several days (Busch, 2010, p.31)

I find it curious here that in an otherwise conceptually clear and coherently argued paper Busch here resorts to what seems to me to be a form of rhetorical pleading in order to make an important point about the need for "daily sessions". In my view this is symptomatic of the

quality of argument employed in the discussions which link session frequency to different forms of analytic practice.

The most obvious flaw in this way of defining difference is that psychoanalysts cannot agree amongst themselves as to what is to count as psychoanalysis. On the American Psychoanalytic Association website, psychoanalytic psychotherapy is described as occurring "between one and four times weekly" (APA 2018a). This difference in session frequency from psychoanalysis is described as a "primary difference". In the British Psychoanalytic Council definitions of the different forms of analytic practice, the degree of intensity is also taken as the defining feature. But here a psychoanalyst is defined as "trained to work very intensively (4 or 5 times weekly)". A psychoanalytic psychotherapist, by contrast, is trained to work "intensively", which evidently means less than 4 or 5 times a week, but more than a psychodynamic psychotherapist, who is defined by the BPC as "trained to work at a frequency of once or twice a week" (BPC, 2018a). On the website of the International Psychoanalytic Association, psychoanalysis is described as occurring at a frequency of three, four or five times a week: "in order to continuously deepen the analytic process, psychoanalytic sessions preferably take place on three, four or five days a week", even adding that "a lower frequency of sessions per week or the use of the chair instead of the couch will sometimes be necessary" (IPA, 2018). It is hard not to see the fact that analysts do not agree with each other over the question of session frequency as a fatal flaw. But in order to restore faith in this way of measuring differences between analytic practices, one would need a rationale for these differences. For instance one can see in the debate between Busch, Widlocher and Kachele that the way they describe their aims and method of working would

determine how they would think of session frequency. For Busch it is the actual physical presence that is important in deep analytic work, which would support his argument for daily sessions. By contrast one might suppose that a "deconstructive" form of listening that attempts to break up and disrupt narrative and coherence might favour a lesser frequency of sessions, or an approach that valued "flexibility and adaptation" would not try to set up an ideal number of sessions in the first place.

But the logic of parameters is hostile to such conceptual and theoretical arguments. All that matters is the specification of the ideal from which all deviations can be measured. This is the great appeal of using session frequency as a primary or defining feature – all one needs to do is to count. Furthermore, the appeal to session frequency has the great merit of appearing to accord with common sense understandings of the way quantitative differences in time spent on an activity can result in qualitative changes. It is widely accepted, for example, that the number of times a week one practices a musical instrument or trains for a sporting event will determine how well one can play or perform, and this logic makes sense to patients who readily understand that session frequency will affect their experience and what they can hope to achieve.

But patients also know that length of treatment is no less important than frequency of sessions, just as we all know that practice and training need to take place over a long period of time in order to be effective. So even within its own parametric logic, why does length of treatment not figure in the APA or BPC definitions and in the way trainings are often described? All it would take would be to specify a particular length of treatment as the ideal

in order to then count the deviations from it. A "very intensive" treatment could be then described as one that needs to be conducted over time period X, an "intensive" treatment as taking place over time period X-Y, and a "less intensive treatment" as X-Y-Z period of time. A clue as to why this might be problematic can be found in Busch's paper, where he does in fact make reference to length of treatment in differentiating psychoanalysis and psychotherapy when he comments "in many ways the themes and results of a 'good enough' psychotherapy are like the results of the initial phase of psychoanalysis" (Busch, 2010, p.31). We can wonder why Busch does not make any attempt to define how long this period of psychotherapy corresponding to the "initial phase" of a psychoanalysis might last, unlike with session frequency, where he invokes the needs of the human psyche to justify the need for daily sessions. The answer must be that he knows very well, as would any skilled clinician, that to spell out in advance how long this initial period needs to be risks shoe-horning the development of the analytic process, which will be different with every clinician and every patient. This is why there is such a strong objection in the analytic community to imposing any sort of predetermined time-limit to analytic work. Why, then, do we think we can do the same with session frequency, that is spell out in advance what session frequency is required for any particular form of analytic process to develop? (Brafman, 2008).

My point in imagining an argument to support length of treatment as no less important than session frequency as a defining parameter is to try to show the arbitrariness of elevating any particular feature of the analytic setting as constituting a primary or defining difference between analytic practice. The point is not that session frequency does not make a difference. Anyone who seriously thinks it does not matter how many times a week a

treatment is conducted has not understood the basic importance of the analytic setting. But what happens to our clinical understanding when we take any particular feature of the analytic setting and turn it into a super-parameter, one which supposedly creates such a difference to the way we understand the analytic process that we can use it as a "primary" way of distinguishing between different forms of analytic practice, each backed by a different form of training and institutional organization. I will try to answer this question by taking an example from my own practice.

Session frequency or analytic process?

I have been working with Mr. A in my private practice for a period now of over 13 years. He came seeking relief from severe anxieties and crippling panics attacks, which profoundly restricted his ability to enjoy his life and plan for a future. He grew up in a family in which he describes himself as the only sane figure. Despite a very traumatic and disturbed childhood he has managed with great determination to develop and sustain close personal relationships and also achieve considerable success and real satisfaction in his work life, although these achievements are continually subject to severe self doubt and are experienced as resting on very weak foundations, liable to collapse at any time.

When he began therapy with me Mr. A was clear in his mind, based on previous experiences of having therapy, that he wanted to start at a frequency of once a week, saying

he could not handle anything more intense. I felt at the time that it might be important to go along with his request, at least initially, as he had indicated how difficult it was to feel safe in therapy and how he could not handle too much closeness or intimacy. After two years of once weekly therapy the degree and intensity of his anxiety lessened considerably, and Mr. A began to feel that he was starting to have more of a normal life. Although a very welcome development, the lessening of his symptoms brought about a sense of crisis in the therapy, as Mr. A then felt the spotlight was now much more on him rather than his anxiety. At the same time particular features of the analytic setup, for example his difficulties in beginning and ending each session which revealed his doubt that he could ever find a welcoming place for himself in my consulting room, attracted our interest and exploration. Mr. A became involved in the therapy in a different way, and started to speak of finding the gaps between the weekly sessions harder and harder, which he felt was now interfering with his wish for the therapy to make further progress. Consequently he asked to increase the frequency to twice-weekly, a change I readily supported.

Initially he found this increase in frequency, which he described as making the therapy feel much more intense and intimate, disturbing and disorienting, and for a time his level of anxiety increased. However after a period he began to settle down to the increased frequency and was able to use therapy in a different way to before, for instance being able to tolerate some transference interpretations and greater exploration of boundary issues. During this period of the work Mr A started to make important changes in his life and began to talk of experiences of spontaneity, intimacy and relaxation, both in his life generally and in therapy which were new to him.

A further crisis in the therapy occurred after about 4 years, following a summer break in which Mr. A appeared to suffer a severe setback. He lost all sense of progress, finding himself once again beset with anxieties accompanied by a profound fear of going mad. In the course of making sense of this experience, which we were able to link very clearly to certain events in his childhood which had remained hitherto in the background, he asked to increase the frequency to 3 times a week. The reason he gave for this was that he was now finding himself remembering events, feelings, and states of mind belonging to this past period of his life, and that coming twice a week no longer gave him sufficient time to recount, process and digest these memories. He also found coming three times a week helped him better manage his feelings of going mad. Once he came through this period of feeling he was having a breakdown, Mr. A continued to come at a frequency of three times a week.

In this account, as is normal in all clinical discussions, I have used frequency of sessions as a way of scaffolding my experience of the progress of the therapy and the development and deepening of an analytic process . The change from once to twice weekly corresponded with a focus which now included the patient/therapist relationship as well as his symptoms, and from twice to three times a week with an experience in which past and present experiences melted into each other in such a way as to make his experience of his present life more disturbing and intense, but also more real.

However using session frequency as a clinically useful way of marking developments in the therapy does not mean these developments would not have been able to take place without these increases in session frequency. If I were to put the emphasis on how the analytic process developed, instead of on session frequency, a different clinical picture would emerge. So looking back over the initial period of the work, I would say that when he asked to increase the frequency to twice a week Mr. A was already working in a deeper way at once a week than when he had started the therapy. The content of sessions may not have substantially changed, he was still largely speaking of his life outside the consulting room and the nature of his anxiety, but he was now doing so in a qualitatively different way, for instance in starting to discriminate more carefully between the different affects and states of mind and link them to his experience. Something was also clearly happening to his experience of the transference, as he was now finding the gaps between sessions too great. Once the therapy was experienced as having the continuity and reliability he felt he needed, Mr. A's defences lessened further, allowing or precipitating the emergence of one of Mr. A's deepest and most frightening terrors, that of going mad. Hence his request to increase the frequency to three times a week. Only when this primitive anxiety could be survived and made sense of could the analytic process develop further.

Was it the increase in session frequency that fuelled or allowed the deepening in analytic process, or was it the already developing analytic process that allowed Mr. A to make use of the increased frequency? I think this is a chicken-and-egg kind of question that can be interesting to pose, but makes little sense in actual clinical work. This is because in clinical practice time is not simply experienced as something to be measured, as in clock time, but as

a framing of experience, which gives that experience particular qualities and meanings. In my work with Mr. A the changes from once to twice weekly and from twice to three times weekly were both predicated by him being able to tell me directly what he feared (more gaps, going mad) and what he wished for (more sessions, more trust and greater intimacy). Suppose I had been unable to accommodate these requests as I had no available slots, and the therapy had continued at the pre-existing frequency. If we were to hypothesize how the therapy might have continued, it is evident that this would have made a profound difference – but this would not simply have been because there would have been a less intensive therapy, with less time within which things could happen, but also because the time available would have taken on a different meaning. If, say, we had continued at twice a week after his request to increase the frequency, then *this twice a week work would not have been the same twice a week work that was being done before his request.* The twice a week work subsequent to his request would have come to mean certain things to Mr. A and to me (e.g. that his stated fear of going mad was too frightening or disturbing to tolerate, or that increasing the intimacy of the work was too risky), and the furthering of the analytic process would have depended on how these transference manifestations were explored and made sense of in the subsequent therapy.

In the 8th year of the therapy Mr. A asked to reduce session frequency to twice weekly. The impetus to this request was to make time for a significant change in his life, in which, after many years of study and hard work, he was able to get a job which not only allowed him to do the kind of work he had always wanted to, but also gave him the experience, for the first time in his life, of working with a group of people with whom he felt he could be himself. I

had considerable misgivings about this request, but Mr. A seemed determined to initiate this change. He said that for him the crucial thing was to come more than once weekly, as that allowed him a session to "recover" from "letting go" in the first session of the week, and so he felt that going down from three times to twice a week was something he could manage.

As this therapy is ongoing, I am still trying to evaluate the impact and meaning of this change in session frequency. In my way of thinking it does point to what I think is a serious problem for Mr. A, one we are still actively grappling with in the therapy, which is his inability (or refusal?) to mourn, to allow himself an experience of loss. In this sense it is troubling that he has not acknowledged any sense of "missing" the third session. At the same time, as far as I can tell the analytic process, far from becoming diminished, has continued to develop in terms of depth and intensity. As Mr. A has come up against new experiences which no longer conform to his expectations of failure and humiliation, he is now being forced in a much more acute and painful way than before to face up to the conflicts and dilemmas in his life which he has hitherto avoided. This has allowed his dependence on me and the therapy to come much more to the fore. Furthermore something of great clinical significance occurred in the 12th year of therapy. Having struggled throughout the therapy - at once, twice or three times session frequency - to connect up the weekly sessions in his mind, so that he would typically arrive at a session unable to remember or connect to what had happened in the previous session, he suddenly declared one day that he was now able to regard the second session of the week as a continuation of the first. His stated reason for doing so, that it had occurred to him that he was acting exactly like one of his family members whom he regarded as pathetically incapable, did not really explain to me why and how this important

development had happened. I could only surmise that, now, something of the basic continuity of the analytic setting had been internalized by him sufficiently to allow for this development. The result of this significant development in the analytic process is that although, at twice a week, we have less clock time that when Mr. A was coming three times a week, the time we do have is qualitatively very different. It is a time which is continuous, which enables links between sessions to be made, unlike the more closed off and ruptured kind of time which was in operation prior to this clinical event. In this new kind of clinical time much more is possible, for instance we can now track what is happening in the transference between sessions in a way that was not possible before.

The danger in elevating session time into a super parameter is that the meaning and quality of time, different with every patient and in different settings, becomes obscured if not lost. I think of my work with Mr. A not as doing one kind of work at once a week or twice a week, and then moving over to a different kind of work at three times a week, and then going back to what I was doing again when the sessions went down to twice a week. Instead I think of my work with Mr. A as analytic work which is all of one piece, with its own intrinsic logic and rhythm. The issue that matters to me is not: is this "psychoanalysis" or "psychoanalytic psychotherapy" (a meaningless question) but: is my work any good? How can I do better? From this perspective the ideas and conceptual distinctions Busch and Widlocher use to construct a distinction between "psychoanalysis" and "psychoanalytic psychotherapy" can be employed to help me think more critically about my work. Perhaps I could have done more to facilitate or speed up Mr. A's newly discovered capacity to allow continuity between sessions, for instance by focusing more on how he fears becoming "intrigued by his own

mind". Perhaps a more "deconstructive" form of listening may help me tune in more to the ways Mr. A constantly avoids any experience of loss, particularly in the transference. Maybe it would have been better for me to encourage, or even insist that Mr. A attend for more sessions, and not have agreed to the reduction to twice weekly? These are good clinical questions which encourage me to spell out my own clinical reasoning, and to imagine different ways of conducting my work. There is no clinical need for such questions to be subsumed within a framework that creates different forms of analytic practice.

In other words the construction of different forms of analytic practice based on the logic of parameters, which appears to be only a clinical question, can be seen to be also a political one, about the kind of analytic community we live in, as well as what Gabbard and Ogden identity as one of the elements in becoming more mature as a clinician, that is what we can "dream up" which our forebears were not able to do. Here, again, I find the work of Richard Sennett of great help in drawing a picture of a different kind of analytic community in which such distinctions between different forms of analytic practice either do not exist, or if they are taken to exist can be described in different ways.

What kind of analytic community do we want?

To make and institutionalize a distinction between "psychoanalysis" and "psychoanalytic psychotherapy", as well as other forms of analytic practice, affects not only the way we think about clinical practice but also the kind of analytic community we have created. In his book "The Craftsman" Sennett makes a distinction between two forms of craft workshops, depending on whether they promote what he calls "sociable" or "anti-social" forms of professional relationships and ways of organizing work.

> There is an inherent inequality of knowledge and skill between expert and non-expert. Anti-social expertise emphasizes the sheer fact of invidious comparison. One obvious consequence of emphasizing inequality is the humiliation and resentment this expert can arouse in others; a more subtle consequence is to make the expert himself or herself feel embattled (Senett, 2008, p.249)

Sennett contrasts this anti-social expertise with what he calls sociable expertise, whose guiding principles are democracy and transparency.

> Sociable expertise doesn't create community in any self-conscious or ideological sense; it simply consists of good practices. The well-crafted organization will focus on whole human beings in time, it will encourage mentoring, and it will demand

> standards in language that any person in the organization might understand" (Sennett, 2008, p.249).

To my mind, creating an artificial distinction between psychoanalysis and psychoanalytic psychotherapy is a good example of an "anti-social" form of professional relationship. It encourages invidious comparison by creating embattled psychoanalysts, who constantly fear their work being exposed as "just" psychotherapy (in setting up workshops with senior analysts in order to compare their ways of working, Tuckett and his colleagues noted how many of them found it difficult to treat their colleagues as fellow psychoanalysts, resorting instead to supervising them or pointing out the ways their work did not correspond to proper "psychoanalysis", Tuckett, [2008]) and resentful psychoanalytic psychotherapists, who have to learn to make do with practising a watered-down version of psychoanalysis. It relies on definitions which are conceptually and clinically weak, and risk distorting our understanding of clinical practice by elevating one aspect of the analytic setting over all the others. When it comes to having to spell out its implicit logic, it comes up with differences, such as number of interpretations made or the degree of intensity of the treatment, which are vague and lack specificity, or with quantitative differences, such as session frequency, which are inconsistent and arbitrary. Based on my own experience, I would contend that these do not conform to what Sennett calls "standards of language which any person in the organization might understand". Perhaps most important of all, it militates against what Sennett calls "sociable expertise" by confusing "good practices", the specification and exploration of which are vital to the development of psychoanalytic practice as a whole, with this arbitrary distinction between different forms of psychoanalytic practice.

In this paper I have tried to "dream up", if only in outline, a way of conducting clinical debates and organizing our psychoanalytic profession in ways which do not rely on making artificial and arbitrary distinctions between different forms of analytic practice. I have tried to describe how I have found it necessary in my own development to claim an analytic identity to which I am not entitled. I do not pretend to know how, if my arguments are sound, they can be taken forward. But a necessary first step is to recognize that there is a problem which is wider than my own personal struggles in claiming a psychoanalytic identity.

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