

Skills for Health Draft on Psychodynamic/Psychoanalytic NOS A Response from The Psychoanalytic Consortium

Introductory Comments

The NOS draft relating to psychodynamic/psychoanalytic therapy represents a highly biased and particular view of what psychotherapy consists of. The covering note which accompanies the draft NOS states that the NOS are based on an appraisal of 'manuals of dynamic therapies that have been used in research trials and which have been shown to be effective when applied'. However, there are simply no manuals of psychoanalysis as psychoanalysis is not a treatment that can be applied: rather, as all the major theorists of psychoanalysis have pointed out, it is something which is invented afresh in each case by the analysand and analyst. This is reflected in the fact that the list of manuals supplied by SfH contains no psychoanalytic texts, only those concerning other forms of therapy.

Psychoanalysis is based on transference and the idea that our conscious demands are moulded by unconscious desires and phantasies. The NOS place an inordinate emphasis on conscious aspects of an analysand's demands and also on the idea of a clarity of communication between analyst and analysand, assumptions which are not accepted by the majority of theorists of psychoanalysis. Furthermore, the NOS are based around an idea of the 'performance' of the analyst, something which can only reinforce and even foster an alienation in the clinician if they feel that they have to distinguish their own activity from what their activity is supposed to be. This is in fact an alienation that many patients complain of and in fact seek psychoanalysis or psychotherapy to resolve. The above assumptions have shaped the NOS and are compatible with most forms of cognitive behavioural therapy but not with Freudian, Jungian, Kleinian or Lacanian psychoanalysis, or with most other forms of psychoanalytic practice that take place today in Britain and around the world.

There is one other general point which concerns all of the proposed NOS. Each section of the document starts with an explicit emphasis on the importance of respecting difference, yet Skills for Health have admitted that the group which has drafted this document has not been formed on a democratic basis. Representatives of the majority of psychoanalytic practitioners currently practising in this country have been excluded from

the working party responsible for the draft despite written assurances that they would be included. There is thus an astonishing contradiction between the ethos which is supposedly at the core of the document and that which has in fact been operative in its construction. This point has to be recognised in order to grasp the essential problems in the draft NOS.

Comments on the PADT

PADT 1

As pointed out above, the notion of performance criteria is inherently flawed. A psychoanalyst does not perform, because the notion of performance implies one is performing for someone, exactly what an analytic work will be aimed to undermine.

Point 1 states that the clinician must 'respond sensitively to the individual's current preoccupations and distress'. But what could be meant by 'need to'? How can anyone determine what would be best in a very particular clinical situation in advance? If a prospective analysand expects a sensitive response, the analyst might decide that the best strategy might be to respond with great insensitivity - on the other hand an insensitive demand for analysis might be met with a very sensitive response from the clinician. Everything depends on the particularity of the individual context, and many schools of psychoanalysis see it as fundamental that the clinician responds in a way that does not match the expectation of the analysand.

Point 2 The clinician is supposed to make an assessment here of how the individual would manage without the therapy's "imposed structure". What does this mean? Some schools think that therapist imposed structure means the empirical meetings with the flesh and blood therapist, while others see it as a structure operative within language that may function without the presence of the therapist. The presence of the therapist is of course no guarantee of any structure.

Point 9 The clinician is supposed to 'encourage the individual to discuss and explore their perception of and feelings about' the therapist. Many schools of psychoanalysis in the world today contraindicate this point and hold that an encouragement by the therapist to the analysand on this point is a technical mistake in treatment.

Point 10 The clinician is supposed to 'accept the individual's view of you as therapist to allow particular experience of the individual self in relation to you to emerge in the session'. This is conceptually and clinically a mistake. How could you know what the individual's view is or anything about their relation to you, as this will of course change from one moment to the next in the course of a treatment. Here, and elsewhere, in the document there is the highly dubious assumption that there is such a thing as 'the therapist' which remains unchanged throughout the treatment.

Point 11 Re the question of interpretation, many schools of analysis today contraindicate transference interpretation, as did Freud.

Point 14 This point tells us that the analysand must 'reflect on their experience of the assessment by interpreting their conscious and unconscious experience of it'. But how can conscious and unconscious experience be interpreted after an assessment? This might take many years before it becomes possible and by that time things will in any case have moved on. In many cases, it might be unwise to encourage the analysand to reflect on this. Everything will depend on the particularity of

the individual case.

Point 17 This tells us that we must 'explain to the individual your assessment of the feasibility of the therapy and suggest alternatives if not suitable'. Most practitioners would not accept this. Suitability depends on the work done by the analysand. The analysand may have several sessions to test whether they are able to pursue a work or not with a particular clinician. The clinician can't really tell a prospective analysand that a treatment is suitable or not given the key point, emphasised earlier, that analysis is not a treatment that is delivered but is invented afresh in each case. This reinvention will involve an elasticity of technical rules, eg, frequency of sessions, use of the couch, style of intervention.

K26 & K27 & K28 & K29 would not be accepted by most analytic practitioners. It is not possible to predict in advance 'the emotional impact of an interpretation' and many practitioners would systematically avoid transference interpretation.

K29 states, in direct opposition to Freud, that the clinician must be able to formulate 'the dominant transference theme from an individual's assessment'. However, for Freud, what distinguished psychoanalysis from other therapies was its refusal to formulate such themes swiftly. As he emphasised, what the analyst has to know is how not to know: in other words, how to be able to avoid formulating a dominant transference theme at the beginning of the treatment. After a rigorous training the analyst must be able to listen to the analysand, which means having the ability to not make formulations. Of course, formulations help with any anxiety the clinician might have. Hence the long term and in depth training of analysts which will allow them to operate beyond a mechanistic framework without too much anxiety hampering their practice.

PADT2

This states that the clinician must respond 'to the individual's presenting issues in a concerned, non-judgemental manner to enable the analytical relationship to develop with sufficient trust to allow the emergence of unconscious life. It includes identifying and agreeing therapeutic aims.' The clinician is not obliged to respond to presenting issues in any predetermined way. In a particular case, the clinician might in fact feel it is prudent to respond in a judgmental way: it will depend on the particularity of the material. There is also a major problem with the idea of 'identifying and agreeing therapeutic aims'. This suits behavioural therapies but not analytic ones since the analyst may aim precisely to work against what the analysand aims at. As Freud, Jones and all the other major analytic theorists argued, the majority of demands for analysis aim to reconstitute the neurosis rather than resolve it. The clinician cannot agree aims with an analysand at the beginning of the treatment for these and many other reasons.

The performance criteria that follow are totally inappropriate for psychoanalytic work and points 1 through to 25 are all in fact specifically contraindicated by most schools of psychoanalysis.

Point 1 The analyst does not have to 'communicate understanding thoughtfully' to the analysand's material. The analytic position is based on the principle of not showing that one understands even if one thinks that one does. Analysis is based on an abdication from the position of the one that knows and hence it is far from the understanding that we might hope for from a friend for example.

Point 2 We are told here that the clinician must evaluate when to focus primarily on 'the individual's internal and external reality'. Apart from the dubious distinctions between internal and external, the very fact that the clinician focuses on anything would involve 'internal reality' because what the clinician says is heard from a point within the individual's internal reality. These confusions were pointed out and apparently dispelled about fifty years ago yet resurface repeatedly in this document.

Point 3

The clinician is told here to 'respect the individual's need for defences'. This cannot be a universal rule as at some moments the defence will be respected but not at other moments. This is something which will depend on the particular context of each case and cannot be elevated to a universal rule.

Point 4

The clinician is told to 'contain' the individual's anxiety by 'engaging with their conscious and unconscious anxieties about the therapy and therapist'. This strategy is contraindicated by most schools of psychoanalysis in the world today, which do not force the analysand into a space where it is only them and their therapist. In addition, analysis cannot progress without a certain level of anxiety in the analysand. Without this no unconscious material will be released and hence no analysis can take place.

Point 5

We are told that the clinician must 'allow the individual's narrative about their difficulties to emerge without imposing a structure'. This would not be accepted by many practitioners who would insist on the presence of a structure, particularly at the start of the treatment. Imposing a structure can be helpful in allowing the analysand to engage with inconsistencies and contradictions in their formulation of their history.

Point 6

We are told here that the clinician must ask 'clarifying questions so as to understand the individual's perspective without making assumptions'. Once again analytic work relies on a fundamental non understanding. It would be very naïve to think that any form of understanding does not make assumptions and in fact the publication of case histories proves this again and again. The clinician might ask questions within the particular context of a particular moment in treatment but this cannot be made into a rule.

Point 7

We are told here that the clinician must 'communicate clearly the boundaries and frame of the therapy'. Although some clinicians would accept this, many would not see the necessity of communicating boundaries and frames as these will evolve within the context of the work. They cannot be outlined in advance.

Point 8

We are told that the clinician must 'explore the expectation of both therapist and individual so as to orient them to a particular style of therapy'. This once again repeats the assumption that therapy is something that is applied rather than something that is invented afresh in each individual case. The analyst should have no expectation about the therapy since how could they know in advance what to expect? Equally, it may be important to work against the conscious expectations of the analysand. Analysis aims to offer the analysand something that they do not expect.

Point 9

We are told here that the clinician must give the individual 'direct information' about the therapy including its 'risks and benefits'. No serious analyst could tell an analysand at the beginning of the treatment what the benefits will be since these cannot be predicted in advance. The only risks which are clear is that the treatment will be long and costly. Telling the patient of other risks might be understood as the malevolence of the clinician and hence might be contraindicated.

Point 10

The technical point here about adopting a more passive stance with disturbed individuals is absurd and will of course depend on the particularities of the individual case.

Point 11

This tells the clinician to give the analysand 'early experience of an analytic/dynamic approach'. This is nonsensical given the fact that analysis begins with a period of preliminary interviews and there is no guarantee that an analysis as such will follow. One cannot give the individual experience of the 'analytic approach' since the analytic approach will depend on their own participation in the work.

Point 13

The clinician is told here to 'provide an account of the individual's subjective experience and how you understand their issues early on in the therapy'. Most schools of psychoanalysis hold on the contrary that the analyst cannot give an account of the individual's experience since it is precisely their own experience and not the analysts. It is also contraindicated to provide an account of how the clinician understands their issues since the whole point of psychoanalysis is not to understand too soon if at all. An ideal way to send a prospective analysand away from treatment is to provide such an account.

Point 15

The clinician here is told to 'encourage the individual to reflect on their reactions to the treatment and focus on feelings and relationship...' This would not be accepted by many analysts who would aim to constantly orient the treatment beyond the two person dynamic of analyst and analysand. This is the analytic concept of the Other. Focusing on the individual's reactions to the treatment risks blocking off this dimension and generating acting out.

Point 16

We are told here that the clinician must 'allow the individual an opportunity to ask questions, explore, clarify and agree treatment aims'. This may be suited to cognitive behavioural therapy but not to psychoanalysis since there can be no possible agreement of treatment aims at the beginning of an analysis. How can the analyst know what they aim at or indeed what the analysand truly aims at at an unconscious level? Clarification may also be important at some points but many analysts would opt for opacity here to generate the dimension of an enigma which would then result in the production of unconscious material.

Point 17

The clinician is told that they must 'enquire about what the individual hopes to achieve'. This might be valuable material as a conscious hope may give a clue to an unconscious desire (which may turn out to be the exact opposite of the conscious hope). However this cannot be made into a

universal rule.

Point 18

The clinician is told that they must communicate 'in addition to the stated aims that there might be less conscious aims'. But why should the clinician communicate this? It may be important in one case but not in another. It cannot be made into a rule.

Point 19

The clinician is told to 'reflect to the individual your understanding of their resources and vulnerabilities in relation to the stated aims'. This would imply, first of all, that the stated aims are taken seriously, and secondly that a 'realistic' assessment can be undertaken, as if the clinician knows anything about the resources and vulnerabilities of the analysand, which may only become apparent after many years and of course may change during the course of the work. For the analyst to assume that they are able to state to the analysand what their resources and vulnerabilities are is an extraordinary appeal to mastery which is opposed to an analytic position.

Point 20

The clinician here is told that they must 'introduce some realism' about what might be achievable by the analysand. This is again extraordinary, as if the analyst were a judge of reality, able to say in advance what the analysand may or may not achieve. This is totally opposed to the analytic position and also shows a fundamental misunderstanding of the way that the aims of an analysis might change radically over the years that the analysis takes place. To state in advance what is achievable and what isn't automatically rules out any analytic position.

Point 21

The clinician is told here that they must 'gain and review/retain the individual's valid, informed consent'. What does this mean? Usually what happens in analysis is that the analysand discovers that what analysis is about isn't exactly what they expected and hence a critical period will ensue when they must make a choice whether to continue or not. What would one be trying to obtain consent for? Is it conscious consent or unconscious consent?

Point 22

The clinician is told that they must 'respond openly to the client's conscious and unconscious experience of difference'. The clinician is not obliged to respond openly to anything, and even if they make an intervention which they think is 'open' the analysand may experience this as closed, for example. Likewise, how could one separate a conscious and unconscious experience of difference? The question of difference imposed here shows a misunderstanding of how real questions of difference will be inscribed in the subjective life of an individual.

Point 23

Here again there is an injunction to 'respond openly to the individual's experience of difference' in the therapy. Yet why should the therapist not respond openly and sensitively to everything else? To think that one can separate and privilege the idea of difference is to misunderstand completely both how human language operates and how the unconscious is formed.

Point 24

This point reiterates the same confusion, referring to the 'actual differences between you as therapist and the individual'. What is 'the

actual difference'? An analysand may relate to a male analyst as if it were their mother. Does this mean they have misunderstood the actual difference between the therapist and their mother or between a man and a woman? At another moment the clinician might be in the place of the breast or a piece of excrement. Would this be an actual difference? The document here is assuming that there is a reality which can be distinguished by analysand and analyst which is not contaminated by unconscious affects. This idea has been refuted about 50 years ago yet resurfaces again and again in the document.

Point 25

The clinician is again told here to 'critically self reflect' on the various attitudes which may be operating with respect to difference, but how could these attitudes be distinguished from any other attitudes? It implies that there are a set of differences which have nothing to do with the effects of the unconscious and the transference dynamics.

PADT3

Point 1 tells us that the clinician must "show interest in and acceptance of the individual's subjective experience". How can anyone be made to show interest in anything? Once again the criteria privilege behavioural variables rather than concepts. In many cases, the clinician will decide not to show interest in and acceptance of an individual's formulation of their experience, as part of the work in the transference. If an individual expects a lot of interest, the clinician may show very little, and vice-versa.

Point 6 tells us that the clinician must "communicate..understanding of the individual's experience and difficulties in a manner that promotes therapy". But what position does a clinician take in order to do this? Many schools of analysis would not accept that analysis involves communicating understanding and that, if understanding does play a part, it is the analysand's and not the analyst's. Claiming to understand may be a breach of analytic ethics.

Point 9 tells us that the clinician must "engage the individual in responding to your formulation and elaborating it and revising it". Many schools of analysis expressly contraindicate this technique, arguing that it can be damaging to the treatment and to the analysand, forcing them into a two-person relation. The analyst here is like a parent who wants a baby to respond to him or her: this may reduce their own anxiety but is detrimental to analysis.

PADT4

Therapy here is described as about "creating another learning opportunity" for the individual. Many therapies hold this view but analysis, as Freud pointed out, is not about learning. On the contrary, it is about, in part, a confrontation with the limits of knowledge. The terminology of learning opportunities reduces the particularity of analytic work to the contemporary ideology of learning that is antithetical to analytic ethics.

The section here on 'Analytic Attitude' tells the clinician that as well as 'free-floating attention' they must 'observe themselves' continually, and "be in the situation as well as observing oneself in the situation". This is not only contradictory but nonsensical: how would free-floating attention be compatible with self-observation? Likewise, the whole point of analytic work is to move beyond the alienating split between being and self-observation, a split which is indeed the presenting symptom of many analysands. The NOS here buy into the culture of self-inspection and self-monitoring which is central to cognitive therapies but not analytic ones.

Point 1 The clinician is told that they must “agree with the individual clear parameters within which treatment will take place”. This is not a matter of agreement between different analytic schools. First of all, how can parameters be predicted or set in advance before working for a time with the analysand? Secondly, if analysis aims to break expectation and ritualisation, parameters may be changed so as to work against the ritualisation that all the major theorists of analysis have warned against.

Point 2 The clinician is told that they must “explore with the individual the meaning for them of any changes to the agreed setting, whether planned or unplanned”. Here again the rule is a form of nannying. A change may be discussed or it may not be, depending on what is happening at that moment in the treatment. The emphasis once again on ‘meaning’ as what will reduce anxiety is opposed to many schools of analytic thought which stress, on the contrary, work beyond the field of meaning.

Point 5 The clinician is told that they must “make an intervention or interpretation about what the client/patient has said about their experience of separations/discontinuities in the treatment frame”. This fits with one view of analytic work and is not shared by the majority of analysts. Again, it is consistent with the nannying view of therapy where everything must be explained and ‘understood’. Other forms of analytic work might see each session as a fruitful opportunity for discontinuity, where the key is that this is not glossed over with meaning or an appeal to the mythology of the two-person relationship.

Point 12 The clinician is told that they must “choose their responses so that the experience of unverballed feelings and unconscious conflicts is not intensified in a way that threatens the viability of the therapy”. This supposes the predictability of an intervention, a point specifically denied by Freud, Lacan and Winnicott: one cannot predict the effect of interpretation and if one could, it would not count as an interpretation. In fact, an intervention may confront the analysand with the choice of continuing with the analysis or not. The analysand must have a freedom here to decide what path they will take.

Point 16 The clinician is told that they must “in advance of planned interruptions in the treatment enable the emergence of the individual’s conscious and unconscious responses to breaks and an opportunity for a valuable intervention”. But how can a response to a break be predicted in advance without making use of suggestion? And how can an unconscious response be formulated in advance or known about at all? In some instances a break may be a valuable moment for intervention, but the clinician risks here being drawn into the trap of assuming that every break will be experienced in a particular way by the analysand. This is very particular orientation in psychoanalysis accepted by some clinicians but not by many. It focuses on their own person, as if the analysis were functioning to give the analyst a sense of their own importance. Many schools of analysis see the position of the analyst as excrement rather than mastery.

K2 The clinician is told here to “apply an in-depth understanding of the impact of the physical setting of the therapy room on the relationship with the therapist”. This absurd point suggests that this can be known in advance when it is a variable that may change during analysis and may often be of no importance at all. But elevated into a rule, the more the therapist makes of it the more opportunities for suggestion with the patient.

K3 The clinician is told here to “apply an in-depth understanding on interruptions in the treatment and their impact”. These cannot be ‘understood’ in advance.

K4 The clinician is told here to “apply an in-depth knowledge of the dynamics of separation, loss and mourning as the basis for understanding the client’s subjective experience of breaks during the treatment”. But breaks may mean different things for different people at different moments in a treatment. Once again, the more the analyst focuses on them, the more coercive the analysis becomes and the more the emphasis is on the self-importance of the analyst.

PADT5

Point 1 The clinician is told that they “need to show an interest in and acceptance of the client’s subjective experience”. There is no reason why they should be either interested or accepting. They may be in some instances, but it will depend on the particular context of the case. If the analysand expects interest or acceptance, the analyst may show the opposite.

Point 2 The clinician is told here that they must “respond sensitively to the client’s current preoccupations and distress”. Same criticism as above, and also the fact that many schools of analysis would advise not focusing on the current sources of distress but on apparently unrelated aspects of the person’s life. This point assumes that the client know what their sources of distress are, when analytic thought always emphasises unconscious and hence unknown causes.

Point 3 The clinician is told here to that they must “direct interventions towards” transference material etc. This was contraindicated by Freud excepting certain circumstances, and most analysts in the world today do not use transference interpretation or focus on the ‘interpersonal’ as this point suggests.

Point 9 The clinician is told here that they must “evaluate when it is most productive to focus on the client’s external or internal reality”. But who is to say what is internal or external? It supposes the position of analyst as a master, able to demarcate the real and the unreal, and hence is not compatible with an analytic position. As noted earlier, whatever the analyst says, what matters is the place this is heard from, which will be the internal reality of the analysand. There isn’t a separate part of the brain which switches on when the analyst claims to talk about external reality.

Point 14 The clinician is told here to that they must “communicate to the individual an understanding of the meaning for them of any shift in style”. The nannying continues. This is incompatible with most forms of analysis, where what matters will be the encounter with what is not known or predictable. The analyst acts to avoid being in a place where the analysand can situate them. Understanding and meaning may be important at times, but here they effectively rule out any efficacy of analytic intervention which relies on surprise.

PADT6

Point 1 The clinician is told here that they must “allow the client to talk without imposing any formal structure or direction in the sessions”. This may be important at times but is not accepted by most schools of analysis. Structure may be important at one moment but not at another, but is

often used in preliminary stages to treatment. Note that this point actually contradicts dozens of earlier PADT points which in fact tell the clinician what they should be doing re imposing a direction on the material (eg explain changes in style, transference material, breaks etc).

Point 2 The clinician is told here that they must “communicate understanding to the client of the internal obstacles to free association”. But how would the analyst know this? The obstacles, according to Freud, simply are the free association, which is never free. How is this point compatible with the earlier PADT admonishment to “respect the patient’s defences”?

Point 3 The clinician is told here that they must “help the client explore their feelings about not being understood or helped”. Perhaps in one context in one case but not necessarily in another. What position does the analyst presume to have here? It may in fact be important for that person to feel misunderstood or not helped.

Point 4 The clinician is told here that they must “understand and manage your own feelings of anxiety about not knowing”. This would mean rejecting nearly all the PADT points, which pretend to ‘know’ something about the dynamics of an analysis. Why should these be ‘managed’? Analysis is not about management but about expression and articulation.

Point 8 The clinician is told here that they must “be curious about what anxieties may lie behind the client’s questions and draw the client’s attention to these”. Well, is the clinician supposed to pretend to be curious or be genuinely curious? How can this be assessed and evaluated? The absurdity of this formulation is apparent. Likewise, there is no necessity to draw attention to sources of anxiety: it can happen as and when.

Point 14 The clinician is told here that they must “identify the client’s response to your use of silence”. How can this be done? Will it involve every silence, a few seconds, a minute, an hour? How can the response be identified? Once again, the analyst is in a position of knowledge here, that specifically contraindicated by Freud, Jung, Lacan, Winnicott etc.

Point 15 The clinician is told here that they must “monitor and interpret the client’s anxiety in response to silence”. Analysis is not about monitoring, first of all; secondly, many schools of analysis do not encourage any persistent interpretation of the ‘two-person’ relation which this would encourage; and thirdly, a level of anxiety is important as a motor for analysis to take place.

Point 16 and 17 tell us to limit silences if this may undermine engagement with therapy and to “increase your level of activity when appropriate”. But these judgements will be made by the clinician in the context of an individual case. Making them rules is absurd: will the clinician not do what they think is appropriate?

Point 18 The clinician is told here that they must “explicate the client’s use of silence in the session”. There is no necessity to do this. It may be important in a particular case at a particular time, but once again the clinician is being coerced to bring everything back to the two-person relation, a technique that may well result in the analysand becoming more paranoid.

Points 21 and 22 reiterate the erroneous stress on sensitivity and the division between internal and external reality that we have discussed

above.

PADT7

Point 2 The clinician is told here that they must “explore areas of omission from the client’s descriptions of their relationships”. This risks imposing a normative view on what people are supposed to experience/feel in a relationship: how can the clinician know what is being omitted? It implies that there are norms as to how to relate.

Point 3 The clinician is told here that they must “use the experience and observation of the client’s ways of relating within the session to inform your understanding of the client’s internal world of relationships”. This is a highly particular view. Other schools of analysis believe that it is in fact what the analysand says that will matter here, and that their ways of relating in the session will usually be a construct of the clinician, using the clinician’s words and not the analysand’s.

Point 4 The clinician is told here that they must “help the client identify and understand recurring affective patterns in their relationships, particularly through exploring how these play out in the relationship to the therapist”. Many schools of analysis would not emphasise this, preferring to listen to what the analysand is saying and making deductions from this. Likewise, in some cases, there is no necessity to attempt ‘analysis’ of someone’s pattern of relationships if this is what keeps them stable.

Point 8 The clinician is told here that they must “communicate to the client an interpretation that goes beyond what the client reports feeling”. How is this different from the clinician’s projection? It risks imposing material on the analysand, which may of course be important at times in an analysis to produce an effect.

Point 9 lists five aspects of interpretation that demonstrate a real misunderstanding of psychoanalysis. The clinician is told to deliver interpretations clearly, ‘matching what the client can bear to think about’, ‘not too close to the end of a session’, ‘moves gradually from preconscious to more unconscious content’, ‘is pertinent to the interpersonal’ dimension and ‘makes it clear to the client how you arrived at the interpretation’. These points are totally at odds with psychoanalytic interpretation: how does the clinician know what ‘matches’, and if so, why should interpretation match? Why not too close to the end of the session? Many analysts will in fact only make an interpretation at the end, thus blocking the analysand’s introduction of resistances to close off the unconscious. The idea of moving from one layer of content to another was disproved about 50 years ago so it is strange to see it resurface here. Finally, letting the analysand understand how the interpretation was arrived at may sound like good nannying, but is absurd: a true interpretation is not arrived at but just happens, according to many analytic theorists. If not, analysis becomes like education with the analyst pushing knowledge onto the analysand.

Point 10 The clinician is told here that they must “integrate information gathered from various sources”. In analysis, what sources are there apart from the analysand’s speech? Should we ask for their dental or medical records?

Point 14 The clinician is told here that they must “receive feedback about the helpfulness or otherwise of an interpretation openly”. This is ridiculous. First of all, in analysis we deal with the analysand’s speech, not with ‘feedback’. Everything said is material. It isn’t about making an

evaluation of a service, like in a pizza restaurant. And interpretations matter by having effects, beyond whether they are deemed helpful or not.

Point 15 This reiterates the confusions of the previous points, urging the clinician to appraise the helpfulness of interpretation and 'correctness' and 'incorporating this into an ongoing process of evaluation'. Analysis is not about evaluation, and many people enter analysis precisely because their experience of the world is one of being evaluated and they wish to move beyond this to attain a certain kind of freedom. Likewise, Freud and other analysts pointed out that the interpretations which matter are not those which are 'factually' correct but those which introduce a new vector or shift in emphasis. If a clinician engages in an 'ongoing process of evaluation', they are just not doing analysis.

PADT8

The clinician is told here not to introduce "new topics that may be unsettling too close to the end of a session". Is the aim nannying or analysis here? Anxiety is essential in analytic work, and interpretations will hopefully be very unsettling. The skill of the analyst is of course knowing when to make these, although their effects can never be predicted in advance. Equally, for those analysts who use variable length sessions (the most common form of analytic work in the world today), the clinician does not know when the session will end so cannot do anything relative to a set ending.

Point 1. The clinician is told here that they must "communicate to the individual that their feelings can be tolerated and thought about by you". This may be important at some moments but not at others. Many analytic schools would disagree with this as technical advice.

Point 2 The clinician is told here that they must "link the individual's non-verbal cues to unexpressed or unconscious feelings". This is very dubious: what is a 'non-verbal cue', unless one verbalised by the clinician, and hence one formulated in their own language? This is suggestion not analysis.

Point 4 The clinician is told here that they must "encourage the individual to stay with a current feeling as it emerges in the session", but what about free association, a hallmark of analysis which means that the analysand says whatever is going on in their head? Staying with a feeling may be coercive and cannot be made into a rule.

Point 6 tells us what interpretations must focus on. This neglects the particularity of each case. There can be no rules for interpretation.

Point 9 The clinician is told here that they must "encourage the individual to elaborate on communication that is unclear, vague, puzzling or contradictory". Is this rule compatible with free association? Who judges what is vague, unclear, puzzling or contradictory? This rule may be useful in an English class at school but is alien to psychoanalysis. The clinician may encourage association around some idea of the analysand but there can be no rule for this. There is also the suggestion here that analysis is about communication

Point 12 again makes the clinician have to "be curious". Same criticism as above.

Point 14 The clinician is told here that they must "encourage the individual to discuss and explore their perceptions of the therapist and how they

think the therapist may feel or think about them". This is not accepted by most analysts and certainly not as a rule. It introduces the analysand to a hall of mirrors and gives undue importance to the person of the therapist, as if the analysis were all about them. Once again, the focus on the two-person relationship may encourage paranoid ideas.

Point 18 tells us that the clinician must "respond non-defensively to the individual's view that the interpretation may be incorrect or badly timed". An interpretation should, for many analysts, always be incorrect and, for the analysand, badly timed. Whatever view one takes here, how can a rule tell someone to be 'non-defensive'? In fact, a defensive reaction may prove valuable for the analysis.

Points 18 to 28 rely on a particular view of countertransference and empathy that is not shared by all analysts.

Point 22 tells us that the clinician must "maintain an 'observing distance' from the part of yourself that is involved in the process". Well, what part isn't involved in the process? Which part should be doing the observing? And shouldn't another part be observing the observing part to ensure objectivity? Criticisms as above.

PADT9

This tells us that "the experiential focus of the here-and-now of the session [should be prioritised] as the basis for interventions..". This represents one particular view of analytic work, one not accepted by the majority of practitioners. Many contraindicate this as actually blocking the progress of analytic work and advise against here and now interventions.

Point 1 The clinician is told here that they must "establish and maintain emotional contact with the individual". Does this mean that the analysand must believe this or that a real emotional contact be present? If so, how can it be a rule for a human being to have an emotional relation to another? Just because they are paying money to see them? In fact, many schools of analysis argue that the less emotional relation the better, as this will not block the analytic work.

Point 2 as PADT9 above.

Point 12 tells us that the clinician must "contain the individual's experience of anxiety if they feel too exposed". This is accepted by some not all schools of analysis. For many, analysis involves the engagement with an abyss which will provoke unbearable anxiety. This will be a crucial phase in analysis.

Point 12 The clinician is told here that they must "monitor and avoid the temptation to make interpretations to manage your own anxiety". Nearly all of the PADT rules could be included here as ways to try to reduce the clinician's anxiety.

Point 21 The clinician is told here that they must "respond openly and respectfully to the individual's conscious and unconscious experience of difference". There is no reason for the clinician to do this actually contradictory practice: if conscious and unconscious oppose each other, responding respectfully to one will be disrespectful to the other. For transference reasons, it may be important for the clinician to respond with little respect, with anger, outrage or with a lack of openness, so that their own position appears enigmatic. If the analysand suspects the analyst of holding some particular view, it may be crucial to keep this undisclosed,

enigmatic. The notion of 'difference' here is highly problematic and shows a profound misunderstanding of analytic thinking, as noted above.

Points 24 and 25 rely on unproblematised views of 'difference' which have been criticised above. The idea of 'actual differences' between therapist and individual is also absurd: what is actual here? Does it mean whatever is not influenced by unconscious phantasy, projection etc? If so, there is nothing left as there is no neutral zone uncontaminated by the effects of the unconscious.

PADT10

Point 4 The clinician is told here that they must "draw the individual's attentions to the feelings they may be avoiding". How would the analyst know what feelings are being avoided? This rule puts the analyst in a position of mastery. Rather like a schoolteacher. Most analysts would not presume to know what feelings are 'being avoided' and would certainly not interpret them systematically.

Point 9 The clinician is told here that they must "distinguish between instances when resistance to therapy is a manifestation of the individual's difficulties and instances when the individual is responding to an accurate perception of differences of opinion between themselves and you". Who is to decide on this? Why shouldn't differences of opinion exist between analyst and analysand? And couldn't these two apparently distinguishable states be in fact one and the same?

Point 14 The clinician is told here that they must "draw the individual's attention to communication that is unclear, vague, puzzling or contradictory with the aim of encouraging the client to better express their thoughts and feelings". This is one of the stupidest of all the points and it is amazing that any clinician could have drafted it. It may be an aim in a schoolroom but certainly not in an analytic situation, where it is precisely the unclear, vague and puzzling elements of someone's speech that are valued as keys to the unconscious. How can the analyst presume to tell an analysand to express themselves 'better'?

Point 16 again relies on the unfounded view of 'actual difference' between the parties.

PADT11

K16 The clinician is told here that they must apply "a working knowledge of the primary target of therapy". In analytic contexts, this cannot be known in advance and may change radically at different moments of treatment.

PADT12

Point 3 The clinician is told here that they must "maintain an empathetic, thoughtful response to the individual's affective engagement..". Many analysts would agree with this but many would disagree, arguing that empathy is a block to the analytic process: we can only empathise with what we know already, so the particularity of the analysand's material is compromised, and there is the further risk of emotional mix-up.

Point 4 The clinician is told here that they must "communicate understanding in response to the individual's conscious and unconscious communications". This would not be accepted by many analysts, who would argue that understanding is a block to analytic work and that to set oneself up as the purveyor of understanding is to adopt a position of mastery.

PADT13

The ending of analysis is stated here to require having reached “a satisfactory point of learning or mitigating ill effects”. Many schools of analysis would not agree here: the end of an analysis is not about reaching a satisfactory point of learning, an assumption suited to education but not to analytic work. Ending can also hardly be satisfactory, even if the analysand has been robbed of what is most precious to them: the unconscious satisfaction in the phantasy, the deflation of their ideals etc. Many testimonies of ending imply resentment and reproach rather than satisfaction.

Points 1 through to 15 here assimilate analytic work to educational endeavours; eg the individual must be helped to assess the results of the work with their aims, an idea which ignores the specificity of analytic work and removes the separation of conscious and unconscious effects. Likewise, we are told that the individual must be reminded of the time frame throughout the work, a rule clearly inapplicable to open-ended work. These points also tend to assume a normative view of endings, when these will have unpredictable effects. We could remember here that for some analysts, ending just means becoming an analyst, whether one decides to practise or not.

