A TIME FOR THERAPY: TIME LIMITED THERAPY IN LIGHT OF LACAN'S LOGICAL TIME

Time is the substance I am made of
Time is a river which sweeps me along, but I am the river
It is a tiger which devours me, but I am the tiger
It is a fire which consumes me, but I am the fire
Jorge Luis Borges

1. How can we embody time in therapy?

'How long do you think this therapy is going to take?' is a question that every psychotherapist in private practice is asked now and then. As a new therapist, I attempted to estimate this time for some patients. However, with time and experience I have learned to withhold the answer to this question. After all, who can predict which course a psychoanalytic psychotherapy[1] will take? Freud also challenged the idea that the answer to this question was predictable (Freud 1913). He had the habit of telling his patients that the work was going to take a lot longer than they had foreseen, and that it could take months or even entire years. According to him, some patients had unrealistic ideas about the duration and cost of an analysis:

> No one would expect a man to lift a heavy table with two fingers as if it were a light stool, or to build a large house in the time it would take to put up a wooden hut; but as soon as it becomes a question of the neuroses - which do not seem so

[1] Lacan made a clear difference between psychoanalysis and psychotherapy. We want to clarify that in this article, we discuss a form of psychotherapy, namely psychoanalytic psychotherapy. The claims and hypotheses that are posed as a result of our study therefore do not apply to an analysis.

> far to have found a proper place in human thought - even intelligent people forget that a necessary proportion must be observed between time, work and success.
>
> Freud 1913: 1045

To counter these unrealistic expectations, Freud found it effective to inform patients in advance about the difficulties and sacrifices of the enterprise, telling them that the journey could take longer than they initially expected.

It is easier to answer the question about the duration of a treatment within a medical discourse: in this setting, the doctor can estimate how long you should take your antibiotics, how long you will have to wear your cast or how long your flu will last. In psychotherapy, however, the question remains much more ambiguous. These different approaches to time demonstrate how the time for a therapeutic process differs from the time for a medical recovery.

Nowadays, patients can find it remarkable that the time for therapy is hard to foresee. Our zeitgeist is not in accordance with the idea that a time estimation for therapy can be difficult. As a heritage of the industrial revolution; efficiency, goal orientation and technological advancement have become central values in our society. The revolution initiated the development of relentless knowledge - a science ready to face any quest imaginable. Within this spirit, body and mind are controllable and understandable through technical knowledge. Since the Age of Enlightenment, mankind started to perceive the world as malleable and manageable, and the same goes for our health (De Schutter 2014; Cushman and Gilford 2000). Our focus on these values of calculability, logic, and instrumentalism has also left its mark on our current healthcare system. The government, and patients alike seem to expect a certain scientific, predictable, technical, and rational healing process. The idea that the length of a therapy is difficult to predict is not in accordance with these popular ideas. Typical for our time spirit, we find it hard to acknowledge that a time for therapy is hard to calculate or estimate.

1.1. Lacan's teaching on time and the unconscious

But why is it so difficult to calculate this duration? We can try to comprehend this question by a Lacanian reading of time in

psychoanalysis, which differs radically from a medical discourse. According to Lacan's teaching, time fulfils a function in discovering a subjective knowledge, and therefore a patients' time in therapy cannot be embodied as linear or chronological (such as the time that predicts how many minutes fit within an hour). The article entitled 'Logical Time and the Assertion of Anticipated Certainty. A New Sophism' (1966) is probably Lacan's most well know article on time, since it brought out the significance of time in a full-fledged way (Wang 2018). In this article, he describes how every analysis has its own tempo, hence a 'logical time' that does not answer to any prescription or prediction. He outlined three different times in an analysis, which he describes by using the apologue of the three prisoners (Lacan 1966). However, for this study we chose to focus on one of his later discussions concerning time, namely how he made time a central dimension in the concept of the unconscious, in Seminar XI. According to these subsequent elaborations, we should embody the unconscious as a subject that manifests itself unexpectedly during the therapy sessions (Miller 2000). The unconscious should therefore be presented as an occurrence or a phenomenon. This leads us to its time dimension: in its essential form, the unconscious appears to us as a discontinuity. It has the temporality of a flash and opens and closes in an unexpected manner. The moments in which something is illuminated (e.g. through dreams or slips of the tongue) alternate with moments of darkness. With time, these consecutive illuminations gradually form a pattern in an analysis. However, this is not a pre-existing pattern (of which the duration is predictable) but one that realises itself during analytical work. It takes an unpredictable form, even in its time dimension. It is hard to predict its duration in advance because the talking cure evolves around this opening and closing of the unconscious (Adriaensen 2001).

Freud conceptualised the unconscious differently than Lacan. He tended to embody the unconscious as a form of knowledge. Only when all the unconscious material within the patient was brought to the surface, the patient was considered as healed. We can use the metaphor of a basement here: only when all the traumas and complexes are cleaned out of the stuffy basement, are we considered as cured of our neurosis. This vision implies that an unconscious knowledge was present in advance, before therapy even started. This would imply that the time to

bring the unconscious to the fore (cleaning out the basement) is calculable (Adriaensen 2001).

Although Freud was reluctant to make predictions about the length of therapy (as we saw previously), at other moments he did refer to the time in analysis in a linear way. As such, in his article 'Analysis Terminable and Interminable' he describes how his own technical advancements ensured that in the future, certain cases could be solved more quickly: 'Since he had to suffer through all my technical and theoretical errors, I actually think that a future case could be solved in half the time' (Masson 1985: 409).

Lacan approached the matter radically differently: according to his teaching, the unconscious can be presented as a subject that realises itself during the sessions (and does not await us in the basement). This implies that it is hard to foresee the duration of an analysis in advance. It is therefore impossible to predict the end of treatment, since we do not know the time for understanding of the subject in advance (Adriaensen 2001). Lacan describes this time for understanding as 'the time necessary to produce a trace of what failed to work out at first' (Lacan 2001: 428). He linked the end of an analysis to the closing of the unconscious, rather than the opening. The end of an analysis therefore takes form when the subject can take a different attitude towards this not-knowing. The logical time is then the time that is necessary to conclude about this not-knowing, namely the real.

2. Time limited therapy

Contrary to Lacan's theory on time in therapy, in time limited therapy the answer to the question: 'How long is this therapy going to take?' is given in advance. As such, it can be foreseen that a therapy lasts for seven, fifteen or twenty sessions. Reasons for implying a time limit to therapy are often economic: to limit possible therapy costs. Scientific research is another setting in which the time limit is often applied. Here, researchers find it important to keep a variable such as the length of therapy constant, to be able to measure another variable (such as outcome). Limiting therapy in time is currently a common practice in our Western society. Within many healthcare systems across different countries, patients with less difficult problems are first acquainted with a first dose of therapy which is outlined in time.

Psychiatric hospitalisations are also conceived increasingly as time limited.

In these economic and research applications of a time limit, the technique is applied for reasons external to the therapeutic logic: the therapy cannot cost society too much or should be measurable within an experimental study. However, this implies we are no longer questioning how the application of a time limit can influence the internal logic of a therapy. Freud was one of the first to use the technique for motivations intrinsic to therapy. In his article 'Analysis Terminable and Interminable' (1937) he describes his experiences with the intervention. He decided to apply a time limit in the case of the Wolf Man because the therapy got stuck on a resistance in which the patient was nestling. In the final months of the analysis, Freud claimed his patient was able to bring back all the memories and connections that were necessary to conquer his neurosis. Although Freud was initially enthusiastic about the effects of the time limit, the case of the wolf man ended less optimistically than hoped for. From his experiences with other patients Freud asserted that, while the time limit could enable access to a lot of unconscious material, it also caused another part to repressed and become 'buried' (Freud 1937).

While Freud dared to experiment with the time limit and investigated the effects it had on his therapies, our current therapeutic landscape seems to have stopped questioning the technique altogether, considering it an application that does not influence the therapeutic process. The time limit easily blends in with our 'technical' zeitgeist: the idea that therapy can be considered as a calculable procedure that can be outlined in time. However, as we can discern from Lacan's teaching, applying a time limit to a Lacanian therapy may cause some strange effects, as it disaccords with its fundamental concepts. We investigated this dissonance in our qualitative research.

3. Therapists' experiences in time limited Lancanian psychotherapy

In our study, we tried to answer the question 'How does a time limit interfere with a Lacanian psychotherapy?' For this reason, we analysed interviews of therapists working with a time limit in a Lacanian psychotherapy. More specifically, we interviewed four psychoanalytically oriented therapists

participating in a large scale randomised controlled trial (RCT). The therapists had three to nine years of clinical experience and had all completed postgraduate education in Freudian-Lacanian psychoanalytic psychotherapy. Although the therapists all identified with Lacanian psychoanalysis, they each provided their own interpretation of this type of therapy in private practice. In the RCT, the time limit was set at twenty sessions, which on average lasted for a period of six months. Patients were not given a rationale for the number of sessions during the study, it was simply communicated to them that the therapy would last twenty sessions. If patients asked about the therapy ending, therapists were supposed to tell them that these matters could be discussed towards the final sessions.

The therapists were interviewed at three moments during their research participation: before the start of the RCT, after finishing their first therapy (after +/- six months) and after the finalization of the research (after +/- two years). This way, we could study the evolution of their experiences with the time limit. The interviews were transcribed and analysed with a qualitative research method. Three themes were derived from this analysis which show how the time limit interferes with some of the fundamental theorems of psychoanalytic practice: (1) Firstly, therapists noticed that the time limit had a restricting effect on the patients' speech. Feeling pressured and hasty, the therapists had the tendency to focus more in the sessions, and to limit free association. (2) Secondly, patients' expectations changed because of the time limit: they seemed to expect a more directive therapist; some kind of expert, which was not in line with the common abstinent attitude of a psychoanalytic therapist. (3) Finally, therapists noticed that patients became alienated from their subjective time because of the predetermined time frame. We will discuss these themes in more detail below.

3.1. The time limit restricts patients' speech

The therapists within our research had the feeling that they had to ignore certain themes in the patients' speech or leave them aside, because they lacked the time to discuss them properly within the restricted time frame. Due of the time restrictions, they felt obligated to lay focus on specific themes in therapy, which felt uneasy for them. Most of the therapists found this narrowed focus hard to jibe with their normal psychoanalytic way of working in

which free association is a key pillar. Chloe for example, discussed how this often led to hesitations in therapy: 'It's almost like deliberating – shall I close this now, because we've only got twenty sessions, or shall I leave it open for something new to appear - which can be discussed?' (Chloe).

The doubts and deliberations regarding the focus in therapy can be linked to the haste caused by the time limit at times. As a result of the time restrictions, the therapists felt the topics in therapy had to be chosen more carefully. The majority of the therapists therefore felt restricted in their role as a therapist. For example, Arthur told us he felt that he could not allow patients to talk as freely as he would have liked. Chloe expressed how she desired to 'leave more room for coincidence' and to let certain themes expand in therapy. These experiences show us how the time limit could have a narrowing effect on therapy. This tendency made therapists feel the desire to broaden the patient's stories, in spite of the limited time.

Regarding psychoanalytic ethics, Arthur found that the time limit stood in way of free association and coincidence in therapy, mainly because it had a restricting effect on the goals of a Lacanian therapy: a speech that evolves around the lack. Arthur noticed that the necessary focus in therapy did not coincide with his clinical desire (where the accent lies more on exploring). According to him, it is one of psychoanalysis' strengths to leave as much open and free in therapy as possible, and thus allowing for almost anything to appear in the patient's free association. He thought that working in a time limited manner required a totally different way of working than his usual technique: 'But you have to know that if you see these people for twenty sessions, the goal is to stop afterwards, and you have to work in a totally different way, you have to pick out certain themes in a directive way and leave some other themes aside. You also have to silence the patient when they talk about these matters while – I can't - I just can't - I'm not trained for that' (Arthur).

Arthur also found it unethical to unfold certain difficult themes with patients, only to then abruptly send them home after twenty sessions. To him, working time limited therefore also meant that certain themes would have to be closed in the final

sessions. The other therapists also mentioned this closing up at the end of therapy. Chloe and Isabel found that in the final sessions, the focus of the therapy narrowed down. Chloe found that she reduced her input in the final sessions, because she did not want to open the patient's speech towards the end. Aside from her own 'closing up', she also noticed this tendency on the patients' behalf. Some of her patients started to bring less material in the final sessions because they felt the end was nigh. Isabel also noticed this tendency and associated it with patients starting to detach toward the end of therapy: 'What you sometimes notice is that people can also … in the eighteenth, nineteenth session, maybe even the seventeenth … start talking in a way that's more like small talk … uhm and they start to detach one way or another and take some distance. They gradually let their speech fade out … (Isabel). By their closing up, Isabel noticed that patients sensed the end of therapy was near and therefore started to take some distance in the final sessions. Thus, the closing up happened on the beat of the proposed time limit, instead of ending naturally in time for the patient and therapist.

The stories of the therapists show us how talking freely in therapy was strained by the time limit. Naturally, this conflicted with the therapist's usual psychoanalytic way of working. Where a psychoanalytic session should behold the possibility for almost anything to unfold in the patient's speech (and thus leaves plenty of room for the unconscious), the time limit seemed to sabotage this process. On behalf of the therapists, their free-floating attention was hindered because of the time limit. Narrowing the focus in therapy contrasted with the Lacanian principle of *gardez vous de comprendre*. The time limit seemed to make it harder to stay open for what's new or different in the patient's speech.

3.2. The time limit changes patients' expectations towards therapy

According to the therapists, the time limit and the research context changed the image and the expectations patients had about therapy. Patients seemed to get the idea more that the therapy evolved around reaching their goals within a limited time frame. It was remarkable how, within the research context, patients seemed to hold the therapists more responsible for this goal instead of themselves. Due to the predetermined time frame, some patients got the expectation that their presenting complaint would

be solved within the 20 sessions. The therapists certainly felt the pressure of this expectation: 'I think this gives people a certain idea before they engage in the research or start the sessions … like okay twenty sessions? I'm coming with this complaint and by then it will be solved. And that – that creates the expectation' (Isabel).

All therapists therefore noticed that patients had higher expectations of them in time limited therapy. Patients seemed more focused on 'coming to get something' in therapy, compared to their regular, time unlimited therapies: 'I had the impression that the limit, one way or another […] created the expectation for them like "I'm coming to get something, and you will have to give it to me" - I felt that way less in my regular therapies' (Arthur).

In Arthur's own private practice, the time is not set in advance and the end of therapy is discussed with the patient, which according to him, diminishes these expectations. For these patients, time is time 'as it passes' and the idea 'time is passing, and you have to give me something' is less present. Marie also noticed that the time limit caused patients to take on a more passive position in therapy. The therapists all noticed that patients expected them to take on a more directive position in time limited therapy. Because of the pressure of the time limit, they also tended to hasten their interventions.

According to Arthur, his patients in the research were less demanding when the transference felt right in therapy. In this case, patients tended to have less expectations or demands for the therapist to give them something. These patients seemed to join Arthur's idea of the time limit as an artificial ending. According to him, they joined in on his idea of therapy, instead of holding on to the research context. Arthur found them to be more engaged in therapy: 'I think these are the people that kept on coming and that still come, while the people who tended to hold on to the fact that I had to – that I had to fix something and that this should be done within a certain time frame – they ended way sooner or after twenty sessions like – okay this was it. It amounted to something or nothing but I'm not coming back, because you have nothing to offer. I found this differed immensely, compared to the people who were like … uhm … there's something in the therapeutic bond and time doesn't really matter, it's me who has to do it here' (Arthur).

Isabel and Chloe both seemed to have developed a certain strategy to work with the high expectations the patients sometimes had. Chloe created a 'time logic' with her patients and started to make resumes with them about the previous sessions: 'Of course, people expect something to happen in those twenty sessions- or that we would have some kind of strategy that allows for, uhm and that's also a strategy I've put in there myself (laughs) – like "we're now halfway". And I kind of started to make more resumes myself –I started to insert some kind of strategy or some kind of time logic myself' (Chloe).

Isabel also tended to refer more to the goals the patients had foreseen at the beginning of therapy and started to ask them about where they were at in therapy and what they wanted to reach. By making the resumes and getting back to the goals, Isabel and Chloe seemed to take on a more directive position than normally. Their structured way of keeping in touch with the patients and their goals almost seemed self-evident for them in a time limited therapy. Although Isabel liked working this way, Chloe feared that her directive way of working closed something in the patients' story. Marie and Arthur, on the contrary, actively rejected taking on this directive role: they resolutely chose to maintain their usual way of working in therapy.

Therapists mentioned another factor that influenced the expectations of patients, namely the instance that imposed the time limit. They considered the research team, and even broader, the university as having proposed a time limit of twenty sessions. The university was anything but a neutral instance to the patients: they considered it a well-respected institution, representing a certain knowledge base. The therapists found that some patients tended to hold on to this image, also when referring to the research context itself. As a result of this association, patients sometimes thought that the number of sessions prescribed by the university would be enough for their issues. The therapists differed in their opinions on whether this could be an advantage or disadvantage in therapy. For example, Isabel found that these high expectations could work as a 'self-fulfilling prophecy' for some patients, making them work towards their initial therapy goals: 'And from that viewpoint I think that a restricted amount of sessions, restricted in advance, has a therapeutic effect in itself because it makes them work towards something they will fill in themselves,

a sort of self-fulfilling prophecy – in which you can absolutely maintain free speech' (Isabel).

Other therapists, such as Marie and Arthur, had the feeling that because of the high expectations, patients could also feel more disappointed when the therapy did not proceed as foreseen.

The time limit, together with its research context, seemed to have changed patients' expectations of the therapy. Of course, patients expecting their problem to be solved is not only the case in time limited therapy. However, where patients' focused on the fact that this had to be done within twenty sessions seemed to fixate something for them, which gave the therapists less space to manoeuvre. From a psychoanalytic perspective, the treatment also revolves around a patients understanding of the function of his or her symptom. This implies patients taking an active position in questioning themselves and how they could be implied in the situation. Unfortunately, our results show that the time limit caused the patients to take on a more passive position and seemed to rely more on the therapists for something to change. This impeded the analytic process.

Within the research context, the therapists (associated with the university) were put on a pedestal. They represented more than in their private practice, a "subject supposed to know". This transference gave them a power to work with, which Isabel did when she referring to her 'self-fulfilling prophecy'. However, when the therapists could not live up to the expectations, the disappointment also tended to be bigger.

3.3. Patients alienate from their own time in time limited therapy

All therapists noticed that patients tended to hold on strongly to the twenty sessions within the research. As such, some patients continued therapy while their initial symptoms had already disappeared, while others continued in therapy even when they were not very convinced of it. They had the idea that the twenty sessions had to be completed before the therapy would have its effect, or to do the therapy properly. The therapists often wondered if the patients would have continued the therapy, had there not been a set time frame. They thought that in a way, the time limit motivated patients to continue therapy: 'Weirdly I wonder if he would have kept coming? … Because those twenty

also suggested that something would be completed and I think people are influenced by this idea anyway - like okay, maybe I should compete the twenty sessions for there to be an effect. And this has an impact in itself' (Chloe).

Patients tended to have the idea that something would change about their problems, only when they had completed the twenty sessions. In a way, the time the research offered in therapy was equated to the time they thought they needed to solve their individual problem. They also seemed to measure the process they had been through in therapy by comparing it to the twenty sessions. Isabel described this way of thinking as such: 'People have this in mind "How many sessions are we at now?" "How many sessions do we have left?" In this discourse, patients own subjective feeling of time – the time they felt they needed to conquer their problem – became less central.

The reason for this 'pinning down' on the twenty sessions could vary from patient to patient. While for one patient, the engagement towards the research and university was central, others tended to hold on to the idea that twenty sessions would be enough according to scientific logic: 'And I thought this was very clear… "Yeah I'm gonna do this now"…uhm…"But I'm gonna stop with it after the twenty - maybe I'll be back"'. She was holding on very much to the idea that scientifically, twenty could be enough' (Chloe).

With no clear rationale foreseen for the time limit, patients seemed to fill in the rationale themselves. The intervention of the time limit therefore became coloured by their own ideas and fantasies. Some patients saw a judgement about their own problem in the time limit. Chloe for example, told us that in the healthcare centre where she worked, a time limit of seven sessions sometimes gave patients the idea that the problem they dealt with was not that serious, or could be easily fixed: 'Some patients feel relieved: "Ah, I only have to come for seven sessions" (…) Some people do you know. And they almost see it as a strength, like, I'm not such a bad case after all (…). For some people it's a relief' (Chloe).

In this case, the time limit of seven sessions told patients something about themselves: the problem they are dealing with is minor, since it can be resolved in only seven sessions. Adriaensens

(2001) points out that this kind of message alienates the subject from itself: where psychoanalysis aims at allowing a patient to find his or her own words to give form to their identity, the time limit seems to hinder this process and objectifies them even more.

As mentioned above, the therapists noticed that the time limit could function as a sort of motivator in therapy. One of Isabel's patients was able to reach her predetermined goals because of their positive transference, but also because in the sessions, she was actively working towards the twentieth session: 'I think those twenty sessions definitely have something to do with it because she really intended to do it right, like, within those twenty sessions I'm gonna do it properly, almost as if she was taking a course, like "I'm gonna pass in the end" (Isabel).

This was also the case in more difficult therapies where the patients might have given up without the time limit. For example, a patient of Marie had a very strict ethic ('I have engaged myself for this, I have to complete it'), and for the first time managed to not quit a therapy prematurely: 'I think this made it possible for her to do what we did on Monday, to finish together, but not to quit it – something she did in her previous therapies' (Marie).

Although the time limit seemed to function as a motivator for some patients to pursue a difficult but fertile therapy, for others it seemed a reason to stick to a therapy they did not find useful, or that they were disappointed in. Some patients in the study kept on coming because they had engaged themselves for therapy but in truth were actually dissatisfied with the therapy. Marie found it hard to see the benefit of these cases, and proposed that in such a case, a patient's subjective decision about ending therapy could have had a larger therapeutic effect: 'I think the restricted character of the therapy caused her to … finish the ride. Uhm but I have serious questions about the added value of this completing. I think it would have been much more effective if she had said – after the umpteenth sessions – like – go fuck yourself. I'm out of here. That would have had an effect. Of her own decision. Now she just went along passively, she passively reduced herself to those twenty and together we completed the ride. But why and how … I have no idea' (Marie).

Marie thus thought that the therapeutic effect would have been bigger if her patient decided herself to quit therapy. In the

time limited setting, Marie found that her patient had reduced herself to a passive object completing the twenty sessions against her own will. Can we say that if patients chose their own ending at a certain point this is more valuable than a foreseen ending? For some patients the time limit could be an advantage, in the sense that they pursued a difficult but fruitful therapy they would otherwise have quit prematurely. On the other hand, this completing could also take the form them dragging themselves to a therapy for which they were not motivated.

Conclusion

In this article we discussed how to give form to an elementary dimension of psychotherapy, namely time. In doing so, we studied the experiences of therapists working with a time limit in a psychoanalytic psychotherapy. Our research showed that a time limited therapy disaccords with the psychoanalytic frame at several points. One the one hand, therapists appear to be compelled to take on a more directive role in their therapies. This focus disagrees with the principles of free-floating attention and the *gardez vous de comprendre* of Lacan. Moreover, the therapists had the feeling that the patients spoke less freely because of the time limit (and the accompanied focus on goals), and therefore hindered their free association. On the other hand, therapists noticed how the time limit influenced patients' expectations. Within the research context, patients seemed to expect a more directive 'expert' – someone who achieved a defined result within a defined time. More than in their own private practice, therapists were attributed the title of 'subject supposed to know', which could have benefits, but also downsides for the therapeutic process.

The results of our study demonstrate that when a time limit is inserted in a psychoanalytic therapy, this not only changes the patients' and therapists' sense of time, but also has severe consequences for other important aspects of a Lacanian psychotherapy, such as the transference, free association and free floating attention. These effects point out that the dimension of time is closely related to fundamental psychoanalytic interventions and mechanisms. In Lacanian therapy, leaving room for the unconscious to appear (and disappear) is essential. When

this space is restricted, working analytically does not become impossible per se, but tends to hold more challenges. Although all therapists found their own way of dealing with the time frame, they also struggled to safeguard a place for the unconscious. Where some chose to undermine the time limit from the beginning, others found a way to compromise between the time limit and patient's free speech.

Another remarkable theme in our results was the patients' tendency to arrange their sense of time according to the rhythm of the time limit, instead of following their own rhythm in therapy. As such, some patients continued therapy longer than usually because they wanted to complete the twenty sessions. Additionally, certain patients assumed a judgement about their problem in the length of the time limit. The author Joke Hermsen (2010) provides an interesting point of view on the subject by sketching the difference between an internal, subjective time and a more general, consensual clock time. Hermsen proposes that mankind has become more and more disconnected from its local and natural time rhythm because of the installation of the international Greenwich time and the globalisation and industrialisation that followed. The universal, economic time became more and more prominent in our daily lives compared to our subjective, internal time. We discussed a consequence of this phenomenon in our introduction, describing how patients can find it remarkable that time for therapy is unpredictable, because they assume this process is (as most activities in our daily lives) calculable in clock time. However, apart from the universal and calculable clock time, we maintain a different, nevertheless important, time dimension in ourselves. Time is in essence part of the subject, as the poem of Borges describes in the beginning of our article: 'It is a fire which consumes me, but I am the fire'. Our relationship towards time is thus part of our identity. The time needed for a therapeutic process takes the form of this internal time rather than the universal clock time. When patients are given a predetermined time frame in therapy, it can alienate them from their own time and subjectivity. A Lacanian therapy, however, is supposed to encourage the subject to discover its individuality, instead of reducing them to a passive object. Though we do not always have the luxury of time in every therapeutic setting, from a Lacanian viewpoint it is paramount to keep pleading for therapies in which patients are acquainted enough space and time

to take on an active position in discovering their own singular truth.

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