90 years of the London Clinic of Psychoanalysis[1]

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Introduction

Over the 90 years since 1926, we can be reasonably sure that the London Clinic of Psychoanalysis has made possible significant life changing experiences for many adults, children and young people who could not otherwise have had access to psychoanalysis. From the figures available, about 6,500 people have had a psychoanalytic consultation through the Clinic over the years. At a rough estimate, around 2,600 have had a Clinic analysis.

This evening I want to offer a sense of the history of the Clinic in order for us to be able to reflect upon its place and significance in the life of the British Psychoanalytical Society. Not only has it made a difference to the lives of many patients, including many who have gone on to train as psychoanalysts and psychoanalytic therapists themselves, but it has also been the institution through which every member has seen their own training patients, and I am sure that none of us will ever forget those individuals who taught us so much.

The ideals and aims that have driven the Clinic has shifted over the years. Pressures from within the Society as well as pressures from the outside world have played their parts in shaping the direction and the challenges encountered.

Whilst preparing for this evening, I have found that it is rather like going through old family photo albums and letters – known to be an incomplete record, biased by omission as well as by commission, as well as the more random selectivity of previous generations.

Tonight is our opportunity to pay tribute to the very many in the Society who have looked after the Clinic and given so much conscientious dedication and service over the years. They are far too numerous to mention by name but the Annual Reports on the Clinic since its inception records most, if not all, concerned.

I have drawn mainly on these Reports, and also on other documents in the Clinic and Archives. This has yielded an incomplete, but even so massive, amount of information, with which I have had to be highly selective. I had considered giving a bit of a sense of the history through some patient case material, the patients being the most numerous and important participants, but realised quickly that it would be impossible to do justice to any of them in such a brief way.

The main key points and 'facts' about who was involved in each decade will be shown on the screen behind me, while I say something about what achievements, what challenges, and what solutions sought around that time.

There are two main reasons why we are able to celebrate 90 continuous years of the Clinic – one is because we were not subsumed under the National Health Service Act of 1947 – which, from today's perspective, is clearly even more fortunate than we may ever before have considered. The second, even more poignantly, is because although the UK and London in particular was bombed heavily in WW2, we were not invaded or subject to occupation by a fascist regime. It would not be right for us to celebrate our longevity and 'survival' without paying tribute to our colleagues in other countries in Europe whose psychoanalytic societies and clinical services were not so fortunate.

[1] Presented at Joint Applied and Scientific Meeting British Psychoanalytical Society 4th May 2016

Before 1926

In the early years of the 20th century, psychoanalysts across Europe were forming formal Societies to think and work together, and also to gain public recognition as Scientific institutions. Offering psychoanalytic treatment for people with limited means, in organised and publically recognised clinics, was also important. The clinics could provide clinical material for institutional discussion and learning. Trainings based in these clinics could become established and formalised.

This was all interrupted by the 1914-18 war. Analysts including Abraham, Ferenczi and Eitingon worked in responsible military positions (Skale, 2008), and were able to demonstrate the effectiveness of psychoanalysis in comparison with other psychiatric methods, such as electroshock treatment aiming to 'shock' the broken men back to the Front. Their successes in the treatment of War Neurosis strengthened and increased the significance of psychoanalysis in the minds of the authorities.

'War Neurosis' was the subject of the 1918 IPA congress in Budapest, where, to an audience including a number of state officials concerned with public health policy, Freud rallied the psychoanalysts there to start institutions and clinics 'where treatment shall be free'[2].

The period after what we call WW1 but which at the time was thought of as having been 'The Great War to end all wars…" was a time of social idealism and progressive thinking across Europe and the West, the League of Nations was formed in 1920, there was more progressive thinking in relation to women and other social class divisions. In Berlin, Budapest, 'Red Vienna', Paris and elsewhere, psychoanalysts were keen to take on the social obligation to treat for free people in distress in these new psychoanalytic treatment centres.

The value for the new psychoanalytic movement of having an institution[3] to establish professional status, to treat patients, to establish systematic training, and have a collegial network to support learning and professional identity when faced with personal inexperience, doubts and uncertainties, is clear.

In Berlin, the Poliklinic opened in February 1920 where analysts enthusiastically took on the social obligation of seeing patients by giving their time freely to work in the beautiful clinic, carefully designed by Ernst Freud

[2] "Now let us assume that by some kind of organization we succeeded in increasing our numbers to an extent sufficient for treating a considerable mass of the population. On the other hand, it is possible to foresee that at some time or other the conscience of society will awake and remind it that the poor man should have just as much right to assistance for his mind as he now has to the life-saving help offered by surgery; and that the neuroses threaten public health no less than tuberculosis, and can be left as little as the latter to the impotent care of individual members of the community. When this happens, institutions or out-patient clinics will be started, to which analytically-trained physicians will be appointed, so that men who would otherwise give way to drink, women who have nearly succumbed under their burden of privations, children for whom there is no choice but between running wild or neurosis, may be made capable, by analysis, of resistance and of efficient work. Such treatments will be free. It may be a long time before the State comes to see these duties as urgent. Present conditions may delay its arrival even longer. Probably these institutions will first be started by private charity. Some time or other, however, it must come to this". (Freud, 1919)

[3] Before I read Hinshlewood's (1999) paper on the Organising of Psychoanalysis in Britain on this subject I had been unaware of the The Medico- Psychological Clinic which, from 1913 to 1922 functioned successfully as a treatment clinic offering psychoanalytical therapy in Brunswick Square (see Meisel and Kendrik pg 187), with staff and students, including Ella Freeman Sharpe, Susan Isaacs, Sylvia Payne, Marjorie Brierley and Edward Glover, with James Glover being Director towards the end, going on to work towards establishing the Society's London Clinic of Psychoanalysis shortly before he died. Money left from the closing of the Medico-Psychological Clinic contributed to the funding of the BPAS Clinic. The Medico-Psychological Clinic had been associated with the women's movement and brought a lot of women as well as other 'lay analysts' into the Society – possibly to Jones' disquiet, see below.

to reflect the philosophy of the project.

In 1922 Freud commenting on the Berlin Poliklinc wrote of his: "… wish that individuals or societies may be found elsewhere to .. bring similar institutions into existence. If psycho-analysis …has a value as a therapeutic procedure, this help should be accessible as well to the great multitude who are too poor themselves to repay an analyst for his laborious work[4]" (Freud 1923).

In Vienna, the Ambulatorium opened in May 1922. Whilst most of the analysts were keen to have a free clinic and to give to it their free service[5], it was difficult to get formal state recognition[6]. Freud himself had said that he did not think that a free clinic would go down well in Vienna. However, it survived and flourished, becoming very well organized, recognizing the publically legitimising value of keeping charts and statistics, and acting as a forum for training and clinical discussion (Diercks, 2002). It was well organized internally, with a clear model for its operation. All analysts treated for free at least one fifth of their practice – and if this did not suit them, then they would pay a colleague to discharge this duty on their behalf, or alternatively paid a monthly cash sum to the Ambulatorium to exempt them from their obligation. All training analysts treated two candidates for free, and candidates' paid 'in kind' for their training by treating clinic patients free for at least two years. This structure ensured that the staffing needs of the clinic were met, training analyses were sustained, and the patients benefitted from being seen in a professional setting.

From 1933, the Nazi regime in Germany decreed for all medical organizations to 'aryanise' their governing bodies. The Society there had the unsavoury choice between either closing down the Poliklinc, dissolving the Institute, and all who needed and wished, to leave, or for the Jewish analysts to go and hand everything over to non-Jewish analysts of purely German origin, and at least in that form to keep psychoanalysis established. Supported by the IPA[7], they chose the latter. The German Society, DPG, thus 'cleansed' of Jewish analysts was absorbed into the new German Institute for Psychological Research and Psychotherapy, headed by Matthias Göring[8], and became the Nazi regime's centre for racialized psychological treatment. Göring believed that the new psychotherapy[9] could transform Germany into a wealthy nation of happy, successful workers by eliminating the mentally impaired and 'adjusting' distressed people with 'bad habits'.

[4] Complete quote: "… wish that individuals or societies may be found elsewhere to .. bring similar institutions into existence. If psycho-analysis, alongside of its scientific significance, has a value as a therapeutic procedure, if it is capable of giving help to sufferers in their struggle to fulfil the demands of civilization, this help should be accessible as well to the great multitude who are too poor themselves to repay an analyst for his laborious work. This seems to be a social necessity particularly in our times, when the intellectual strata of the population, which are especially prone to neurosis, are sinking irresistibly into poverty (These institutes are) in a position to overcome the difficulties which otherwise stand in the way of thorough instruction in psycho-analysis. (To protect).. against injury to patients by ignorant and unqualified persons, whether they are laymen or doctors" (Freud 1923).

[5] Motivated in large part not just by a sense of social obligation but also in order for an established clinic to give legitimacy to psychoanalysis as a treatment method and thus also boost their private practice.

[6] The State opposed it being in the hands of the Vienna Psychoanalytic Society, and it was a struggle to get a license to open as the authority for this lay in the hands of the conservative medical community who were suspicious of and opposed to psychoanalysis. Freud had been called as an expert witness concerning war neurosis in the trial of an important military psychiatrist who had used lethal levels of electrotherapy on shell shocked soldiers – unfortunately this man got off the charges and was then all the more opposed to psychoanalysis.

[7] Under Jones' Presidency.

[8] Cousin of Herman Göring, who held high office in the Nazi party, and was very close to Hitler.

[9] The new German psychotherapy reflected the fascist aims to strengthen their patients' beliefs in core values, life and the greatness of the pure German people. Under the dual principles of 'healing and extermination', if the treatment of mentally ill patients 'failed', they would be in danger of euthanasia (Danto, 2005).

On March 12th 1938, German troops marched into Vienna, Göring appointed a Nazi chemist as the administrator of the Ambulatorium, the Vienna Society was subsumed under the now aryanised DPG and all non-aryians who had not already gone, were expelled at once. Danto (2005): "The entire apparatus of progressive psychoanalytic activity in Vienna was eliminated". After World War II a very long time needed to pass until the Ambulatorium under the Vienna Society was reopened in 1999[10].

The vicissitudes of War also closed other clinics in Frankfurt, Budapest, Paris and elsewhere and I have gone into some detail about Berlin and Vienna because it would be impossible to celebrate the continuity and longevity of our own without setting it against the wider frame of this tragic history which their stories represent.

In London, Ernest Jones at this time – and for a considerable time to come – was the President of the British Society and throughout played an important and powerful role in all developments. It seems that with regard to the 'free clinics' project Jones was rather more conservative relative to the enthusiast progressive thinking amongst analysts in the rest of Europe. Around 1920 he wrote: 'We have to think carefully before we throw the aegis of our prestige over an institution that can do psychoanalysis more harm than good.' Danto suggests that he feared that we'd be overrun by patients and that there may be pressure to allow lay, non-medically qualified people to train as analysts. Barbara Low and Joan Riviere opened discussion about it at the Board, Glover was keen to start something like it, Low offered to go to Berlin to find out how the Poliklinic was organized, but the Board recorded in the minutes in October 1921: 'no definite line was adopted as regards its formation' and shelved it for four years. However, a Clinic Committee was set up and began to explore who would give how much time to working there, and what would be a fair allocation of time. James Strachey (Meisel and Kendrick, 1986, pg 187) reports in 1925 that Rickman had offered 1 or 2 hours a day, Glover 1 hour, and that Jones had commented 'Well, I am sure it is extremely generous of you to offer so much of your time. As for myself, I shall be unable to give more than 2 hours a week."

Jones' ambivalence however seems to have dissolved when an ex-patient of his, Pryns Hopkins, an American industrialist, donated £2000[11] to set up a Clinic "for the purposes of rendering psychoanalytic treatment available for …patients of the poorer classes[12]". With this money, the British Society purchased the lease on 36 (renumbered later to 96) Gloucester Place[13] and our building has continued since then to form a major part of our assets[14].

During 1925 Rickman had reported to the IPA that the British Society 'hopes soon to open a Clinic'. James Strachey (Meisel and Kendrick, 1985) wrote about the Clinic idea to Alix: "I suppose in the long run the success of a Clinic would mean a general encouragement of psychoanalysis, and would eventually benefit us personally."

[10] Although conditions had, of course, changed, the motives were still similar: the necessity to create a clinical institution that represents psychoanalysis in the public in a competent way, the need for an adequate institutional framework to meet the challenges of the analyses of borderline cases and, last but not least, the need to deepen our knowledge and experience. (Diercks 2002)

[11] £600,000 to £850,000 in today's terms by some measures. See endnote i. Currently a 2 bed flat in 96 Gloucester Place is valued at £1.3M.

[12] Decennial Report London Clinic of Psychoanalysis

[13] Jones wrote to Freud with the 'good news' about the Clinic donation and Freud replied with congratulations, saying that he has 'always said that America is good for nothing but giving money. Now it has at least fulfilled this function…."

[14] Pryns Hopkins continued to support the Clinic until the mid '50's – Winnicott wrote to Bion that 'it is due to Pryns Hopkins that we have a Clinic at all'.

This new Clinic officially opened with a session being offered to a patient by Rickman at 8am on 6th May 1926[15]. In other respects, the country was at a standstill and under martial law, due to the all-out General Strike of workers.

1926-1936

In the first ten years, over 600 people were seen for consultation, queuing up to wait for the intake interviews held on Tuesdays from 5.30pm by either Jones or Edward Glover. Almost all became psychoanalytic cases, at a small payment to the Clinic, with treatment lasting between 6 months and 4 years or more. Clinic staff, about 8 of them plus 4 'clinical assistants' who were in training, saw, for free, between them about 25 patients a day.

The Clinic Committee started by setting up a system for patients to receive their bill from the Secretary and to pay the Housekeeper on Mondays. At its second meeting, the Committee revised this, noting the disadvantage of an arrangement that 'does not afford the physician an opportunity of handling that part of the transference which is concerned with money."

By 1929, the Institute needed to cut costs and all the Society's members were unilaterally appointed as 'clinic assistants' with it being understood that all would be obliged to treat one patient daily at the clinic or render an alternative but equivalent amount of service to the Institute. This obligation was contentious and there was much committee work over the years on working out 'equivalence' of various roles to exempt people from taking on a clinic case, with some offering financial donations in lieu.

The Clinic began a tradition that went on for some years of having a huge waiting list relative to the number of vacancies that would have been likely to occur – there were 204 patients on the list in 1934, whilst in each year around this time there were no more than 58 patients in treatment, 19 candidates in training and 12 supervising analysts. Even allowing for all the 39 members listed as clinic staff, and so presumably prepared to offer at least one free analysis, this was excessive.

1937 – 1945

Preparations for War began in early 1939[16]. In a communication[17] to the membership, Glover announced that the Clinic would remain open, members who wished could continue to see patients who were able and willing to attend, and candidates could also continue with their control patients. The offer was made that analysts called-up for emergency war work could transfer their patients to the Clinic to be seen by analysts who were free to work[18].

[15] But in fact, due to building works, the Clinic actually became operational from the Autumn that year.

[16] There is a fascinating and very testy correspondence (archives ref PO3/B/A/01) between Glover and the Department of Health about their decision to only consult the Royal College of Physicians and Royal College of Surgeons concerning mental and psychological medicine in contingency planning for publically available services in war time.

[17] A communication that interestingly avoided the word 'War'

[18] He added: "It will be apparent that to keep the analytical organisation as closely knit as possible it is necessary for all concerned to keep the Secretary's office posted as to their movements and practical plans."

In May 1939, lectures were offered about the treatment of the war neuroses[19] [20] and in November a Temporary Psychological Aid Centre was set up 'to advise on various psychological problems arising out of emergency conditions" – an advertisement for this appearing in the Medical Press and circular.

There are apparently no formal annual reports after 1938 until 1946 for understandable reasons, though the Society certainly continued to function during the war and patients continued to be seen at the Clinic, or elsewhere, when possible. As I have indicated, unlike most of the rest of Europe, in many ways we were free to continue as usual during the War years. I have sometimes thought of the parallels our Clinic has with the Windmill Theatre[21], whose slogan was 'We never close', as it too continued throughout the war, and beyond, to provide much needed entertainment for soldiers home on leave.

London was bombed heavily in 1940 – 41. There is a note that 'in spite of black-out and traffic difficulty patients attended regularly'. Zetzal[22] (1969) reports that she had got a little way into presenting her membership paper at a Scientific meeting when the air raid siren sounded "I plodded on, paying no attention whatever to the increasing noise around us. Finally, about half way through, Dr Winnicott got to his feet and said: 'I don't like to interrupt this interesting paper, but there is an air raid going on and I think we should decide what to do if the situation gets worse.' "We were meeting as usual in the big room on the second floor and agreed we would move to the basement if the situation worsened. The air raid gradually receded and I was able to finish my first scientific presentation without further interruption".

There was a huge number of consultations carried out in this decade[23], even though by 1942 there were only 21 staff analysts and 7 candidates.

1946 – 1955

The early years of this decade concerned the post war period of reorganisation and planning for the training and the Clinic. I had a sense of *déjà vu* to see a note in the 1946 report of the Northern training! – the Manchester training had 6 candidates[24].

[19] NB when the clinic reports listed the diagnoses of patients in the period up to the late 30's, the diagnosis 'war neurosis' occurs just once, for one, presumably post WW1 patient.

[20] Also distributed was a detailed confidential document on the administration of sedatives for the psychiatric casualties and management at various levels of care depending on severity of trauma. In June there is a call to members for information about what war work they could do for the Clinic, what they are qualified and able and willing to do. Letters in the archives from several members in response to this. There are records of correspondence with the Mental Health Emergency Committee asking the Clinic whether records of pts in treatment are available, details of whether the Clinic would remain open, what sort of treatment and for adults and also children etc.

[21] The story of the Windmill Theatre is immortalized in the excellent film, *Mrs Henderson Presents*.

[22] I commend her paper not only for this vivid description, but also for her account of the atmosphere in the Society around the time of the Controversial discussions, as well as her decription of what it was like to be a candidate at that time: She describes the candidate group 'talking shop while we had a light supper prepared by the caretaker Mr Knight' while "our control patients sat in the waiting room discussing both their analysts and analyses with considerable freedom. We all knew a good deal about each other's pts not only from the reports given at clinical conferences but also from each other and from our patient's frequent references."

[23] In a letter to the Ministry of Health in 1941/2 Glover writes that we have a war time emergency centre for psychological aid and that cases are sent for diagnosis from Army recruitment boards, recruiting examination centres, psychiatric and general hospitals and probation officers and magistrates courts.

[24] Manchester training presumably related to the home that the already long established Jewish community in that City, was able to give to colleagues from the rest of Europe.

Over two or three years, some of the patients seen for consultation were those whose Clinic analyses had been interrupted by the War and who had come back to the Clinic wishing to resume.

The waiting list problem continued and was addressed in pragmatic terms by Gillespie who stated that there should be no more than 200 on the waiting list and proposing that there had to be a reduction in number of new patients by restricting consultations to those who looked from preliminary information as if they could be seen for 'simple and straightforward analysis' by candidates, that is, the only realistic treatment resource we would be likely to have[25].

Around 1946/7 a more systematic and fuller recording of consultations was introduced, with a printed report format over 4 pages replacing a simple and brief index card system– along with the good news that 'a new filing cabinet has been obtained'. The regular reporting on cases by candidates was introduced in the form of six monthly and final reports. Evidently in following years it was quite a struggle to get these reports in as is apparent in the paucity of some of the files.

Some Clinic analyses are paid for by the Ministry of Pensions, the RAF Benevolent Association, or seen via the Tavistock and the Cassel. About 40% of the patients were seen at the Clinic where there were 7 Adult rooms and two child rooms available, the rest in private consulting rooms. Income from consultations in 1948 was £58/10/0 and from patient contributions, £1,772/1/2 (£38k - £100k today, see endnote i)

In 1948 with the institution of the National Health Service, the Ministry of Health 'claimed' the Clinic to be part of it – there is a considerable file on this in the archives, indicating quite a struggle, but briefly, the Clinic successfully worked hard to get itself 'disclaimed' on the grounds that the particular nature of the educational programme of the Institute for its students, would occur more smoothly if the Clinic were to remain independent. Note was made of hopes for increasingly close collaboration with the NHS, through colleagues and candidates working in various NHS hospitals and clinics.

By 1950, 22 of 85 patients were funded by the NHS[26], and NHS funding for the equivalent of 10 new patients a year continued into the 1990s. By 1951, fewer patients are being seen by Members and Associates as part of their obligation to have a clinic case in their practice.[27]

In October 1952, the Clinic moved to Mansfield House where there were 13 new rooms for adult patients and 3 for children. Significant soundproofing issues were soon identified… There were detailed guidelines provided for clinic staff about moving their patients to this new setting, where evidently the patients were to be given notice of no more than a long weekend. Another push was made for record keeping, with ambition of recording the age, sex, months on waiting list, diagnosis, duration and outcome of treatment. As far as I have seen, notes vary considerably but on the whole are very thin and incomplete by today's standards.

Bion became Clinic Director from 1953 and there is much evidence of his bringing his military, mathematical and institutional mind to bear on the administration. Statistics on what patients paid were collected: 103 patients paid in total each week £18/8/6d, with 7 paid 6d, most paying between 6d and half a crown, and 4 paying between 10/- and £1/5/0. Having got the facts, within a couple of years he was not only firmly noting

[25] While in 1947 there were 73 patients in treatment, with 30 being seen by candidates and 43 by members and associates, some at least of these may have been those who had started with the now qualified analysts while they were candidates.

[26] Under contract with the North West London NHS authority and latterly more local Health Authority areas. 2,500 hours a year (= 10 patients) at £5.20 a session in 1977, rising to £9.20 by 1983 (about £45 in average earnings terms now).

[27] though in places the numbers are inconsistent and so it is hard to know if there may have been more who were just taken on at a low fee in private practice that did not show up in Clinic records.

that 'forwarding of these fees to the Clinic at the proper time helps to reduce waste', but also urging analysts and candidates to make it clear to their patients that the fees they pay are of material consequence to the Clinic and that they should be paying according to their means. Calculating on the basis of costs incurred by the Clinic, he set 8/- as the minimum fee to aim for in 1957, provided this would not impinge on the analysis, and by 1962 this went up to 12/- (£11.50[i]).

He collated lists of how many patients were seen at the Clinic, what category of analyst was seeing how many clinic patients, where and for how many hours. The figures in reports now clarify whether Clinic cases were being seen by Candidates or by qualified analysts. There is considerable concern about the resources available to the Clinic as fewer members were giving their time, and in general it is clear that Bion had found that the operation of the Clinic was pretty vague.

1956 – 1965

In October 1957 Bion presented a major report to the Board on his four years by then as Director. It is an incredibly comprehensive, , fearlessly straightforward and precise summary of his observations about the Clinic from when he first came into post, the problems he saw, the steps he took to overcome these, the underlying difficulties that came into view as a result of his interventions, and, as he put it, "a view of what remains to be done."

A step that was taken as a result was the establishment in 1959 of a whole new way of running the Clinic. This was to move on from a 'clinic staff' that formally, though not in practise, consisted of just about the whole membership of the Society[28] headed by the Director who, with a couple of assistants, in fact did all the work. A far smaller and more specific group of members called the Clinic Directorate was established. This body, under the leadership of the Director, shared the Clinic responsibilities with the aim of solving many of the problems Bion had identified. In Bion's (1961) terms, it was 'a work group'.

Up to 1953, however, the Clinic had no means to ensure systematic recording of essential information, from basic statistical and financial transactions through to issues regarding the establishment, conduct and not infrequent premature ending of analysis, for example when a candidate qualified. Bion points to the reputational damage to the Clinic and the Society that was on occasion being created, and to the fact that, as Director he was responsible for things he could not be sure of being informed about and which in any case he had insufficient authority to do anything to remedy.

As he noted, patients can be expected to create a muddle because they are in analysis, and moreover, their analysts are also in analysis and so also subject to 'difficulties' in dealing with essential administration. Apart from complications arising from acting out, the reputation of the Clinic was evidently poor with many professionals inside and outside the Society unhappy that the Clinic failed 'to relieve (them) of (their) most tiresome and difficult patients'. As Bion noted, such patients are unwelcome to supervisors and there is no chance they will be taken on because "the Clinic's capacity for treatment was virtually limited to the work students could do." The idea that experienced analysts could see these difficult patients as part of their 'obligation to take on a Clinic case' at no fee could not be fulfilled because many members were just not coming forward to take cases on. Meetings arranged to dispel misapprehensions about 'the work the Clinic could be expected to do" and how it may do it better did not help, as the critics of the Clinic's operation did not attend[29].

[28] in 1956, 98 members are listed as members of Clinic Staff

[29] In a letter to Bowlby May 1957 Bion wrote "Clinic Staff Meetings: I have always believed that one should, in a responsible position, afford every opportunity to people to make criticisms, and that even though these may often be rather silly, the helpfulness and value of a safety valve outweighs disadvantages. Yet, these Meetings have been

Bion was also very concerned about the Clinic facilities at Mansfield House – not only did the elegant and spacious stair well present an obvious suicide risk for those seen in consulting rooms at the top of the building, but also the large "waiting room affords too much opportunity for undesirable conversation between patients and we may be held legally responsible for any ill-effects." And he had concerns about the secretarial staff of the Institute: given that clinical staff capacity was restricted by the work being voluntary and part time, the secretarial staff were left saddled with responsibilities beyond their non-clinical capacity.

Above all, Bion pointed out the basic contradiction between the need for other professionals to have the Clinic provide psychoanalytic treatment not available in the public sector, and the Institute's need for patients suitable for students'. He notes: the 'fact that the Clinic is really a by-product of a training institute means that the work is costly in finance, in reputation - since the work is done by students and not experienced analysts -and in frustration and irritation to the participants." One of his suggestions was for a Handbook to be prepared and constantly kept up to date that sets out the rules and procedures of the Clinic and basic guidelines to ensure that it is better able to run in a proper and accountable way. Some suggested that patients could, like for the Child training at the time, be drawn from institutions like the Tavistock, Portman, Cassel and Maudsley, but he feels this would not be welcomed by members who would fear the prestige of the Society would be harmed if the Clinic was not in a positon to take referrals itself.

Bion set up the Clinic in the way that it would run for some years.

1966 - 1975

The main concern of the Directorate from 1964 was the criteria for selection of cases suitable for candidates in training. Peter Hildebrand undertook a study of the selection procedure with a view to reducing the discrepancy between the number of cases applying for treatment and the small number considered by consultants suitable as training cases. An application form for patients to complete giving information about themselves in reply to a number of open ended questions about different areas of their lives and history was drawn up and rating scales devised for psychologists to use to rate the written information from patients. Subsequent work with these suggested that the rating scale could be reliably used to screen out patients who would not have been offered analysis after interview. Helpful as this was, it led at times to 'embarrassing situations' resulting in 1985 in a policy to interview any patient referred by a fellow psychoanalyst, regardless of how badly they scored on the rating scales.

Much work went on by members of the Directorate in these and subsequent years in researching these questions of analysability and suitability. More recently, research efforts in the clinic have taken a different perspective looking more at the process of consultation (Reith et al 2011, Crick, 2014, Perez et al 2015).

In 1970, Joffe (1970) prepared a paper on the history of the Clinic, interestingly illuminating much of what I covered here, and describing a further revision of the procedures in the Clinic to tackle some of the problems identified. In 1973, shortly after she had taken over as Director, Nina Coltart opened a discussion about the Clinic at a Society meeting where her question was: what sort of Clinic does the Society *want*?[30] Many

attended only by the barest handful of people, and overt criticism is negligible or non-existent. This is a complex problem, but I am sure it must be tackled or at least recognized."

[30] She further asked the Society if it was happy to help finance an only partially self supporting Clinic which renders a public service? She put forward some ideas for discussion including the suggestion that the Clinic could and should be offering less intensive psychoanalytic work to bring more people into analysis who were otherwise being siphoned off into other organisations, through this provision, and to also give candidates and newly qualified analysts some experience in what they would inevitably be doing in practice in order to make a living. This was supported by many in

interesting issues were raised but the main point was about what she called the Janus face of the Clinic – with one face turned towards the Public and the other face towards the Training. As continues to be the case, there are huge numbers of enquires, many very difficult and demanding, from the Public. She felt that the the face of Janus was over-weighted towards its gaze on the training. The research and development efforts in the Clinic were "devoted to the needs of candidates", concerned with how best to select out of the masses, patients for the training. Joffe in discussion described "a dilemma I experienced very deeply all the time I was Director of this Clinic: I thought that we were … creating a completely false public image; we were encouraging people to refer patients to us suggesting that we could offer them a treatment service, and in fact we were conning them into sending patients so that we could select a chosen few who we thought would remain (as training cases) for two years".

1976 - 1985

Following on from the kinds of discussion going on in the 70's[31], a sense of disquiet about the functioning and running of the Clinic continued into this decade. Concerns and criticisms about its reputation abounded. The Director reported rumours that the chances of being taken on as a clinic case were so remote that it was not worth applying or advising a patient to apply. There was certainly a strong sense of criticisms, dictating the kinds of projections into the Directorate. This 'work group' was increasingly being seen as remote from the membership, more shutting patients and others out than inviting them in.

For its part, the Directorate was working hard to appear more 'customer friendly' in its communications to would-be patients, trying to find ways to involve the candidates in its work and so on. The upper age limit of, I think, 40 or 45 for applicants for low fee analysis was lifted[32]. And note is made of the need for the Directorate to mobilise more active support for the Clinic from the membership.

But getting the referrals was one thing, and getting referrals of people who, once strict screening and acceptance criteria were applied, would be deemed suitable for psychoanalysis by candidates, was quite another – an intractable tension between the needs of the public, the membership and the training[33]. In the 1984 Annual Report, the Director put out a plea to recognise that the Directorate was 'not a Quango'.[34] But it was in fact a body to which power had effectively been delegated by the Society; but with several different and contradictory views of its purpose, and in the absence of clear lines of accountability, there was scope for negative projections. It was hardly surprising that the Directorate's links with other parts of the Society seem at times to have been under strain, and were mainly carried by the person of the Director but it is hard to know to whom he or she was supposed to be responsible and accountable.

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the discussion, though there were others adamantly opposed that anything other than five times weekly analysis should take place under the aegis of the British Psychoanalytical Society

[31] E.g. There had been a working party set up by the Associates and students in 1974 to investigate the functioning and running of the Clinic.

[32] This possibly followed research that co-incidentally I had been involved with as a research assistant at the Tavistock Clinic in the late 1970's on 'Psychotherapy in the Second Half of Life', Hildebrand (1980, 1987)

[33] Interestingly, over this period, there does not seem to have been any overall drop in the numbers of patients seen for consultation and taken into analysis, though from year to year it seems that there were times when it was harder than others for candidates to find a patient to see. And always the bottom line is how many candidates there are with vacancies to be filled, and will they and their supervisors take on the patients available.

[34] Quasi-Autonmous Non-Governmental Organisation

1986 – 1995

But meanwhile, the work went on! However, NHS funding ceased from 1990 and much is made in the Clinic's annual reports in this decade of the need for outcome research as a condition of public funding – "but how this is to be done without damaging the analytic relationship is in need of resolution soon."

This was an age of technology for the Clinic: It got its own telephone line, Martin Miller and David Tuckett oversaw the installation of its first computer, and very helpfully as it turns out, the World Wide Web was invented! Our technological frontier pushed even further in the next decade when we had a Fax Machine installed, and even received a few enquiries by E-Mail!

There are many areas that I have not been able to address in the limits of this evenings presentation, but it is important that I now say something more specific about the Child Clinic over the decades:

Child Clinic

The Child Department has had its ups and downs, and many entries in the Annual Reports over the years refer to the need to reorganize/improve/develop the Child Department, as either not enough people come forward to train or not enough patients can be found to meet training requirements. Records show a very distinct period from 1951 to 1974 when high numbers of children were in clinic treatment, on average 35[35] a year, compared to an average of 3 or 4 in other years.

This 'heyday' for the Department starts while Winnicott was its Head. From 1939, he was given the particular care of it, until then subsumed within the Clinic generally. He remained in post until 1960, when Barbara Woodhouse took over, with him continuing as her deputy, until 1966.

Winnicott had written a report on his first five years to the Board in 1945, from which it can be deduced that he was having a bit of a struggle to get agreement that training cases could be drawn from his clinic at Paddington Green[36]. He had presented more or less the same thoughts at a Scientific meeting at the Society in 1942 (Winnicott, 1942): He reviewed in detail each of the cases he had been called upon in his role in our Clinic to consult on over a year. His conclusion was that the aim of the Child Department to see children in consultation in order to provide suitable cases for candidates and members who wanted to go on to do child analysis, just could not be achieved. This is because it was only for a tiny proportion of those seeking help for whom psychoanalytic treatment was recommended and also sustainable – that is *not* to say that it was *not* possible to analytically help many children and families, but not in the form of analytic treatment that also met the requirements for analytic training. Winnicott expresses great frustration with the situation, both longing to train more analysts in child work, wanting very much to put children into analysis, but at the same time being 'acutely aware that analysis is very seldom both applicable and available'.

He advocates drawing on another clinic – such as his own - where a large number of psychiatric cases of all kinds are seen, for the occasional case which would provide good analytical material for candidates. In 1953 it is recorded that Paddington Green "forms the basis of the Child Department activities". Reports through until the 1970's say that when child training cases were needed, they were drawn from other clinics, such as Paddington Green Children's Hospital, the Tavistock, the East London Child Guidance Centre and the Child Guidance Training Centre. In later years, many training cases were also seen through the Hampstead Clinic [37].

[35] Not all of these may have been training cases and many will have been seen as part of members' obligation to see a psychoanalytic case for little or no fee.

[36] Winnicott retired from Paddington Green in 1963; he died in 1971.

[37] More latterly called the Anna Freud Centre. In the late 40's Anna Freud founded the Hampstead Clinic, out of the Hampstead War Nurseries, and developed a child psychoanalytic psychotherapy training that was recognized by the Association of Child Psychotherapists, though not by the Society. Between 1993 and 2000, when the Anna Freud Centre training was ending, many of those in the Society who went on to train as child analysts did so with the clinical

There are reports in the early 90's of how successful and mutually rewarding was this co-operative link, which finally came to an end in the early 2000's.

The Clinic has always had some rooms specifically set up for child work. In 1933, when, due to distressed financial circumstances, the question came up about whether to rent out a floor of Gloucester Place, it was decided instead to make more rooms available for child work, due to the numbers of cases being attracted to the Clinic by Melanie Klein and her new methods. There are indications in the Board minutes that Melitta Schmideberg questioned this and the ability of the Clinic to provide properly for a child service where only full analysis would be on offer (Danto, 2005). Given the acrimonious relationship between her and her mother Mrs Klein, Danto suggests that this was seen as agitating trouble and strife within the Society, but Jones (1936) diplomatically reports that "In organising (the new rooms) at the Clinic Mrs Schmideberg has been particularly active and helpful."

Three rooms at Mansfield House were allocated as child rooms, but regretful note is made in several reports of the low usage of the rooms[38]. The move to Byron house in 2000 also allowed for three rooms in the basement; it is generally agreed that they are really inadequate for the task and work is in hand now to improve the clinic's child facilities.

There is much frustration noted over the years that there is not more child psychoanalysis going on within the London Clinic of Psychoanalysis[39], and that not only are children not being seen in great numbers but also that not many analysts are training in child work at the Institute. Strategies to encourage more child work right from the 1980's on have included improvements to child consulting room accommodation[40] and payment of subsidies[41] to trainees to encourage them to undertake the training. The recommendations of a recent significant study of the future of the Institute's child services carried out by external consultants are now being implemented.

1996 – 2005

From the late 90's, there were several major reviews about the Vision of the Clinic, subsequent reorganisation, followed by a further review reporting in 2003. This period of review and reorganisation was not universally welcomed in content, and the process also inevitably caused considerable frustration all round. Brendan MacCarthy shortly before standing down from being the Acting Clinic Director wrote[42]: "…this is the third

work for their training based there, while others had their training based in the Clinic – I believe that at times at least they all shared the seminars programme at the Institute. The psychoanalytic therapy training at the Anna Freud Centre came to a complete end around 2007, but since 2000 when the last of our members qualified by that route, all our training has been based here.

[38] In 1974, the child waiting room was given over to Clinic administration as it was unused.

[39] 1962 report notes a requirement for at least one of an analyst's or candidate's child cases should be seen on Clinic premises. In the same year it is noted that Dr Winnicott gave a talk to visiting psychiatrists from Scandinavia 'illustrating his talk with drawings shown on the epidiascope.'

[40] 1981 report on Mansfield House notes that 'some rooms required by the Education Committee for treatment of child patients were build and it is hoped that this modest change will bring about an improvement in the treatment of children at Mansfield House'. 1983 Noted that there is only sufficient demand for one child consulting room to be used, and this is being redecorated and reequipped.

[41] 1982 'Efforts are continuing to increase the number of analysts and students doing the child training. To this end the subsidized scheme has been extended to include 5 patients of either the LCPA or the Hampstead Clinic. So far none of these vacancies have been taken up, which is partly a reflection of the difficulty in finding children who need 5 times a week analysis whose parents are also willing and able tobring them. It is also partly a reflection of the fact that the subsidy of £7 per session is no longer a realistic fee in view of the financial strains already involved in the adult training…welcome the increase to £10.'

[42] Letter to March 2000 Board written February 2000 and copied to Directorate, supervisors and candidates.

administration in less than two years ..and it is two years since the management committee set up a Clinic working party whose primary task was to find a new … Clinic Director. The failure to find a Director is largely because the …Clinic's remit is unclear and has not been costed. There is therefore no possibility of a clear job description for the advertisement…"

A massive amount of work went into all that work over some years and I cannot possibly do justice to it all in a few brief words. The 2003 review made some significant recommendations and as a result the Board took the decision to form the Clinical Management Services Committee which would have a chair responsible to the Board, and a Clinical Director who would be responsible to this Committee, itself containing representatives of the relevant training subcommittees. This was an entirely new way for the Clinic and its work to liaise with and be accountable to the Board, and finally by 2005 led to the appointment of a Clinical Director given the brief of developing the Clinic and its services to both serve the training needs of candidates as well as provide an accessible and helpful psychoanalytic service to the public.

The 2003 review formulated a hypothesis about what had been going on in recent years which was that the Society had attempted to deal with the shortage of psychoanalytic patients for everyone by setting the Clinic the impossible task of solving this problem but in a split off way.

It has become clear to me that the Clinic has a number of fantasy functions in the minds of different people, all, in their way, entirely justifiable: to reflect the charitable aims of the Society to provide psychoanalysis for those who would not otherwise be able to afford it; for many of the general public, some members, and many other professionals, it has an 'asylum' function: to contain at little or no financial cost disturbance, distress and unmanageable anxieties; for the training, to provide patients of the right gender at the right time and place and with just the right amount of disturbance to be a rewarding training patient but not so much as to interfere with training needs; and for many analysts it should be providing a steady stream of psychoanalytic referrals.

Here I would like to endorse the sentiments that Clifford Scott as Clinic Director put at the end of a number of his Annual Reports, where he thanked all who worked in an honorary capacity for the Clinic, as well as the administrative and caretaker staff, adding the "wish to express my regret to, and desire for patience from, the many patients and doctors I have had to disappoint in my correspondence with them. My solace, and I hope theirs also, is in knowing " of the help being given to others.

2006 – 2015

I think the functions of the Clinic were obscure right from the very start in 1926. Many efforts have been made to clarify this over the years, but I would suggest that the institutional unconscious has also worked to retain obscurity. In time no doubt the failings of the current administration will be revealed, but for now we are where we are.

While inevitably failing to fulfil fantasies all round, I hope that the Clinic now[ii] offers a decent, though necessarily limited, psychoanalytical service to the general and interested public, as well as providing a clinical base and analytic setting to support candidates in the clinical part of their training and newly qualified analysts beginning their analytic career. I think that the Clinic is now more effectively joined up with other parts and functions of the Institute. This is mainly characterised by more formal structures and lines of responsibility, with clear lines of accountability to the Board.

At the inception of the Clinical Service Committee, it was called the Clinical Service Management Committee, but over the recent evolution of the Clinic services, as well as the Board, it has become clear that a committee cannot really meaningfully 'manage' a service, and the Committee's role is more to do with ensuring that the Institute's clinical services and their governance are in line with the Board's strategic planning. The Chair is a

member of the Board, and the committee is made up mostly of ex-officio representatives from other key committees, together with the Clinical Director[43] and Heads of the Adult, Child and Northern services.

While it remains, of course, a central part of of the Clinic's task to provide candidates with training cases, this is very much on the basis that the candidates are members of the Clinical staff, albeit honorary ones. It is hard for the Clinic to keep a creative and responsible balance between the needs of patients and the training needs of candidates[44]. I think it is very important that candidates are involved from the start in the work of the Clinic, and that they are in a position to see that training cases do not arrive like 'oven ready chickens' from the supermarket but have an understanding of the difficult and demanding processes that go into creating an analytic case (e.g. Levine, 2010; Ehrlich, 2013). Apart from anything else, this is going to be a main preoccupation for them in their future professional lives.

It is fantastic that this Clinic has been able, mainly through the unpaid work of our candidates and the training organisation, to enable so many people to have had full analysis over the years. It is vitally important for the future of psychoanalysis that we also value and support the provision of psychoanalytical services underpinned by this deep and thorough training experience – not least by our members and colleagues who work in the National Health Service. The value of 'alloying' the 'pure gold' of psychoanalysis[45] was part of Freud's 1918 rallying message to democratise the provision of psychoanalysis. He noted that to offer only five times weekly analysis seriously restricts the number of people that any one analyst can help in their professional life time. We must not underestimate the ways in which the NHS has been our constant ally and partner over much of this time.

I am sure you will join with me in hoping that the work of the Clinic to provide a psychoanalytic service to the public will continue and develop over many years to come. I hope that it is abundantly clear from all this is that a phenomenal amount of work has been put into the Clinic by very many members of the Society over the years to keep this heart of our institution and our training beating steadily, and we applaud and remember them now.

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[43] The Clinical Director is managerially responsible to the CEO and in turn is managerially responsible for the Head of the Child and Northern services and for the work of the Adult service, the administration, auditing and provision of the clinic's facilities. She meets regularly with the Chair of the CSC, with the CEO and head of the other services. She is a paid member of the Institute staff and an integral part of the institute's senior staff group. As head of the Adult Department, the CD sets up consultants' workshops, chairs the low-fee Panel, meets with all honorary members of clinic staff, that is, the candidates individually when they come to take on a case and in groups from time to time from the start of the training. The CD sits on the Education Committee taking part in any discussion about training issues as they relate to the clinical service and its governance.

[44] As a telling example of how the institution generally had lost sight of the relative functions of the clinic and the training, I found when I started in post, it seemed that no one was quite sure if the candidates' six-monthly reports on their patients were or should be kept in the candidate's Education office file, in a folder in the Clinic labelled 'six monthly reports', or in the patient file in the Clinic. They are now *termly* reports, without any doubt for the *patient* file and have to be sent in good time, for any management concerns to be addressed between the head of service, the student and the supervisor so that shared clinical responsibility can be properly discharged.

[45] We shall then be faced by the task of adapting our technique to the new conditions…It is very probable, too, that the large-scale application of our therapy will compel us to alloy the pure gold of analysis freely with the copper of direct suggestion; and hypnotic influence, too, might find a place in it again, as it has in the treatment of war neuroses. But, whatever form this psychotherapy for the people may take, whatever the elements out of which it is compounded, its most effective and most important ingredients will assuredly remain those borrowed from strict and untendentious psycho-analysis. (Freud 1919)

[i] Working out relative worth of money is complicated, depending on whether it is related to income value, labour value or 'real price'. I have used a judicious mixture of these using website: https://www.measuringworth.com/ukcompare/relativevalue

[ii] Today the operating model of the Adult Clinic is not to invite applications for low fee analysis but instead to offer psychoanalytic consultation for anyone who is interested to have this (unless it is clear to us beforehand that they have really come to the wrong place with their troubles) to help them think about whether this is the approach for them. Consultations take place over two, sometimes more, meeting and are paid for at a proper rate, with a lower fee for those on limited means. Clinic consultants are paid a reasonable fee, on delivery of their structured report. The consultation service usually breaks even financially.

Consultants are encouraged to join a small workshop to discuss the patients they are seeing, prior to and after the first meeting and after the second, to help them with their thinking about the patient and the process of the consultation. The consultation is *to* the patient rather than an assessment *of* the patient, though of course there is assessment going on: the consultant of the patient's state of mind and capacity to use a psychoanalytic setting and so on, and the patient of this approach to thinking about themselves and whether it is something that they feel they can use in a helpful way. The consultant discusses their recommendation with the patient and then the Clinic considers the case overall and puts the final recommendation into action – private referral, advising the patient or liaising with other services as necessary.

If the recommendation has been for an analysis through the Clinic, or if the consultant feels that further consideration is needed, the case, report and consultation process is considered in a small Panel. There we find that taking a third perspective on all cases is very helpful and this discussion informs the Clinical Director's decision. Sometimes we feel that an individual patient could probably make good use of analysis but, particularly if they have not had any previous treatment, that they are not quite ready for this and would benefit from a period of analytic therapy. To this end, we have begun to develop the Clinic's time limited twice weekly service, staffed by candidates and newly qualified analysts under supervision. A psychotherapy service in the Clinic has been suggested before – for example it was one of Nina Coltart's proposals, as well as more recently in the late '90's as it would give candidates and newly qualified analysts experience and a training in what they will need to be doing anyway to make a living – but not until now operationalised.

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