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Selecting a patient or initiating a psychoanalytic process?

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The defences provoked in the analyst by the anxieties associated with the difficult tasks of 'assessment' and 'selection' for psychoanalysis can result in a tendency to think in terms of 'hurdles to be cleared' by potential psychoanalytic patients, rather than 'opening the gates'. This can result in a diminution of the analyst's capacity to enlist and sustain a psychoanalytic stance. Only within a psychoanalytic frame can a meaningful psychoanalytic process unfold, at all stages of a potential patient's movement from their first contact through to, possibly, entering into an analysis. The author illustrates the value of this thinking by describing the work of the London Clinic of Psychoanalysis where there has been a shift of emphasis in psychoanalytic consultation towards working with individuals on their potential to initiate a psychoanalytic process, and away from the sole aim of 'selection of a suitable patient'. In this paper, the author notes that when institutional culture and practice supports psychoanalytic identity, this makes it more possible to recognize and articulate the anxieties provoked by the 'emotional storm' inevitable in psychoanalytic consultation, and the draw towards unhelpful enactment that may otherwise obscure the initiation of a psychoanalytic process that may or may not result in analytic treatment. Illustrative case material from the Clinic is presented.

Keywords: assessment, analysability, consultation, initiating psychoanalysis, first interview, psychoanalytic identity, selection criteria, low-fee analysis, training case

Introduction

There are various routes by which an individual may embark on having psychoanalysis. Some start with a conviction that they wish to have an analysis; some may feel the need for some help with difficulties in their lives but have little if any idea of whether psychoanalysis is what might be the way forward. The former can usually readily find the contact details of an analyst through professional registers or relevant professional networks. For the latter, psychoanalytic communities need to find ways of providing sufficient information and opportunity for this potential population of analysands to be able to make informed decisions. In Britain, the London Clinic of Psychoanalysis[1] is a significant 'portal' between the public and the British Psychoanalytical Society, with very many people contacting the Clinic to find out about psychoanalysis, many going on to have a psychoanalytic

[1]The London Clinic of Psychoanalysis is part of and funded by the British Psychoanalytical Society.

consultation and then analysis, either through the Clinic at a low fee, or psychoanalytic treatment through its referrals service.

In this paper, I am addressing the way in which customary ways of 'assessing' potential patients for 'analysability' has perhaps created more hurdles for people to jump than opened gates for them to fruitfully pass through. In considering individual private practice, Levine (2010), Wille (2012), Rothstein (1994), Ehrlich (2004) and others, from various perspectives, have addressed the effects of this relative to the general decline in numbers of those seeking analysis. In this paper, I am considering institutional practice when it comes to assessment and selection, for example, where Clinics are attached to psychoanalytic institutions to provide training cases for candidates and other forms of low-fee treatment for prospective analysands (Crick, 2007).

I will be illustrating this by reference to the London Clinic of Psychoanalysis where the model for psychoanalytic consultations has been developed in recent years. For many years, the Clinic assessed applicants who applied for low-fee analysis, selecting those who would be appropriate for analysis provided by candidates in training. With the aim of broadening the potential patient population to include those who may not otherwise have specifically sought out an analysis when looking for psychological help, but who might nonetheless be able to use an analytic form of treatment, the Clinic now offers a psychoanalytic consultation service for anyone wanting to explore their difficulties from this perspective. Experienced analysts see patients for a psychoanalytic consultation, usually over two sessions, and then discuss options for further treatment, which may include a low-fee analysis with a candidate in training or may be a referral into the private practice of a qualified analyst for analysis or psychoanalytic therapy. We now emphasize the consultation as a psychoanalytic experience *for* the prospective patient rather than as a meeting where the emphasis is on 'assessment' and 'selection' *of* the patient. Continual discussion and active learning from experience, recorded in papers (Crick, 2008, 2011; Crick and Lawrence, 2009), discussions, teaching, research (Perez *et al*., 2013; Reith *et al*., 2010, 2012) and audit, are essential to keep alive a culture that supports analytic work, guides and shapes development of services and thinking about technique and the aims of psychoanalytic consultation. To this end, the Clinic now also offers a post-qualification training in psychoanalytic consultation as well as opportunities for candidates to undertake psychoanalytic consultations under supervision.

The Clinic model is to see psychoanalytic consultation as offering an opportunity to a person to have a psychoanalytic experience. We can see what an individual is able to do with it, what process it is possible to generate and observe in the analytic setting offered in a particular consultation, and what recommendation it is then reasonable and helpful to arrive at in discussion with the potential patient. We hope that this results in people who come to analysis, or analytical therapy, who might not otherwise have done so; and in addition, that they make this decision in an *experientially* well-informed way (Klauber, 1986). This should advantage not only the

patients but also the future analysts who will see them. Ogden (1992) has also very helpfully addressed the aims and technique of the first psychoanalytic meeting of a potential analysis from this perspective.

There are a number of different ways in which the Clinic might measure 'success': In an overall way, it is a success for the Clinic to offer to as many people as we can a good psychoanalytic experience by way of a high quality analytic consultation. This is good for the help seeking public, for the British Psychoanalytical Society, and also for psychoanalysis and its reputation in the wider world. In terms of the psychoanalytic training, it is a success for the Clinic if we are able to ensure that candidates have access to cases that provide a good training experience, where the way for psychoanalysis has been opened up and prepared for through consultation. The main aim of the consultation training that the Clinic also offers is for analysts to be able to build up the skills and psychoanalytic confidence necessary to help prospective patients think about whether they wish to embark on analysis – this is good for the analysts and for prospective patients.

For the individual who has approached the Clinic for help, success may be a good consultation that helps that person decide what they want to do now concerning the difficulties which brought them to the Clinic – *whatever* it is that they do now decide to do. This may be to seek psychoanalysis or analytic therapy. Sometimes it is quite prolonged contact with the Clinic where the Clinic clearly plays the role of a containing object, the 'brick mother' as the old asylums in that role were described, while something gets worked through. Sometimes the consultation work in itself is experienced by the person as helpful and sufficient. Success can also be claimed when there is evidence of a good consultation which has resulted in the person being most suitably and realistically either placed on the Clinic waiting list – and thence into low-fee treatment, or referred into private analysis or psychotherapy. And in terms of final outcome, it is certainly also a success for the Clinic if the person's analysis or other recommended treatment turns out to have been helpful and achieved such ends as could be hoped for.

As for an individual consultation, I think there is another way of thinking about 'success' that is less to do with outcome and more to do with '*process*' – that within the limits of the capacity of the patient and the consultant, and the dyad that they form, a consultation has been properly 'psychoanalytic'. That is, that there is evidence that a psychoanalytic process has taken place and, at least by the consultant, understood as such, whatever the final outcome might be (Argelander, 1978). However, consultation is not easy; it is not 'just an interview'; it is in many ways far more demanding of the consultant's psychoanalytic capacities than 'ordinary' day-to-day analysis (Bolognini, 2006; Klauber, 1986).

This takes us back to the shift in emphasis from 'assessment' and more towards the *process* that unfolds between – and involves – both patient and consultant analyst. From this point of view, we are thinking of psychoanalytic consultation as being more for the person who may or may not become a patient, than being primarily for an assessing clinician intent on gathering decision forming data (Ogden, 1992; Wille, 2012).

Selection

In the past, the emphasis in the Clinic was on considering 'success' in terms of predictive success of the selection process – selecting from applicants for low-fee analysis those who it is expected will be 'good analytic cases' – who will stay long enough and who will allow the candidate to have a reasonable training experience not too trammelled by a disabling retreat into stasis, or excessive anxieties about imminent breakdown of analysis or patient. That is perhaps fair enough when the objective is solely to find suitable cases for candidates. But we also have to be mindful of serving not only candidates' training needs, but also the clinical needs of prospective patients. And of course all analysts will testify to the fact that many a prospective 'good case' has turned out to be very complex and technically demanding once the process of analysis is under way. Equally, many cases felt to be more dubious as far as conventional criteria of 'suitability' is concerned turn out to do very well in analysis and to be rewarding patients. 'Outcome' will without doubt depend to a considerable extent on the psychic 'chemistry' between individual analyst and patient dyads, thus making conventional outcome research all the more methodologically challenging and inconclusive.

It is now well established that there is no convincing research evidence to suggest that there are assessable variables in prospective patients that predict outcome, or 'success' in selection for psychoanalysis (e.g. Bachrach *et al*., 1991), and this is well illustrated in Caligor *et al*. [2009]. In that study, prospective patient applicants to a psychoanalytic clinic, rather like the London Clinic of Psychoanalysis, were subjected to a vast battery of standardized tests addressing every aspect of what one would *a priori* judge to be significant in predicting selection for analysis. The same patients also had the ordinary clinical evaluation interview on the basis of which, entirely independent of the standard test results, the clinical decision was made in the way usual for that Clinic about whether or not analysis should be offered. It turned out that there were virtually *no significant differences* in the test scores of the patients chosen by clinical interview as suitable for analysis as compared to those rejected as 'unsuitable'. The decision whether or not to recommend analysis was apparently made on the basis of something much more subjective and personal than on one that could be captured by standard tests tapping patient factors. This significant conclusion points to the 'dyadic' nature of the first meeting between a potential patient and an analyst, and this is key to our model of consultation.

So why should we bother with any kind of evaluation? If there is no convincing evidence to suggest that it is possible to predict a good selection or a positive outcome in psychoanalysis, why do we have such systems of consultation and assessment? Why not just offer an analysis to anyone who thinks that they would like to work in that way and see how it goes? Why not just start straight in with analysis, and avoid all the complications of assessment, and the three-person scenario of patient, consultant and eventual analyst?

Before proceeding, it is important to state that the primary consideration in all this is the interests of the person who has sought advice: we have an ethical duty to 'first do no harm', to only recommend to someone that they undertake analysis, or psychoanalytical psychotherapy, if we have reason to believe that it would be the 'treatment of choice' for that person, that it will not be an unhelpful waste of their time and money, and that, as far as we can tell, they are in a position from a practical and internal point of view to be able to engage meaningfully in an analysis, without undue risk.

The Clinic has many enquiries from those who are very troubled or disturbed. Some are referred by mental health professionals out of desperation, idealization of 'The London Clinic of Psychoanalysis', or optimistic lack of knowledge about the scope of psychoanalysis; some self refer for similar reasons, and a judgement needs to be made from the outset about how much at risk the patient might be as a result of embarking on a psychoanalytic exploration.

We can do something of a screening from initial communications with a person, but not always, and the judgement that needs to be made may not be related to the presence or absence of obvious symptomatology, but may be something that arises out of the person's initial response to the psychoanalytic setting in a consultation (Milton, 1997). Useful information can come from previous professionals' reports, but we also need to beware of being overly swayed by the views of others, either by the warm recommendation from a colleague or over-reliance on a conventional psychiatric view.

It can sometimes be very helpful to the person to have a psychoanalytic consultation to help them find out enough about the process to see that this approach would not be something that they are in a state to be able to manage. Some individuals can be relieved to be able to acknowledge and begin to face up to the extent of their disturbance and to relinquish the defensive fantasy that the idealized 'psychoanalysis' would resolve or remove their pain. Quite often, referrals to the Clinic are the result of the ending of a previous therapy not having been sufficiently worked through and consultations can enable patients to do some useful work on this. For example:

> A therapist recommends to the Clinic a woman in her late 50s from a very disturbed background, who speaks of anxiety, inability to have close intimate relations and friendships, and despair because she cannot develop further following her 11-year psychotherapy which has resulted in a significantly improved life which is however still limited due to blocks and self-defeating behaviour. The Clinic consultant writes that: "[The] rather strong recommendation from the therapist to the London Clinic of Psychoanalysis gave me the impression that the patient has a hold on her therapist and that the Clinic may have become an idealized enclave which diffuses the painful reality of a final separation and ending of their therapeutic relation and of some despair on the patient's part about her limited future at her age. … It seemed to me that we are dealing with a patient whose severe problems raise the question of interminability and that the difficulties and the conflicts and anxieties aroused between her and her therapist are being dealt by an idealized referral to the very expert and robust Clinic as an enclave able to deal with all conflicts." And from the report when discussing recommendations with the pt, the consultant

> writes: "I pointed out that (the patient's eternally frustrated) need for robustness and expertise was placed in the low-fee scheme at the Clinic … I drew her attention to her life-long need not to get too involved and to protect a safe haven at the cost of isolation. Perhaps she would find 5 times weekly very unsettling." It was finally recommended to her and her therapist that they work together towards an ending and that, if after some months, she found that she wanted it, she could ask us for a further consultation to think about whether she wanted a referral for far less intensive private psychotherapy. She later got in touch to warmly express her gratitude for the helpful consultation which had allowed her to work towards a good ending in her therapy, and her decision to not pursue further treatment.

But, after the screening out of those for whom it is very clear that analysis is not the way forward, what need for any further ado? If someone has the time, and the resources, and are able to find someone to see, then why not just give it a go? Rothstein (1994) makes a strong argument for this. But is that it? Surely we need to have something more substantial to say: to other professionals, something to guide candidates, the inexperienced, and the not so inexperienced, in their decision-making? What do we need to know about a person before we would, or would not, recommend an analysis to them? Different analysts have their own views about whom they feel they are able to work with, and in private practice the decision about whether or not to offer an analysis is of course an entirely personal, though hopefully ethical one.

The situation in a Clinic is not so simple as in private practice: there are many more considerations, but ultimately these come down to what resources there are. When we are making decisions about what to recommend to someone, we are not just doing this on the basis of what may be the treatment of choice but also on the basis of the available resources: What can the person pay[2]? What is then available? If only a low fee can be paid, what can we offer? Treatment with someone who may not be not very experienced analytically, or who may be more experienced but also have their limitations? Most cases taken on through the Clinic will be discussed with a supervisor who also needs to agree to the particular case, and this presents another dimension to this matter of 'selection'.

In addition, while there are many common issues, there are of course also significant differences between a psychoanalytic consultation that may result in a recommendation and possibly referral for treatment with a different analyst, and a first meeting between an analyst and prospective patient that may turn out to be the beginning of an analysis. This is a big topic and merits particular consideration, but this is beyond the scope of this paper. Some psychoanalytic trainings involve candidates seeing cases for assessment which may then go on to be their analytic training cases (as in the Caligor *et al.* [2009] study already mentioned, for example). Currently, the London Clinic of Psychoanalysis does not routinely adopt this procedure

[2]In the UK at present it is highly unlikely for psychoanalytic psychotherapy to be offered in the National Health Service, and private medical insurance is not only something that most people cannot afford but also very unlikely to cover the cost of more than relatively few sessions.

although the particular skills required in psychoanalytic consultation could well form a valuable part of any psychoanalytic training.

In reviewing assessment of analysability and selection of patients for analysis, and also of candidates for training, Limentani (1972) recommends us to remember that: "There are no ideal patients waiting to be assessed by omniscient assessors for treatment by omnipotent analysts" (p. 359). In his paper, in which I think he was making some political and institutional points, Limentani seems to be putting forward a plea to notice the extent to which we may be drawn to operate under the sway of idealisation of our profession and procedures, and the consequent omnipotent fantasies about our abilities to predict the outcome of psychoanalysis.

Freud (1933) in making a similar point in a different way notes that, while we could guard against failures by carefully excluding 'unsuitable' cases, we generally only know about those after the event: Our assessments, he wrote:

> resemble the Scottish King's test for identifying witches … The king declared that he was in possession of an infallible method of recognizing a witch. He had the women stewed in a cauldron of boiling water and then tasted the broth. Afterwards he was able to say: "That was a witch", or "No, that was not one".
> It is the same with us, except that we are the sufferers. We cannot judge the patient who comes for treatment (or, in the same way, the candidate who comes for training) till we have studied him analytically for a few weeks or months … After this period of testing it may turn out that the case is an unsuitable one. If so we send him away if he is a candidate, or continue the trial a little longer if he is a patient on the chance that we may yet see things in a more favourable light. The patient has his revenge by adding to our list of failures, and the rejected candidate does so perhaps, if he is paranoid, by writing books on psychoanalysis…
>
> (Freud, 1933, p. 154)

Anxieties

We have many good reasons for 'selecting' but paradoxically we are also aware that this is not going to achieve what we like to imagine is possible. Having clear procedures or assessable criteria to guide rational decisions about such an important thing as offering an analysis into which one is going to be investing a vast amount of time, mental and emotional energy and professional identity is an appealing fantasy: it does away with having to face all kinds of anxieties and uncertainties (Feldman, 2009).

Like any fantasy that holds sway over reality, the concept of 'selection' in psychoanalysis and psychoanalytic institutions (Reed and Levine, 2004) may be one that paradoxically has created some obstacles to our being best able to function analytically with those who may benefit from psychoanalytic treatment. Certain anxieties and defences tend to become activated in 'selection' and 'assessment for analysability' so that, instead of opening the gate to the possibility of psychoanalysis, we have rather tended to think in terms of the hurdles to be cleared. It seems it is hard to give up the idea of an ideal patient who can be found if only one (or the Clinic) tries hard enough.

In the work involved in developing the Clinic model of consultation, the kinds of anxieties and defences that emerge both individually and institutionally in the work of assessment and consultation become apparent. If we can face these and work with them through challenging our assumptions, reviewing the ways in which we use our technique and procedures defensively, this will be to the benefit of prospective patients and analysts.

I would suggest that there are a number of anxieties that are inevitable in the work in and around a Clinic such as ours in London. There are the anxieties about psychoanalysis generally, about the validity of our methods, about how analysis is perceived, about how we can present ourselves and analysis as 'respectable' in a competitive and sometimes sceptical world. More specifically, there are the anxieties related to the whole issue of 'evidence-based' treatment options – generating an undercurrent of pressure to demonstrate with 'objective' evidence data that meets 'scientific' criteria for the effectiveness of psychoanalysis as a treatment method (Crick, 2013). Related to this, there is the continuing underlying sense that 'prediction' about who will and will not do well in analysis must be more possible than it seems to be and than research indicates.

In the Clinic, there are many sources of anxiety. The Clinic has a good reputation for providing a good psychoanalytic service and some analysis at a very reduced rate, but we know that this reputation can be damaged if the expectations of referring colleagues, other professionals and self-referring patients are disappointed. Equally, if we offer treatment to people who turn out to become disturbed or to create serious problems of management in response to analysis, this too can be damaging to our reputation not only with others outside the Clinic who may thereby judge the efficacy of psychoanalysis, but also with candidates in training and their supervisors who feel that the training is being compromised. The high hopes vested in the Clinic that it will provide help to those seeking it, and the training resources needed by candidates, inevitably give rise to some degree of a corresponding projection of blame when hopes are unrealized. And, as we know, profound anxieties can be generated in the recipient of projections.

The work of psychoanalytic consultation is intense and demanding (Klauber, 1986), in ways that are illustrated by the sorts of defences consultants may find themselves adopting: a patient may provoke a sense of disturbance in the consultant who may defend themselves by distancing themselves, perhaps by moving into a more diagnostically assessing state of mind, falling back on previous experience in psychiatry, for example, in order to be able to find comforting evidence that it is 'not me that is disturbed, it is the patient'. A patient may intensely provoke the wish to help and provide, no matter how unrealistic this may be – it can become too painful to say 'no' to a patient and to help them to face the realities about what is really possible. Consultants sometimes try to resolve a sense of confusion about a patient that arises in consultation by seeing them again, and again … and again, as if hoping that the uncertainty will lift at some point, instead of tolerating the confusion sufficiently to be able to understand something of its origins. The anxiety is that the patient will not be able to tolerate something and must be protected from being overwhelmed by

offering 'an answer' or 'a diagnosis', whereas facing and acknowledging the confusion, allowing it to be put into words, can sometimes be deeply relieving, as if to expose the patient to this would be overwhelming rather than very possibly relieving. The reports our consultants write will be seen by others in the Clinic staff and training supervisors, which can feel very exposing of their analytic thinking and capacities. Consultants can feel exposed to the judgement of colleagues who may not agree with their methods and conclusions, and thus fear that this may reflect badly on them as analysts.

An analyst or candidate in training considering whether to take on a case of course has many anxieties. These are not only all the anxieties that are provoked in the countertransference in response to that particular patient, but also all the anxieties which are inevitable and legitimate for anyone who is training.

In the London Clinic of Psychoanalysis, we try to create an institutional setting where the kind of anxieties arising around the particularly intense nature of encounters with a prospective patient can be acknowledged and faced, and in fact utilized as a legitimate and potentially valuable facet of the process (e.g. Crick, 2013). Consultants are encouraged to give time and attention to thinking over the first of the usually two consultation meetings with a patient, often discussing consultations in dedicated work discussion groups, and all consultations that result in a preliminary recommendation for a Clinic analysis are discussed by a Panel, usually without the consultant present to allow a freer, more disinterested consideration of the case to take place.

And, in addition to these kinds of anxieties, there are also those which are encompassed by what Bion (1979) referred to as the 'emotional storm' that is created when two personalities meet:

> If they make sufficient contact to be aware of each other, or even sufficient to be unaware of each other, an emotional state is produced by the conjunction of these two individuals, and the resulting disturbance is hardly likely to be regarded as necessarily an improvement on the state of affairs had they never met at all. But since they have met, and since this emotional storm has occurred, the two parties to this storm may decide to 'make the best of a bad job'.
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> (Bion, 1979, p. 247)

Having Bion's formulation in mind in relation to the first meeting between an analyst and prospective patient, Vermote (2012) writes: "Maybe we are touching here at the heart of psychoanalysis. In the meeting of two people, a psychic change is created: neither of the two people will be the same after the meeting" (p. 345). Reading this, I was struck by the contrast with a document about the Clinic selection procedures by a former Clinic Director who notes that regretfully: "The consultant who has met the patient loses some degree of objectivity and this may impair his judgement". This of course is true, but I think it is also a statement made under the sway of the anxiety that Clinic selection procedures should be 'scientific', and thus it highlights only the potential disadvantages and none of the opportunities created by the disturbing nature of this meeting. A good consultation will inevitably involve 'tasting the broth'.

The psychoanalytic consultation is, of course, a 'dyadic' event where the nascent transference and countertransference of both parties is active right from the start. Being such an individual thing, in fact a dyadic thing, this transference–countertransference dynamic is not amenable to being forged into a standard questionnaire or screening instrument. But I do not think that it is simply a matter of not having yet found a way to master that problem that the fantasy of a relatively 'objective' measure has continued to be quite tenacious. The Clinic has always been under pressure to make 'better' decisions and to find 'better' cases, and this sort of institutional pressure can drive anyone in the direction of an omniscient fantasy that an objective judgement that will accurately predict a good outcome can be achieved.

Clinic consultants have a tough job – not only to face and manage the 'emotional storm' engendered with the patient – but also to cope with the disabling anxieties that may be generated by the sense of responsibility to the patient, the Clinic, and the candidate or other analyst who may end up seeing the patient.

Initiating psychoanalysis

The emphasis in the Clinic now on providing a psychoanalytic experience, rather than having the job of getting the 'selection' right, is partly aimed at relieving some of this pressure on the consultant. Levine (2010) makes what I think is a very helpful distinction between '*finding*' a patient by selection on the basis of 'criteria for analysability', and '*creating*' a patient in a psychoanalytic consultation process; the EPF Working Party on Initiating Psychoanalysis project (Reith *et al.*, 2010) has been in the same spirit.

From this perspective, the consultation is conceived of as being in every way a psychoanalytic encounter. The focus is not just on the patient and his or her capacities and characteristics, but is also on the functioning of the mind of the analyst in response to the patient and to the analytic dyad.

As Levine puts it, the consultant analyst will profit from wondering:

- Do I feel able to function as an analyst with this patient and in what ways?
- Does the patient's internal world and history have a meaning for me?
- In what ways does it resonate with my own feelings and internal experience? Can I represent this patient's internal world for myself?

If the analyst consultant finds that he or she cannot think and function as an analyst, then the next question is *why that should be* – is it due to a defence in the patient or a countertransference response in the analyst?

We all are familiar with the pressure to fall back on thinking in terms of 'diagnostic' or 'analysability' criteria, and feeling the need for more 'information'. In such ways one can build up an illusion of knowing where one is, reducing the disturbing sense of being all at sea. However, while there may be something defensive in the analyst who turns to 'selection criteria' rather than struggling under pressure to think analytically, there may be something equally defensive about accepting into analysis anyone who wants it, which could indicate an omnipotent defence against uncertainty.

The analytic setting that 'frames' (Bleger, 1967; Green, 2005) the consultation, and includes the consultant's analytic stance, is of course what provokes the particular nature of the 'emotional storm' as well as being the arena for grappling with it. I referred earlier to how psychoanalytic consultation is more demanding than 'day to day' analysis. This is because the analytic frame of the consultation is more unstable than in the established analysis where patient and analyst are familiar to each other, know the ropes and where the analyst is in a relatively better position to be able to make sense of the ways in which the setting is put under pressure of one sort or another. In the consultation, both parties are unknown to each other, except in fantasy, and both, including the analyst, will be less aware of the amount and nature of unconscious phantasy that has already been generated in the pre-transference and countertransference. The inevitable 'emotional storm' will have all the more impact on the analyst and the analytic frame than it would in an established analytic treatment. It is thus more challenging to deal with and will inevitably provoke anxieties and defences.

A 'good consultation' does not necessarily result in the person going into analysis. But if the consultant analyst has been able to maintain an analytic stance in relation to the meeting and to function analytically or restore analytic function when it fails, then the person who has come for consultation has had the best possible chance of having a meaningful experience of analytic understanding. This does not always need to be manifested in direct interpretations, but is there in the quality of the analyst's receptivity and responsiveness. The person's decision then to go into analysis, if this is recommended, is not just about accepting the consultant's 'expert' advice or 'prescription'. That would be a rather fragile basis on which to start. A much more secure foundation on which to begin – or decide not to begin – is when the person has been able to use an analytic experience on which to base their own judgement and personal decision.

I will give a short extract from a consultation report to illustrate the value of sustaining an analytic stance:

> Mr A was a young man in his early 20s, and we knew little about him beforehand as he was unable to say much about what was bringing him other than vague sexual anxieties that could be an exaggerated expression of 'normal' adolescent/young adult concerns. He saw Mrs B, an experienced consultant.
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> "I opened the consultation to Mr A as an opportunity to look at what was happening inside him. He struggled to articulate his thoughts, feelings and ideas about his difficulties. He sat on the chair looking anxious and very unsettled, he moved around not able to find a comfortable enough position. Several times Mr A made an attempt to communicate what felt like his internal turmoil, but he couldn't. He felt lost for words, not knowing where to start and very confused.
> I said I could see that he was trying to put words to the scenarios inside him, but that he felt unable to do this, finding it very difficult. He agreed and described the state that he is in and keeps himself in a 'semi-awake state, not allowing myself anything, not even getting aroused', as he put it. I enquired gently but further about the meaning of that, to which he replied that he doesn't do anything specific

> and doesn't actively stop himself from anything, it is rather that he feels he does not have any drive and that he feels in a state of depression and lethargy that does not allow for anything to happen.
>
> I had a sense of him not even allowing himself a state of being fully awake and that it was both part of the problem and a solution, inasmuch as it kept him safe and there were no risks involved. Interestingly, as I was having this thought, his mobile phone rang. Mr A apologized and switched it off.
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> I took this opportunity to bring us both into the room where this scenario was being played out, and to try to understand how this was happening in the consultation. I said that he was neither switched on or off; he was with me in the consultation and yet he was keeping a link to the external, outside world, so that he was not totally switched on or awake and perhaps keeping himself safe and protected from being disturbed in any way.
>
> Mr A agreed and said that it felt 'very right'; he sees himself doing what I described. That led to him feeling more able to talk about what he is struggling with…."

And the consultation went on to be a very alive and emotionally meaningful meeting, resulting in a recommendation for an analysis. Mr A, I would suggest, would not have been able to attain that level of emotional meaning outside the context of an analytic frame.

The 'emotional storm' is there right from the start of a person's initial contact with the Clinic. I often hear from the Clinic administrator about the particular sort of impact someone has made on her in the first enquiry, and it is notable how much is unconsciously communicated in the manner in which arrangements are made concerning appointments. We often notice how when something goes wrong, for example, with communications about arrangements, another layer of meaning seems to be revealed. There is plenty of scope from the start and right through the processes of screening, consultation, recommendations, and discussions at the Clinic Panel meeting where recommendations are considered, for observations to be made that are informative but that equally bear closer examination in terms of what anxieties are stirred and what defences mobilized. It might well be that a person is not likely to be able to make use of our services or of analysis, but it is worth examining this thought – does it result from a countertransference response that has provoked a wish to distance or reject the person – is it an enactment of something that cannot be conveyed in any other way? And similarly, of course, the thoughts about *recommending* analysis or treating a case in a 'special' way may be the result of quelling some kind of anxiety that has been generated in the countertransference.

I will now present the case of Ms J to illustrate some of these points about the consultation process, and the whole process of a patient's movement through the Clinic Panel, onto the waiting list and into analysis. In this case, the patient lasted just three months in analysis before bringing it to an end and I saw Ms J a few weeks later for a review.

Ms J, a woman in her early 30s who had been seen in the NHS for two years of twice-weekly psychoanalytic therapy, time-limited by the funding

contract, was shortly afterwards recommended to the Clinic. My initial response was to suggest that she wait for a while before having a consultation in order to give time to consolidate the gains from her previous treatment and allow the ending to be worked through, but the strong recommendation from the previous therapist and the reviewer persuaded me otherwise and Ms J went forward for a consultation not long after finishing her previous treatment. Unusually, the consultant saw her for just one meeting and suggested that there were facets of her difficulties consistent with a borderline personality disorder, but that it had been possible to establish a constructive contact with her, and recommended a low-fee analysis through the Clinic. The consultation report was relatively brief, noting more about the facts of the consultation than the process (the to and fro), but indicating that Ms J had been direct with the consultant about her feelings about the consultant's power to give or withhold analysis, in a way that suggested a good capacity for contract and reflection.

I will give a few highlights from the notes for the Panel discussion of the case:

> The Panel endorsed the recommendation for a low-fee analysis for this woman. While perhaps her previous therapy was slightly idealized, we did also think that she knows that she had something good and is upset at losing it prematurely which we felt was good prognostically.
>
> We also noted, however, that, unusually for the consultant concerned, we did not have much detail of the process of the consultation and did not know a lot about her early history and significant relationships. We can infer quite a bit from how she relates to others, but also had a sense of something missing. ….
>
> We were not entirely clear about her problems – we hear a lot about her strengths, but we were left speculating and hypothesizing about this woman. She comes with strong recommendations and we acknowledged that sometimes consultants can 'see' that a patient is suitable for, motivated and wants to have an analysis and then it is hard to take a consultation further as it doesn't seem appropriate. We also wondered about the part played in how the patient was presented by the NHS department where she had been seen, and whether a certain picture of the patient had been created which was enhanced by the guilt and anxiety about having prematurely ended good treatment
>
> There was material to indicate that she had felt painfully displaced by the arrival of a baby sister when she was 2 and had striven to put herself between mother and baby and avoid at all costs being the excluded one. She has had just two years of therapy and she was just 2 when her sister was born so only had two years of Mum before she was told to be "a big girl". Were we colluding in her avoiding mourning and accepting the loss of therapy/one to one with mother? This was regarded by some on the panel as rather overly 'superegoish' and a rather harsh dismissal to her to 'be a big girl and go out and use your potential' in a premature and unhelpful way. There were quite strongly held views on both sides.

Ms J was on the waiting list for six weeks and started analysis with Dr Z, just six months after contacting the Clinic. Ms J is described as being "relentlessly critical and bullying in the sessions … with the countertransference

dominated by hatred…". There was an idealized picture of the former therapist, with Dr Z becoming "the hated present object who replaces the lost good object" and the impression of "an internal world of cruel and hated objects." There were occasional moments too of a more hopeful contact with a vulnerable and genuine aspect of Ms J, but also threats to leave the analysis, though she did not miss a single day. "Perhaps if there is enough surviving sense of a good object one can hope that … the analysis will stand a chance." However, a planned break of two weeks seemed to accentuate the situation for Ms J and she made up her mind before returning to stop the analysis. Ms J avoided contacting the analyst directly, conveying the message only through the Clinic office and doing so in a complaining way – she had left messages, no one answer the phone or returns her calls, etc. (though no messages were found on the system). She was eventually able to go for a session to speak about this decision and, when confirming with the office that she would attend the proffered time, Ms J added that she wanted to know her "rights" – could she have another analyst if she stopped with Dr Z?

Dr Z wrote in his report about how Ms J functioned quite well until she got close, when she then becomes mistrustful and aggressive, seeing attack on every front, with retaliation then as her only defence. "It was impossible to penetrate her defensive stance of relentless criticism and gratuitous nastiness." The final meeting with Ms J was reasonable and she is described as "meek and making an effort to charm", expressing her wish not to hurt Dr Z, and, perhaps in the interests of getting further help, able to exercise restraint.

As Clinical Director, I saw Ms J for a review and went into this with every intention of hearing her side of the story in an even-handed way, to come to an appropriately balanced view of the situation and what we might now do. It was not long before I found myself struggling and failing in this. At first, I began to get the idea that Ms J had found the analyst's interpretations formulaic and that Dr Z had perhaps, out of understandable anxiety, not made much room for what Ms J had to bring, even though I knew that Dr Z was experienced in analytic work. But it quickly became clear that Ms J's difficulty in tolerating even the possibility of a difference of perspective was going to make it impossible to try to tease out her experience and what it might mean for her. She very nicely described how "in therapy, something grows, it is constructed between the two, rather like a piece of knitting, and then you look at it and see what you have" – but my attempts to follow up on this thoughtful view of how things grow between two people went nowhere, with her interrupting and foreclosing on everything I said, twisting the meaning, making me feel as if I was being formulaic and insensitive, and I could only conclude that this idea of something being created between two people was at best little more than an intellectual idea that could not be related to experience or, worse, the creation was of something perverse. It was not possible in the review to get involved in much 'knitting' and instead some mutual 'needling' of quite an unpleasant nature went on, where I felt at times provoked into retaliation at Ms J's pressure on me to come up with quick answers rather than taking time to think. In Ms J's view, she had come to the end of one therapy, been seen for a review and then reallocated to a Clinic analysis which "didn't

work" and that she now required another replacement "therapist". There was no sense of an ending and moving on from the previous therapist or even institution, and no sense of having experienced a clinic consultation – she had clearly obliterated it, reporting that the meeting merely consisted of being asked if she wanted to be seen for once-weekly psychotherapy sessions or for five-times-weekly analysis. There was no sense of a lost opportunity or concern about what she may have done to contribute to the failure of her analysis – with the previous therapist "it worked" but, with Dr Z, "it didn't". I discussed with Ms J the idea that she had perhaps not been able to finish her previous therapy properly through having a period during which she could work through her loss, consolidate what she had got and face the disappointment about what she had not got, and that the processes here had got in the way of her being able to do that. She kind of agreed with me, although maybe just out of compliance, and accepted it when I said I would not put her back on the list but that if she found she wanted a further consultation in the following term, then she could get back in touch with us. I later thought that this would have been rather soon, but realized that I had been under the sway of the same sort of pressures that drove her referral to us in the first place.

I am not trying to say that we could have predicted this outcome had more weight been given to key observations at various choice points, but with hindsight we can glean from it some evidence for what we are trying to understand about the process of consultation. Firstly, the Clinic acted under pressure from the referrer who in turn was perhaps driven by a sense of guilt with which, given the current pressures on the NHS, we sympathized but also over-identified. Secondly, from the consultant's report and decision to see the patient just once, it appears that she did not engage the patient as she more usually would have but accepted the 'direct' reasoning of the patient: 'include me, don't make me work through the possibility of being excluded'; thus enacting through submission to that demand rather than being able to stand back, as she might have done if she had seen the patient a second time, and finding a way of exploring that pressure with the patient. The consultant may have unconsciously decided to not see the patient again as a way of distancing herself from the uncomfortable sense of underlying threat that only became apparent much later in the whole process. Then at the next stage of discussion, the Panel had noted a sense of something missing, of not really understanding the nature of the patient's problems, of having to fill in the gaps with hypotheses and speculation, but dealt with this by opting out of further investigation, thus avoiding engagement and instead foreclosing by becoming 'experts' with strong views. And finally, there was a division on the Panel, with strong feelings either side, and we did not explore the differences, perhaps fearful of ending up needling each other.

Our responses in the Clinic to the patient were driven by our needing to help her to avoid unbearable frustration at being the one who is 'without'; we needed to avoid the experience of ourselves being the frustrating, withholding object who has nothing worthwhile to offer. Rather than something of the object relationships of this woman being understood, which would mean penetrating her in a way she, and then by projection we, could not

bear, we were drawn into keeping at a safer distance, not too close, but neither so far as to be in the position of being accused of neglect. And then it all breaks down when she is exposed to the intensity of analysis.

So in our model of consultation, not only does the consultant analyst need to be attentive to the pressures that are put on the analytic setting and stance, but also the Clinic needs to strive to retain an analytic perspective and mindset about the whole encounter and the recommendations we find ourselves inclined to make throughout the whole contact with the prospective patient including, as in the case of Ms J, whether or not to go ahead with offering a consultation at the point of request.

Finding upon reflection that the consultant has become drawn into an enactment in the consultation, and then making use of that to deepen the understanding of what the patient is bringing to the process, can be very helpful and illuminating. Inevitably, an enactment often only gets recognized at some later stage, in discussing the case with a colleague, or when the Panel hears about the consultation, or indeed when the Panel gets drawn itself into an enactment of something that continues to exert pressure to demand expression. In the case of Ms J it was only after her exposure to analysis that recognizing these enactments allowed us to understand more about the patient.

Conclusions

The idea of 'initiating psychoanalysis' over 'selection for psychoanalysis' is a contribution to the response to concerns voiced in the EPF and the IPA about the drift away from psychoanalysis as a sought after treatment.

What is the cause of this 'drift'? Have the characteristics of the population of prospective patients changed in ways that makes fewer 'suitable for analysis' or judged to be 'analysable'? Has the socio-cultural environment changed so much that the relatively long, slow and expensive process inevitable in psychoanalysis means it is no longer seen as an attractive option? While socio-cultural and economic factors most probably do play a part in the 'drift' away from psychoanalysis, it is clear that the ambition to 'select' people to start analysis on the basis of patient factors alone is unreliable and does not make sense given the dyadic nature of the analytic process. I have argued in this paper that the drive to find patients who are 'suitable' results in part from our own anxieties about psychoanalysis: anxieties relative to the world external to the analytic community, as well as anxieties internal to the individual analyst and also to the analytic process between patient and analyst.

All these anxieties, and more, many of which I have touched upon in this paper, are very much related to the suggestions that many are now making about the 'drift' away from psychoanalysis being also to do with 'analyst factors' and a contemporary crisis in the sense of psychoanalytic identity (Ehrlich et al., 2004; Levine, 2010; Møller, 2011, 2014).

As Møller, Lagerlöf and Reith put it in the introduction to *Initiating Psychoanalysis: Perspectives* (2012, pp. 2–3):

> Psychoanalysts who doubt their work may become less able and less motivated to involve their patients in full psychoanalysis, or alternatively they may be tempted

> (for economic and professional developments reasons, present author's addition) to take on patients who are not likely to benefit from it, both extremes resulting in a vicious circle of insufficient experience, poor outcomes, discouraged practitioners, poor science and a sceptical public…

The hope is that this cycle can be reversed:

> …if we understand more about the process process of initiating psychoanalysis, this may lead to more meaningful beginnings, more experienced and fulfilled clinicians, more opportunities for good outcomes and clinical research, and a better informed and more optimistic and interested public.
>
> (Reith *et al*., 2012, pp. 2–3)

In this paper I have used the example of the model of psychoanalytic consultation being developed at the London Clinic of Psychoanalysis to illustrate how the 'initiation of psychoanalysis' can be better understood if it is firmly kept in mind that a psychoanalytic process can only unfold meaningfully in a psychoanalytic 'frame'. The entire passage of a patient from their first contact with the Clinic, their psychoanalytic consultation, the consultant's reflection and discussion of the consultation, the Clinic's consideration of the consultation in its decision-making and subsequent management of the patient, is conducted within an analytic frame which strives always to support the psychoanalytic identity, and thus practice, of our consultants and candidates, and to privilege 'meaning' over 'action'.

The analytic framework relies on all that sustains the psychoanalytic identity of an individual analyst, which critically includes our clinics, our supervisory and colleague networks and our psychoanalytic institutions (Møller, 2011, 2014). A secure psychoanalytic identity supported by the psychoanalytic community of colleagues, or Clinic, makes it more possible to recognize and articulate the anxieties provoked by the 'emotional storm' inevitable in a consultation or first meeting with a prospective patient, and the draw towards unhelpful enactment that may otherwise obscure the initiation of a psychoanalytic process that may, or may not, result in analytic treatment.

Translations of summary

Auswählen eines Patienten oder die Einleitung eines psychoanalytischen zu bearbeiten?. Die Abwehrmechanismen, die im Analytiker durch die Ängste mobilisiert werden, die mit der schwierigen Aufgabe der „Begutachtung" und „Auswahl" potentieller Psychoanalysepatienten einhergehen, können eine Tendenz begünstigen, in erster Linie nicht etwa darüber nachzudenken, wie man dem Patienten „die Tore öffnen" kann, sondern „welche Hürden aus dem Weg geräumt" werden müssen. Diese Tendenz geht Hand in Hand mit einer Abnahme der Fähigkeit des Analytikers, eine psychoanalytische Haltung zu beziehen und zu wahren. In sämtlichen Phasen, beginnend mit dem ersten Kontakt bis hin zur möglichen Aufnahme einer Analyse, kann sich ein bedeutungshaltiger psychoanalytischer Prozess nur innerhalb eines psychoanalytischen Rahmens entfalten. Die Verfasserin illustriert dies, indem sie die Arbeit der London Clinic of Psychoanalysis beschreibt, wo sich die Betonung in der psychoanalytischen Beratung verschoben hat: von der ausschließlichen Suche nach „geeigneten Patienten" hin zur gemeinsamen Bearbeitung des Potentials, einen analytischen Prozess zu entwickeln. Die Verfasserin erläutert, dass die Stärkung der psychoanalytischen Identität durch die Kultur und Praxis der Institution es dem Analytiker erleichtert, nicht nur die Ängste, die durch den in der psychoanalytischen Beratung unweigerlich auftretenden „Gefühlssturm" geweckt werden, anzuerkennen und auszusprechen, sondern auch das Drängen

auf ein nicht hilfreiches Agieren, das die Einleitung eines psychoanalytischen Prozesses, die möglicherweise zur Aufnahme einer analytischen Behandlung führt, vereitelt. Die Überlegungen werden durch Fallmaterial aus der Klinik illustriert.

¿Seleccionar un paciente o iniciar un proceso psicoanalítico?. La defensas provocadas en el analista asociadas con las difíciles tareas de 'evaluación' y 'selección' para realizar un psicoanálisis pueden tener el efecto de pensar en términos de 'obstáculos que hay que superar' para un paciente psicoanalítico potencial, en lugar de 'abrir las puertas' para ellos. Esta tendencia va de la mano con la disminución de la capacidad del analista de lograr y mantener una actitud psicoanalítica. Sólo dentro de un marco psicoanalítico puede desplegarse un proceso psicoanalítico significativo en todas sus fases, en un movimiento que va de un paciente potencial en los primeros contactos hasta su posibilidad de entrar en análisis. El autor describe el valor de este pensamiento describiendo el trabajo que realizan en la Clínica de Psicoanálisis de Londres [London Clinic of Psychoanalysis] en dónde ha habido un cambio de énfasis en las consultas psicoanalíticas hacia trabajar con los individuos su potencial para comenzar un proceso psicoanalítico y no teniendo como única meta 'seleccionar un paciente apto'. En este trabajo, el autor señala que cuando la cultura institucional y la práctica apoyan una identidad psicoanalítica, esto posibilita reconocer y articular las ansiedades provocadas por la 'tormenta emocional' inevitable en la consultas psicoanalíticas y la tendencia a realizar puestas en escena [enactments] que pueden oscurecer la iniciación de un proceso psicoanalítico que termine o no en un tratamiento analítico. Se presenta un material ilustrativo.

Sélectionner un patient ou instaurer un processus analytique?. Les défenses suscitées chez l'analyste par les angoisses associées à la difficulté d'« évaluer » et de « sélectionner » les patients en vue d'un traitement psychanalytique peuvent donner lieu à une tendance à penser la situation en termes d'« obstacles à franchir » par les patients potentiels, plutôt qu'en termes de la nécessité de leur « ouvrir les portes ». Cette tendance marche main dans la main avec la diminution de la capacité de l'analyste de mobiliser et de soutenir une position analytique. Un processus analytique sérieux ne peut se développer à quelque stade que ce soit du parcours d'un patient potentiel, depuis le tout premier contact jusqu'à son engagement, le cas échéant, dans une cure analytique, qu'au sein d'un cadre psychanalytique. L'auteure de cet article illustre la pertinence de ce point de vue à travers la description du travail effectué à la London Clinic of Psychoanalysis où les consultations psychanalytiques préliminaires tendent désormais à favoriser chez les individus le développement de la capacité d'instaurer un processus analytique plutôt qu'à chercher à atteindre, comme on avait coutume de le faire précédemment, le seul objectif de « sélectionner un patient approprié ». L'auteure observe que lorsque la culture et la pratique institutionnelles soutiennent l'identité psychanalytique, il est dès lors plus facile de reconnaître et d'articuler les angoisses provoquées par l'inévitable « tempête émotionnelle » de la consultation psychanalytique, de même que la tendance à recourir à des mises en acte de peu d'utilité pouvant par ailleurs contribuer à brouiller l'instauration d'un processus analytique, que celui-ci débouche ou non sur un traitement analytique. L'auteure présente du matériel extrait de cas pour illustrer ses propos.

Selezione del paziente o inizio del processo psicoanalitico?. Le difese attivate nell'analista dall'ansia legata al difficile compito di 'valutare' e 'selezionare' persone atte a intraprendere una psicoanalisi possono risultare in una tendenza a concepire il processo in termini di ostacoli che il potenziale paziente deve superare, piuttosto che in termini di 'accoglienza analitica' del soggetto da parte dell'analista. Questa tendenza va di pari passo con una diminuzione della capacità dell'analista di assumere e mantenere un'assetto psicoanalitico. È infatti soltanto all'interno di un quadro psicoanalitico che il processo analitico può essere generato e mantenuto lungo le varie fasi iniziali: dal primo contatto che il paziente ha con l'analista fino all'eventuale inizio dell'analisi. L'autrice illustra l'importanza di questo tipo di atteggiamento mentale con la descrizione del lavoro svolto alla London Clinic of Psychoanalysis. Attualmente, in questa istituzione, l'obiettivo principale della consultazione psicoanalitica è più quello di valutare le potenzialità che un individuo ha di iniziare un processo psicoanalitico, che quello di selezionare 'il candidato adatto'. In questo lavoro l'autrice constata che quando la cultura e la prassi di un'istituzione valutano e sostengono un assetto psicoanalitico, è molto più possible riconoscere ed esprimere l'ansia provocata dalle 'tempeste emotive', inevitabili nella consultazione psicoanalitica. Diventa inoltre più facile identificare ogni tendenza all'*enactement*, tendenza che rischia altrimenti di compromettere l'esordio del processo analitico; e ciò a prescindere dal fatto che questo sfoci nel trattemento psicoanalitico o meno. Viene inoltre presentato materiale illustrativo tratto dal lavoro svolto alla London Clinic of Psychoanalysis.

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