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Papers

Thinking about judgement in psychoanalytic assessment and consultation

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The role and nature of clinical judgement in psychoanalytic consultation are discussed and illustrated with clinical material from psychoanalytic consultations. The considerable and inevitable pressures that act on 'judgement' and 'judgementalism' are considered. A model for psychoanalytic consultation that takes these pressures into account is described, showing how the subjectivity of clinical judgement is an essential element in understanding and decision-making. Internal as well as external pressures on the formation and proper valuation of psychoanalytic clinical judgement are noted.

Introduction

'Judgement' is a weighty word: it carries with it the sense of considerable gravitas – a judgement may arise from wisdom, experience and compassion or it may arise from prejudice, ignorance, unwarranted omnipotence or cruelty. In a legal setting, judgement is a highly formalised and socially sanctioned means used by society to enforce and order criminal and civil matters. Sports are governed by the rules all participants agree to follow and these are enforced by the judgements of formally appointed umpires or referees. Moral, legal and ethical judgements are made by the agents of social institutions and, on the whole (depending on the prevailing sociopolitical situation), are respected or if necessary challenged through formal procedures.

But judgement is also a personal, reflective activity that goes on all the time – we make a judgement about how much room we have to pass a car on the road and observe that sometimes we get it right and sometimes get it wrong; we make a judgement about whether we like a painting, whether we like or trust a person on first meeting. These sorts of judgement are personal, subjective and not

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necessarily conscious, and we learn from experience so that next time, hopefully, our judgement may be more accurate or cautious.

With training and experience in a particular area, personal and reflective judgement will be less purely 'intuitive' and more consciously processed – a driving instructor will know the perceptual cues to use in judging road widths, an art critic or dealer will bring relevant knowledge and specific experience to bear on how he/she judges a painting. But, no matter how finely tuned a specialist's trained capacity to make judgements may be, the *subjective* quality of any judgement that depends on personal observation means that it will be influenced by countless aspects of an individual's experience and personality and be subject to unconscious pressure of one sort or another. This may come from external sources, such as peer group conformity or the power of propaganda, or from internal sources – the person's personality, their internal world and the way that it structures their perception, choices and defences: the optimist will not make the same judgements as the pessimist. The one who has a perfectionist internal object will not make the same judgements as the one who is more tolerant of imperfection.

Training and experience help us to know what to attend to and hones our capacity to make judgements and to revise and develop them in the light of experience. Internal objects as well as external ones continue to judge how we are doing, perhaps overly critically, perhaps overly complaisantly. We observe how our patients can sometimes feel preoccupied with what judgement is being made about them, and we can correspondingly feel judged by our patients and our 'internal supervisor'. A fundamental aim and function of psychoanalytic training is to help us to be sensitive and observant of how these judgements, and inevitable judgementalism, are being influenced and affected by internal and also external forces, as part of the psychoanalytic process. We can then make use of these observations to go on to develop a hypothesis about what this 'feeling' is about, its meaning or function, in any particular case.

Thinking about judgement in psychoanalytic assessment and consultation in different settings

By 'psychoanalytic' here, I mean any form of psychotherapy that is based on the principles of psychoanalytic theory, that is, 'applied psychoanalysis'. And so I am thinking of a wide range of settings including the private practice of the qualified and experienced psychoanalyst or psychoanalytical psychotherapist, the various charitable/voluntary sector organisations that are able to offer psychoanalysis or psychotherapy, sometimes at a reduced rate, and the public sector and National Health Service-based psychotherapy services. I am very much drawing on the experience that I have as the Clinical Director of the London Clinic of Psychoanalysis. This is a charitable sector service, offering a consultation service at affordable rates and low-fee psychoanalysis, much of which is conducted by those in the latter stages of their psychoanalytic training. I am also drawing upon the case study research from the European

Psychoanalytic Federation on Initiating Psychoanalysis, with which I have been involved for some time (Reith, Lagerlöf, Crick, Møller, & Skale, **2012**). In that research too, the cases have ranged from those seen in clinics rather like the London Clinic of Psychoanalysis, to private practice cases, to cases where medical insurance terms and conditions apply, to cases seen in public sector settings. In all these different sorts of settings, a range of pressures from both internal and external sources will be influencing 'judgements' and treatment recommendations and decisions.

Subjective judgement, refined and informed by experience and training, seems to be what is meant by *clinical judgement*. This term, used by all health and mental health professionals, seems to capture the element in clinical decision-making that cannot quite be captured by anything else: the element that is subjective, in the sense that it is beyond the objective data that may be available. It is difficult to define, but we recognise it when we see that someone has 'good clinical judgement'. It seems to me that it is to do with a person's capacity to bring observations made available through their receptivity and intuition, together with their experience, expertise and knowledge, and to arrive at a judgement that has a confidence and authority derived from a secure professional identity.

That sounds very idealised, hard to attain and difficult to know how to 'teach'. Could one reduce it to measurable 'objective' elements? Probably not completely, though I would guess that much that is now objectively measurable would originally have been identified through 'clinical judgement'. For example, in the history of the use of smell in medical diagnosis, being receptively curious to registering, subjectively, the varying smell of a patient's breath, skin or urine led to the observation that particular odours are characteristic of particular physical conditions. This in turn has led to the identification of the chemical elements that made this discrimination possible, leading to research that in due course has allowed instruments for the objective gathering of data to be developed (Sims et al., reported in *Leicester University Magazine*, **2012**). Sensitive curiosity that goes beyond what is already known about and set out in the textbook, the corpus of knowledge, is part of 'clinical judgement'.

In our own field, projective identification (e.g. Rosenfeld, **1971**; Spillius, Milton, Garvey, Couve, & Steiner, **2011**) is a theoretical concept of great value that has been arrived at through the sensitive and courageous observation of the analyst's state of mind, even – or perhaps particularly – when that state feels unwanted, unpleasant or out of character, and then submitting it to careful examination and discussion with colleagues.

Nightingale's nurses in the Crimean War faced with tending a festering wound could either turn away from its objectionable smell and particular appearance and dismiss it as 'disgusting' or, in the spirit of her pioneering epidemiological approach, suspend judgement – and judgementalism – cope with their reaction and go on to apply curiosity, carefully observing similar instances and thus refining their clinical judgement and making it possible to learn more about the things to do with particular sorts of wound. Equally, in the

psychoanalytic setting, one can either turn away and defend oneself against a disturbing communication from a patient or apply curiosity to wonder about its disturbing qualities; to reflect upon the effect on you and in that way to learn more about the nature of what is being communicated. By such means, we learn more about our patients and their difficulties.

Apart from receptivity and the capacity to be curious, 'good clinical judgement' also comes from being able to think for oneself through clinical experience. Certainly, it is essential to have internalised knowledge from the 'text book' and from teachers and supervisors, but that itself is not enough, and can only form the foundation on which to build a secure professional identity, a base from which to be able to move forward with freedom to think independently.

Of course, this freedom also opens up the possibility of the sort of false confidence, which results in the poorest of clinical judgement where curiosity is replaced by blind certainty, and independence of thought by narcissistic, self-idealising omnipotence.

Psychoanalytic judgement

Psychoanalytic judgement could be described as a specific form of clinical judgement. As such, it is just as liable as any other sort of clinical judgement to be on a good sound footing or to become unhelpfully omnipotent. Psychoanalytic judgement is made in a psychoanalytic setting and is therefore part of the psychoanalytic *process*.

By 'psychoanalytic setting', I mean not just the external elements of an analytical workplace, but also, and most crucially, the setting for the work that is *internal* to the analyst, their psychoanalytic 'frame', or stance. Increasingly this is being addressed in contemporary literature concerning the important issue of all that is needed to sustain psychoanalytic identity (e.g. Ehrlich, **2004**; Wille, 2012), to facilitate a psychoanalytic process with an individual patient, particularly in the face of internal and external pressures on the analytic frame.

Psychoanalysis makes *a virtue of the subjective nature* of clinical judgement. Through psychoanalytic training, involving not just detailed theoretical knowledge and learning, but also and fundamentally, personal analysis and supervised psychoanalytic work, the specific qualities of clinical judgement hopefully become refined to a considerable degree. Like every other profession, we need to be able to make judgements, and we will inevitably at times become 'judgemental', but we also need to be open to critical self-examination when this happens.

Freud (**1912**) gives us the basic guidance on managing the subjective nature of judgement: in his 'fundamental rule of psychoanalysis', he sets the patient the task of suspending judgement and censorship on what is said, encouraging the patient to 'free associate', to say whatever comes to mind, to try not to select, be logical or careful in where their thoughts take them or what they allow themselves to say. The necessary counterpart to this is that the analyst too must set 'judgement' to one side and to adopt an attitude of 'evenly suspended attention'. The analyst should not, says Freud,

> … direct one's notice to anything in particular…in the face of all that one hears.…In this way…we avoid a danger which is inseparable from the exercise of deliberate attention. For as soon as anyone deliberately concentrates his attention to a certain degree, he begins to select from the material before him; one point will be fixed in his mind with particular clearness and some other will be correspondingly disregarded, and in making that selection, he will be following his expectation of inclinations. This however is precisely what must not be done (pp. 110–111).

Now, this is not to say that Freud is advising us to suspend 'judgement' to the point where no thinking is allowed! The attitude of 'evenly suspended attention' is in order for the analyst to be better able to think, to follow the *flow* of his thinking in relation to what the patient is saying. The aim of this basic of psychoanalytic technique is to keep open the possibility of finding 'meaning' and not to obstruct this by being drawn instead into 'action'. In terms of the subject of this paper, the aim is to make use of one's capacity to form a judgement without getting drawn into an intractable 'judgementalism'.

It is not only the analyst's judgement that is at risk of becoming judgemental. Internal judgementalism is often at the core of a person's problems and of what brings them to be looking for help.

Ms B came for a psychoanalytic consultation having had some brief psychological interventions in the past for her long-standing depression, which had manifested itself in her sabotaging herself at key points, for example coming up to exams that she would later go on to pass very well. Stuck in her work and depressed since the break-up of a relationship, she again sought some help and was recommended to have a psychoanalytic consultation to think about whether to consider this approach. There was, it seemed, a split in her. There was the strong, managing part of herself that could overcome obstacles and was attracted to a structured 'action plan' of treatment for her problems, and a more vulnerable part, fearful of collapse, but for which she quite consciously had contempt. This was reflected in the ways in which she would go either for kind and gentle men who she would then judgementally dismiss as weak and ineffectual, or for more active, but rather bullying, brash men who would treat her badly. She spoke of how the previous treatment did not help, describing in a dismissive way her view that the therapist was inept, 'probably a student', certainly not experienced, 'too nice to me', and in whom, consequently, Ms B did not really confide her real vulnerabilities. In this consultation, Ms B listed her problems and self-destructive behaviours, almost flaunting them in a provocative way, clearly and openly anticipating criticism and negative judgements, and ultimately rejection from the analytic consultant. When she did not get this, to begin with it seemed she was likely to dismiss this 'nice', apparently non-judgemental consultant as 'weak' and not up to 'confronting' her. The consultant pointed out to Ms B how she had come for help, desperately needed it and yet was also steadily undermining her chances of getting it by inviting the consultant to join in with her self-destructive judgementalism and to consequently reject her from the clinic as 'too sick' or 'not good enough'. Ms B recognised this familiar pattern, and in the course of the

consultations became more aware of her considerable capacity for her own contemptuous judgement of the needy, 'weak', part of herself that she had projected onto the consultant. During the second consultation meeting, she became tearful and overwhelmed by finding that she had not been so judged by the consultant who had also shown herself to be very much 'up' to the patient's attacks, despite 'being kind'.

As a result of the psychoanalytic consultation, Ms B became much clearer about wanting to have help and was in the end able to make the reasonable and benign judgement that long-term analysis would be the treatment of choice for her, rather than the 'quick fix' treatment plan she had idealised over this more reflective process. This proved to be the case and Ms B benefited considerably from her subsequent analysis.

In this case, the analyst provided in the consultation a setting and process that allowed Ms B to get to know about her own, hitherto projected, judgementalism and began to see how she needed help if she were to stop its damaging effects on her life.

How analytic judgement is used in the decision-making process

Given the way in which internal and external pressures influence judgement in subtle and often invisible ways, it is understandable that the notion of important treatment decisions being made on the basis of essentially subjective judgements, however well informed they may be, is one that creates considerable anxiety, not just in the individual analyst's mind but also institutionally. This anxiety is at the root of much of the criticism of the psychoanalytic model, especially in the climate of the need to make evidence-based treatment decisions. The kinds of judgements that lie behind a psychoanalytic treatment decision are often quite hard to specify, quantify or measure. 'Clinical judgement' is the non-specific variable that is cited, or implied, in study after study of efficacy of assessment methods and accuracy of treatment decisions where the more specific variables do not all account for the results.

In recent years, the administratively efficient introduction of evidence-based practice has shifted the authority for 'best practice' from the individual 'clinical judgement' to the 'randomised controlled trial' (RCT). As Freddi (**2008**) notes in a very thoughtful and unusually entertaining paper on this subject, the RCT aims to provide relevant evidence to 'close the gaps' in studies between what seems to *actually* work and what it is possible to *prove* works statistically. He points out that this ideology implies a scientific optimism, which suggests that these unruly gaps can be done away with if there are enough of the right kind of RCTs: the logic dictates that RCTs will eventually result in authoritative evidence for 'best practice treatments' that will yield far more 'superior treatment outcomes' to those based on 'old fashioned training of the analyst's independent clinical judgement'. As he says, 'psychoanalysts beware!'

This does seem to be part of the current ideology dominating mental health provision and training in this country. The image selected for the publicity for the

conference at which a version of this paper was given was a rather startling depiction of 'Justice' where the 'blindness' of the woman holding a balanced scale in her hand appears to have been inflicted in a cruel and disabling way.[1] It is not the purposefully, self-adopted 'blindness' of 'evenly suspended attention' in order to avoid undue bias. The image seems to stand for one of the dilemmas that we, in our particular area of professional work, are faced with: that is, the weight of authority is shifting increasingly away from the experienced clinician and his or her clinical judgement, towards the demand for evidence-based treatment decisions, on measures taken by the often clinically inexperienced, thus disabling the 'judge' from being in a position to adopt a balanced, considered clinical view. Instead, we have a different form of 'blindness' forced upon us by the requirements of not only the RCT but also management policies and contractual restrictions and obligations that are not necessarily based on clinical judgement.

Peter Hobson and the late Phil Richardson in an inspiring paper entitled 'In Defence of NHS Psychotherapy' (**2000**) write (pp. 64–65):

> Scientific evidence can tell you about what works for the average or typical patient – the textbook case. Doctors and psychotherapists will always have to call on their clinical judgement for the treatment of the individual case – however much the evidence may tell us about the average case. In psychotherapy we believe that everyone is an individual – the concept of the average patient does not make much sense. (Richardson & Hobson, 2000)

Fonagy and Higgitt (**1989**), in a most helpful paper from 1989 on considering how a psychotherapy clinic might set about best demonstrating its efficacy, note that over-reliance on objectivity at the expense of the evident value of the subjective may 'lead to the development of rigid rules that would stifle clinical judgement and inhibit flexible treatment strategies and further innovation' (p. 134).

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, Galatzer-Levy, & Skolnikoff, **1991**). This is well illustrated in a study reported by Caligor et al. (**2009**), where the test results from a huge battery of standardised tests addressing every aspect of what one would *a priori* judge to be significant in predicting selection for analysis barely correlated at all with the treatment decisions made on the basis of a psychoanalytic clinical interview. The decision whether or not to recommend analysis was evidently not made on the basis of standard 'patient factors' but on something far more subjective. This would be entirely consistent with the dyadic nature of the psychoanalytic encounter, which, because of the unique qualities of each 'dyad', simply does not lend itself to standardised tests based on a 'one person' psychology.

Lagerlöf and Sigrell (**1999**) conclude from a study of their Stockholm Psychoanalytic Clinic model for selecting patients for supervised psychoanalysis, that far from agreeing with those who 'have stressed the potentially misleading influence of subjective factors and who suggest that psychological tests should be applied in order to minimise subjective factors in evaluating the patient'

(p. 168), they would rather emphasise 'the *importance* of the subjective factor', learning much from what is conveyed in the transference and the countertransference.

So where are the points at which treatment decisions about the individual are made and how are our judgements likely to be affected at such points? We first have an ethical responsibility to ensure in so far as we can that the treatment offered is at best likely to be helpful and at worst not likely to put a patient at risk. So as far as possible, we offer the 'treatment of choice'. When the setting is one where there are limited resources relative to the demand, the available treatments need to be allocated to those most likely to make good use of them. In addition, it can sometimes be that we have to decide which of a limited range of possible treatments will best serve a particular individual's needs. In many treatment settings, there is also the reality of needing to have appropriate cases for our students to see so that they get a good training experience. In different ways, all these factors will likely sway our judgement in various ways, just for institutional reasons. And increasingly the economic, contractual and managerial pressures on NHS services are having a very particular and powerful effect on the exercise of clinical judgement. Many would say that 'clinical judgement' is in serious danger of being devalued in ways that are detrimental to patient's well-being.

When it comes to the interaction between the analyst and the patient in psychoanalytic consultation, whatever the external setting for this work may be, we need to hold on to the understanding of how the pressures that sway judgement are considerable and unpredictable. Bion (**1979**) evocatively described the 'emotional storm' that is created when two personalities meet. 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).' While the term conjures a more dramatic 'storm tossed' scene than how it may in fact be experienced in the course of a consultation, it is certainly a good description of how the 'evenly suspended' judgement of the analyst can be blown in unexpected directions. Both at the Clinic and in the EPF research work[2] on first interviews that I have been involved with recently, the importance of attending to 'the storm' is very clear. It is often the moment when the consultant's analytic judgement is put under a particular sort of pressure, and it is clear that the 'first meeting' in an analytic setting has a particularly intense quality, often bringing the central anxieties of the patient in a very direct way, thus evoking particular pressures in the transference and countertransference on the analyst's analytic judgement. It is vital to recognise the anxieties arising around the particularly intense nature of encounters with someone who may *never* have spoken in depth to *anyone* about themselves in this way before.

Freud's advice to the analyst in finding an internal setting from where to attend and listen with free-floating, non-judgemental attention is consistent with being in possession of what Keats (**1817**) called: 'Negative Capability, that is

when man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason' (pp. 40–41).

When overwhelmed by the impact of a patient's communication on him, the consultant may defend himself by reverting to 'irritable reaching after facts' in order to have something to hold onto, in the midst of the 'storm', trying to get his bearings perhaps by unhelpfully latching onto some 'judgement' to find certainty.

Feldman (**2009**) describes how the analyst may relieve the pain and anxiety of doubt and disturbing uncertainty by seizing with conviction on a particular formulation. Britton and Steiner (**1994**) too wrote of how the pressure to 'know', to have a clear 'judgement', can result in latching onto an idea to dispel painful uncertainty, but that the relief this affords can lead to that idea taking on undue weight and value, that it can become an 'overvalued' idea. They describe how important it is to keep oneself open to the *accumulation* of impressions – which may include the sense of feeling very uncertain, or drawn to judgementalism, or the awareness of being tempted by the comforts of holding onto an overvalued idea. This accumulation of impressions begins to coalesce around a 'selected fact' that actually proves to be of more value in understanding and forms the basis of the judgement that allows an interpretation to be made. But it is just a hypothesis, which remains open to revision on listening to the response. They describe the unhelpful consequences of mistaking an 'overvalued idea' for the 'selected fact'. This, we can see, is in line with Freud's advice to retain evenly suspended attention, and Keats' to sustain 'negative capability'. Feldman (**2009**) similarly describes how important it is to be able to be open to a degree of uncertainty, doubt and confusion. Creative work, he says, comes out of being able to sustain a dynamic relationship between 'certainty' and 'doubt'.

Sometimes, the judgementalism experienced by a consultant psychoanalyst turns out on psychoanalytic exploration to be a projected form of the internally damaging judgementalism of the patient. In the example that follows, the importance in psychoanalytic consultation of recognising this and the value in going on to discern the communicative function of that projection are illustrated.

Mr A, a man in his early 40s, was referred to a psychoanalyst, Ms S, who saw him for an initial consultation. Mr A had a long history of depression but of always trying nonetheless to keep up 'a good front', but not sleeping well, frequently feeling waves of fatigue and anxiety. The consultant had the impression on first meeting Mr A that he was quite anxious about how he would 'perform' in the consultation, as if it were a sort of exam, and she felt aware of Mr A checking her out from behind his own fairly formal presentation and 'good front' to see if she approved of him. We can note how Mr A seems to have arrived with an anticipation of being judged. His symptoms had all worsened in the last few months since he had been involved in an official enquiry concerning the death of a patient in the medical setting where he had been working. Towards the end of a shift, Mr A had been involved in the care of an elderly patient who needed immediate attention due to unexpected complications suddenly arising, which later turned out to be due to a serious error of judgement that had been

made in the treatment plan, given the patient's diagnosis. Mr A had been part of a team that acted promptly to relieve the immediate problem but tragically, the patient later died and it turned out that the communications the team had set up to alert the next shift to the urgency of the situation did not get through due to an institutional system breakdown, and the consequent delays were fatal. While not at all held to be responsible, Mr A had ever since felt even more anxious and depressed, with worsening sleep problems. The consultant analyst was caught up with this difficult and painful story when Mr A suddenly seemed to have swept it and his own response to one side by saying that, of course, if the now deceased patient had not been a heavy smoker, the problem would not have arisen, so really it was his own fault. The consultant, Ms S, was taken aback and noticed that she now felt very judgemental of Mr A and lost all sympathy for him. Ms S struggled with her reaction, about the sudden and shocking judgementalism of Mr A towards both the deceased patient and towards himself and his own suffering, conveyed in the way he had apparently swept aside the effect the episode had upon himself. Ms S realised that she needed to grapple with managing this powerful countertransference interaction in the immediacy of the consultation. As she began to recover her analytic functioning, she became able to form the idea that Mr A was telling her something very important about himself. She formulated the view that the patient in the hospital had represented a part of himself, someone alone, frightened, ill, getting worse and needing serious attention, and that he had little but contempt for this part of himself. The analyst noted that when she put this to him, Mr A then went on to tell her about his history and how he felt that his lack of any really meaningful relationships over the years was linked to his relationship with his parents, in particular his father who had always criticised him as a child and adolescent, calling him ‘stupid’ when things did not go well, rather than helping or encouraging him to sort things out. Mr A went on to talk of having coped with his depression on his own for years but that recently he had discussed this with his General Practitioner (GP) when he had gone to ask for sleeping pills, and the GP had suggested a psychoanalytic consultation. The consultant interpreted that Mr A is relieved now to feel able to bring his depression into the consultation, having started off the interview with presenting ‘a good front’. Mr A needs this to keep going, and if he cannot sustain it, he feels a sense of emptiness or, even worse, at risk of being criticised by Ms S. Mr A was noticeably relieved by this and went on to talk of a memory of one of the only times he had felt emotionally ‘touched’, in his early 20s, by a girl he had met while he was working as a ‘temp’, and who he had felt really able to talk to, but who he had not kept in touch with. This seemed to convey a sense not only of how he had felt ‘touched’ by Ms S but also of how if contact were possible, it could only be on a transient basis and so it was not surprising that Mr A did not at that point feel that he could enter anything as intensive as psychoanalysis, but cautiously agreed to enter twice weekly therapy. After an initial and significantly difficult period of feeling intensely ambivalent, Mr A slowly began to be able to

trust the analyst's capacity to tolerate him and thus to be more able to tolerate his own vulnerability.

Consultation process at the London Clinic of Psychoanalysis

Some years ago at the London Clinic of Psychoanalysis, a research effort was made to go about the selection of patients for analysis in a 'scientific' way by attempting to identify the factors that would reliably predict a good outcome and at the same time indicate reliable 'exclusion' factors. Some useful guidance came out of this, but in common with other similar studies, the results were inconclusive. A former Clinic Director wrote, with regret, in relation to this research, that 'the consultant who has met the patient loses some degree of objectivity and this may impair his judgement'. This, of course, is true and inevitable.

Following that, at the London Clinic of Psychoanalysis, we have observed a number of ways in which psychoanalytic judgement is subjected to powerful forces throughout the whole process, from someone first contacting the Clinic through to eventual starting in psychoanalysis. While recognising that this is inevitable, we strive to be attentive to this in an 'analytic' way, from which follows the way the Clinic's consultation service is organised. We take account of the ways in which judgement will be vulnerable to be 'impaired' and 'some degree of objectivity lost' as a result of meeting with a patient, and to see this not as a disadvantage but rather as an opportunity to better understand what is being brought.

In our consultation service, we make a distinction between an 'assessment model' and a 'consultation model'. This is to do with whether the emphasis in what is going on is primarily '*of*' the patient for the analyst to gather 'data' in order to make a decision or '*for*' the patient to have a psychoanalytic experience. In practice, the distinction between the 'assessment model' and the 'consultation model' is not often as clear as this. In both 'models', in a psychoanalytic setting the analyst will be forming judgements in their mind and then scrutinising and modifying them all the time, as part of the process. The patient will, hopefully, get a lot out of a good assessment, and in the consultation model, there is of course an element of 'assessment' going on too. But the key to the distinction I am making is that the consultation is primarily more *for* the prospective patient, to offer to the person the opportunity in an analytic setting, to think about what has brought them to be looking for help and to make their own judgement about their state of mind and therapeutic needs. A similar perspective is offered by Levine (**2010**) who writes about 'creating' the analytic patient rather than going out and 'finding' one.

For this person, who we should really be calling the 'prospective' patient, this may well be the very first time that they have ever had the experience of speaking to someone at some length about themselves and their worries, fears and feelings, where the other person is being attentive, thoughtful, not joining in to recount their own experiences or trying to compete or judge. This in itself can be a remarkably therapeutic and important experience and it is very important not to forget the kind of emotionally significant impact that it can have.

The analyst attends to the process as carefully as they will in any analytic session, using analytic technique and employing their analytic judgement in order to be in a position to make a recommendation to the person. I believe that this first meeting is of such importance and significance that it merits carefully examining the model, or framework, within which it takes place. If the framework in the analyst's mind is that this is 'an assessment' of various factors about the prospective patient to be gathered together to make a decision, then the work that goes on is not quite the same as if it is on the model of 'a consultation'. Klauber (**1972**) notes how a person can only think about having an analysis on an 'informed' basis if this is on an experiential basis and cannot be done simply on the basis of being intellectually 'informed'.

The Clinic's consultation model aims to allow for the anxieties that will inevitably affect psychoanalytic judgement, to be acknowledged and faced, and in fact utilised as a legitimate and potentially valuable facet of the process. Clinic psychoanalytic consultations almost always take place over two meetings. This is to allow for both patient and analyst to 'metabolise' the experience of the first meeting. It is very important for the analyst to have the chance to reflect on it, perhaps in a consultation seminar or discussion with a colleague, in particular to think about the impact of the 'emotional storm' and hopefully to be able to process that, notice and make use of ways in which something may have been communicated, for example, through projective identification. It can sometimes be in the form of the analyst having been drawn into the enactment of some internal object relationship.

Dr C sees Mrs J for the first time for a psychoanalytic consultation. She arrives a few minutes early and rings the bell for *slightly* too long in a way that *slightly* annoys Dr C and makes him feel *a little* intruded upon. This is indicated in the wording he used in his report, which, when reading it, I noted as a bit 'judgemental': for example, instead of noting that she has arrived in good time, he writes that she arrived 'early'. When he opens the door, he feels almost at once Mrs J slightly seductively drawing him into what seems to be her belief that the two of them do not need to take this meeting very seriously. He wrote that his internal reflection was that if he does not respond to this he may be seen as overly severe, but that if he does respond, he will feel he has lost his analytic stance of benign neutrality. Dr C notices a little while into the meeting that Mrs J is speaking about being very unhappy and increasingly depressed by being in an emotionally and sometimes physically abusive marriage, but that at the same time she is smiling and joking, inviting the analyst to smile and laugh in response and to minimise and dismiss what sounds very troubling. Attempts to comment on this and try to engage the patient in thinking about this disjunction are evaded. The analyst begins to feel irritated again but manages to silently think about this response so that the danger of being drawn into an enactment of an abusive object relationship in the session is averted. Mrs J soon becomes irritated herself and conveys to the analyst that she finds him cold and 'judgemental', just like her husband. During this first meeting, the analyst is aware of experiencing a strong

sense of disturbance, feeling controlled and unable to think, which adds to his sense that this is a very irritating woman. He wonders later about this unaccustomed and particular form of judgementalism on his part: is it to do with him and his own personal life or is it something in Mrs J? Having thought about it some more and seen how he had lost his 'analytic stance' in his reactions, when he saw her for the next appointment, he was able to find again his stance and bring a third perspective (Britton, **1989**) to bear, in order to observe what was going on between himself and Mrs J. He could see now how he had been drawn into an enactment of Mrs J's internal world: a world dominated by a split between a superficial smiling exterior, which on no account can risk any contact with an enraged, desperate and aggressive internal object which has to be projected into others, particularly the men, in her life. The 'emotional storm' involved evoking a judgemental state in Dr C. Recognising this allowed him to recover his analytic stance so that the storm could be worked through in the second meeting. Dr C could use his psychoanalytic judgement to arrive at a formulation about Mrs J, which he could explore through interpretation. His formulation seemed to be confirmed by Mrs J's decision that she could only tolerate perhaps once weekly therapy, but nothing involving any greater intensity of contact.

Most consultations at the Clinic are discussed, either between meetings or at the point of considering whether an analysis from the Clinic's resources can be offered. Having this opportunity to view the case from another perspective can be so helpful when a consultant has been drawn unwittingly into an enactment or needs some assistance in metabolising the 'emotional storm' of a first meeting. What is very clear in such case discussions is how very much easier it is to be 'judgemental' of the work of others than to think about it! I notice that in some cases we find ourselves being very 'expert', perhaps even competing with each other for 'who knows best' about this patient. In other cases, we find ourselves to be uncannily in agreement and find little to discuss – until, that is, we notice how mindless we have become. Looking more carefully at such cases, we may find that the 'expertise' is a repetition of the patient's defence of having to expertly 'know' about themselves rather than face the pain of a more diffuse sense of identity, or in the other case that we are unconsciously responding to the patient's intense need to not think and to know nothing. These dynamics, if not worked through in the consultation, seem to push themselves through to the next level of 'analysis'. A second look at all these resonating reactions generally reveals that they are our efforts to cope with our own anxiety about not knowing, about being uncertain or confused by the material. In a recent case, we found that, like the consultant, we warmed to the patient and were seduced into an uncritical acceptance of his theory about his impossible partner being the cause of the problems. Looking again at the case and the detail of the process of the consultation, and our own group discussion, we concluded that the consultant had been drawn into this form of judgementalism as a form of enactment where she turned a blind eye and lost sight of the ways in which the main defence of the patient is projection of his own disturbance into others.

Countertransference reactions and enactments are frequently where the 'judgementalism' of the analyst is provoked, perhaps to resolve a sense of confusion or unbearable uncertainly, by grasping for certainty. If this is not recognised as countertransference, or of some judgementalism resulting from some blind spot of the analyst, then the opportunity is missed to reflect and explore the meaning of the judgement that has pushed itself upon the analyst. The analyst may then become caught up with enacting his part in some significant projected object relationship – that is, to be drawn into *action* instead of seeking *meaning*, or to put it another way, to be drawn into unscrutinised *judgementalism*, instead of being free to develop a judgement.

The psychoanalytic identity and functioning of any individual analyst can be put under huge pressure, especially at this peculiarly intense moment of a first psychoanalytic encounter, and the analyst's capacity to sustain it relies more than we often acknowledge on being part of a supportive analytic institution or community of colleagues.

The model that Lagerlöf and Sigrell (**1999**) write about also involves a group discussion of psychoanalytic consultations, and they discuss how objectivity can suffer from group processes as well as processes that are a parallel 'repetition' of what has gone on in the original consultation, but that, equally, these processes can generate new material which, if viewed analytically, can greatly enhance the understanding of the case. It also seems that when the 'emotional storm' provoking an enactment is particularly powerful, perhaps due to the intensity of the need for this to not find meaning but to reside more comfortably in action, the countertransference pushes through even to affect subsequent levels of case discussion and judgementalism can continue to rule the day unless the analytic framework can be re-established.

Conclusion

In psychoanalytic consultation work, we are forming hypotheses about what has brought the patient to be seeking help, what is the state of their internal world, whether their unconscious phantasy, their object relationships, will allow them to be able to make use of whatever treatment options we have available to offer, and we are doing this work in a psychoanalytic setting. This setting is not just the external, physical and institutional setting, but also crucially and fundamentally the 'internal setting', the analytic stance that allows an analytic process to unfold between the patient and the analyst. A fundamental element of this internal setting is the use to which, in the analytic process, the analyst is able to put their subjectivity, their subjective response to the patient and how this influences the judgements that lie behind the formulations and decisions that are then made. In this paper, I have illustrated some of the ways in which the exercise of clinically trained, psychoanalytic 'judgement' and the ability to scrutinise 'judgementalism' are of fundamental value in psychoanalytic consultation. I hope that I have also been able to convey how very unhelpful and damaging it may be to

overvalue ‘objectivity’ at the expense of carefully and thoughtfully exercised subjective clinical judgement.

1. This image of ‘blind judgement’, which was used on the publicity flyer for the conference at which this paper was given (Making Judgments or Being Judgmental? A Problem in Clinical Assessment and Beyond, TCCR November 2012), is found on ‘Google’ images under ‘Blind Justice’ and what distinguishes it is the blood that runs down the woman's face from behind the blindfold; ‘Justice’ is usually seen holding a balance scale in her hand, and is sometimes also blindfolded in the service of avoiding any bias in the balance of judgement, but is not in any other representation shown in this particular way.

2. European Psychoanalytic Federation: Working Party on Initiating Psychoanalysis. See Reith et al. (**2012**).

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