Papers and Articles

A Clinic Consultation
Introduction and Background[1]

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At the Scientific meeting on 20th February, a consultation carried out by one of the consultants for the Clinic will be presented. The case to be discussed is one where the consultation resulted in a recommendation for a low fee analysis through the Clinic. The case and the consultation was then discussed in the Clinic low fee Panel, the consultant's recommendation was endorsed and the patient went on the waiting list for treatment and was subsequently taken into treatment by a candidate in the training. For reasons of confidentiality, details of the case, including the initial pre-consultation form completed by the patient, the consultant's report and the notes from the low fee Panel discussion will be circulated on the evening and we will have the opportunity to hear about the progress of the analysis. We look forward to a discussion of the clinical material from the consultation.

The focus of the Scientific meeting will be the case and the process that unfolded through the consultation, but people may also be interested to have in mind the recent revisions in the Clinic organisation. This paper will not be read at the meeting but will be taken as read, by those who are interested, and I will make a few introductory remarks to set the consultation in context.

Apart from some details about the organisation, what I wish to emphasise is how recent changes in the Clinic are to do not just with procedures but more so with a shift of culture which we hope will open up further potential developments in the Clinic and the Society. The 'charitable' status of the Institute and its Clinic is organisationally valuable in that we are an official charity, with all the financial benefits that this attracts. But this has also had a profound influence on the culture of the Clinic, the consequent procedures and organisation and its relationship with the Society over the years.

What we have done in the recent revisions to the Clinic service is, I think, to bring about a change of culture which takes the emphasis off our being a charity in the sense of being like a wealthy benefactor giving 'free' treatment to a few of the 'deserving poor'. I hope that we are now in a position to offer a professional service with a different emphasis, where interested people can have access to an affordable possibility of a psychoanalytic consultation. They can have the opportunity to explore their difficulties, or sense of needing some help, in a consultation where they get a 'taste' of the psychoanalytic method; where, to use the thinking of the EPF workshop[i] of the same name, an analytic process can be 'initiated'. We can then do what we can to facilitate someone's decision to embark on psychoanalysis or analytic therapy. I hope that in this way we can fulfil our charitable aims by making analysis more accessible to more people, not only through Clinic treatment, but also through our Referrals service to members of the Society. There is also an important way in which a good psychoanalytic consultation can itself be therapeutic even if it does not lead to an analysis.

One of the major consequences of this shift, and one that we are still struggling with in some ways, is that we are no longer really offering 'assessments of analysability' to 'applicants' for analysis at a low fee, but are now aiming to offer psychoanalytic consultation that helps someone to think about their difficulties in a new way through offering them something of a psychoanalytic setting and process.

[1] This paper will be taken as read at the Scientific Meeting on February 20th and clinical material will be made available at the meeting.

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I am drawing a distinction between Assessment and Consultation which I think is an important distinction to make when trying to work out the primary task, both for the individual patient and the consultant and also for the institution, that is, the Clinic and its procedures and practices. As far as what goes on in the consulting room, it may well be that the actual activity that goes on between patient and consultant is the same whatever it is called; an observer of the scene may not detect any difference between what I am calling an Assessment and a Consultation. But I do think that from a technical point of view what goes on internally in the consultant may be distinct; the consultant may have a significantly different 'internal' setting as the basis for their work with the patient when the Institution's primary task is not to 'assess' the patient but rather to offer an active and skilled piece of work aiming to initiate a psychoanalytic process for an individual. The 'assessment' element is largely to do with whether an individual is willing and able to have such a process 'initiated'.

But of course, in the Clinic another aspect of the 'assessment' element is introduced at the point in the process when we have also to take into account not only the clinical needs of the patient but also the training needs of the candidates who see most of the low fee analytic cases.

If a consultant's recommendation has been for the patient to be offered a low-fee psychoanalysis through the Clinic, then the consultants report is discussed in a small Panel of experienced colleagues in the Clinic. The Panel includes at least one or two supervising training analysts, people with experience in psychotherapy services in the NHS, and a representative of the candidates. The task is to consider whether we agree that the patient is probably going to be able to use an analysis and then to decide whether have the treatment resources to make it realistic for them to go onto our waiting list. We do not like to put anyone on the waiting list if they are going to have to wait for more than about six months for treatment. We see how many are on the list already, how many vacancies are likely to become available with candidates. We think about whether the case is likely to be accepted by supervisors as a training case, and, if we are doubtful about that, we look at other resources: some qualified analysts are able to see five times weekly patients for a low fee, especially if they are looking for a case to take for supervision to gain full membership of the Society, or if they are trying to build up their five times weekly caseload.

Why do we not just accept the consultant's recommendation with no further discussion? There are two main reasons: firstly, we like to be realistic about our waiting list and need to keep it in line with likely treatment vacancies. Secondly, we find that it is helpful to look at the process that has unfolded between patient and consultant from a 'third' position and that this helps to be more objective when a consultant is drawn, for example, into undue optimism or pessimism about a case. Often consultants feel that the patient 'needs' an analysis but is not able to really say that the patient has been able to demonstrate that they could use analysis, especially through seeing a candidate. It is often hard to think about what the right thing would be when there is a needy patient in the room with you. We write up the discussion at the Panel and try to be realistic about the pros and cons of a case, even though candidates and supervisors, quite understandably, are often in search of the chimera of the 'good training case'.

Partly because fewer men refer themselves to the Clinic and yet we need to have the same number of men as women available to the candidates for their training, we find that we sometimes apply rather different criteria for 'analysability' for men and for women. I think that we tend to be far more tolerant of their narcissism and of their ambivalence and their often related acting out. We find that the men tend to be the ones who do not confirm appointments or who cancel at the last moment or go to the wrong address for their consultations. I find the Clinic Administrator 'chasing them up' to see if they have received letters and so on, in a way that we would probably not do with most women – but most women do not seem to act out in these ways.

Can we predict the patients who will stay for two years or more? The patients do know that the low fee is offered on the basis that they make a commitment of at least two years[ii]. We can probably see where there are factors

that might predict a risk here, but I don't think that it is possible to define the factors that predict no risk (except in the cases where the risk is more that the patient will never leave!).

A report of the discussion in the Panel goes into the patient's file and is seen by the prospective candidate-analyst and their supervisor. There is a temptation when writing up these discussions to play into the candidates' anxiety by emphasising the positive aspects of the patient as training case. We have discussed how we should be able to voice our doubts and concerns without the candidate being too put off. Analytic cases in ordinary practice do sometimes break off or not last more than a year or so. We understand how some candidates are able to face this possibility and can accept that they will learn from all cases they see, and that others have pressures to keep their training moving. We are also concerned, however, that the Training organisation may tend to view the candidate negatively if a patient drops out, perhaps to the candidate's detriment if it is in fact more to do with the patient's potential for staying the course. We have concluded that if we are able to make clear the pros and cons that we have considered about a particular patient, then there is a record of this for the candidate, supervisor and the Training organisation to take into account when reflecting on the treatment outcome[iii].

This example illustrates some of these points:
Mrs J is 32 and has recently divorced. She is academically successful but is on a fairly low income. She and her husband had both been depressed and had, it seems, come together with this in common. When he went on a course of anti depressants and then into therapy, he seems to have come to life, became happier and had an affair. Mrs J could not bear this and left him. After the divorce and a move to another part of England, she had a resurgence of previous experiences of anxiety, racing thoughts and consequent inability to focus on her work. This resonated with her early history where she had a racing heart that required surgery when she was two, which her parents do not seem to have been able to manage emotionally, and a childhood compulsion to masturbate which her mother could neither tolerate or help her to manage. She was referred by a previous therapist to a psychoanalyst in London who saw her for a consultation. She could not afford to start a private analysis and he worked with her on the idea of referring herself to our Clinic. She had managed to lose the consultant's contact details a number of times and he ended up, very uncharacteristically, chasing her up until he finally got to see her. She was clearly very much in need of an analysis but delayed over contacting us, feeling that she would be seen as a 'time waster' and not 'worthy' of our charitable funds, an opportunity which friends of her had told her would be like 'winning a lottery'. After she did get in touch with us, she had a consultation with a Clinic Consultant. Both consultants found her to be very interesting, both recommended her for a low fee clinic analysis with a candidate, and both noted an identification with a mother who cannot bear her pain. The Clinic consultant however, found it hard to feel as if she was really in touch with the patient and in the Panel, we sensed a somewhat 'lifeless' quality to the meeting. The question was raised about whether she would, as she has done before, run away from the analytic relationship if it began to come alive and have an impact on her. In the Panel we took seriously the way in which Mrs J seems to project her need for help so that we were left wondering if she was able to be aware of needing help and wanted an analysis or whether this was just the desire of the consultants. What would the implications of this be for a candidate who may actually need the patient to be in and to stay in an analysis? On the other hand, perhaps she so much needs someone who will be able to recognise her difficulties and contain her anxieties that being 'chased' into an analysis is the only way in which she will be able to start to get the help she needs. We decided to put her on the waiting list. At the time of writing I don't know if she has accepted this or whether she will be taken on by a candidate. Because of their need to have a patient for two years, candidates are often put off a patient who has a history of running away.

In short, there is always a tension between the training needs of candidates and the clinical needs of patients and being aware and accepting of the clinical realities may help to dissipate some of that tension.

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Finally, in September 2007, partly out of the work of the EPF Working Party on Initiating Psychoanalysis, I had a meeting with the Clinic in Vienna to discuss common concerns about the organisation of a low-fee psychoanalytic clinic and consequent clinical implications, such as the impact of the low-fee on the psychoanalytic process. This will now be the subject of a panel at the EPF congress in Vienna in March 2008 on 'Freud's Free Clinics' where the Medical Director of the Vienna Ambulatorium and I will both give papers on how the setting and the low-fee in the Clinics affect the psychoanalytic process.

Our Clinic in London has been going for nearly 82 years, and, unlike other Clinics in Europe we have never closed. I think we all are aware that, as a result, and of course because of other factors, we have something quite special in our Clinic. I would like to conclude by considering the functions of the low fee clinic – for patients, candidates and psychoanalytic community as a whole:

1. To provide psychoanalytic consultation and in many cases full psychoanalytic treatment for people who would not otherwise have been able to afford it.

2. To provide clinical cases for candidates in training. The cases have all had thorough consultations and in this way have not only been assessed as being suitable for treatment as a training case, but also, through the consultation process, have been prepared for an analysis.

3. The psychoanalytic community benefits from the wider range of patients that are seen through the Clinic than would normally pass through a private practice. Candidates, supervisors, Clinic consultants and others who hear about the cases all have their analytic experience enriched.

4. Its work and its very existence increases the public profile of psychoanalysis. People may not approach the Clinic themselves, but they may see leaflets, hear about it, see it on the website, and so on. Other professionals may understand and appreciate psychoanalytic work more through our liaison with them over particular cases.

5. The psychoanalytic psychotherapy that is carried out in the NHS is based on psychoanalysis, often taught and practiced by psychoanalysts – through the low fee clinic we are all able to have good experience of five times weekly, full psychoanalysis in order to have the fullest possible experience as the basis of whatever other work we do later in various settings.

6. It helps to keep five times weekly analysis alive. We see that in other countries psychoanalytic training requirements have been modified to 4 or even 3 times weekly sessions because candidates find it difficult to find patients who will come 4 or 5 times a week and pay a full fee. Our scheme in London does allow candidates to have this experience and we do not find it difficult to find patients who do commit to 5 sessions a week analysis.

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[i] The EPF Working Party on Initiating Psychoanalysis

[ii] We are very aware of candidates' concerns when selecting patients about the risk of patients dropping out and thus holding up their training. Very few patients do in fact drop out before the two year minimum and most patients continue in treatment for longer than this, usually transferring to the analysts' private practice. But the anxiety remains. At a recent meeting of our Panel, a candidate, Dr Una McDermott, made the very good and interesting point that with a first patient, a candidate's preoccupation is like a new mother's primitive anxiety about her first baby and her capacity to look after him – it is all life and death, will the baby survive? All being well, by the time the next baby/patient comes along, the maternal confidence is enormously boosted on the basis of experience of having been able to safely hold the first one.

[iii] There is, of course, also the supervisor's view of the situation and a record on each patient of the view of any other supervisors and candidates who have seen the file.