Papers and Articles

Annual Research Lecture
How can we know more about what goes on in psychoanalytic consultations?
Methodology and initial findings about the process of recommending psychoanalysis.

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This is an extended and more complete version of the lecture than was presented at the Institute of Psychoanalysis on 4th December 2013 by Penelope Crick and Alejandra Perez.

The London Clinic of Psychoanalysis offers a psychoanalytic consultation service which aims to help prospective analysands and consultant analysts come to an experientially based view on whether psychoanalysis is the preferred treatment of choice. There is little systematic research into how analysts arrive at a recommendation for psychoanalysis, and yet this is an extremely potent and significant moment in the beginning of any analysis, and merits further exploration and understanding. Using a mixed methods approach, this study attempts firstly a qualitative exploration of the intra- and inter- psychic dynamics that emerge in a consultation, as understood by the psychoanalyst, based on all 100 consultations taking place at the Clinic over one calendar year. The second, quantitative part of the study compares consultations where psychoanalysis was recommended with those where it was not, with the aim of investigating whether there are different trends between prospective patients and consultation processes. Patterns in the consultants' thinking and communication, phenomena arising in the consultations, and prospective patients' history and current life circumstances, are described and further explored through clinical material. The relevance of these results will be discussed, as well as the strengths and weaknesses of this research methodology.

Introduction

This Annual Research Lecture is when psychoanalysts are challenged to think about some of the more difficult questions that are posed to our profession: like "what's your evidence?"

By its nature, psychoanalysis not only relies on subjectivity, but it privileges a particular *use* of subjectivity. This is a special and highly trained form of clinical judgement, used as the basis for interventions that are intended to make significant differences to the psychic lives of those who consult us. And yet, many would suggest, surely the basis of 'science' and therefore the nature of acceptable research evidence has to be '*ob*jective', untrammelled by the vagaries of the 'merely' and notoriously unreliable *sub*jective.

But this is a view that can be seriously challenged in many fields, not just psychoanalysis, where the basis for a great deal of important research derives from the 'subjective' responses involved in skilled specialist judgement. However, it is a challenge to find a robust model for research that can accommodate subjectively derived data.

Psychoanalysis, like other psychological treatments that have for many years been offered with benign intention and generally good effect within mental health services, is subject to pressures to demonstrate 'evidence based practice'. Such evidence for what we actually do, how we think, and how we work with our patients is not easy to produce. But the pressures get to us, partly at least because of the ways in which we are uncertain about our work.

And yet we *have* to be uncertain and to work within a framework that respects doubt and uncertainty, and uses that to interrogate subjective judgements and thinking (Feldman, 2009; Crick, 2013). A 'subjectivity' where there is *no* doubt, *no* questioning, which has, in effect, been re-construed as 'objective truth', perhaps for research purposes, is omnipotent and maybe seriously misleading. But of course we want to protect and defend ourselves

against the discomforts of uncertainty and so can be easily tempted into the use of inappropriate models of research, shoehorning our data into the right 'shape' to fit the glass slipper of 'scientific respectability'.

But we have to think carefully about what we do want and *need* to know about, and are able to research. What are the questions for which we seek psychoanalytically meaningful answers[i] on the basis of the psychoanalytic data available to us?

In our Clinic, from the large number of cases seen for consultation and analysis within relatively circumscribed parameters, we potentially have good 'data' to address a number of important questions: if for the moment we limit these to an evaluation of our services (Crick, 2011), there are two right away:

Firstly, we could see to what extent the analyses that are carried out in the Clinic are successful in that they make a significant and positive difference to the patient. This is outcome research and while fraught with difficulties in finding the right sort of measure and methodology for the complex and multivariate data involved, it would be a highly worthwhile venture.

At another level, we could explore the extent to which our recommendations to people for further treatment are accurate in that they lead on to a treatment, either in the Clinic or elsewhere, that is found to be helpful. This is more to do with an *evaluation* of our consultation and assessment work and procedures, and is probably better thought of as clinical audit[ii] work. Its results would be a good basis for the more complex outcome research and this may be something that we can more easily aspire to in future.

These are both important questions because we do need to be as sure as we can that we only recommend for analysis those who we believe will be likely to benefit from it. In the past, the Clinic here has developed methodologies and research instruments to try to work out the best way of 'selecting' from those who might like to have an analysis the ones who will derive most benefit. But these studies, while yielding some helpful conceptual guidelines, have run into the sand, defeated by the data that just refuses to fit into the *a priori* models. A former Clinic Director wrote despondently about this research and how the attempt to accumulate objective research data was marred by the clinic assessor's judgement being impaired through meeting with the patient, loosing in the process 'some degree of objectivity'. He thus precisely captured the need, in fact, to respect and take into account the *subjectivity* that is at the heart of a psychoanalytic judgement.

Other studies, such as one by a group of researchers at Colombia University, (Caligor et al, 2009), have confirmed through a very comprehensive and clear, systematic study in a Clinic rather like ours here, that the decision to recommend analysis or not is made on *some* basis but not one that can be captured by standard tests tapping *patient* factors. In practice, they conclude, variables leading to a recommendation for analysis seem to be more *implicit to the particular individuals involved* and are not accessible to conscious conceptualisation. This is also the impression that we have in the work over many years in this Clinic.

This lecture is concerned with the research that we are undertaking in the London Clinic of Psychoanalysis about our psychoanalytic consultation work, where we are trying to get an understanding of what *is* involved in the consultation process that leads to a recommendation for analysis. Our basic premise in approaching this was to identify a research model and methodology that is capable of exploring the subjective, implicit data derived in the dyadic psychoanalytic processes involved in consultation, without sacrifice of psychoanalytic meaning.

As psychoanalysts we consider it of utmost importance that we take care not to just try to 'fit in' to a model that we feel we 'should' comply with in order to meet some research criteria that are not actually appropriate for the nature of our work. So the more we can first define and specify the underlying components of what it is that is sensitively picked up in our clinical judgements, the better equipped we will be to carry out a meaningful clinical audit of our work. This, in turn, we hope, would lead to a meaningful evaluation of the outcome of the analyses conducted through the Clinic.

How can we know more about what goes on in psychoanalytic consultations?

Aims of our research in the Clinic

A few years ago, from 2006, the Clinic changed its basic model of '*selecting*' patients who specifically applied for psychoanalysis, to instead offering psychoanalytic consultation to anyone who may be interested, to help them to decide with the help of a consultant psychoanalyst, in a psychoanalytic setting, whether this would be the right sort of thing for them to embark upon. We have placed great emphasis on the psychoanalytic consultation as the key 'portal' to psychoanalysis and psychoanalytic therapy for people who may not have considered this as potentially helpful for them in dealing with their difficulties.

And so it is important for us to know what it is about what goes on in our consultations that is helpful or otherwise to those we see, and also what goes on that is of value in coming to the most appropriate sort of recommendation. We specifically want to know more about what goes on in the consultations that results in someone going on to have psychoanalysis, and whether this differs in any particular sort of way from those where psychoanalysis is not recommended or undertaken. We want to know if, from this sort of investigation, we can learn about technique in this specific psychoanalytic consultation work so as to be better able to support, guide and train consultants. And we also want to look at who comes to the Clinic and whether we can learn anything about how to improve upon our procedures in promoting, setting up and managing consultations for the best outcome for all concerned.

There is a growing literature (e.g. Reith et al, 2012) on the psychoanalytic consultation or 'first meeting', describing differing models of work, with differing aims, but with overall agreement that it is demanding work where very powerful dynamics are operating, starting even before the first meeting between the analyst and the patient, and certainly playing a very potent part throughout – captured well by the concept of the 'emotional storm' (Bion, 1979; Reith et. Al, 2012; Crick, 2011 and in press). If we are to be able to train and support our consultants in this work, we need to really understand this as well as we can.

We are grateful to the IPA research fund and to the Scientific Committee of this Institute for their financial support in the developmental stages of this research. Alejandra Perez, Susan Lawrence and Penny Crick are the researchers for this work and we all are most grateful to each other for the special qualities and skills each has brought to the project so far. (The work is also to be described in two papers being submitted for future publication.)

The Study

The material we have chosen to study are the consultation reports that are written up after a psychoanalytic consultation for purposes of summarising the consultation work, conveying sufficient information about the patient and the process that took place to communicate to the reader the rationale for the recommendation made.

The material is helpfully circumscribed in terms of its variability by being to do with those who consult this Clinic and who are, therefore, by and large, suffering sufficient difficulties in their lives that they feel they need to seek help with, and a psychoanalytic sort of help at that. So although our research and the methodologies developed may well have application beyond this Clinic, the sorts of questions that give rise to it are relevant and important to the work and aims of our Clinic.

The consultation reports are written to a semi-structured format with headings under which consultants are free to write what seems relevant for the purpose, with an emphasis on both the patient's history and current circumstances, and also on the process that took place between patient and analyst, over usually two meetings. Not only is the consultant analyst processing and metabolising information, consciously and unconsciously, while actually seeing the patient, but also between appointments, perhaps with the help of a work discussion group; and this processing continues in the actual work of writing the report.

Consultants often say that it is sometimes only in writing up that certain information or impressions or sequences of exchanges with the patient are recalled or find their place. Or it may be that only at this point of writing does an overall theme or dynamic appear evident.

The very writing of the report, like writing up an analytic session, is a transformational experience: just as in analysis, the analyst is able at certain points to take a 'third position' to observe what is going on between himself and the patient, so in the *writing* this third position is what is fruitfully discovered and employed (Perez, Crick and Lawrence, paper submitted for publication).

We see about 100 new patients a year for psychoanalytic consultation through the Clinic. The consultations are for the prospective patients to have the opportunity to have something of a psychoanalytic experience to help them to decide if this sort of approach feels right and helpful for them. The consultants, in turn, are offering a psychoanalytic setting, and thinking psychoanalytically, insofar as they can, about and with the patient, observing how the person is responding to and using the setting. In this way, the consultants can arrive at their own assessment of the extent to which a psychoanalytic approach is likely to be of help to that person, and then on that basis discuss with them a recommendation.

This may be for psychoanalysis through either a private referral or through the low fee scheme in the Clinic, or for lesser frequency psychoanalytic psychotherapy through private referral, or some other treatment recommendation or appropriate advice. Sometimes the person themselves finds the consultation sufficient for the moment and decides not to pursue any further work for now.

It is important to keep in mind that when we are speaking of a 'recommendation for analysis', this is not equivalent to 'an assessment of suitability for analysis': if a consultation results in a recommendation for an analysis, this is where a consultant has discussed and considered with the patient the idea of an analysis and together they have agreed that the recommendation to go forward to the Clinic would be this. Some patients might well be assessed as 'analysable' or 'suitable' for analysis, but if this is not something that they want to proceed with at this point, perhaps preferring to start in less frequent analytic work, then the recommendation going forward to the Clinic would not be 'for analysis'.

What we looked at

We began by identifying a number of variables that we thought, from experience and observation in the Clinic over some years, would be likely to be helpful in characterising and describing the cases. These included characteristics of the patient population, demographic data and also some other more qualitative information; and also characteristics of the consultation process as revealed in the reports available to us. The population is not subject to any selection bias as it consists of all who approached the Clinic for a psychoanalytic consultation during one calendar year, and the data is routinely gathered in the course of the Clinic's work.

We are, of course, also wanting to make use of the very rich information we have from so many cases and to build on some of the observations we make in the Clinic. By systematically collecting detail from a number of cases about particular sorts of patterns that seem to crop up, we can begin to explore implicit theories or 'hunches' arising out of experience in the Clinic. An example of this is the idea of 'the good object': frequently, when discussing an individual case, we find ourselves looking for evidence of a 'good object' in the person's history, as if the implicit theory is that someone needs a 'good object' in order to be able to make use of psychoanalytic help. In some cases, we are struck by the absence of 'a good object' in someone who nonetheless goes on to make impressive use of analysis – this all raises some fascinating clinical and research questions.

From the prior information we have about a person and also from additional information that comes up in the consultation, we recorded for each person requesting a consultation several characteristics where they were known: Age, gender, nationality, ethnicity and sexual orientation; on the basis of what was notable in many cases, we also looked for each patient at information about losses of mother or father before age 16[iii], and the quality of the maternal and the paternal relationships. Because they were things that often come up in discussion of cases, we also looked for the presence of a 'good object', whether the person was working or studying and if so judged potential or not, whether they had previous treatment, and if so how helpful they, and also their previous clinicians, had thought this was, and the degree of current pathology and of past pathology.

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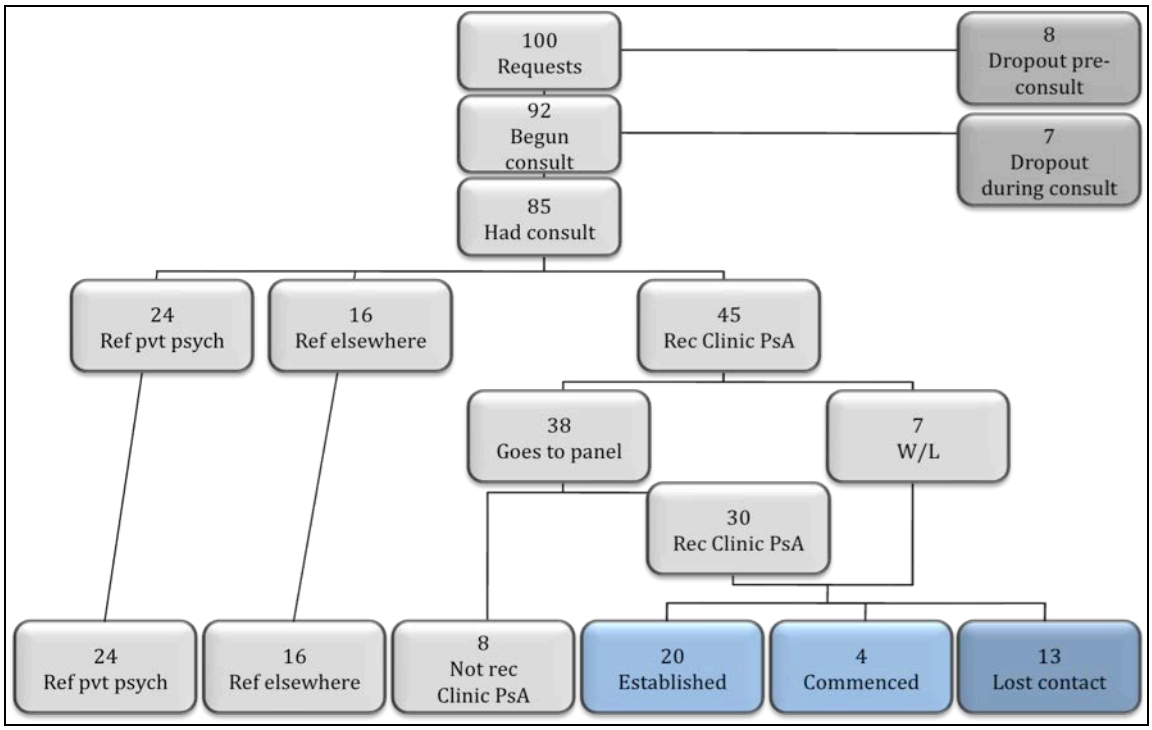
And finally, because these things were noted in the administration of the cases, we also rated the ease of arranging consultation appointments, and noted how the person had found out about the Clinic – through a friend, relative, professional recommendation or via the internet.

Some of these things were simple to rate, some more complex, relying on clinical judgement as psychoanalysts. In trying to capture meaningful information, we needed to work out for ourselves some rating definitions: for example, in rating degree of current and past pathology, we arrived at criteria to indicate: 'normally neurotic' and then moderate and severe pathology; we found that it would be impossible, psychoanalytically, to rate anyone as free of pathology.

We already know from other previous studies (Caligor et. al, 2009; Bachrach et. al, 1991) that to really understand how a recommendation for psychoanalysis in a Clinic service like ours is made, it is insufficient to look simply at factors that are intrinsic just to the patients themselves. The dyadic process of a consultation or 'assessment meeting' itself seems to play a highly significant part. But it is important firstly to have a picture of the population of those who come to the Clinic.

The patient population of the study

In one calendar year, 100 people asked to arrange a consultation (through the Clinic). The flowchart shown below summarises what happened to them all and we will go through it. Of these 100 prospective patients, 8 dropped out before the consultation actually started, and 7 dropped out during the process. But we ended up with a total of 90 consultation reports[iv], and we will describe our exploration of them shortly.



Flowchart to show the progress of patients through the Clinic consultation process from first request for a consultation to final outcome.

The overall patient population:

The patients were aged between 20 and 58 with an average age of 35 (SD=8.27). 68% were women and 32% men. People came from various different countries and ethnicities, 73% were white, 63% British. Most (78%) were heterosexual, but some were bisexual (9%) or homosexual (3%). Nearly 60% of them lived alone or in a flatshare, and were not in a relationship or dating. The majority (82%) were working or studying; however 34% were doing so below their potential.

With regard to the 'good object' rating, about half (49.41%) of all the patients described having experienced a good relationship with someone significant in the earlier part of their life.

For quality of relationship with parents, a fifth (20%) had a positive and sustained relationship with mother and about the same with father, nearly a third (31%) conveyed that there had been a distant relationship with mother and also with father, a quarter (27%) had a disturbing relationship with mother, slightly fewer (at 19%) having a disturbing relationship with father. A very small number (3.5%) described a violent or abusive relationship with mother and slightly more (12%) with father.

A substantial number (42%) had effectively lost one or both parents at or before the age of 16. This could be by death – accidental, illness, suicide, or by abandonment through family break up or by the parent being severely mentally ill[v]. It is hard to find comparative data about the 'norm' but it seems to us that this is a high proportion and would be interesting to know more about, in terms of predisposing childhood risk factors in needing to seek therapeutic help in later life.

Almost half of the prospective patients were considered[vi] to have a current 'moderate' psychopathology (48.24%), with a third (30%) falling into the 'normally neurotic' category and a fifth (21%) considered as 'severe'. In respect of their past pathology, again almost half (45%) had a 'moderate' psychopathology, with a fifth (21%) being 'normally neurotic' and a third (32.94%) having a 'severe' psychopathology.

Only 11 of the whole population had *not* had any previous form of mental health treatment, and the vast majority of the rest had some form of 'talking treatment' in the past. We rated[vii] how helpful or otherwise they had found previous treatment, and also in the majority of cases we had reports from previous clinicians, which we also rated in this way.

Drop outs

Of course we are interested to know what happens when people drop out, and to reflect upon whether this has to do with our procedures or is more intrinsic to the patients. Looking at the figures, we found no significant *demographic* differences between the 85 who completed the process and the 15 who dropped out before or during the consultation.

However, we did see a highly significant difference (FET=35.043, p=.000) in how straightforward it was to arrange an appointment, where drop-outs had presented the Clinic with far greater difficulties in scheduling, cancelling once agreed and asking for rescheduling, or not turning up for a first appointment.

Five of the people who dropped out before or during the consultation filled out the questionnaire with enough detail for us to rate the quality of parental relationships. An interesting trend (FET=6.055, p=.056) was found between 'drop-outs' and 'completers of the consultation process', where drop-outs were more likely to describe a relationship with a mother that we could rate as 'disturbing' – that is, with a mother described as paranoid, overwhelmingly over-protective, giving mixed messages, or with constantly changing moods.

Exploring the consultation process

An important part of this research was to explore the consultation process; we realised that to do this, it was necessary to immerse ourselves in the richness, depth and variety of the consultation reports. We looked at the report from the analyst who conducted the consultation, the notes of the Panel discussion where this had taken place, and when available, a report explaining the recommendation decision from the Clinical Director.

Consultation report as the object of study

Because reports are not simply a transcription of what occurred during the meetings, but are a crucial stage in consultants' working through and understanding of the encounter, they reflect an analyst's implicit patterns of working and thinking; thus they far better demonstrate the *psychic processes involved* in a meeting than would an audio or video recording. Consultants put into reports more about their thinking than will have been conveyed in what they actually said to the patient.

Looking at a series of reports across the common format allows us to see a whole range of consultants reporting styles and ways of thinking. Some describe what happened and

how they made sense of it, others also reflect on how they felt affected by the encounter and what they could have done differently. In some reports, the consultant writes from the perspective of being an active participant in the story of what happened. In others, the analyst writes like a narrator, giving the account from a third person perspective. Some reports convey the depth of the evolving experience and take the reader through the analyst's thinking process, and others just include the final processed formulation. In some cases, the analyst shows their capacity to integrate various dynamics and to conceptualise, if not during the consultations, then in the course of writing up. Often the writing *style* seems to convey the analyst's experience: a relatively incoherent, fragmented report may well reflect that the analyst was overwhelmed by the intense experience of being in the room with the patient; in others, a more coherent experience may be conveyed where a report shows that the analyst was able to integrate and to conceptualise the dynamics. As in analytic session notes and case studies, some unconscious elements of the experience are only captured later, for example, by the reader, supervisor or, in this case, the researcher (Perez, Crick and Lawrence, paper submitted for publication).

From the literature and from day to day experience in the Clinic, we had some ideas about what may be important about the consultation process: that is, what goes on when patient and analyst meet in a psychoanalytic setting for a limited focussed piece of work aiming to result in a treatment recommendation and a hopefully useful and therapeutic experience for the patient. But rather than just focusing on the *a priori* ideas, we first set about an exploration of all 90 consultation reports. We each read some of them, noted our observations, met together and compared notes, discussed and began to formulate and define dimensions or 'themes' that seemed descriptively valuable, without losing a sense of the consultation report as a whole. We re-read, re-discussed and in this iterative way carried out a *qualitative thematic analysis* to arrive at eight main themes that seemed to capture important elements of what goes on.

We soon realised that we were looking at the consultation reports from different angles: how they were written, what we could infer about the analyst's way of working and thinking, and what we thought about the quality of the encounter that took place.

The diagram shown below summarises the process of this thematic analysis and the themes we, the researchers, identified from the consultation reports. The reader will find it helpful to refer to this in order to get a sense of the exploration process.

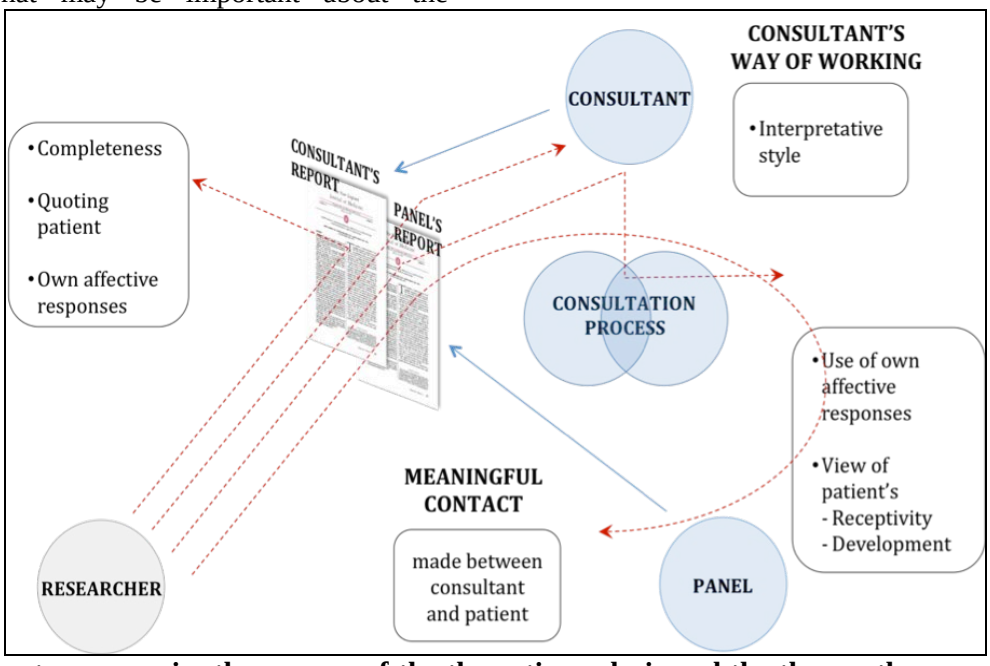


Diagram to summarise the process of the thematic analysis and the themes the researchers identified from the consultation reports.

From the perspective of looking at **how the reports were written**, three themes were identified:

Theme 1. Completeness of the report: this seemed to signal relevant aspects of the consultant's capacity to capture, process and synthesise the encounter – was this a complete account of the patient and the process, does the reader get a relatively clear picture of the patient's life, difficulties, internal world, and ways of relating, as well as how the patient used the consultation meeting? Or were there large gaps in the information? The majority of the consultation reports gave a relatively clear picture but when looking at reports we found had significant gaps of information, we wondered whether this was to do with the patient withholding or whether it the analyst's intention was to wait and see what and when information emerged in the meetings, or was it rather perhaps enacting the patient's anxiety about revealing or finding out about things?

Theme 2. Use in the report of the patient's own words: An interesting characteristic of some consultants' reports is the inclusion of and importance given to patient's words or expressions said in the meetings. Some consultants quote the patient's own words as a matter of personal style, bringing the consultation 'to life', often very effectively, giving the reader a strong sense of the patient's thinking and experience.
In most cases where the patient's own words are quoted, this is in conjunction with an account of the analyst's affective responses to the encounter. However, sometimes patients' words are quoted but not explained or reflected on, it seems, because of some obstacle to the processing or understanding of the meaning of what has been said, yet conveying a feeling that this was highly relevant but requiring a 'third' to form a view or to catch the sense of this obstacle first hand.

Theme 3. In a large number of reports, an **account of the consultant's own affective response** is included, at times clearly named as countertransference. This allows the reader to view the psychoanalyst as an affected participant of an exchange, part of a dyadic experience and subject to inter-psychic processes. This gives the reader a particular perspective from which to understand the material, seeing clearly two people coming together and getting a view of the affect generated.

Theme 4. Interpretative style. Looking at **the psychoanalyst's way of working**, an important element in the consultations was the way in which the consultant communicated to the patient his or her understanding of them. We developed a simple schema of interpretative style: 'in-consultation transference': which could be 'verbalised', or 'not verbalised' but noted and made use of to inform and guide the consultation process, and 'extra-consultation transference' verbalised, or 'not verbalised' but similarly noted and used. Of course analysts differ in their styles of interpretation, and in this study, about a third of the reports showed how consultants believed that speaking about the dynamic in the room with the patient, or what we called **'in-consultation transference** verbalised', was a useful way to bring to the patient's awareness his or her unconscious processes. Some consultants indicated in the reports that to verbalise the 'in-consultation' transference would have been *inadvisable*, possibly making the patient overly anxious, or possibly unhelpfully opening up and intensifying the immediate transference. A small minority of consultants *described* in the report their view of the transference/countertransference but did not communicate this to the patient – sometimes because they chose not to, and some because it only became clear to them later, in the process of reflecting on the meeting and writing up.

In terms of the **consultant's conceptualisation** of the patient and the consultation experience: their awareness and (**Theme 5**) use of their own affective response to understand the patient seemed important. As mentioned before, most consultants reported having some affective reaction during the process. However, some specifically linked their response to their understanding of the patient's internal world.

What we call 'the patient's receptivity' (**Theme 6**) is to do with **what consultants reported about patients' ability to reflect** on interpretations and tolerance of new views about themselves and their situation; ways in which they demonstrated an openness to an exploration and understanding about themselves. This was often to do with how a patient would make new associations or talk

about a dream in response to the analyst's efforts to understand their internal world. It is important to note that here 'receptivity' is not only an agreement or acknowledgment to a consultant's 'correct' interpretation, but may also encompass responding to the consultant's attempts to explore.

Another important dimension (**Theme 7**) was **how the consultant described the patient developing from one meeting to the next**, often revealed in the second meeting about what the patient has 'done' with the first meeting. For example, some report the patient as 'cutting off', perhaps by claiming to have forgotten all about it, or otherwise appearing not to have taken in any of what was explored in the first encounter. In other reports, the patient comes with material that links meaningfully to the previous meeting, implicitly or explicitly, for example, the consultant notes that the patient brings a dream or describes having contacted a person discussed in the first meeting, indicating that what had been explored has triggered something in them, even if they are not consciously aware of this.

A final perspective taken was:
(Theme 8) the **researcher's global evaluation of the meaningful contact made** between consultant and patient. This dimension makes use of the third position of the researcher in a specific way: that is, by us considering the contact between the two (consultant analyst and patient) from a position of looking from a distance at the process as a whole and with the particular perspective informed by the experience of having reviewed a variety of different consultation reports in the same cohort and with the aim of understanding that particular consultation. We found that where meaningful contact between consultant and patient has been made, there is definitely the feel of a psychoanalytic process having taken place, with both patient and analyst having made links and being open to what was occurring in the consultation, arriving at a genuine and new understanding of the patient.

Crick (2011 and in press) wrote: "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", and quoted Levine (2010): "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?"

Crick goes on to say: "If the analyst consultant finds that he or she cannot think and function as an analyst, then the next question is to do with *why that should be* – is it due to a defence in the patient or a counter transference response in the analyst?" In the present research, we explored the quality of the psychoanalytic encounter by looking at the consultation process as a whole, from a third, external perspective.

While this qualitative exploration of the consultation reports provided a rich overview of the various ways of conducting, thinking and writing about the consultation process, as well as how both parties are affected by the encounter, we were also interested in exploring possible differences or similarities between cases where a recommendation for analysis resulted and those where it did not. To do this, we needed to develop codes from these dimensions and rating criteria. We then needed to determine whether we understood and agreed on these defined codes sufficiently to reliably rate the consultation reports and compare them. In addition to the identified 'themes' of the qualitative analysis we also included themes derived from theory. More specifically, the possible effects that result from the intensity of the first encounter, such as the analyst's possible enactment, the ability to think psychoanalytically (by both consultant and Panel) about the case, and the consultant's capacity to metabolise intense affects during the consultation – that is, what is discussed elsewhere as 'the emotional storm' (Crick, 2011; Reith et al 2012).

Not surprisingly given the subtleties and complexities of these aspects of the consultation, we found that we did not reach sufficient agreement on all of the previously described themes. This was either due to a

poorly defined theme that we each understood differently, a difficulty in understanding the set out definition or, in many cases, the type of information in these reports did not lend itself to these categorisations. However, we had substantial to almost perfect agreement (determined by Fleiss kappa statistic) in characteristics of the consultation report (completeness and main type of information referred to); consultant's use of affective reactions and view of patient receptivity and development; as well as in overall quality of contact between consultant and prospective patient.

Looking at differences between cases

From the flowchart on page 33, we can see that of the 85 people who had a full consultation, 45 were recommended by the consultant for a Clinic analysis, 24 were referred for private psychoanalytic therapy, and 16 were referred elsewhere or decided not to take things further. When we say 'recommended for a clinic analysis', this is not simply 'an assessment of suitability for analysis': we are talking about a consultation where a consultant has discussed with the patient the idea of an analysis and together they have agreed that the recommendation to go forward to the Clinic would be this. Other patients who the consultant may well have considered 'suitable' would not necessarily want analysis and may have then been referred for less frequent private psychoanalytic therapy.

The formal research has not yet included a statistical analysis of this element of the data, and the numbers are extremely small, but these observations clearly indicate areas of future study and exploration. It would be interesting to know more about what led to the decision to nonetheless recommend analysis, and if these cases can be distinguished from others that showed similar pictures from the consultations that did become more engaged in analysis for a longer period. It also has to be remembered that there will have been many possible reasons that led to these patients leaving analysis within a year, including of course those to do with how the work developed with the particular candidate analyst.

This work is far from perfect or complete, but it is a start and one from which we learned a number of things relevant to our aims:

Firstly, we learned that we could use a mixed methods approach to carry out a comprehensive and psychoanalytically meaningful study of a series of 100 cases. This is important for our clinical audit as well as being a good basis for future research. We can review the strengths and weaknesses of the study and the problems we encountered to valuably inform and improve further work. For example, transforming the data from qualitative to quantitative presented various problems. Despite having clear definitions of concepts to be coded, and having standard format reports by a relatively small number of consultants who are all members of the British Psychoanalytic Society working within a particular Clinic, there were severe limitations on what could be implied from the information included in the reports. Coding from such diverse and implicit theory-driven reports carries the risk of over- or under-interpreting information. However, the aim of this work was to make a first step, to gauge and describe the research difficulties with the hope of encouraging new studies, as well as its main aim of discovering implicit and unconscious processes within the analytic consultation process. The methodology can be used in future studies in the Clinic and also has applicability to other psychoanalytic research.

Secondly, we got a good overview of the consultations in the Clinic over a year: on the whole our consultants were able to work through the intensity and uncertainty of the consultation experience to elaborate a report which included: a relatively clear picture of the patient's life; their difficulties; their internal world and way of relating; and how they used the psychoanalytic setting in the consultation meetings. We learned that in the majority of cases, a psychoanalytic process took place in the consultations. Whether it did or did not is certainly the result of a dyadic process between patient and analyst. Individual patients *may* have responded differently to different analysts, using a different technique – it would be impossible to know. We learned a lot about writing reports: some features in the writing are of particular help when it comes to a reader viewing the consultation process as a way of understanding more about the patient and the recommendation. This will be helpful to feedback to consultants and to take account of in the training of analysts in this specialist consultation work.

For example, the 'completeness of the report' makes a big difference. We can see that

sometimes a report is 'incomplete' in a way that indicates an unconscious enactment on the part of the consultant of the patient's need to be 'incompletely' understood as part of their defensive psychic structure, and it may be fruitful to further elucidate the different processes that lead to an 'incomplete' report.

We also observed that sometimes it was very difficult to know what had actually been said in a consultation, for example when it is reported that a consultant 'wondered' about something, we did not always know if this was an example of a *verbalised* in-consultation interpretation and whether the material following was the patient's response, or whether the consultant is just reporting their internal thinking, so that the subsequent material had some other less well understood relevance. Encouraging consultants to consider such things and to describe their ways of thinking and working more explicitly in their writing up, would not only aid further research efforts but may also provide more valuable clinical information about the decision about treatment recommendation.

Thirdly, we were able to get a comprehensive picture of the population of people who request psychoanalytic consultation and to systematically explore and find out about the process that could then unfold for them in the consultation process. We learned about what tends to distinguish the patients who tend to be recommended for psychoanalysis rather than some other form of treatment: and critically, we learned a lot about *the consultation process that brought that recommendation about*. The consultants demonstrated in their reports that these patients are receptive within the meetings to the analyst's efforts in the consultation to understand them. While this receptivity is *part* of what the researchers took into account in evaluating how psychoanalytically meaningful the contact between analyst and patient was, it is not the whole story: the critical thing is also to do with what is revealed in the report about the psychoanalytic nature of that contact, when it is viewed *from a third position.* So this may involve seeing how receptive the *consultant* was able to be to the patient: for example where the draw towards a countertransference enactment due to a projection from the patient could not be recognised and resisted so that further understanding became blocked. This may suggest something about the consultant's analytic capacities or preferred consultation technique, but it may also suggest something about the necessity and strength of a prospective patient's need to evade deeper contact, thus indicating something of their capacity and motivation to use an analysis in future. This clearly points to further areas of clinical research. For example, the role in the Clinic consultation process of making use of the third object perspective in the consultation and recommendation process: the consultation workshops where many Clinic consultations are discussed between the two consultation meetings, provide an opportunity for a triangulation where the consultant can be supported to view their work with a patient from a third perspective, thus deepening the work that they can then go on to do in the consultation. Similarly, discussions in the low-fee analysis Panel often indicate the value of a 'third' perspective on the consultation process as a way of understanding more about the nature of the psychoanalytic contact between patient and consultant in ways that were inaccessible in the course of the consultation.

In conclusion, we hope that we have demonstrated the use of valid research methods to explore psychoanalytic data to produce interesting and valuable information and we now welcome a continuing discussion to help us to continue to think about and develop our audit and research work in the Clinic.

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[i] If we ask a psychoanalyst the age of her patient and for how many sessions she has seen him, this is not 'subjective' data, but if we ask her about the processes that she observes in herself and her patient in the course of the work, the data can only be subjectively derived, because this *is* the method of psychoanalytic methods and technique. If we ask her patient to complete some kind of mental health questionnaire prior to the start of treatment and then to repeat this at some interval during and after treatment, then we have a form of 'objective' data, but whether it is psychoanalytically meaningful data would be open to further exploration: for example, the person may have become 'more depressed' but analytically, this could be construed as being an improvement on a previously rather manic state of mind where the person was out of touch with loss.

[ii] See Parry (1998): "Instead of prescriptive commissioning, an alternative way of fostering evidence based psychotherapies was recommended in the review (Roth and Fonagy 1996) and is also summarised by Roth et al. Clinical audit plays a significant role here, but forms part of a wider strategy. This strategy recommends single case studies and case series evaluation of innovative practices prior to formal research. Research findings are then incorporated into clinical practice guidelines and other influences on psychotherapists clinical decision making. Research and clinical consensus, sometimes formalised in guidelines, can be used as the basis for setting audit standards and benchmarking outcomes. These activities should also influence education and training in the psychotherapies…. The task of achieving consensus may not be as impractical as is sometimes thought; for example, when psychotherapists move from arguing abstractions to formulating single cases, significant levels of agreement can be obtained (Persons et al 1991). Psychotherapeutic formalution in routine clinical practice has also been shown to have considerable validity in terms of formal research instruments (Bennett and Parry, 1997)"

[iii] Up to and including 16 – have noticed that several pts 'lost' a parent around the critical period of GCSE/school leaving age.

[iv] Written by 29 consultants each seeing between 2 and 5 patients each over the year.

[v] 15 lost their mother, 32 lost their father and this included 6 who had lost both parents.

[vi] Ratings were based on an overall picture of the patient that emerged from what they said of themselves, previous clinicians' views, and the presenting problem as identified by the consultant analyst, and so were to do with both symptomatological and more characterlogical indicators of pathology.

[vii] From what the patient reported about previous treatment in the preconsultation form completed for the Clinic and from what was reported about the consultation.