"MAKE OR BREAK":
The Transfer of Patients from Clinic to Private Practice *

Caroline Polmear with Pip Garvey, Anne Harrison, Steven Isaacs and Sally Weintrobe

The clinical material and thoughts which make up this presentation arose from weekly meetings of a clinical discussion group which we formed in April 1990. The five of us had all qualified within a few months of that date. Consequently our analytic training cases had been with us for about the same length of time and transferred to our private practices within a few months of each other. The purpose of our meetings was peer supervision, support, and discussion of any issues arising from case presentations which related to our work as analysts. Although we did not restrict our presentations to our training cases, we began to notice how often similar anxieties and issues arose when we did discuss them. It became clear that, around the time of the transfer from being a Clinic patient to a private patient, they all experienced crises in their analyses. It is something of the nature of that crisis which we wish to explore in this paper.

We decided to write about this because as we worked through this fascinating and eventful phase of the analyses, we realized how important and different in quality it was to earlier phases. In effect the changes dramatically alter the parameters of the analysis. In some cases it involved an actual change of location. Central issues of the analysis and the transference were brought into sharp focus. This proved for some patients to be both dramatic and productive and by the same token to be too stressful for others to remain in treatment. In fact four of our ten patients ended their analysis at this point.[1] One analysis was terminated by the analyst for personal reasons and one patient continued to struggle with the effects of the changes but has managed to remain in treatment. Four patients have continued.

There are two issues which we have found ourselves discussing at length during the writing of this paper and we would like to mention them. Confidentiality has exercised us greatly both in our clinical presentations to each other and more particularly in writing this paper as there are clearly special issues in writing about Clinic patients who can be easily identified. In addition to the usual disguising of material, we have not identified which patients were seen by which analyst and all analysts are referred to as female. Of course the clinical substance and understanding in each case was the analyst's rather than the group's or the writer's.

The second issue concerns the usefulness of making generalizations. It is tempting with such a wealth of clinical material to abstract and generalize rather in the style of research findings. But as we began to do that we felt that we lost more and more meaning. We think that the drama of each individual's experience, interwoven as it was with their own personal story, conveys far more powerfully than lists and tables, the nature of this change in the analysis. For this reason we have opted to describe our thoughts and discussions under a few headings and illustrate our points with selected case material.

But before proceeding there are some theoretical considerations. Though there is a mass of literature on the psycho analytic setting, there is very little written about changes in the setting. In fact one of the essential and most often quoted features of the setting is its stability; its unchanging nature.

From 1895 onwards, Freud in his Technical Papers, outlined the conditions required to facilitate the development of the transference neurosis and thus the rules and features of the setting. He outlined two main areas: those constants which are specific recommendations and which govern behaviour and the less tangible yet equally important aspects summed up as the mental attitude of the analyst.

For Freud the constants included the six, full one hour sessions a week at the same time each day, use of the couch with the analyst sitting behind and out of sight, the fixing of fees and the observation of the fundamental rule. The mental attitude of the analyst requires "free floating attention", observation of the rule of abstinence and analytic reserve. In 1912 Freud wrote, "the doctor should be opaque to his patients and like a mirror, should show nothing but what is shown him".[2]

It is interesting to read in the report of the International Committee on the Setting in the Psychoanalysis in Europe Bulletin of Autumn 1992, that despite considerable differences in the constants, "we were unanimous in viewing the setting and its parameters as offering the conditions for promoting the analytic process.... The analytic process is characterized by the constitution of a transference neurosis analysable in the transference". We may debate the 3,4 or 5 session week (interestingly none was following Freud in requiring 6 sessions) and the 40 or 50 minute hour as against Lacanian Free Time, but in essence we still hold Freud's recommendations sacrosanct.

In considering the transfer of clinic patients to private practice we clearly are drastically changing

* This paper will be given at the Scientific Meeting on 5th May 1993.

1 One of the four left at the point of qualification.

some though not all of the constants of the setting. Indeed through our own development as analysts inevitably our analytic attitude will also change.

E.H. Etchegoyen [3] is very helpful here. On the subject of the analytic attitude he stresses the importance of the analyst holding the attitude in his mind, introducing the least number of disturbing variables. Within a well established analytic stance, the inevitable disturbances of the setting can be tolerated and valuably used to further understanding.

It was noticeable in our work that those patients who could tolerate the change were able to go on using their analyst's ability to analyse and to rely on her analytic stance and did indeed reap the benefits of the new material evoked by the changes.

José Bleger (1967) [4] offered a valuable contribution when we were trying to understand what might have happened to those who could not tolerate the disturbance of the setting. Bleger in shifting the emphasis from the analytic setting to the analytic situation draws attention to the interaction between the process and the setting. The setting, he tells us, is by definition stable. The process takes place within it and interacts with it. If the setting alters then new configurations will appear; put another way the setting becomes process. This we certainly found to be true.

He speaks too of how the muteness, immobility and unchanging aspects of the setting become a depository of psychotic anxieties. His idea is that the psychotic part of the personality takes advantage of the lack of change of the setting to remain mute. It is often when the setting is changed that the psychotic elements come to light.

Winnicott (1956) [5], approaching the subject from a different angle also speaks of occasions when the patient experiences the setting not as a symbolic representation of the analyst mother but as the mother. The past becomes the present and the setting rather than the interpretation becomes of primary importance. Here Winnicott is speaking of using a regression to understand an early environmental failure and to begin to allow for the emergence of the "true" rather than the "false" self.

Without going into the different theoretical views of Bleger and Winnicott, with their different approaches they both point to ways in which the setting can be experienced concretely; whether it be acknowledged and met by analyst and patient as in Winnicott's description or unacknowledged and mute as in Bleger's. Clearly a disturbance in the setting for these patients would have a far more disastrous effect than for more neurotic patients.

A related issue about which there is much written is the question of the setting and regression. The debate about whether the setting brings about the regression or merely reveals the regression inherent in the illness need not concern us here. Rather we need to acknowledge that the setting "holds" it in Winnicott's sense (1958) [6], or, using Bion's very different concept, "contains" it. (1962) [7]. A disturbance in the "holding environment " or "container" will have different meanings or consequences for patients at different developmental stages.[8]

Arnold Modell (1988) [9], adds something when distinguishing between the 'dependent/containing transference' and the 'iconic transference'. The 'iconic transference' might be called the transference neurosis by other writers while the 'dependent/containing transference' is that transference to the analyst and the setting which gradually develops as the analyst proves himself trustworthy and safe. He says, " patients are not only concerned with the fear of being overwhelmed by their affects, but they are also concerned with whether their analyst is able to contain and accept their effects". As the analyst proves his dependability the 'dependent/containing transference' grows and makes possible the analysis of the 'iconic transference', which will gradually diminish. For this process to work the setting must be a place of safety. " Patients need to know that their analysts will not recreate an archaic danger situation ". When we changed the setting by transferring our patients they all experienced an increase in anxiety suggesting that we had in fact recreated an archaic danger situation and had interfered with the development of the analytic process.

Finally some thoughts about the third party in the setting. Jacqueline Godfrind-Habers' report of the Committee on "The Setting"[10], emphasises the fundamental importance of the presence of a third person in the analyst's mind. She goes on to say that, "it is also important to emphasise that the existence of an external setting is indispensable to the analyst as a barrier against the ever possible shifts of a third person reference point". In the analytic life of every clinic patient Dr MacCarthy as Clinic Director is a very real third person, as indeed he is to the trainee analyst. His disappearance from the analysis leaves a third person vacuum which patient and analyst must adjust to as best they can.

Jane Temperley in her helpful paper "Settings for Psychotherapy" (1984) [11], is unusual in examining the implications for patient and therapist of practising psychotherapy in an institution. She draws attention to the importance of the 'institutional transference' for patients and we can support that view from our experience. She describes too how the "task of the Institution is an important parameter" exploring ways in which there may be conflicts in practising psychotherapy in certain institutions. Relating this to our own situation it raises the question of whether we have explored sufficiently the possible conflict between the Institute as a training organization and as a provider of Psycho-Analysis.

Finally she raises the question of the attitudes therapists, paid on a salary by that institution, may have to patients' fees and missed sessions. Although our situation is different there are parallels and we do discuss later in the paper ways in which financial matters seem to be under-analysed in the analysis until the move to private practice happens.

To return to our ten patients: in this phase of their analysis some common features occurred. The first concerned money.

MONEY

At one point in the year after qualification, but before our patients transferred to private practice, we began to feel that there was nothing else spoken about in the analysis except money. As we examined how each patient explored or avoided the subject of paying a direct fee to his or her analyst, rather than to a charitable institution, we noticed how the subject of money, often contained, and then revealed, central anxieties stirred up by the impending change.

One patient had received a NHS subsidy for most of his Clinic analysis. He paid £1 per session. His analyst came to regret that the issue of fees had effectively been excluded from analytic scrutiny for two years, as it began to emerge that the patient used money as a focus of excitement and conflict. In brief, she describes it thus: "Any difficulty over money - paying a bill or setting a fee - provided the patient with an occasion for drawing me into the kind of struggle for which he longed. This would fulfil two crucial and apparently divers ends: firstly to secure my total attention, so that as we became more embroiled, my capacity to think or to hold anything in mind, far less to move the analysis along, would be quite lost. Secondly, the tormenting, oppositional quality of this would allow my patient to feel close to me, while retaining his sense of boundary and narcissistic integrity. Effectively, we would live together in an eternal battling present". Throughout the analysis it had been important for this patient to keep as much as possible of the actualities of his life from his analyst. She knew that there was little money in the family; that his wife and their two children lived on his small salary. It was only in discussing the fixing of his fee, however, that the real disarray of the family finances emerged. What also came to light was the defiance with which the patient and his wife contrived to get themselves into debt over the period of the analysis. The patient was angry and humiliated at the exposure of his poverty and fecklessness and yet his analyst sensed a note of triumph too. She felt trapped and unable to see how she might ask for a reasonable fee without pushing them further into debt. Indeed she found it hard to see what a reasonable fee might be.

His use of the debate was taken up with him and after much work the analyst told him that in the New Year his fee would rise from £1.00 to £3.00. Haggling was followed by sullen acceptance.

Some months later a fresh aspect of the matter became available for thought. The patient was speaking of his plan to meet the increased fee out of his own pocket money rather than the family budget. In parallel with the money discussions, the analyst challenged the patient with the disjunction which there appeared to be between his growing capacity for insight and self observation in sessions and, on the other hand, the vista of unchanging misery which he represented as his life elsewhere. He really did seem to relegate his analysis to a pocket money budget rather than central financing. The patient conceded his intense wish that analysis should be seen to make no difference to his life, either from his own point of view or that of other people. Otherwise he would have to grant his analyst a reality and significance beyond the sessions and allow them both to know of his humiliating dependence on her. He had avoided any negotiation with his wife for support for his analysis and, with it, any admission that it mattered to him. The unrealistically low fee served both as a talisman of his denying his analyst's importance and as an enactment of it.

About a month before the summer break and several months after the patient had moved to private practice, the analyst told him that she had given a lot of thought to what they had understood about the fee as a marker of the reality of what they were doing, and that she felt that, as such, it should have a reality of its own and be raised beyond the level of a token sum. Since it would be unfair for this to happen all at once, she proposed that by the following Easter he should pay £10.00, the fee having risen to £6.00 in September and to £8.00 in the New Year. The patient did not respond at once but after several days spoke of an offer of some freelance work which he had turned down in the previous week, but had not mentioned in his session. After what she had said about the fee, however, and about it being up to him to find the money, he had thought again. Now, although he felt apprehensive about his ability to do the work, he had agreed to accept the project. The payment he reckoned would cover the increased fee over the coming year.

We hope this example of just one analytic couple's struggle with money matters around the change, illustrates the way in which the fixing of fees became a focus first of what had been avoided, then of the anxieties and habitual defences aroused and subsequently of constructive and productive work which moved the analysis into the next stage and a much deeper level of work.

ANXIETY AND THE LOSS OF DR MACCARTHY

The most noticeable response to the move to private practice was an increase in anxiety in all of our patients. Several experienced some form of claustrophobia, fear of getting too close and fear of entanglement with the analyst. Fears of something sexual happening were common and homosexual anxiety was particularly marked. A few patients expressed fears of madness or irreparable breakdown; one had a psychotic episode in a session. Separation anxiety was manifest by some and others showed fear of violence or injury.

There are numerous examples we could use to illustrate here and we would like to show you some of these.

There was the male patient whose analyst had moved consulting rooms. He reacted in two ways. At first he found the new room rather nauseating with its over cosy suburban feel and its net curtains. Later in the session he had to go out to check if his car lights were on. On his return he explained that he was really worried that his flies might have been undone and his analyst might have been looking at his penis. Following an interpretation about how intrusive he found the analyst's interest in him, he described how his mother had fondled his crotch through his jeans when he was an adolescent and had shown an hysterical concern that he might see her undressing.

Even more dramatic was the reaction of one female patient.

This was a young woman who had suffered an adolescent breakdown at 16. She was put on medication and sent back to school after six weeks. The subject seems to have been closed and the patient riveted together an obsessional character armour, which had served her reasonably well until the transfer to private practice. She began to fear her homosexual feelings towards her analyst and in a session found herself feeling that she was going mad in the same way that she had at 16. Then she had imagined she was having sex with God, being kissed by the Devil and being damned for it. In the session she lay rigid on the couch with her legs tightly crossed and her hand clasped over her mouth both wanting and fearing to be kissed or entered. Next day she spoke of her fears that sex was like an addiction. She said she feared that she was only involved with her boyfriend because she craved sex, and that she didn't really admire him physically, let alone in any other way.

Towards the end of the term she spoke about how she'd realized she could only really be attracted to someone of a particular body type and build, who rides a bicycle. (She was describing her analyst whom she had seen riding a bicycle to work that morning and other mornings that week.) She realized that her boyfriend relieved her of her fears that she had lesbian or incestuous feelings because he provided a physical outlet for her sexual feelings. She spoke too about her difficulty really letting her mind go into the analytic relationship.

On the last day before the summer break she spoke about her breakdown and how she realized that it was all still there in her mind in all its detail (hand over mouth etc.). She wanted to end the analysis, to put it all away, yet if she did that she feared that at some future time it could "unhinge" her. She did not return after the Summer break.

After the move to private practice patients found themselves in an unmediated relationship with their analyst. Although most patients had never met Dr MacCarthy, they received letters from him, usually regarding fees, and were aware of his importance in the institution. As we discussed our individual patients the exact part he had played in their analytic life varied of course. For some Dr MacCarthy and the Clinic seems to have protected them against fears of fusion. For some they were used as part of a defence against intimacy. For others they had helped to maintain a state of regression and an avoidance of internal and external reality. Perhaps for some he had provided an unacknowledged yet safe figure of attachment. Sometimes he was seen as providing supervision, assistance and containment for the analyst. But whatever part he had played his exit from the analysis was significant and sometimes traumatic.

A male patient greeted the news of the transfer with panic. Subsequently he became resigned to the change and explained how the clinic had been a safety net for him. He had believed he could phone Dr MacCarthy and that now he would lose his protection. He feared too that his analyst would not be able to cope without the Clinic Director's support and that would result in his analyst's getting rid of him. He spoke of losing his special status of Clinic Patient and then of being on his own with his analyst. His next thought was whether or not he would be able to use the Clinic Emergency Service.

The analyst understood this as fear of being alone with her and without a strong father to intervene. For the first time thoughts began to emerge of an all embracing mother who could trap him in a private, seductive, claustrophobic relationship. He was overwhelmed by waves of panic at the thought of this very private practice.

Although only three of our patients spoke directly of losing Dr MacCarthy, we nevertheless had a strong impression that his loss was important, at some level, to almost all of them. Interestingly enough the one patient we felt this did not apply to, had been fatherless.

Below we describe one further example of a male patient whose experience illustrates several of the themes we are discussing and particularly the present one.

For him, Dr MacCarthy had been an ever present transference object in the analysis. This was a man whose father had been considerably older than his mother and largely unavailable to him. The patient believed that because of his mother's childlike incompetence his father had hired a nanny to care for him. On receiving an initial letter from the Clinic offering him a preliminary meeting with his analyst he rang the Clinic office to check that the person he was meeting was the secretary who would be making the appointment for the real analyst. His fantasized "real analyst", if not Dr MacCarthy himself, was a senior male analyst. He was incredulous to learn that his analyst would be a woman.

When the analyst was nanny in the transference, the patient would walk into the consulting room on days when the bill was due, pick the envelope up off the table and pocket it without waiting for the analyst to give it to him. Understandable since his analyst was only the hired hand and he was paying Dr MacCarthy direct. When this was taken up with him *and the truth that the analyst actually wrote the bill dawned on him he was at first deeply shocked then very excited, saying " that means I have some of your handwriting at home" and then very frightened. He missed the next session and came late for a few sessions after that. This episode proved to be a warning of things to come.*

In the weeks before the transfer, the patient expressed the conviction that he just could not move into the analyst's private practice. He felt he couldn't pay a realistic fee and yet he couldn't accept a subsidy from his analyst by paying less than the going rate. It emerged that without the distant senior figure of Dr MacCarthy he would be left alone with his analyst and vulnerable to her caprices and demands; at her mercy. She emerged as someone who aroused his desire to be close, excited him, then humiliated him. In session after session he gave his analyst an experience of just how unbearable that was, by doing it to her. It also emerged that he feared too that without Dr MacCarthy being in the background to support the analyst, he wouldn't be able to continue his attacks on her. He feared her ability to survive him alone and brought frequent material relating to marriages and partnerships of various kinds in which one partner died or failed to withstand the attacks or behaviour of the other.

After considerable work he was able to contemplate remaining in analysis. Further anxiety arose as he began to wonder what his analyst must be getting out of the relationship. He spoke of his private dentist who fixed his broken bridge free because it was such interesting work. He thought she must be so interested in him that she had an unhealthy interest. In one session he heard the sound of his analyst moving her foot rhythmically and thought she was probably masturbating.

As a primary school age child this patient felt that his life dramatically changed. His paternal grandmother died and his father went into a depression from which he never recovered. He withdrew from the marital bed and the patient seems to have felt like his flirtatious mother's inadequate partner and supporter. His analyst had often speculated that he had experienced her as over close and seductive with him. It was as if the move to private practice pitched him back into that crisis and he seemed to be desperately fighting the emergence of an erotic transference.

Before leaving the subject of the loss of Dr MacCarthy there was one further feature. Sometimes we noticed a split between the idea of an impersonal clinic, represented by Dr MacCarthy, and personal contact with the individual analyst. The change from clinic to private practice threatened the maintenance of this split as it focused both sides of the split onto the person of the analyst.

One patient said that it was easier to cheat an institution of money than a person. He was aware that his fee was too low. He saw Dr MacCarthy as being conned and triumphed over as well as a persecutory figure who watched on and judged him. The cheating was then projected onto his analyst who was seen as dishonest and colluding with the patient, as he thought, by not telling Dr MacCarthy of his deception.

We have been speaking of the loss of Dr MacCarthy as a figurehead of the Clinic. For some patients there was a more generalized attachment to the Clinic or Institute.

TRANSFERENCE TO THE SETTING

For patients seen at the Clinic there was often a further change when the analyst moved to private consulting rooms. We became aware of the importance for some patients of a transference to The Institute itself. The loss of this setting then constituted an enormous loss, and its defensive function usually emerged at that point.

The male patient with the elderly distant father, who helped us illustrate the importance of the loss of Dr MacCarthy was also very attached to the Institute. Mansfield House with its air of genteel poverty and its historic connection with the Freuds, linked him with his successful and genteel grandparents and elderly father. It allowed him to maintain a split and bypass the humiliating relationship with his mother and nanny represented by the analyst in the transference.

In the case of one patient, Miss T, for whom there was a clear and important transference to the setting, we came to wonder if the move from the Clinic to the analyst's own premises had been somewhat premature and traumatic given her developmental stage.

This young woman had been the child of a single mother and had spent her early years clinging as closely as she could through the shifting of the latter's moods and locations.

She had always found it difficult to think about the transference, and interpretations of this kind quickly made her feel anxious and confused, fearful even, that she was being made fun of. It seemed that for the patient to begin to think about the disorder of her life, past and present, her relationship with her analyst must remain an invariant, a kind of psychic blind spot.

What she readily spoke of, however, were her feelings about the setting of her analysis and of its order and reliability. On a level of strict common sense she knew of her analyst's part in this. But in a more profound way it was the building itself which offered this refuge of sufficiency and calm. As with the heroine of Capote's novel " Breakfast at Tiffanys", for whom in the Fifth Avenue store there was the assurance that, " nothing bad could ever happen to one", so for Miss T she and her analyst undifferentiated in their personal poverty, could shelter in the basement of Mansfield House as she had with her mother in their years of travelling together.

Miss T learned of the move four months before it was due to happen. She struggled to think about *what it might mean, but beyond the practicalities she could not. As the weeks went by, her panic grew and she bitterly reproached her analyst, demanding help, understanding and an explanation. Nothing that was said to her had any meaning. It reached a crisis when she had a tattoo done, which she immediately regretted. Identified now with this disfigurement, inseparable from her own skin, she was appalled and terrified by the concreteness of her action and subsequent despair. Miss T made the move with her analyst and could speak of the shame of feeling a burden who had to be taken along. After a year, however, and after a crisis in which it seemed as if the analysis had broken down, she could think of the trauma of what she had lost.*

What the analyst came to feel about this patient was that at the time of the move, she was still in an almost fused transference. She had not had to provide for a representation of this in her inner world. Developmentally unprepared for the move she was driven to find some representation of herself in relation to the analyst. This she did in the semi-delusional enactment of the tattoo, with its terrifying break-through of primitive affect.

In concluding this section we report our thoughts about those who left their analyses at or soon after the moment of transfer. We wondered whether they were patients who would not have been able to accept and tolerate an analysis at all, had it not been in a clinical setting. We feel there was enough evidence to support this view.

THE SETTING AS A DEFENCE AGAINST DEPENDENCY AND ENVY

There were many examples available from our shared material to suggest that the Institute as a neutral clinical setting had served to defend many of our patients against the acknowledgement of their dependency and envy. One patient for example clung to the notion that his analyst's personal belongings, a newly upholstered antique couch and chair, were included as part of a standard pack issued to analysts by the Institute.

We have decided to describe Mrs Y 's experience because while illustrating the point about envy and dependency, we hope it also conveys something of the extremity of rage and pain which is stirred up by the sudden loss of these defences. It seemed, on several occasions, as if our patients experienced the change as powerfully as an assault on them.

Mrs Y, a woman in her 30s, had kept her analyst both at a distance and under her control. The analyst was required to be someone onto whom the patient could unburden herself or whom the patient could impress. Mrs Y had a painful and severe medical condition, clearly stress related, which she often used to bind people to her with guilt or anxiety. She managed to convey a belief that she should be looked after and not required to make much contribution herself. The analyst told her patient of the move to her own consulting room two and a half months before it took place. Mrs Y's reaction was to go straight home and paint her bedroom. The next day she raged at her analyst and accused her of plotting her downfall. She dismissed the analysis as useless, and suggested that her analyst only thought of washing machines. She called her a housewife with a hobby on the side. Later there was some confusion between "hubby " and "hobby" and she said she hoped it was the "hubby " that was on the side. With tremendous sadness the patient described how she had wanted to find a job she could do at home whilst she still had young children to care for and how her analyst had gone and done it first. Not only that but her analyst was "rubbing her nose in it".

As the weeks passed Mrs Y became fearful that her analyst would not want, or risk, such an angry patient in her house. She worried about the strength of her anger and destructive wishes and she was uncertain whether to view herself as powerful or harmless. By allowing her into her home, the analyst had shown that she wasn't afraid of her. Whilst she felt relief at this she also regretted a loss of power as she realized that her analyst didn't feel she needed to see her in a secure place. During this phase Mrs Y was able to begin to accept just how destructive she could be, and realized how much real damage she had done to her own body, as her way of getting at someone else.

Mrs Y was sad to lose the grandeur of The Institute, particularly the spectacular sweep of stairs. In that setting the analysis could be seen as something grand. In the analyst's home both she and her analyst seemed more ordinary. It became clear that meeting on neutral but glamourous ground had helped Mrs Y buoy herself up and had protected her from the inequality of their relationship, from her envy of and dependency on her analyst. She now had to acknowledge her analyst's independence of her.

Mrs Y spent the day following her penultimate session at the Institute walking around the area where she had been brought up. She described how furious she had been when her parents sold the house after she had left home, and how she had refused to go back and pack up any of her things. Her mother had to do it for her. A few days after the move menacing undercurrents warned of the rage and disturbances to come. Mrs Y wondered how prostitutes got their clients to leave. Murderers and rapists (old themes) reappeared in her material. Then her physical illness returned with a vengeance.

This patient was one who did survive the move. Despite her anger she felt the analysis was worth preserving. She recognised how much she would hate people to treat her as she treated her analyst; she wouldn't tolerate others trying to stop her having other relationships.

To conclude this section we return to the story of the male patient for whom Dr MacCarthy and The Institute had been important transference objects.

The patient had managed to make the transition into private practice and had decided to increase his fees too. However, he came back after the first holiday break in a desperately pained and hurt state, furious about his analyst's "lack of interest" in him. He decided to leave his analysis and fixed a termination date two weeks hence. During these weeks he confided that whenever his analyst understood something, he was filled with rage. It seemed to show him she was able to think which made him feel empty and brain-damaged in comparison. While they lived together in the basement rooms of this great house, the analyst as the hired hand and he as the little master of the house, the situation was tolerable. With a change in the arrangements he would be forced to take back his projected stupidity, emptiness and something which he felt was disgusting about himself, which the analyst's apparent low status in the institution had allowed him to deposit with her. For him this was intolerable and he left his analysis.

CHANGES IN THE ANALYSTS' RELATIONSHIP TO THE CLINIC AND THE TRAINING

We have been speaking of the changes our patients were faced with. We were aware too of our own loss of relationship to the Clinic and wondered how this might have played into the experiences our patients were having. When patients spoke of a fear of our being unsupported following the move to private practice there was an element of truth in it. We found we all reacted differently to the loss of supervision and relationship to the training and the Clinic. There were mixed feelings, of course. While missing the support, we sometimes felt anxious and insecure. At other times we felt exhilarated at being metaphorically "let off the lead " to explore our own style in the privacy of the consulting room. We were grateful to our patients for the part they had played in our training and qualification and at the same time were glad to be able to be more confronting now that we were no longer dependent on them to get us through.

As described earlier the forum for confrontation was frequently that of deciding on fees. This posed enormous problems for most analysts. Some were faced, following qualification, with an open ended analysis on an almost negligible fee. One analyst had two patients who were unlikely to be able to increase their fee to anything like the going rate and yet occupied ten prime hours of her working week. It was uncomfortable to acknowledge that this could affect a newly qualified analyst's attitude to hanging on to a slow and difficult patient year after year. The problem often arose, we believe, right at the beginning in the first contact between Clinic and patient. Traditionally the Clinic has needed patients more than it has needed fees. It is admirable that the Clinic does have a charitable aspect, and enables many people who wouldn't otherwise be able to afford an analysis to have one. But we felt that in some cases it meant that an unrealistic fee was agreed because the issue was not tackled in the consultation. Presumably the consultant was concerned to find suitable patients for the students and that was uppermost in her mind.

We recognise that newly qualified analysts now receive a continued subsidy. We wondered whether, whilst helping the individual analyst, this might actually have the effect of putting off the serious analysis of this central issue even further.

We were concerned that our patients might have picked up some of our dilemma about low fees. They could well have felt triumphant at having us tied to them, and/or fearful of our possibly changing attitudes to them or troubled by being a burden on us.

A further important change, in some ways similar to that being experienced by our patients was happening in our own analyses. We were all wrestling with the decision whether to stay or leave. For those who ended their analysis there was working-through and mourning to be done, and for those who stayed in analysis there was a sense of a very different experience with the loss of the training element, and an acknowledgement of our need.

We don't feel able to pinpoint exactly the effect these changes had on our patients. Rather we mention them because we find it hard to believe both that they wouldn't be picked up by our patients at some level and that we would always be able to distinguish between our own anxieties and those of our patients.

One example may be relevant here.

A female patient left her analysis at the point where her analyst was moving from the Clinic to private rooms. While fear of a psychotic breakdown and an emerging homosexual transference were paramount in her decision to leave, there was another factor. She wrote to her analyst, "....I've been made redundant and this has prompted me to reassess my position in a number of areas...." She had indeed been made redundant and had financial difficulties although this possibility had been discussed in the analysis, and an arrangement about reducing fees had been made, should this arise. But had this patient's awareness that she was no longer necessary to the analyst, and in that sense no longer in control of her analysis, made her feel redundant?

TABOOS AND BLIND SPOTS

From all that has gone before we hope that we have made the point that with the move to private practice and the end of the subsidy, issues which had previously gone unnoticed quite often came into sharp relief. At this point there was a sudden loss of defences which could make or break the analysis.

Recognising this led us to question whether we, our supervisors, seminar leaders, peers and patients had previously had blind spots which had created "no go" areas in the analysis. These areas particularly concern the decisions on fees and the meaning to the patient of paying a low fee to an institution rather than directly to their analyst. Equally important is the question of dependency and who is dependent on whom. The analyst's fear of losing her patient, while in training, is a very real fact. One area which we haven't focused on above is that of our trainee status.

Mr C knew which day his analyst received supervision. He taunted her about her need for supervision and her inability to have her own ideas on other days of the week! Although there was contempt in his taunts there was also a sense of relief and reassurance in knowing that there was somebody helping his analyst. This was a patient who had lost his father during his childhood and feared the loss of his analyst's supervisor as a familiar catastrophe.

This patient was unusual in that it was possible to talk to him about this as he brought the material so directly. One other patient spoke freely about his analyst's trainee status and used it constantly in an attempt to control her. However, we felt in most cases it was often such a delicate and resisted area, touching as it did on our own anxieties about our competence in the early stages, that some patients steered clear of the subject in order to protect the narcissistic vulnerability of their analysts.

Perhaps the real measure of the strength of the taboo is expressed in the dearth of literature on the subject. Our search was probably not exhaustive, but we found very little with the noticeable exception of M Philip Luber's article - " A Patient's Transference to the Analyst's Supervisor: Effect of Setting on the Analytic Process ". [12.] He found that the patient's fantasies about the analyst's trainee status and the fact of supervision were frequently avoided.

Mrs B asked her analyst about her student status at the preliminary interview. The analyst in reply wondered if the patient feared that the analyst would not be competent to help her with her difficulties. A perfectly proper response! However, when it came to the transfer, the analyst felt that there was an interest in her changing status in the patient's material. She raised it with her patient who replied, "Oh no. We dealt with that in the first meeting". The subject was hurriedly and anxiously closed by the dutiful patient.

We speculated that the patient had picked up, in her first communication, that this was a "no go" area and had become unable to think about it or explore her thoughts and fantasies arising from it.We wondered too if our supervisors and seminar leaders had also been protective of us in suggesting consistently that we were analysts, that this was an ordinary analysis like any other written up in the books and journals when clearly the reality is that these are extraordinary analyses with different parameters and ingredients. We feel that the differences are valuable in themselves, but perhaps due to our anxieties some of the interpretive mileage was lost. We are not necessarily advocating a declaration of our trainee status or suggesting that by declaring it the problem would go away. Rather we are saying, as we did with the question of fees, that we need to be clear about the reality and willing to keep space available in our minds for both our own and our patient's exploration of the subject.

We wondered why during the training little mention is made of the fact that it is a training for private practice. There seems to be a taboo surrounding the whole question of fees and little preparation for dealing with them. Perhaps Freud can shed light on this.

In his "Papers on Technique" [13], Freud points out that " An analyst does not dispute that money is to be regarded in the first instance as a medium for self-preservation and for obtaining power; but he maintains that, besides this, powerful sexual factors are involved in the value set upon it. He can point out that money matters are treated by civilized people in the same way as sexual matters - with the same inconsistency, prudishness and hypocrisy".

Could it be that we all need some further analysis before this aspect of the work can be taught without difficulty in the training ?

CONCLUDING REMARKS

We hope that in this paper we have drawn attention to the drama of this phase of these analyses for both patient and analyst. We feel it is a phase which tends to lack attention coming as it does after seminars and supervision. We have found it to be fascinating and important yet little described and discussed.

We hope too, to have highlighted how unlike an analysis in private practice and a Clinic Analysis is, and by implication what a lot we are asking of our patients when we transfer them at the end of two or three years.

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