Papers and Articles

What goes on in consultations?[1]

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Since the London Clinic of Psychoanalysis was founded in 1926, thousands of people, one way and another, have been seen through the Clinic to discuss the possibility of embarking on an analysis. Many of these have gone on to have five times weekly analysis with members of the Society or with candidates in training. Many of those people have come to the Clinic knowing that they wanted an analysis and that this could be a route to a lower-fee analysis, but many come not having much idea at all about what sort of help would be right for them. Psychoanalysis has waxed and waned in its reputation with the public, in how desirable it is seen as a form of treatment, and in how accessible it is to the general population. Partly in response to a period of distinct waning, in recent years the Clinic has sought to open up a conduit for people to find out about psychoanalysis as a treatment modality and to explore whether it might be for them. Our relatively new consultation service now sees over 100 new patients a year, some of whom contact us explicitly seeking low fee analysis, but many of whom just want to have a consultation to think about things and get a recommendation from us and then maybe help towards getting this established.

We are not so much in the business of 'selecting' 'suitable' people for psychoanalysis, but are rather operating on the basis of offering to people the possibility of considering their difficulties and their wish for some sort of psychological help from a psychoanalytic perspective. They then are able to decide if this is the treatment for them and we are in the position of deciding if this is something we would recommend and can provide in some form or another.

As a consequence, we are focussing on trying to define what is distinct about a psychoanalytic consultation, so that we can get better at offering this and also train psychoanalysts to become competent at this work. We make an explicit distinction between the idea of 'an assessment of suitability' and the idea of a psychoanalytic consultation (Crick, 2008), where the primary aim is a service to the person who may become a patient. Relevant here too is the role of the Clinic in identifying patients who can be suitably seen as training cases by candidates. We find that the wish to offer a clinical service to patients highlights the issues arising from the tension between the clinical needs of patients and the training needs of candidates.

We are trying in various ways to find out about what goes on in consultations in order to get more specific about what makes a 'good' consultation. Firstly we have a cohort of about 30 consultants in the Clinic who are learning by doing, seeing patients two or more times, writing up reports in a considered and structured way, some reflecting on their work in consultation workshops. There is also closer supervision for those who are less experienced and are getting training in consultation through the Clinic. Secondly, in the Clinic Panel, we discuss in detail all cases where a low-fee analysis is recommended by consultants and in this way accumulate knowledge about what can and does go on in consultations. Thirdly we put our consultations to perhaps the ultimate test when we place the patients into an analysis or other form of analytic treatment, either with candidates or through our referrals service.

We are beginning to try to draw all of this knowledge together in two ways: research and reflection on experience[i]. In a research project in the Clinic, carried out largely by Susan Lawrence, we are examining in detail a cohort of cases[ii] through from beginning to end of the process from first contact with the Clinic

[1] This paper will be given at a Scientific Meeting of the British Psychoanalytical Society on 1st July 2009, and will be taken as read. A shorter version presented at the meeting, together with clinical material which will be available for reference but not retained.

through to the establishment, or otherwise, of analytic treatment and its eventual outcome. We are also trying to be systematic about reflecting on our practice. There are periodic meetings for all consultants in the Clinic to discuss consultations and in this way to learn from each other and to accumulate ideas. Notes of those discussions, as well as those from the regular Clinic Panel meetings, are a valuable source of information and observations about the consultation process and the sorts of patterns that emerge. Some very helpful work went on here when a consultation was presented for discussion in February 2008[iii], and I hope that this evening we will be able to build on this by opening up for discussion two clinic consultations and considering the question of what goes on in consultations – and what difference does it make.

Many of you will be aware too of the EPF Working Party on Initiating Psychoanalysis, the WPIP, which was started about five years ago aiming to address the problem of why more people don't enter psychoanalysis and the question of how to get more people to do so. Like our new Clinic service, the aim is to figure out how to reach people who are seeking some sort of psychological treatment or therapy and who stand to gain from psychoanalysis, but who don't necessarily have prior knowledge of it. The WPIP derived its 'initiating psychoanalysis' name from an acknowledgement that more needs to be encompassed than the concept of assessment of 'analysability' and here again is a parallel with the developments in our own Clinic. There are 10 members of the WPIP research team from around European societies, and I have the good fortune to be one of them. Very briefly, this work involves offering clinical workshops at EPF and IPA conferences where a consultation or first meeting with a prospective patient is presented and discussed in considerable detail, and deconstructed using some specific focussing questions. The WPIP research group later examines the clinical material and the workshop discussion, carrying out a kind of 'meta' analysis and further deconstructing the key elements of the consultation. The aim is to identify the elements specific to initial analytic contact to elucidate what is specifically psychoanalytic about the interaction, and to understand it in the light of the final outcome. (Workshops are very popular at the EPF and IPA conferences – people are clearly very interested in discussing the initial contact with patients and the factors that may be critical in initiating an analysis.) The WPIP work has been very helpful to me in developing ideas about what we are offering and trying to improve on in the Clinic.

What we learn about the patient in the consultation process, how we do it and why.

I am going to introduce the discussion of the cases by briefly discussing some of the things that are becoming evident from the accumulation of observations of our work in the Clinic. For ease of speaking, I am going to mostly refer to the patient and the consultant, but would like to note that although we call the person who comes for consultation a 'patient', we are really taking about an individual who has in fact come to us to find out if he or she will, or will not, become a patient.

We learn a lot from the direct verbal communication about the presenting problem and the person's history, situation and wish for help, and this includes information gleaned from the pre-consultation form sent out by the Clinic.

But we probably learn more through observing what process unfolds when we provide a psychoanalytic setting in consultation. This setting facilitates a process of free association in and between both the individual and the consultant, and so the person's problem will be brought in some form into the meeting and will connect to what is going on between them and the analyst.

Something fundamental about the person, be it the predominant object relationship or defensive organisation, will be brought to the consultation, by one means or another, and will have a bearing on the transference to the consultant. If the consultant can be receptive to this, something affective will go on between patient and analyst. Barriers to the analyst's receptivity may be located predominantly in the analyst, or in the individual, or may be generated between the two of them in a way that may or may not be accessible either at the time or upon later reflection. But in a general

way, if we see an emotional response and association to what both the consultant and the patient says, about the history, or about the 'here and now', this suggests that in analysis it would be possible to follow and pick up on associations and work with this person.

When Clinic consultations were last discussed at a Scientific meeting (Crick, 2008), there was quite a bit of discussion about technique. Is it all free association in an 'analytic setting'? What about the value of a more structured approach and exploration of developmental history, sexual history, dreams and so on? Some felt that what emerges from the way the patient responds in consultation is more informative than any history taking could be. Others felt that having details of family history, an idea of what sort of childhood a person has had would helpfully illuminate the issues arising in the consultation process. I do ask all Clinic consultants to be sure to read carefully the pre-consultation information they have about the patient before they see them, so we do not expect consultations to take place 'blind', though what use any individual then makes of the information depends on their personal technique for consultation.

This issue of technique, about whether you treat a consultation as something like an analytic session in which the material is understood from the start in the transference, interpret accordingly and in this way further explore the transference as a way of understanding the patient, or whether it is treated as something different and distinct, is often thought to be a group issue. What we see in practice is that clinic consultants all seem to move between the two, gleaning facts to illuminate transference material and also exploring the transference, silently or by way of verbalised direct or indirect interpretation, in order to direct factual enquiry. The technique adopted also does depend to some extent on the patient and what seems to be most appropriate.

And the why? The assessment component of the consultation has several facets: Is the person able to make use of the analytic setting or does this have to be significantly modified? This will be a key question when it comes to making a recommendation for the treatment of choice for any individual. What information do we have about patient factors that are known to be indicative of whether analysis is likely to be the treatment of choice? What does information about family history, developmental factors, psychiatric history and more psychic facts, such as reported dreams, earliest memory, sexual fantasy etc., yield in terms of prognostic information that will affect the recommendation made? In the discussion at the February 2008 Clinic scientific meeting presentation, some said it is central, others that it is less important and is incidental to the process.

It is not sufficient to select patients, for example as potential training cases, by patient factor criteria alone. While a patient successfully established in analysis may fulfil the criteria, there will be others who don't but who are equally successful as patients, some who do but who don't get going in analysis. Any of these outcomes may be due to analyst factors, to the 'chemistry' between patient and analyst, or to the failure to pick up in consultation some positive or negative factors in the patient. And maybe this just tells us that attempting to predict the course of the unique, personal developmental process of an analysis is very, very difficult.

So rather than emphasising patient factors and selection, the *why* of consultation is primarily to offer the prospective patient sufficient psychoanalytic experience to enable them and the consultant to make a judgement about whether psychoanalysis is likely to be something they can use and feel able to commit to (Klauber, 1971).

Our research to date also confirms that consultation helps people to think about and get interested in the idea of psychoanalysis, and even in those who come believing that analysis is what they want, it can prepare them for it in a particularly personally relevant way. We have also seen that consultation can be deeply affecting, not just in a positive way but also can be quite destabilising and this is something we need to think more about when considering technique. However, the impact of a first psychoanalytic consultation cannot be emphasised too much. For the future analyst, it can make a consultant 'a hard act to follow'; but apart from how the transfer from the consultant can be difficult, the idea of there

being this important and substantial experience in the background can also be helpful in sustaining an analysis.

In our research we are trying to identify the factors that seem to be related to a good outcome – that is, where a person who has sought a consultation at the Clinic gets something really meaningful and helpful out of it, whether or not they go on to become established in the treatment of choice, which may or may not be full psychoanalysis. Naturally we also need to be identifying the factors that are related to a poor outcome – that is, where the person drops out of the consultation process, does not respond at all to an offer of treatment or further contact, or where the patient is disappointed and angry with the Clinic for not providing what is wanted or expected.

The fact is that each case is entirely unique and this makes it exceptionally difficult to define what makes 'a good consultation'. The nature of the consultations vary: not only do consultants vary in their skills and experience with this work, but also there is variation in what patients bring, and what impact any individual will have on any particular consultant and the process that unfolds between them. However, it is probably less difficult to identify what distinguishes a psychoanalytic consultation from some other psychologically-informed clinical situation.

From the WPIP work and also from our consultations in the Clinic, we can see that during the psychoanalytic consultation the consultant tries to find a way to help the patient to move from a banal, common form of dialogue to a psychoanalytically meaningful conversation. When this is possible, what takes place between consultant and patient is a shift from an ordinary form of interaction to another kind of conversation that opens up otherwise inaccessible thoughts and feelings; precisely the areas not reached in other forms of clinical meeting.

The consultant's technique needs to facilitate such capacity as an individual may have for free association and reflection upon that. This may involve interpretation from the consultant and, vitally, the subsequent observation of and listening to the patient's response. The consultant will also be thinking silently. Whether silent or voiced, both indicate the consultant's receptiveness to the patient (Bolognini, 2006 'concave' receptive stance). The consultant's processing of that, their internal mental activity, thinking, their observations of the pressures to act, will communicate itself to the patient for whom the emotional significance of some event, be it in the 'here and now' or the 'there and then', may be illuminated and their response to this will have a bearing on the 'change of level' of communication.

In some consultations, we can see that there has been such a shift but in others it appears to be absent and sometimes this is due predominantly to consultant factors, where something goes wrong, a poor judgement made about technique with a particular patient, for example. And sometimes it is due to patient factors, for example where a patient is so schizoid that meaningful contact is simply not permitted or where there is some other defensive organisation rigidly in place. Consultants will write of the consultation 'running into the sand', or it being 'hard to make contact', or describe a struggle to think about the person in the course of the meeting.

We notice in the consultation reports that there is far more described in some than in others about the difficulties with a patient experienced in the countertransference, with this being more immediately and powerfully experienced with some patients than with others. In those cases where there is a clear recommendation for a full low-fee analysis, there is in general noticeably less emphasis placed on the description of countertransference experience. Is this because our Clinic patients do not use projective identification? No, we would not say so, by any means. But perhaps it does indicate that we feel more confident about recommending for analysis those who do not only have predominantly projective ways of communicating available to them but who in the context of a consultation, and perhaps in everyday life to some extent at least, are able to rely on their capacities to communicate verbally, not needing to have recourse to the more immediate, powerful and vivid means of projection (Rosenfeld, 1987), until the analytic situation provokes more primitive anxieties.

What goes on in consultations

Consultants will inevitably be sometimes drawn towards, or right into, enactments in consultation – the question is the extent to which they can recognise this, reflect and recover in order to deepen understanding of what the patient is bringing. Something significant and deep about the patient may perforce be communicated through an enactment in the consultation that is only recognised later by the consultant, or only at the point where the consultation is discussed in a work discussion group or in the low fee Panel. This is a finding too of the WPIP where enactments are often only seen when the case is presented, or later in WPIP research group discussion.

We have found in the Clinic very clear evidence to indicate the value of having two meetings at consultation, in order to explore the person's response to a first meeting, the impact it has had upon them, and, in addition, to give the consultant time to metabolise and reflect upon the material, pressures to enact an object relationship, and the impact the person has had on them, perhaps with the help of supervision or peer discussion.

But where there is a shift, there has been a significantly meaningful consultation and it may or may not result in later analytic treatment being established. The hypothesis of the WPIP research is that analysis gets established if this shift has been seen in a first meeting, but in my view as far as consultation (for referral on) is concerned, this remains to be seen. We have found that people who have prior knowledge of or other experience or contact with psychoanalysis are much more likely to be offered analytic treatment, and it may be that they have, as it were, already experienced such 'shift' as is necessary for an analytic process to be initiated as a precursor to treatment.

Consultations

We will present two cases, both of which we would say are 'good consultations' and in both you will hear that there was a 'shift' in the ways we have discussed here, as well as different forms of communication. One case became established in treatment and the other did not. We will describe the consultation, concentrating mainly on the consultation process and then open the discussion.

- Is psychoanalytic consultation helpful? To patients as an experience, whether or not they move forward into treatment? To psychoanalysts in determining recommendation for further treatment or predicting outcome?

- What constitutes a 'good' or 'successful' psychoanalytic consultation? What goes on in a consultation that makes it more, or less, helpful or successful? If we can identify this, can we learn more about technique to help psychoanalysts learn how to do better consultations?

References

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End notes

[i] Periodic revision of guidelines for consultants take into account the observations that are made, where we are able to draw useful conclusions regarding practice and technique.

[ii] We are studying the 100 patients who requested a Clinic consultation in 2007 along a number of dimensions, including parental relationships, previous use of relevant services, the nature of the consultation process at the Clinic, recommendations and final outcome to date. The intention is to develop out of this descriptive study a research instrument that can be used in future prospective studies of Clinic cases.

[iii] A written summary of the discussion taken from notes and the tape recording of the meeting is available from Penny Crick at the Clinic penelope.crick@iopa.org.uk