CONTENTS

Foreword xiii
Anne-Marie Sandler

Acknowledgements xv

General introduction 1
Mette Møller, Sven Lagerlöf and Bernard Reith

Part I
‘Are you a doctor, Sir?’ 11

Introduction 12
Sven Lagerlöf and Elisabeth Skale

1 Katharina: Case histories from Studies on Hysteria (1893) 16
Sigmund Freud

2 The psychoanalytic initial interview and its method: A postscript to Freud’s case ‘Katharina’ by Hermann Argelander 24
Commentary 24
Elisabeth Skale

Paper 26
Hermann Argelander

3 A short overview of the development of ideas about ‘first interviews’ after Freud 35
Sven Lagerlöf

Part II
Consultation and referral 41

Introduction 42
Penelope Crick

http://www.psychoanalysisarena.com/initiating-psychoanalysis-9780415554985
4 Well, then, anything new? What that ‘first’ interview can teach us by Evelyne Kestemberg 48
   Commentary 48
   Alain Gibeault

   Paper 51
   Evelyne Kestemberg

5 Personal attitudes to psychoanalytic consultation
   by John Klauber 61
   Commentary 61
   Penelope Crick

   Paper 63
   John Klauber

6 The development of a therapeutic space in a first contact with adolescents by Catalina Bronstein and Sara Flanders 75
   Commentary 75
   Penelope Crick

   Paper 77
   Catalina Bronstein and Sara Flanders

7 The analytic encounter: A historical and process-oriented perspective by Jean-Louis Baldacci and Christine Bouchard 104
   Commentary 104
   Alain Gibeault

   Paper 108
   Jean-Louis Baldacci and Christine Bouchard

8 The analytical encounter by Jean-Luc Donnet and Michel de M’Uzan 120
   Commentary 120
   Alain Gibeault

   Paper 123
   Jean-Luc Donnet and Michel de M’Uzan

9 The profession of ferryman: Considerations on the analyst’s internal attitude in consultation and in referral by Stefano Bolognini 146
   Commentary 146
   Ronny Jaffè

   Paper 148
   Stefano Bolognini
Part III
The analyst’s struggle with the experience of a first meeting

Introduction
Mette Møller

10 Comments on transference and countertransference in the initial analytic meeting by Thomas H. Ogden
Commentary
Mette Møller

Paper
Thomas H. Ogden

11 Observations on the subjective indication for psychoanalysis by Josef Dantlgraber
Commentary
Peter Wegner

Paper
Josef Dantlgraber

12 The opening scene and the importance of the countertransference in the initial psychoanalytic interview by Peter Wegner
Commentary
Elisabeth Skale

Paper
Peter Wegner

13 The consultation in psychoanalysis and its ‘location’: Working on the frontier by Agostino Racalbuto
Commentary
Ronny Jaffè

Paper
Agostino Racalbuto

14 Consultation, reverie and story-telling by Antonino Ferro
Commentary
Ronny Jaffè

Paper
Antonino Ferro
II CONSULTATION AND REFERRAL

Introduction

Penelope Crick

In this section, the papers we have selected concern the psychoanalytic interview where a potential patient meets with an analyst in order to be referred on to the treatment of choice, which may, or may not, be psychoanalysis. These are not the ‘first meetings’ of a potential psychoanalysis, but are the ‘assessment interviews’ or ‘consultations’ commonly carried out with patients in psychoanalytic institutions, and also in the private practice of analysts who elect to work in this way to guide or ‘ferry’ (Bolognini, 2006, this volume p. 148) would-be patients for whom it is appropriate towards analysis by referral to colleagues. These are not, then, the ‘two-person’ situations where analyst and future patient meet and perhaps ignite between them the fuse of an analysis, but are by contrast, ‘three-person’ scenarios: you, me and the potential other, absent, as yet unknown, future analyst.

In the former, we can assume to some extent at least that both analyst and future patient come to it in the expectation that some form of treatment with the interviewing analyst is what is sought – even if this does not turn out to get initiated by that meeting. In the latter, the expectation is that a referral on to another clinician is the most likely outcome. But for both, at this starting point, the consultation is an open-ended situation: the person may not know what they want, they may not know if they wish to become ‘a patient’, or ‘an analysand’, or know very much at all about what psychoanalysis may involve psychically, emotionally and practically, or even if it is the approach they want to take. The consultant analyst equally may not at the outset know much, if anything, about the person at all, let alone whether the person is going to be able to make use of analysis, whether it would be the treatment of choice that they would recommend or whether some other form of treatment would be more appropriate.

Whatever it is that goes on in the process of a psychoanalytic consultation-for-referral is no doubt very similar in many respects to what goes on in a first interview of a potential analysis, and it is this ‘something’ that the EPF Working Party on Initiating Psychoanalysis (WPIP) is exploring (see General Introduction; Møller, Lagerlöf, & Reith, this volume, p. 1). However, the ‘setting’ for a consultation which is conducted with the intention of then making an appropriate referral on for treatment, is a distinct one which has implications for the rationale, expectation and technique of consultation. In examining examples of both ‘types’ of consultation in the WPIP research work, we have found that there is a lot to be learned from the
‘three-person’, referral on, consultation scenario which can usefully inform thinking about the ‘two-person’ consultation.

Not only will the analyst’s ‘internal’ setting be significantly different and distinct if they are seeing someone that they know they will not be taking into treatment, but also the external setting may be different, the work may be carried out in or on behalf of a clinic, other professionals and reports and letters of referral may be involved.

Such meetings are often referred to as ‘assessments’, and behind this is often the assumption that the consultant analyst will ‘assess’ the patient, much as a doctor will make an assessment of the condition and symptoms of an unwell patient, in order to be able to ‘prescribe’ appropriately. Literature on the subject will discuss the ‘suitability’ of a person for analysis, the factors in a person that are thought to make them more likely to be ‘analysable’, and would, it follows, predict ‘a good outcome’. Cases for candidates to see as training patients are generally selected on this model. However, analysts universally will testify to the fact that many a prospective ‘good case’ has turned out to be very complex and technically demanding once the process of analysis is underway, and equally that many cases felt to be more dubious as far as ‘suitability’ is concerned, turn out to do very well in analysis and to be rewarding patients.

The inadequacy of a simple ‘patient factor’ approach to ‘assessment for psychoanalysis’ is well illustrated in a recently published study in the USA (Caligor et al., 2009). The decision to recommend analysis, or not, was made on some basis, but not, it was found, one that was captured by standard tests tapping patient factors. In practice the variables leading to a recommendation for analysis seem to be more implicit to the particular individuals involved and not accessible to conscious conceptualization.

So, if there is no convincing clinical evidence to suggest that there are assessable variables in prospective patients that predict a positive outcome in psychoanalytic therapy, why do we have such systems of consultation and assessment? Why not just offer an analysis to anyone who thinks that they would like to work in that way and see how it goes? Why not just start straight in with the two-person situation of analyst and patient, as recommended by Rothstein (1994, this volume, p. 281) and avoid all the complications of the assessment, referral and ‘three-person’ scenario?

In the context in which many such consultations may take place, one important reason is that first and foremost the assessment will need to take sufficient account of the patient’s clinical needs in terms of whether a psychoanalytical therapy is the treatment of choice. In public health and other services where people who are very troubled or disturbed may be seen, perhaps referred by mental-health professionals out of desperation or optimistic lack of knowledge about the scope of psychoanalysis, perhaps self-referred for similar reasons, the psychoanalytic consultant may need to make an initial judgement about how much at risk the patient might be as a result of embarking on a psychoanalytic exploration. This may well be beyond the normal level of a basic ‘psychiatric screening’ and, indeed, not be related to the presence or absence of obvious psychiatric symptomatology, but be more something that arises out of the person’s initial response to the psychoanalytic setting in a consultation. Milton (1997), in a very helpful paper entitled ‘Why assess? Psychoanalytical
II: Consultation and referral

assessment in the NHS’, describes how, once the consultant is reasonably satisfied that the prospective patient will not be at physical or mental danger from this form of treatment, the level of the consultation can deepen towards a more complete exploration of whether this approach would be likely to suit them. She gives vivid clinical examples illustrating how a sensitive consultant can pick up when a patient’s response to the psychoanalytic setting in the consultation indicates that their safety may be put at risk as a result of becoming involved in an analytic process.

It can also sometimes be very helpful to the person to have something of a psychoanalytic consultation to help them to find out enough about the process to see that psychoanalytic treatment would not, in the longer term, be something that they are in a state to be able to manage. Some individuals can be relieved to be able, with the help of a psychoanalyst, to acknowledge and thus begin to face up to the extent of their disturbance and to relinquish the defensive fantasy that the idealized ‘psychoanalysis’ would resolve or remove their pain.

Another and perhaps more ethically complicated reason is to do with the economics of limited resources. If a person is seeking treatment that is to be funded by the state or by a charity, then this ‘setting’ will dictate criteria that need to be met before treatment can be provided. The organization concerned will almost certainly have limited resources and have an ethical duty to ensure that these are allocated in the most equitable way; that is, to the people who are most likely to be able to make use of and benefit from the available treatment vacancies. This of course highlights one aspect of the ‘assessment’ component of psychoanalytic consultation: the psychoanalyst must, in the broadest terms, assess the capacity of the patient to make use of psychoanalysis, and in particular the psychoanalytic setting that would be available to be allocated. For example, in the case of organizations where patients can receive low-fee treatment from candidates in training, then it is in the interests of both candidate and prospective patient that the assessment has taken account of the relative inexperience of the candidate, and perhaps also the advantages of the analysis being contained within a training and supervisory structure.

Psychoanalytic consultation gives the prospective patient the opportunity to make their own assessment of whether this is an approach that they feel interested in and able to work with. All the papers in this section emphasize the value and importance of the patient having an experience in consultation which allows them to make as informed a decision as possible about embarking on a future analysis.

The papers by Klauber and Bolognini in particular emphasize the value for the individual of being able through consultation to explore and understand something of the motivation for seeking treatment now. What is the person’s desire to communicate, and can communication develop to a deeper level in response to interpretation? Or, as the consultant may learn from the person’s response to exploratory interpretations, is this something that their defensive organization cannot accommodate? Does the person want to explore and face painful feelings? Until someone has experienced something of the process, has found out experientially about what is involved in the analytic process, their motivation may well be unrealistic. For example, the person may be keen to come along provided s/he can remain passive while something is
done to her/him. Having some interpretive work can give a much better idea of what is going to be involved and thus allows the real motivation to emerge. Not just the consultant but also the potential patient may learn a great deal from this and thence have a good basis for being able to make a decision about next steps.

The question of what and how much is interpreted about what can be discerned about the patient’s discourse presents itself at once: in psychoanalytic consultation, is interpretation offering containment through understanding or does it run the risk of being unhelpfully intrusive? Klauber warns against the temptation to attempt a ‘mini analysis’ and suggests that what should be offered is: ‘enough tentative explanation and interpretation to give the patient a glimpse of the emotional and intellectual processes involved without unduly seducing him’. A trial interpretation also gives the patient the sense that they are understood, or at least that the consultant is making an effort to try to understand them. And this can, in itself, help the person in getting to deeper and more meaningful areas.

There are those who argue against the use of trial interpretations – on the grounds that it makes the patient feel as if they have opened up to the interviewer and have got close to them through having gone a long way towards being understood by them. However, this does not need to be a negative experience for the patient: the impact of a first consultation on someone who may never have really spoken about themselves in such depth, and perhaps not had the opportunity before to discover the meaning of what has been incomprehensible or disturbing, can be profound and significantly therapeutic in its own right. Interpretation does not, of course, have to be verbalized to the patient and a thoughtful and sensitive consultant will be judicious in what they decide to share with the patient and what they keep in their minds and find more tangential ways to explore other than through direct interpretation.

But if a ‘psychoanalytic experience’ is to be offered in consultation with an analyst who will not go on to be the analyst for this patient, then what of the transference that is stimulated by the analytic setting and inevitably becomes part of the currency of the interaction? What kind of technique is used in such meetings to both evoke the material and emotional experience that makes them ‘psychoanalytic’ and yet also protects the would-be patient and their defences from potentially unhelpful or even traumatic intrusion? How should a genuine but highly limited psychoanalytic experience be offered so that, while it may be quite challenging, it is more likely to be experienced as helpfully containing rather than damagingly intrusive? Most who advise on the conduct of psychoanalytic consultation suggest that two meetings are most helpful – to give both the individual and the analyst the opportunity to digest their experience, to dream, associate and think about their response and to bring this back to learn from in the second meeting; and for there to be a proper ‘leave taking’ and ending of the intense, potentially very meaningful and yet constrained process.

This implies a potentially considerable degree of involvement by both parties; Donnet and de M’Uzan are among those in the papers that follow who advise against the analyst getting ‘too involved’ by which they mean that the analyst should retain a receptive stance, not being too active but rather observing relatively silently how the patient responds to the setting. However, this does not mean that the

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analyst is not internally very involved, and Bolognini and Klauber in particular stress the demands that this particular sort of work places on the analyst. Being receptive in the intensive and condensed situation of consultation, whatever the setting, is hard work, requiring a lot of energy and a different sort of perhaps more active concentration to that of an ordinary analytic session.

For example, the intensity of the consultation can result in the consultant getting unconsciously drawn in to an enactment of the patient’s internal object relations or identification with some aspect of the patient so that their judgement about the recommendation is influenced in a way that might only be perceived by the external ‘third’ of the Institution. At the London Clinic of Psychoanalysis, for example, consultations are often discussed in work groups and recommendations reviewed with the Clinical Director, before a final decision about what to offer to the patient is made. In this way, blind spots or enactments can sometimes be identified, which helps to refine or more thoroughly understand some important aspect of the potential patient. Inevitably such enactments are liable to take place whether it is a first interview or a consultation for referral on – in the former, there is the rest of the analysis ahead in which this can be understood and worked through, but in the consultation, the perspective made possible by the consultant having the ‘third’ in mind, be it institution, clinic or prospective referred-to analyst, can be very helpful to the consultant’s thinking as well as clinically very valuable in ensuring the best care of the prospective patient at that point in time.

Donnet and de M’Uzan, and also the other French papers, put special emphasis on the three-person nature of consultation and how the experience of this constellation can in itself be made a valuable aspect of the assessment of the capacity of the patient to use analysis. They note that a very positive indication of a person’s capacity for analytic treatment will be present when it is clear that the future patient recognizes that the transference belongs to him/herself and is not specific to the consultant.

The consultations that are discussed in this section are often carried out within an institution: a prospective patient may well elect to seek consultation and advice from an institution or intermediary with a good and trusted reputation, allowing them to have time and opportunity to think about and decide what they want to do rather than going direct to a potential analyst and feeling that they have started right in on a two-person relationship without having had a mediating stage. Of course much may be learned about the person, their motivation and the nature of their anxieties from their choosing to approach an institution and their fantasies about it as revealed in their communications around the setting up of a consultation.

The crucial role of the institution in giving space through psychoanalytic consultation for the fostering and development in an individual of an internal therapeutic arena is highlighted in some of these papers. The individual’s decision to become ‘a patient’ may be relatively straightforward, or, as illustrated in the clinical material in the paper in this section by Bronstein and Flanders, the decision to commit may arise out of an appetite for analysis being stimulated by the consultation process, where it could truly be said that a psychoanalytic process has been initiated in the patient as a result of the consultation work.
The institution which provides the consultation can have a number of important roles, not least in the patient’s fantasy, where it may be the institution which is the third object, perhaps helpfully facilitating the relationship with the consultant, perhaps rather seen as cruelly and bureaucratically preventing the relationship from continuing. It may also be the continuing and more ‘neutral’ link that holds the patient between consultation and eventual referral on to analysis or other recommended treatment of choice; in which case it may be that for the patient the institution is the constant, facilitating object, helping them through the process of detaching themselves from the consultant who they may experience as having ‘rejected’ them in their fantasy of being able to continue into treatment.

The consultation will, ideally, come to an end with the consultant having discussed with the prospective patient what will be the next step in terms of treatment. There may be a referral on to a colleague or the person may be placed on a waiting list managed by the institution. Or some other form of treatment may be proposed. Whichever of these, the consultant is carrying a considerable responsibility, which they may or may not be in a position to share with the potentially containing institution. Bolognini makes a particular point about the demand on the consultant who has to find a way of supporting ‘handing over’ the patient whilst at the same time renouncing the status of having been the important and significant other. The community of colleagues or more specific institution into which one is ‘referring’ can at this point provide a very particular support.

But what of the patient, left waiting, perhaps for some months, only to have to form a new relationship with someone else altogether? The transition to the future analyst can be very difficult and unless handled with care may result in the person breaking off treatment early on. Klauber observes that the patient will be sensitive to whether the referral on is made with the personal qualities of both patient and future analyst in mind or whether it is the result of some more random or routine process. However, if the ‘ending’ with the consultant is worked on and made part of the consultation experience, then the positive aspects of the good relationship will have more of a chance of being internalized and kept safe to remain as a helpful reference point later when on the waiting list or when treatment has started. The consultant and the consultation can become a valuable object in difficult times in the analysis in the future, the one who can usefully stay in the patient’s mind as a trustworthy ‘midwife’ to whom gratitude is due for having aided in the initiation of an idea of what they might get from analysis.

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