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# **Medical psychotherapy consultation: Psychoanalytic psychiatry for the patient and professional**

## **Abstract**

**Aims and method** To evaluate a psychoanalytically informed medical psychotherapy consultation service offered in acute and community psychiatric settings in an NHS Trust as a basis for sustaining the service in the future. We sampled 87 patients from a total of 210 referred between 2006 and 2013 to ascertain demographic and diagnostic profiles and outcomes of the consultation process. We conducted an online survey of local consultant psychiatrists' views about the service, and undertook a thematic analysis of the free text comments. We also conducted a survey of members of the Medical Psychotherapy Faculty to ascertain whether similar services existed in the UK and had been evaluated.

**Results** Of the 87 patients, 48 (55%) had a diagnosis of personality disorder. The survey of local consultants showed high levels of satisfaction with the service. The main themes were problems for the consultant precipitating referral, improving understanding, help with case management, containing risk, mitigating clinical impasse, changing psychiatric practice, and enhanced team working. While some medical psychotherapists offered similar consultation to mental health teams, the particular structure of the Leeds service was not used ('consultation sandwich') and no evaluations had been published.

**Clinical implications** The evaluation provides evidence that the medical psychotherapy consultation service offering a psychoanalytic understanding benefits both patients and professionals in circumstances of clinical complexity, risk and uncertainty.

**Declaration of interest** Dr [redacted] established and leads the Medical Psychotherapy Consultation Service in Leeds.

## **Introduction**

The Medical Psychotherapy Consultation Service in Leeds was established in 2000 to attempt to address a problematic culture of patients being referred to the psychotherapy service for assessment who were unlikely to make use of psychotherapy by professionals for whom there had been evidence of a struggle to help the patient. The aim was to counter the assumption that taking the patient away from the referrer was the only way to help and to begin to think about the patient with the referring professional. The cultural change sought through the consultation approach had two ambitions – to enhance the care of the patient and to build a relationship between the psychotherapy service and the rest of the mental health services – or rather the professionals in them. The aim of the model of consultation developed is of a psychoanalytically informed ‘sandwich’ – the first and final layers of ‘bread’ being professionals’ meetings to think about a patient with whom the psychiatrist and team feel stuck, focusing on the countertransference of the professionals, both in relation to the patient and in relation to each other. The filling or lack of filling in the consultation sandwich in this dynamic field is the patient who the consulting medical psychotherapist may or may not meet – the latter situation being informed by the professionals’ shared view of whether or not having a ‘meet in the sandwich’ would be in the patient’s (and/or team’s) best interests.

## **Aims of psychoanalytic consultation**

The aim of the consultation process is to try to enhance understanding of the *dynamic field* of the patient as an application of the analytic situation of the patient and professional relationship (Baranger and Baranger 2008). The transference and countertransference form the bi-personal dynamic field of the one to one analytic situation. In the typical context of working with complex patients in mental health teams multiple professionals are involved and the bi-personal field is multiplied with many personnel in a sometimes fragmented field. The conscious or unconscious emotional experience of each professional may be to feel differently from one another about the patient and also to hold different opinions about how best to help or to face not being

able to help the patient from the other professionals (splitting in the individual and between individuals). This dynamic field involves projective and introjective identification in its structuring and the emotional experience oscillates between integration and splitting, animation and suspended animation, change and stuckness. These emotional processes occur within each person in the dynamic field and between them as a consequence of the changes occurring in their relationship with the states of mind of the patient. The Barangers described the analyst's work as allowing oneself to be involved in the transference-countertransference micro-neurosis or micro-psychosis and interpretation as a means of simultaneous recovery of parts of the analyst and the patient involved in the field. In the dynamic field of the spaces between patient and professional and between professionals in consultation seen through a psychoanalytic lens, the sometimes disintegrated emotional field of investigation may necessitate a focus only on the professional experience of their patient in order to think with them about the patient or requires meeting with the patient after reflection with the professionals. The consulting therapist echoes the analytic situation of allowing themselves to become involved through the professional experience and to facilitate their recovery for the professionals of parts of themselves from the patient experience – the word recovery being used in the psychoanalytic sense of recovering projected parts of one's mind, or returning aspects of the affective experience of the patient to themselves. The psychiatric emphasis on the affective experience of the patient as other is subverted in the central importance given to the affective experience of the professionals as emotional data through which to understand their patient. This *affective subjectivity* (Yakeley et al 2014) gives weight to the feelings of professionals as the primary focus of consultation, restoring subjective emotional experience to a central position in a scientific field which may be suspicious of subjectivity and disavow the value of learning about the patient through one's emotional experience of them.

It may seem paradoxical in this light of thinking about the emotional wavelength of the patient and our identification with them as a tool for thought that some of the consultations that the consulting therapist offers do not result in meeting the patient.

However, while this limits the countertransference experience to reliance on hearing the emotional echo of the mind of the patient in one's colleagues, not being directly involved in the unconscious to unconscious communication can allow a freedom to see and reflect. This reflective space – the freedom to have one's own mind - can be lost when one is drawn headlong and mind short into a visceral experience of participation – reminding one of the difference between the chicken and the pig's relationship with a meal of bacon and eggs – the chicken's involved - but the pig's committed.

### **1. Consultation vignette – being liberated**

*A consultant psychiatrist working in a pre-functional model was responsible in both community and the ward for the patient. She was anxious about the discharge of the patient from the ward as she feared this would lead to the death of the patient. The patient was not seen in this consultation and part of the dynamic field was to recognise the experience of omnipotence in trying to reflect on someone in danger without seeing them. The risk of death was less immediate for the consulting medical psychotherapist and he was therefore both compromised in not having direct clinical contact (one arm tied behind his countertransference back therapeutically) and liberated by being able to use this relative emotional distance to assist the transition from the brick mother with those more acutely emotionally involved.*

In this consultation the experience of the threat of patient death (being liberated from the pain of living), discharge (being liberated from the brick mother) and the consultant offering consultation having a space to think (being liberated by virtue of emotional distance and space to think).

### **The patient and professional bastion**

The development of the Baranger (2008) concept of the analytic situation as a dynamic field in this paper is to extend this unconscious dynamic field to include patient and professional relationships which are not analytic situations but which nevertheless reflect

transference and countertransference conflicts recognised in the analytic relationship. The description of the analytic relationship as a dynamic field being extended to include the patient and professional relationship in other treatment settings also extends the Baranger's concept of a *bastion* – a mental defensive fortification which acts as a kind of mental reserve or *psychic retreat* in Steiner's terms (1993) – a pathological or perverse organisation which is an area of omnipotence and resistance in the patient. The bastion is a 'no go area' which serves a protective function in phantasy for the patient as integral to their defence of their sense of self without which they would not survive. The analogous bastion in the professional might be considered a position taken which if breached would jeopardise their identity and their reparative function - in particular an attack on their loved object which is their reparative function. This develops analytic theories of resistance to change by including the impact of the professionals' desire for change predicated on ignoring the relationship factors which threaten their idiosyncratic reparative *raison d'être* which requires disavowal of their countertransference and pursuing a treatment based on their own reserve of omnipotence – a professional bastion.

It can also be seen that the bastion, existing in a bi-personal field exists between the patient and professional involves the omnipotence and resistance of the professional. For example, the imperative to cure, the denial of limitation, the need to be loved, the anxiety about being hated, all may contribute to the professional resistance which may itself become a bastion – a no go area which remains hidden and because the bi-personal bastion remains unconscious it becomes a dynamic field which is inimical in psychoanalytic terms to change. Resistance to change is a mutual phenomenon just as mutative change is a mutual phenomenon.

The clinical aim of the consultation service is to provide a vicarious service to the patient by helping the professionals who work with severe and sometimes intractable disturbance in people for whom the majority of interventions have been of limited help. This psychoanalytic aim is to foster understanding of what might lead professionals to

feel stuck in the care of a particular patient, with the professional conflict in facing the limits in the capacity to help and the feelings associated with failure to help being frequent underpinning themes. . The potentially painful experience of facing limits in the capacity to help a patient and becoming aware of the associated feelings requires a reflective position in which there is a credible and non recriminatory setting in which to describe their emotional experience of the patient and one another in a way that shifts the focus from the problem of the patient to the problem between patient and professional without shifting to a sole focus on the problem of the professionals. This is an application of psychoanalytic thinking in psychiatry which is without a mandate to offer psychoanalytic psychotherapy in the consultation. For such a psychoanalytic perspective for psychiatry to become part of the setting consultation necessitates a reflective cultural context. Consultation can be seen as a form of 'acute reflective practice', and the organisational culture becomes more receptive if reflective practice is established in the institution, as a form of 'chronic consultation'. Discussing a particular patient with experience of the value of reflecting on one's feelings is helped by a culture in which this happens ordinarily week by week in reflective practice groups on in-patient wards, in community teams, crisis teams etc (Johnston and Paley 2013).

## **2. Consultation vignette – being loathed**

*A patient was very critical of her care coordinator and in the consultation the consultant psychiatrist seemed to echo an experience of dismissing the care coordinator. In a series of professionals' meetings it transpired that a psychotherapist in the third sector was seeing the patient who was idealised and the care coordinator left holding the bad feelings of being impotent and ineffective. The psychiatrist was in the position of holding the privileged position of prescriber but was it emerged anxious to please the patient and not to fall from grace. The withdrawal of the care coordinator and the end of the therapy allowed a split to be crystallised in which the psychiatrist was loathe to be the bad object for the patient as a new care coordinator soon took on the role of attracting the patient's bad feelings.*

In this consultation the pain of being loathed - or experienced as the bad object - is being moved round – the projective requirement is for a scapegoat for bad feelings so the bastion of being the good object can be maintained.

The psychoanalytic consultation process offers an opportunity for the professionals working with a patient to reflect on the emotional experiences evoked in them, both in relation to the patient and each other. The invitation to consult on behalf of patient and professional may unconsciously be born from a helpful worry about veering towards becoming increasingly impatient and unprofessional. In 'Suffering Insanity' Hinshelwood (2004) describes the emotional difficulty for professionals of bearing psychiatric work with people suffering psychosis. The psychotic patient might be considered an ill but legitimate patient while those often experienced as illegitimate are those diagnosed with personality disorder or more precisely relationship disorder, with whom the professional experience of being disturbed lies with reminders of everyday problems of dependency, destructiveness and doubt – in this sense they are suffering *sanity* – the reminder of the ordinary human conflicts rather than the extraordinary but more remote suffering of madness (Johnston 2010). The psychotic wavelength described by Lucas (2009) describes the way of feeling one's way into the dream furniture of the mind scattered from the home onto the pavement of the outside world in psychosis. In the experience of those with personality disorder the personality wavelength may be closer to our own frequency and all the more disturbing for this psychic proximity to the inside, a disturbing resonance resembling a damaged version of the furniture of our own home.

The process of vicarious change on behalf of the patient lies in the professional beginning the process of working through their countertransference conflicts made manifest in the consultation process (Brenman-Pick 1985). However, consultation is not psychotherapy and offers only a limited, indirect and ultimately private opportunity for professional reflection which may not become manifest and if it does can only be evidenced in subsequent work within the dynamic field, within the patient, between patient and professional and between colleagues.

### **3. Consultation vignette – being limited**

*A care coordinator desperately wanted to secure what she called an exit strategy for what she felt was a hopeless contract with a patient who like her was a nurse and who valued her highly. In professionals' meetings she disclosed her struggle with the patient and her desire to rescue the patient in reparation of loss in her personal life. The patient being seen allowed a recognition for the consulting therapist of the pain for the patient of mourning his career and in subsequent meetings with the care coordinator an exit strategy emerged as the care coordinator began to accept the limitations professionally, not only for the patient, but for herself and it was only in this process of working through the limits of her reparative potential that she could let the patient go. Though she felt he could not leave her, to allow separation she had to be able to leave him and what he represented for her – most of the personal aspects remaining implicit and private..*

In this consultation the challenge of facing one's limitations in the process of mourning the capacity to cure can be seen as a patient - professional bastion in which the identification between a patient and professional lies in the mutual pain of facing impotence and disappointment.

The application of psychoanalytic thinking to quotidian psychiatry lies in paying close attention to the feelings of professionals, their behaviour and their struggles, to provide a reflective space to make manifest their uncertainties and unconscious doubts (Feldman 2009). Professional shame in such exposure is inevitable and the establishment of this service has required a relationship of confidence and credibility in the medical psychotherapist leading it to be developed so that it can be used meaningfully and sought again.

### **4. Consultation vignette – being like me**

*A psychiatrist was ashamed of her struggles in the face of trying to help a young doctor whose resistance to all her best efforts to help denied the feeling that the doctor reminded her of herself. The consultation process could not be about the treating*

*psychiatrist but in recognising an unconscious echo and putting this to the back of the mind, it was possible to see that the young doctor had got under the older doctor's skin in a tantalising and painful promise which was never fulfilled. Focusing on the ways in which the doctor patient could not allow herself to be a patient was implicitly informed by the experience of professional resistance to receiving help. In the triangle between a doctor as a patient, a doctor treating her and a doctor consulting with them was a less exposing space in which there was a doctor who found it easier to treat the problem in the other, harder to face the need to have a problem to treat in themselves.*

In this consultation the unconscious identification between the patient and the professional leads to impasse – a bastion connected with the no go area of treating someone who exposes the professional resistance to experiencing the need for help.

## **Method**

The evaluation of the medical psychotherapy consultation service aimed to:

1. Inform further service development, evaluation and research;
2. Provide relevant information for others wishing to establish similar services.

The service evaluation was approved by the Research and Development Department of Leeds and York Partnership NHS Foundation Trust. Its main aims were to ascertain:

1) The demographic and diagnostic profiles of referred patients, and the nature and outcome of the consultation they were offered; 2) the views of referring consultant psychiatrists about the usefulness of the service; and additionally 3) whether other similar services exist in the UK.

A sample of 87 patients was arbitrarily selected from the list of 210 patients seen in the service between 2006 and 2013. At least 10 patients were sampled from each year.

Information was gathered on patient demographics (gender, age and ethnicity), previous treatment, referral source, diagnosis, waiting times, and type and outcome of

consultation, based on reviewing the psychotherapy case notes for the patient, the referral (usually in the form of a letter and email), consultation process notes, psychoanalytic formulation and recommendation and discharge letters.

An online survey form was devised in Survey Monkey (<https://www.surveymonkey.com>) asking questions about the respondent, awareness of the service, number of referrals per consultant, reasons for referral and helpfulness of the service for themselves, the patient and the clinical team, in the form of Likert scales along with space for free text comments. The questionnaire was piloted by 10 consultant psychiatrists in Leeds. The final survey form is included in Supplementary Material. The survey was sent via Trust email link to all 57 consultant psychiatrists in Leeds on 10 December 2013. An email reminder was sent early in the New Year and the deadline for responding was 10 January 2014.

Thematic analysis of the free text comments was undertaken based on the methodology of Braun and Clarke (2006). Each of the four authors independently carried out coding of the transcripts and generation of initial themes. These were then discussed together to derive final themes and sub-themes.

A second online survey of the Medical Psychotherapy Faculty in the Royal College of Psychiatrists was conducted to ascertain the existence of other similar services and whether evaluation or research in the services had been carried out and published. The survey was sent to all Medical Psychotherapy Faculty members on 22<sup>nd</sup> July 2014. An email reminder was sent on 1<sup>st</sup> September 2014 and the deadline for responding was 1<sup>st</sup> October 2014.

## **Results**

### **Demographics**

Of the 87 patients sampled, 36 were male (41%) and 51 female (59%). Mean age was 40.8 years (s.d. 11.9), range 19 to 65 years. Of those who gave their ethnicity, 61

(92%) were White British or Other White ethnicity, 3 (4.5%) were Asian, and 2 (3%) were of mixed ethnicity.

### **Previous treatment**

Twenty six (30%) patients had had at least one inpatient admission, and 40 (46%) patients had received previous psychotherapy or psychology input.

### **Referral source**

Most referrals were from psychiatrists (59%), with an additional 10% from another member of a secondary care mental health team, most frequently the care coordinator. Additionally, a feature of the medical psychotherapy consultation service is that it retains a direct referral link with primary care, thereby allowing professionals' meetings to take place in GP surgeries. In 12 (14%) patients the source of referral was primary care services and the rest from other NHS services.

### **Diagnosis**

Forty eight (55%) patients were diagnosed with a personality disorder by the referrer, and 25 (29%) with an affective disorder. Six (7%) patients had a neurotic or somatoform disorder, and 3 (3%) were diagnosed with schizophrenia or other related psychotic disorder

The remaining diagnoses are: 1 patient (1%) was diagnosed with a mental and behaviour disorder due to psychoactive substance use, 1 patient (1%) had an eating disorder, 1 (1%) had no mental illness and in 2 patients (2%) there was not specific diagnosis recorded by the referrer.

The diagnoses were based on the referrer description in the referral and these did not frequently encompass presenting co-morbidities.

## **Waiting times**

Sixty of the referrals (69%) were responded to within two weeks of referral. Twelve (14%) referrals were responded to within four weeks of referral and the remainder within 10 weeks. The response was in the form of an initial letter that included commenting on the issues/dilemmas mentioned in the referral and arranging a professionals' meeting usually within one month.

## **Consultation offered**

In 63% of referrals there was a professionals' meeting with the referring team before seeing the patient. In 20% of referrals the patient was seen before the professionals' meeting and in 8% of referrals a professionals' meeting only was held.

## **Outcomes of consultation**

At the conclusion of the consultation process, a psychoanalytic formulation and recommendation on management was offered to the referring team. This was the primary focus of the consultation task as opposed to offering therapy to the patient.

As the consultation culture has developed most patients referred are, given the combination of complexity, clinical impasse, and concomitant risk, unlikely to be offered psychotherapy as an outcome as they are referred at a time of acute fragmentation without that degree of stability required to begin a therapeutic relationship. This is not a factor of professionals, services or therapeutic models available, it is a feature of the nature and degree of disturbance and the provision of psychotherapeutic thought for patients who would not usually be coupled with the concept of therapy. While in the majority of consultations an offer of psychotherapy would not be the expected outcome of consultation, and in 78% of patients this was the case, the provision of therapeutic consultation may state 'not now', but cannot state 'never'. For some professionals the therapeutic consultation process may foster the foundations of a future therapy for a patient for whom it might previously not have been possible.

## **Online survey of local consultant psychiatrists**

Twenty nine consultants responded to the survey (51% response rate). The mean length of time as a consultant was 11.3 years (s.d. 8.2), range 3 months to 30 years.

### *Referrers and non-referrers*

Nineteen (66%) consultants had referred patients to the service. The number of patients referred by each ranged between 1 and more than 10. Nine (31%) consultants had not referred patients; of these, 5 gave additional information that they had not heard about the service, 1 had not had a patient with 'particular relevance to the service', 2 had 'used another service', and 1 did not specify the reason.

### *Referral source*

This explored the origin (service) of the referrals. Sixteen consultants completed this section, some having referred from more than one service during their careers. Nine (56%) had referred patients from inpatients services, 13 (81%) from community services, and 2 (12.5%) from the crisis team.

### *Reasons for referral*

Fifteen consultants (52%) responded to this question. All of these consultants referred a patient because of reasons pertaining to the patient, the same number (15) for reasons relating to them as treating clinician and 13 referred for reasons relating to their clinical team. Consultants could indicate that they referred for reasons pertaining to any combination of the patient, themselves and/or the clinical team.

### *Helpfulness or unhelpfulness of the service*

Fifteen (15) consultants completed this section. There were no ratings less favourable than neutral reported.

*Relating to the patients:* 13 (87%) consultants either agreed or strongly agreed, and 2 (13%) consultants remained neutral, that the consultation process was helpful for the patient

*Relating to the psychiatrist:* 14 (93%) consultants either strongly agreed or agreed that the consultation service was helpful and 1 (7%) remained neutral about the helpfulness of the consultation

*Relating to the team:* 12 (80%) consultants strongly agreed or agreed that the consultation was helpful for the team, 2 (13%) were neutral and 1 (7%) did not respond.

### **Consultant psychiatrist survey thematic analysis**

The thematic analysis was based on free text comments given by 15 of the 29 respondents regarding reasons for referral, helpfulness and impact of the service, and further general comments. The length of text comments is reflected in the exemplars in the text and tables which are directly transcribed.

The main themes which emerged were: problems for the consultant precipitating referral; improving understanding; help with case management; containing risk; mitigating clinical impasse; changing psychiatric practice; enhanced team working; and general comments and suggestions for the service.

The main themes, sub-themes and exemplars of this online survey are given in Tables 1 and 2. There were also a number of general comments, as follows:

*Positive comments* included 'the (consultation service) letters are inspiring – serving both as important interventions for the patient and team, and generally as valued sources of knowledge/education on psychotherapeutic theory and process.'

'I wouldn't want to lose it.' 'I have found it to be an excellent service and would feel very much at a loss if it did not exist.'

*Negative comments* included 'some consultations were more useful than others for me and the team. Some were not useful'. 'It would be helpful to see if the Medical Psychotherapy Consultation Service can contribute to reviewing and developing formulation further and even possibly doing some work with the patient.'

*Suggestions for the service* included 'I would like to consult about people who have experience of providing psychotherapy to cases of schizophrenia, mania and psychotic depression.'

'It is important to reserve this intensive resource for patients presenting considerable difficulties for team – often those with complex and risky PD but also those who have previously diagnosed with mental illness – usually bipolar disorder – when it appears that they have complex personality problems.'

'I would like the consultation offered by the Leeds Personality Disorder Clinical Network and that offered by the Medical Psychotherapy Consultation Service to be more "joined up" –since it doesn't make much sense to me not to use the expertise of medical psychotherapy colleagues when discussing the challenges of managing patients with some of the most disturbed and damaged personalities.'

'I think it (consultation service) should be a mandatory part of an in-patient service.'

### **Medical Psychotherapy Faculty survey**

Results of the second online survey, of members of the Medical Psychotherapy Faculty of the Royal College of Psychiatrists, revealed that medical psychotherapy consultation services existed in the UK but a service with a structure like the Leeds consultation service 'sandwich' model did not exist elsewhere.

No evaluation of or research in medical psychotherapy consultation activity had been published at the time of the survey (early 2014).

## Discussion

Most referrals were from psychiatrists or other members of secondary care mental health teams and most patients were diagnosed with a personality disorder. The diagnostic emphasis on personality (or relationship) disorder reflects a central clinical theme of the intractable nature of complexity manifest in clinical impasse relating to treatment limitations, both physical and psychological. In practice, at the time of referral pharmacological treatment was often seen as secondary to the need for a psychoanalytic formulation to aid understanding of difficulties in the patient and professional dynamics. Most cases followed a 'consultation sandwich' model of 1. Top 'slice of bread': meeting with the clinical team; 2. 'Filling': a potential meeting with the patient if this was thought to be in their interests and aimed at informing the consultation rather than assessment for therapy; followed by: 3. Bottom 'slice of bread': a further professionals' meeting with the clinical team to use the conclude the consultation and offer a psychoanalytic formulation with recommendations. The primary outcome of every consultation is the dialogue with the referring clinician and team, focusing on the emotional experiences of the involved clinicians. This patient and professional countertransference communication takes priority over the sole focus of understanding the psychopathology of the patient.

The results of the online survey of local consultant psychiatrists are consistent with the ethos of the service: many consultants referred for reasons relating not just to the patient but also to themselves and/or the clinical team, and most found the service to be helpful in all three of these areas. One of the psychiatrists preferred that 'some work be done with the patient' and this view may echo that of other psychiatrists and teams who do not use the consultation service.

The thematic analysis results for reasons of referral revealed the themes of frustration, feeling stuck and splitting to underlie the concerns for the referring psychiatrist and a desire for understanding of the dynamics for the patient, the psychiatrist and the team. The helpfulness and impact of the service were manifest in themes linked to help with case management, risk, mitigating impasse and offering a space for reflection and

support for the psychiatrist and the team. Changes in psychiatric practice emerged in relation to new understanding provided for both patient and professional.

The online survey of the Medical Psychotherapy Faculty members revealed the existence of similar psychoanalytically orientated medical psychotherapy consultation services but none with a consultation sandwich model and there were no published evaluations of their impact or place in mental health services at that time (early 2014).

In the descriptions of the consultant psychiatrists about why they sought a consultation, there was a leitmotif of the experience of being *stuck* in the patient and professional relationship. The word *stuck* echoes the words immobilisation and stagnation which the Barangers (2008) use to describe the movement between the disintegration of emotional contact, the disconnection of the bastion and the quality of separateness and partnership between patient and professional when there is a movement towards integration. It is a feeling that each is in their role, a working relationship in which there is clarity about what belongs where and with whom. The frequent use of the word *stuck* in the thematic analysis evokes thoughts of glue – the adhesive emotions of a collapse of space between patient and professional and within the mind a loss of space for thought. The stuckness is often accompanied by feelings of resentment and bitterness – a mutual recrimination maybe spoken in one party (the patient), unspoken on the other (the professionals). Explicit and hidden grievance acts like a glue preventing grieving – evading the pain of mourning disappointment, the repetition of transference disillusionment and the pain of countertransference shame in perceived or real therapeutic impotence. Another metaphor for this adhesive bastion between patient and professional might be *Velcro* – the *hooks* of aggrieved projections attaching tenaciously to the *felt* experience of the professional guilt in which the grievance hooks find a secure but perverse home.

These analogies render consultation as a kind of solvent or force to help pull apart to allow space and separateness between patient and professional. The risk of being glued or stuck in the messy experience is clearly part of the experience for those whose omnipotence might lead them to believe they can help to un-stick their colleagues.

## **Limitations**

Detailed information about consultations was based on a sample of 87 patients. While there is no evidence that the sample was unrepresentative, based on general knowledge of the service, it is possible that some variation in results could occur if other patients had been selected or if it had been feasible to analyse information from all 210 consultations in detail. Likewise, while the response rate of local consultants was relatively good (51%) for an online survey of this nature and probably included responses from those consultants with the strongest views about the service, the views of those who did not respond are unknown. The thematic analysis was based on brief free text comments from the online survey. While this probably captured the most salient views about the service, further insights could be gained, for example, from more in-depth semi-structured interviews. Additionally, the psychoanalytic approach in this consultation service has not offered comparison with other models.

## **Conclusions**

The Medical Psychotherapy Consultation Service in Leeds offers an application of psychoanalytic psychiatry for professionals working with complex patients who are acutely or severely disturbed to help with understanding, formulation and risk management. The service also fulfils a number of other purposes, including providing a consultative window of 'acute reflective practice' and support for professionals in acute psychiatric or crisis work in the assessment and management of the patient (Johnston 2010, Johnston and Paley 2013)

The emotional experience of the professionals involved in working with severely disturbed and disturbing patients is pivotal to informing the psychoanalytic understanding of the nature of the clinical impasse for both patient and professional. This offers benefit not only for the patient and professional, but contributes to the health of the organisation and resilience of professionals in mitigating anxiety and helping to

contain the unconscious at work within the institution (Bion 1962, Menzies-Lyth 1988 and Obholzer et al 1994).

The containing function of psychoanalytic psychiatry for the patient and professional might be conceived in terms of facing the unconscious regressive limitations afforded by the setting known as the *Brick Mother* (figure 1), the description the psychoanalyst and psychiatrist Henri Rey used to describe the Maudsley Hospital in London (Rey 1994).

### **Implications for the service and further development**

The future of a consultation service led and delivered by a medical psychotherapist is predicated on the assumption that there is a specific value, a unique selling point (USP) that a psychiatric and psychotherapeutic training confers to this work. Psychoanalytic applications outside the consulting room: 'off the couch' (Lemma and Patrick 2010) in or outside the *Brick Mother* may be offered by professionals trained psychoanalytically from different backgrounds. Perhaps the important factor lies in their credibility with consultant psychiatrists prepared to expose their feelings of being stuck in their work to another professional in whom they can trust and from whom they believe they can learn.

### **Further research/evaluation**

While a medical psychotherapy consultation service in the Leeds model does not exist, we have gathered evidence of psychoanalytic and other models of consultation activity within the Medical Psychotherapy Faculty of the Royal College of Psychiatrists across the UK, which lends support to the exploration of a proposal for a UK evaluation of medical psychotherapy consultation services in NHS Mental Health Trusts, which might explore the role of different therapeutic models in comparison with a psychoanalytic approach.

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## References

- Baranger, M. & Baranger, W. (2008) The analytic situation as a dynamic field. *Int J Psych-Anal*; **89**: 795-826.
- Bion, W R. (1962) Learning from experience. London: Karnac.
- Braun V, Clarke V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*; **3**: (2) 77-101.
- Brenman-Pick I. (1985) Working through in the countertransference. *Int J Psych-Anal*; **66**:157-166.
- Feldman M. (2009) Doubt, conviction and the analytic process. Selected papers of Michael Feldman. Edited by Betty Joseph. The New Library of Psychoanalysis. London and New York: Routledge.
- Hinshelwood R. Suffer the mad. (2004) Countertransference in institutional culture and epilogue, Being psychotic, being a person. In *Suffering insanity: psychoanalytic essays on psychosis* (pp. 107-165). London: Brunner Routledge.
- Johnston J. (2011) Transference: keeping mum or mummified? *Adv Psychiatr Treatment*; **17**: (6): 417-418.
- Johnston J. (2010) Being disturbed: integration and disintegration in the patient and professional relationship. *Psychoanalytic Psychotherapy*; **24**: 231-251.
- Johnston J, Paley G. (2013) Mirror mirror on the ward: who is the unfairest of them all? Reflections on reflective practice groups in acute psychiatric settings. *Psychoanalytic Psychotherapy*; **27**: 170-186.
- Lemma A, Patrick M. (Eds.) (2010) *Off the Couch: Contemporary psychoanalytic applications*. London: Routledge.
- Lucas R. (2009) *The psychotic wavelength. A psychoanalytic perspective for psychiatry*. The New Library of Psychoanalysis. London and New York: Routledge.
- Menzies Lyth I. (1988) Containing anxiety in institutions. Selected essays volume 1. London: Free Association Books.
- Obholzer A, Zagier Roberts V (Eds.) (1994) *The unconscious at work. Individual and organisational stress in the human services*. London: Routledge.
- Steiner, J. (1993) Psychic Retreats. *Pathological organizations in psychotic, neurotic and borderline patients*. New Library of Psychoanalysis: Routledge.
- Steiner, J. Foreword in Rey, H. (1994) *Universals of psychoanalysis in the treatment of psychotic and borderline states*. London: Free Association Books 1994.
- Yakeley J, Hale R, Johnston J, Kirtchuk G, Shoenberg P. (2014) Psychiatry, subjectivity and emotion – deepening the medical model. *Psychiatric Bull*; **38**: 97-101.

**Table 1 Thematic analysis: reasons for referral**

<b>Main theme</b>	<b>Sub-theme</b>	<b>Exemplars</b>
<b>Problems for the consultant precipitating referral</b>	Concerns regarding the patient	<i>'Frustration due to splitting and dependency of patients'</i>
	Concerns regarding the psychiatrist themselves	<i>'To help the team, including me, to coordinate our response to a difficult set of problems and to think carefully about the best ways forward'</i>
	Concerns regarding the clinical team	<i>'Evidence of splitting and/or patient inducing strong emotional reactions in involved workers'</i>
	Concerns regarding clinical complexity of patient/situation	<i>'Complex presentation, stuck'</i> <i>'Complex case with dynamic issues in the background'</i>
<b>The consultant wants to improve understanding</b>	Understanding of the patient	<i>'Trying to formulate and understand patient's presentation and impact on services'</i>
	Understanding for the psychiatrist themselves	<i>'To understand the dynamics between me and the patient better, understanding my own psychology and psychodynamics better'</i>
	Understanding for the team	<i>'Better understanding of dynamics between patient and staff: to improve the staff's knowledge and awareness of psychological issues'</i>

**Table 2 Thematic analysis: helpfulness and impact of the service**

Main theme	Sub-titles	Exemplars
<b>Help with case management</b>	<b>Doubt and anxiety:</b> uncertainty that the approach to patient management adopted is 'right'	'I always find it helpful to have more time to think about complex case presentations when there is a great deal of anxiety regarding the best way to manage distress and risk'
<b>Containing risk</b>	<b>Therapeutic risk taking:</b> allowing a different perspective	'The expert input allowed me and my CMHT colleagues to radically change our management of the patient, taking big therapeutic risks in the process'
<b>Mitigating clinical impasse</b>	<b>Being stuck and un-stuck</b>	<p>'I have never felt dissatisfied with the outcome of a referral. The outcome has invariably been educational, pragmatic, exceptionally thoughtful and allowed interventions or changes in approach that have made a difference or "unstuck" a difficult clinical scenario'</p> <p>'Some patients become stuck and the perspective of the medical psychotherapist can help us all get un-stuck (patient and clinicians)'</p>
<b>Changing psychiatric practice</b>	<b>New understanding</b> of the patient and professional dynamics	<p>'I have found it extremely valuable in working with complex patients. It offered perspectives on the patient's inner world which we had not previously considered. This understanding augmented the team's ability to work more effectively with the patient thereby giving them a better experience of our service'</p> <p>'Having a psychoanalytic formulation of the patient's problems has often been inspiring and helpful, making sense of the way the patient's problems play out in clinical practice'</p>
<b>Enhanced team working</b>	<b>Reflection and support</b>	<p>'The MDT benefits greatly from the supervision and advice which flows from the process'</p> <p>'The team benefitted from a clearer understanding of how the patient was impacting on them'</p>

## Supplementary Material

### Consultant Psychiatrist Survey

The Leeds medical psychotherapy consultation service began in 2000. The aim of the service is to offer a psychoanalytically informed medical psychotherapeutic perspective for health professionals who are managing severely disturbed and high risk patients.

We would be grateful if you could spare a few minutes and help us to improve the service by completing the questions below.

1. Your Gender: *Male/Female*
2. Number of years as a consultant psychiatrist: *(free text box)*
3. Have you ever referred a patient to the Medical Psychotherapy Consultation Service?  
*Yes/No*
4. If answered Yes to Q.3 please enter the number of patients referred to the service? *(free text box)*

5. If answered No to Q3, please could you select from the reason(s) below:

*Used another service, not heard of the service, not had a patient with particular relevance to this service, did not think the service would be useful.  
Other- (additional comments box)*

*For those answering no to Q3 there is no need to complete the rest of this questionnaire but clarifying numbers of non-referrers and the reasons why is important so please return your survey.*

6. Which service(s) was the patient referred from? (Select more than one option if multiple referrals)
  - *Inpatient*
  - *Community*
  - *Crisis team*
  - *Other (please specify)*

7. What were the reasons you referred to the Medical Psychotherapy Consultation Service in relation to each of the following?

a) *The patient?*

*(free text box)*

b) *You?*

*(free text box)*

c) *The team?*

*(free text box)*

8. Please select one of the following statements with regard to the Medical Psychotherapy Consultation Service

The consultation service was helpful for:

*The patient?*

Strongly agree    Agree    Neutral    Disagree    Strongly disagree

*You?*

Strongly agree    Agree    Neutral    Disagree    Strongly disagree

*The team?*

Strongly agree    Agree    Neutral    Disagree    Strongly disagree

9. Please give comments relating to your responses to Q.8

10. Any final comments on your experience of Medical Psychotherapy Consultation Service?  
*(free text box)*

## Medical Psychotherapy Faculty membership Survey

The Leeds Medical Psychotherapy Consultation Service has been running since 2000. The service was established and is led by Dr James Johnston, Consultant Psychiatrist in Psychotherapy. He offers a psychoanalytically informed medical psychotherapeutic perspective for health professionals who are managing severely disturbed and high-risk patients.

Dr Johnston would be grateful if you could spare a few minutes to help him and colleagues evaluating the Leeds service to assimilate information about psychoanalytic and other medical psychotherapy consultation services in the UK and to gather your views on the place of a medical psychotherapy consultation service in developing psychotherapeutic psychiatry.

### 1. Your gender

*Male*

*Female*

### 2. What is your current position?

*Foundation trainee*

*Specialty doctor*

*Core trainee*

*Consultant psychiatrist*

*Advanced trainee*

*Academic psychiatrist*

*Other (for example medical student associate):*

### 3. Number of years in psychiatry:

*0-1 year*

*1-5years*

*5-10 years*

*10-20 years*

*Over 20 years*

*Other (for example year at medical school):*

4. What is your psychiatric sub-specialty:

- None - pre MRCPsych*
- Medical Psychotherapy*
- General Psychiatry*
- Academic Psychiatry*
- Psychiatry of Intellectual Difficulty*
- Psychiatry of Older Adults*
- Child and Adolescent Psychiatry*
- Forensic Psychiatry*

*Other (for example Addictions, Liaison):*

5. Do you have a Medical Psychotherapy Consultation Service in your NHS Trust?

- Yes*                       *No*                       *Don't know*

For those answering No to Q.5 please respond to question 10 and press done at the bottom of the page.

For those answering Yes to Q.5, please continue with the survey below.

6. Which of the following therapeutic theories underpin the Medical Psychotherapy Consultation Service?

- Psychoanalytic*
- Cognitive behavioural*
- Systemic*

*Other models of therapy (please specify):*

7. Does the Medical Psychotherapy Consultation Service primarily focus on one or more of the following:

- The patient*
- The professional*
- The patient and professional*
- The team*
- The organisation*
- Other (please specify)*

8. Has there been research or evaluation on the Medical Psychotherapy Consultation Service in your Trust?

	Audit	Service evaluation	Research	Case studies
Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Don't know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes please describe the audit, case studies, evaluation, research and list any publications

9. Does the Medical Psychotherapy Consultation Service have a role in one or more of the following:

- Organisational consultancy*
- Reflective practice*
- Continuing professional development (CPD) for post MRCPsych psychiatrists*

- Advanced medical psychotherapy training*
- Applications of psychoanalytic thinking*
- Applications of cognitive behavioural thinking*
- Applications of systemic thinking*
- Requiring intensive psychoanalytic practice in the NHS*

*Other (please specify, for example application of another therapeutic model)*

10. Do you have any final comments on Medical Psychotherapy Consultation Services? *(free text box)*