training institutions where the situation may be rather different), we must realise that training needs, given that we are trying to train people to work in the public sector, are more confluent with service needs than might at first appear. The supervisor has a vital role here, in helping the trainee extract something valuable from the experience of treating a great range of patients.

Financial considerations come at the end, and I have included this because the outcome of an assessment interview in terms of what is offered, may depend very much on whether the decision has been made by the organisation on pragmatic, resource-led grounds to offer mainly a short-term therapy service, or mostly group rather than individual treatment, and so on. In some patients we know short-term therapy is contraindicated, as it will do more harm than good. It is important for a service to acknowledge the limitations of what it offers. The worst thing, I think, may be an idealisation of brief therapy, especially where it is organised and packaged and marketed in such a way as to give the institution and therapist the comfortable illusion that a complete treatment is being offered, and that any failure is subtly the fault of the patient. The best sort of brief therapy in my view is the sort where analytic principles are adhered to and an acknowledgement is made of the incompleteness of the process, and the resulting pain, deprivation and dissatisfaction. Paradoxically, the better containment offered by this sort of philosophy and approach to brief treatment is likely to make it suitable for a wider range of people than treatments that are ostensibly more 'sewn up' by having a so-called 'focus' that is other than a straightforward focus on the transference.

The question of rationing is implicit in all this too. Extreme rationing is totally inevitable in psychotherapy services in the UK at this time, and we often have to turn down people in great need, or offer them something that is really quite minimal, because the sort of psychotherapy they need is not available. We must be straightforward about this to ourselves, and not use the excuse 'the patient is unsuitable', when what is actually lacking is the appropriate treatment. In the assessment process, the tension must be borne by the service of the realisation of its own limitations. The patient should never be left at the end of an assessment interview with the message 'you've failed our test', but with the message, 'this is what I think you could benefit from and why', even if it is not available.

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patients, the transference, and it is usually a negative or paranoid transference, is immediately very intense, and functions as a resistance to any exploration in the assessment. In these situations the transference has to be interpreted in order to avoid an impasse. With other patients the transference manifestations and countertransference responses are an integral part of the patient’s narrative, facilitating the beginning of the process of exploration and understanding which can be continued in the therapy.

Case example: Miss B

Miss B, a 51-year-old single woman, was referred by her GP with a long history of physical illness and disability, which the GP considered had a major psychological component. In a telephone discussion with me, the GP expressed his concern about Miss B’s frequent seeking of expert medical opinions, leading to a potentially dangerous fragmentation of her medical care. Miss B missed her first appointment with me, because, as I learnt later, she was in hospital. She subsequently wrote requesting another appointment urgently.

First meeting. Miss B carried the signs of her ill, fragile state in the form of two large cushions, one of which she placed behind her back, the other on her lap supporting her arms. She wore a large black surgical neck-collar, and she was dressed totally in black. Her clothes emphasised how thin she was in a particular way which conveyed to me a certain awareness of the impact she made on others. She constantly flicked her long hair away from and over her face in a gesture which seemed to express her conflict about being seen or remaining hidden, as well as an anxious need to exert control.

She seemed to deal with her feelings of anxiety, vulnerability and desperation by adopting a controlled, scrutinising interviewing stance towards me. Any attempt on my part to touch on her feelings about relationships, past or present, met with an angry, contemptuous response. She indicated that she thought I was being unnecessarily intrusive and heavy-handed. She conveyed that she was the expert on herself, an impasse. With other patients the transference manifestations and countertransference responses are an integral part of the patient’s narrative, facilitating the beginning of the process of exploration and understanding which can be continued in the therapy.

With Miss B, it seemed that my words were experienced in terms of my being the cruel mother injecting her with painful stuff. There was no ‘as-if’ transference. Steiner (1993) points out that the formidable technical problems arising from this situation are in part due to the uncomfortable countertransference feelings evoked in the therapist. Steiner makes a very useful distinction between understanding and being understood, and points out that the patient who is not interested in acquiring understanding about himself nevertheless has a need to be understood by the therapist. I think it is obvious, from what I have said about Miss B, that there was a danger of the situation becoming stuck in an impasse. Unless I could find a way of using my countertransference responses to maintain a dialogue with the patient, the assess-
ment would fail, and only add to her list of such abortive encounters with Health professionals.

However, in using our countertransference, we have to take into account our own defensive needs. At the most obvious level, in the example I have given, it would have been easy to react defensively to the experience of being accused of abusing the patient and behaving in a crass and inexpert way. None of us likes to feel useless and guilty with a patient. We may need the help of colleagues and supervisors, space away from the patient to regain our balance, to regain a third perspective on our experience. One outcome of the patient's excessive use of projective mechanisms is that the therapist's separateness is experienced as extremely threatening. Hence the attack on the therapist's capacity to think. Inevitably, such patients are very difficult to assess, because the primitive and extremely paranoid transference and countertransference response dominate the interaction, considerably impairing and distorting the therapist's ability to obtain a psychodynamic history. The therapist's capacity to contain unpleasant emotional states is placed under severe strain, frequently eliciting hatred, guilt and anxiety. Consequently, patients like Miss B may themselves be subjected to inappropriate treatment. They may be rejected as unsuitable or taken on for therapy without sufficient thought. Not infrequently, they are placed with the most inexperienced therapists within an organization, with the advice that the patient may not improve but the therapist is sure to learn a lot.

I certainly felt the need to discuss with colleagues what, if anything, our Clinic should offer Miss B. I thought that if we offered her therapy she was likely to become a patient of the whole Clinic, and not just the patient of her therapist; and therefore it was important for members of the Department to know about her and to agree collectively whether we should offer her therapy or not; in other words, to protect the individual therapist from having to carry the whole responsibility for the patient, and to ensure that the therapist had sufficient support.

After careful discussion, we decided that we should offer her individual therapy with fairly limited aims, including enabling her to stop her endless round of visits to private medical specialists in the search for a cure.

The context of the assessment meeting is of some importance. The anxieties elicited by the assessment process will differ to some extent, depending on where the assessment is taking place: for example, in a GP practice, a psychotherapy clinic, a hospital, or in private practice. Interestingly, we seem to use the term 'assessment' in the public services, and 'consultation' in private practice (although 'to assess' comes from the Latin word as sidere = 'to sit beside'). This in itself reflects some of the different issues pertaining to these different settings. Therapists in a public service are inevitably concerned about the building up of long waiting-lists and the rationing of insufficient resources. So the assessment carries a particular significance which is related not only to the patient's needs. As I mentioned earlier, the assessor has a gate-keeping function which undoubtedly increases the patient's anxiety and the therapist's sense of guilt. The relationship between the referrer and the assessor may also increase the assessor's anxiety and disturb the countertransference responses. For example, Miss B's referrer was a fund-holding GP, and I was aware of the Clinic's need to be seen to provide a useful and efficient service to our purchasers. Similarly, referrals from senior colleagues may evoke anxiety about wishing to please, which could lead to an over- or under-estimation of the patient's pathology.

I would like to make a slight detour here about the usefulness of having more than one assessment meeting. A second meeting gives the therapist the opportunity to observe the patient's reactions and response to the first meeting. Has the patient been able to think further about him/herself? Has he/she been able to engage actively in the process of self-exploration? Or has he/she got rid of the experience, returning with no further thoughts, as if to another first meeting? As Garelick (1994) points out in his comprehensive paper on psychotherapy assessment: by offering the patient several sessions the assessor has the space and freedom to address the range of factors that should be examined during the assessment process. The assessor can adopt a more analytic stance at a certain point to encourage free-association and allow an examination of the interaction that takes place. At other times, the assessor can more actively take a history from a psychodynamic point of view. From the assessor's perspective, he is able to offer an interpretation to the patient and monitor the response, thus forming a judgment as to whether the patient can benefit from a psychoanalytic approach. In this way, it is important to differentiate the patient who can be understood from the critical factor of the patient's capacity and motivation to use such understanding for the resolution of the his/her problems.

History-taking is a very important activity, not only because it reveals important and helpful information, but also because it helps in indirect ways. Implicit in history-taking is the idea that present problems are rooted in the past. The patient is invited to think consciously about his past and the possibility of making meaningful links between the past and the present. The patient's ego-capacities are mobilized in the serve of understanding his/her difficulties. History-taking from a psychoanalytic perspective also gives the opportunity to get some idea of the patient's development, to enquire how they have negotiated or failed to negotiate the important tasks of separa-

One of the questions that often comes up in the discussion of the usefulness of more than one assessment meeting is how to manage the patient's developing transference to the assessor, which could make transfer to another therapist difficult. I think this is an over-stated or mis-stated problem, since the patient develops transference fantasies and feelings as soon as the referral process is initiated, before they have actually met the assessor. In my experience, the patient's transference, as it may develop over the course of two or more sessions, need not be a problem if the assessor remains mindful of the danger of using such feelings to seduce the patient into therapy. The assessor can with care interpret some of the patient's transference feelings.
in a way which facilitates the patient's developing understanding and motivation for therapy. I think the usefulness of several assessment meetings far outweighs the problems which include a premature referral on when the patient has insufficient understanding and motivation, and unresolved idealised or denigratory transference feelings to the assessor.

Here I present two patients, with whom there was space for reflection in the assessment meetings, Mr A and Mrs C. These patients' manner of communicating both verbal and non-verbal, was informative and evocative in a way which facilitated the development of some preliminary understanding of their difficulties and personal histories. From a developmental perspective, this suggests that these are patients who have achieved some measure of psychological separateness and have reached, however partially, an oedipal three-person situation.

Case example: Mr A

First meeting. Mr A was a 27-year-old single man referred by his GP. He wore black-leather trousers and a red T-shirt, with an earring in each ear. He spoke in a coherent, articulate manner, without much expression of feeling. He outlined his areas of concern: the recent break-up of the relationship with his girlfriend, his relationship with his parents, and his inability to give up smoking marijuana. He described how committed he had felt to the relationship, whilst knowing and trying to deny that it could not last. In his two previous relationships with women he had felt frightened by their outbursts of feeling. He was very angry with his parents for being emotionally unavailable to him, but said he wanted a better relationship with them as they were getting older. He could not recall ever being told that he was loved, or being asked what he felt about anything.

When he was 18-months-old, his mother gave birth to twins, the first of which was born dead. He was sent away to live with another family for about six months. This early traumatic separation was apparently never talked about in the family. He described himself as a lonely child with few friends. He became depressed in early adolescence, and was preoccupied with thoughts about death. He also developed an interest in what he called 'madness'. He wanted to explore how far he could push himself and his ability to give up smoking marijuana. He had begun to feel that maybe he could. His asking for a referral for psychotherapy was clearly an indication of this, and the initial consultations were important in engaging him in the therapeutic process. He was able to let me know about his need for more intensive therapy through a subsidised scheme.

Second meeting. He arrived early, greeted me warmly, and seemed keen to talk. He had not smoked marijuana since the day after our first meeting, and was feeling pleased about this. He went on to talk about how he has tended to live dangerously, seeking excitement in order to feel alive. I wondered then about his identification with the dead twin, and suggested his living dangerously was not only a way of testing himself and seeking excitement, but also an expression of his suicidal fantasies; and his fear that no-one really cared about him. He spoke of his fears of being on his own, and how when he left home he went 'wild'. He would dress up in outrageous clothes to shock people. I had noted to myself that there was still this element present in his appearance, and I wondered to him whether he felt he had to break through what he felt to be my and others' indifference to him. I thought his evident need to shock me expressed his transference fantasy of an unavailable object who left him alone with terrifying feelings. He then described his father as unloving and never satisfied with his achievements. He felt dissatisfied with himself, and uncertain as to what he wanted to do, what he could experience as being of value to him. I suggested he might be feeling this here with me, and that was perhaps why he had felt angry at the end of our first meeting. He retreated from the immediacy of these feelings of uncertainty and pain into philosophical speculations about the meaninglessness of life. I noted that he did not speak here of his mother, as though that aspect of his internal world remained inaccessible to his conscious mind.

Though he again expressed fears of 'taking the lid off', he also said that in the past he had thought he could not learn anything from anyone. But that recently he had begun to feel that maybe he could. His asking for a referral for psychotherapy was clearly an indication of this, and the initial consultations were important in engaging him in the therapeutic process. He was able to let me know about his need to seek excitement, and we could talk about the possible meanings of this behaviour. His lack of memory, and the associated affects about the early traumatic separation from his mother and father, showed the presence of powerful defences of denial and projection against the experiencing of painful affects, including an identification with, or guilt about, the dead twin and rivalry with the younger, living, sibling, which he attempted to bolster through his use of drugs and travelling. What I think became more evident to him through the assessment process was the conflict between his narcissistic defences and angry refusal to take responsibility for himself in certain ways, and his genuine wish to make and sustain better relationships. His motivation for analytic psychotherapy increased, although he could not at this point take on the commitment for more intensive therapy through a subsidised scheme.
Case example: Mrs C

First meeting. Mrs C, a 36-year-old married woman, was referred by her GP. She arrived three minutes late. She talked quite eloquently, and with evident anxiety about her difficulties. She had placed her glasses on the adjacent chair soon after she sat down, and I noticed that at times she had a very miserable, hurt-child expression in her eyes, which I thought she was not consciously aware of, and which had quite an impact on me. It was as though at one level she was allowing me to see the very miserable, traumatised aspect of herself, whilst her glass on the other chair suggested a defensive process, a splitting-off of her own awareness, as well as perhaps the presence of a persecutory observing other.

She said she was in an extremely precarious situation: she could 'fuck everything up'. She described herself as a workaholic, working at high levels of stress; she was very successful now in her work. In marked contrast to her manic work-self, she felt utterly depressed and withdrawn in the mornings, and had a great struggle getting up. She was always late for appointments, though I noted she had barely been late for this one. Prior to leaving for an appointment, she said, she 'blanks out', she loses time. Sometimes she drives when she is very tired, aware of the danger of having an accident. Indeed, she had had an accident two years before.

Mrs C had had therapy before, for an eating-disorder, which began in mid-adolescence. She was initially anorexic, and then became bulimic. She spoke of how she constantly pulls her hair around her face, as if to protect herself. She said she had not thought of that, and showed interest in this idea. More difficult for her to tell me, was that she attacks the skin on her back, and sometimes her face. She picks at imaginary spots, and has the fantasy that there is a great boil which will explode. She added, in a wry way: 'leaving all the bad stuff out'. There was time for me only to acknowledge that as well as being a cause of anxiety, shame and distress to her, this behaviour seemed to contain some of her feelings of anger and hostility towards her mother, now directed against herself. She responded by talking again of her anxiety about losing time, and I suggested that she was describing a kind of protective measure which had developed in childhood of disconnecting herself from very painful experiences. This seemed to make some sense to her. At this point I did not take up these anxieties and defences directly in the transference, because I was aware of some countertransference feelings of being drawn in to rescuing her in her current state of crisis. I preferred rather to wait and see what would transpire in the second meeting.

Second meeting. Mrs C arrived fifteen minutes late. She apologised, saying she had been held up in traffic. She was very occupied with a great deal of work, and she had told her husband about it.Whilst this was said in an overtly positive way, I felt some misgivings, both about the development of an idealising transference and about her needing then defensively to distance herself from contact with me. She commented also suggested the likelihood of a sadomasochistic relationship developing in the transference, along the lines she had described with her lover. She returned to the stress at work and how self-conscious she feels about the effect she was very cruel to her, and conveyed vividly her fear of the constant presence of her mother's hand about to hit her face.

Some of this material came up when we were discussing her difficulties in getting to appointments on time. I had suggested that maybe she found it difficult to leave. I think, in retrospect, this was an instance in which I had become preconsciously aware of a transference dynamic. She went on to describe her mother as a very attractive woman with beautiful long hair which she had longed, as a child, to play with and comb; but her mother would never allow her to do this, saying she had a sore head. Her mother never showed her any physical affection, in contrast to her father, whose lap she sat on, and who allowed her to comb his hair. She thought her parents' marriage was difficult and unhappy, and now she felt her parents were a nuisance to her.

There was a sense of pressure throughout the meeting, and she once or twice wondered if she was giving a garbled account, worrying whether I could make sense of it. Towards the end of our time, she referred to other worries, with evident feelings of anxiety and shame. She spoke of how she constantly pulls her hair around her fingers, which she felt was childish: a relative had said she should no longer be doing it. She noted that she had not done it in our meeting. I wondered whether she thought it might have something to do with her conflictual feelings about her mother, which seemed focused on her mother's hair. She said she had not thought of that, and showed interest in this idea. More difficult for her to tell me, was that she attacks the skin on her back, and sometimes her face. She picks at imaginary spots, and has the fantasy that there is a great boil which will explode. She added, in a wry way: 'leaving all the bad stuff out'. There was time for me only to acknowledge that as well as being a cause of anxiety, shame and distress to her, this behaviour seemed to contain some of her feelings of anger and hostility towards her mother, now directed against herself. She responded by talking again of her anxiety about losing time, and I suggested that she was describing a kind of protective measure which had developed in childhood of disconnecting herself from very painful experiences. This seemed to make some sense to her. At this point I did not take up these anxieties and defences directly in the transference, because I was aware of some countertransference feelings of being drawn in to rescuing her in her current state of crisis. I preferred rather to wait and see what would transpire in the second meeting.
she did not want a fragile husband. She said she longs to have a flat painted bright her husband because he was so fragile. She paused and look away, and tearfully said wanted the marriage to continue. She referred to a friend saying she could not leave from her primary objects, this leading to difficulties in her sense of ownership of her relationship -with her mother, with the consequent oedipal reverberations. The devel-

she is drawn because he is aggressive and assertive and very successful, in contrast to her husband who is passive and unsuccessful. She was uncertain as to whether she with the other man, which she finds much more interesting sexually, and to whom rest of the time talking about her husband and their relationship and her relationship with me, and her need to resort to action as a defence against feeling. She talked of allowing time and space for herself seemed to be quite an issue.

Third meeting. She arrived ten minutes late, looking ill. I wondered why she went at speed down the motorway from a meeting where she had gone to get an important contract. She said she did want to go ahead with therapy; and I pointed out that I was rather more aware of her tendency to cut-off from herself and from contact with me, and her need to resort to action as a defence against feeling. She talked a how important work is and how much she enjoys being successful. She spent the rest of the time talking about her husband and their relationship and her relationship with the other man, which she finds much more interesting sexually, and to whom she is drawn because he is aggressive and assertive and very successful, in contrast to her husband who is passive and unsuccessful. She was uncertain as to whether she wanted the marriage to continue. She referred to a friend saying she could not leave her husband because he was so fragile. She paused and look away, and tearfully sail she did not want a fragile husband. She said she longs to have a flat painted bright colours, with just a cat, where she can be on her own.

I think that in the course of the three meetings, Mrs C conveyed quite a lot about the predominant conflicts in her life, which centered on an intensely ambivalent relationship with her mother, with the consequent oedipal reverberations. The development of an eating-disorder in adolescence suggests particular problems in separating from her primary objects, this leading to difficulties in her sense of ownership of her body and her sexuality. Success at work seemed to be associated with an intensification of her anxieties in relation to the internalised hostile and rivalrous mother, which

CONCLUSION
In this paper I have illustrated something of my own approach to assessments. In the NHS we are acting as gate-keepers to the service in which demand is so much greater than the supply of resources. The assessor is therefore in a very powerful position, but also usually feeling under great pressure, which can lead to distortions or to the mise of the transference and countertransference, particularly in the direction of getting caught up in the negative, paranoid or idealising transferences; that is, rejecting or rescuing the patients. In private practice, the supply-demand situation is different, and may indeed be reversed.

Whilst all three patients I have described were showing borderline psychopathology, there were important differences. With Miss B, I felt there was little or no space to reflect within the assessment meetings. She experienced my interpretations as destabilizing her sense of psychic balance; or as my unwillingness to play any role in her attempt to actualise an internal relationship between herself and her object (Sandler 1976). Her motivation was directed towards maintaining her current state of defensive balance; thus change was seen as extremely dangerous. Such patients are very difficult to assess properly, and extended assessments are needed to process the interaction. This is not to say that these patients should not be offered psychotherapy; rather, that the aims and setting need to be carefully considered, and that a network of involved professionals needs to be in place.

MR A and Mrs C did not manifest such an obviously intense transference reaction as Miss B. I could use the transference and countertransference responses to make