In this paper I consider the uses of the transference and countertransference dynamics in the assessment process. Patients referred to an NHS Outpatient Psychotherapy Department are discussed. In the Department the assessor will usually not be the patient's therapist. In this situation I suggest that the transference relationship is not the sole or central focus of interpretation, unless the transference is manifested as a resistance to the exploration of the patient's unconscious conflicts underlying the presenting symptoms and difficulties. However, the transference relationship and countertransference responses alongside the patient's history form the basis of the assessor's understanding and dynamic formulation.

Introduction

The understanding and interpretation of the patient’s transference affects and fantasies, and the therapist’s use of their countertransference response, are generally regarded as the essential and basic elements in psychoanalytic therapy aimed at facilitating psychic change in the patient. In this paper I want to consider how these tools are employed in the assessment process, their uses and misuses or pitfalls.

The patients I shall be discussing were referred to an NHS Outpatient Psychotherapy Department. The majority of patients referred are offered an assessment, and it is the usual practice that the assessor will not be the therapist if the patient is offered therapy within the Department. The assessor can be said to be fulfilling a gate-keeper function. This particular situation inevitably affects the transference and countertransference, and informs the way in which these elements are used in the assessment process. I differentiate an assessment session from a therapy session in terms of the aims and the context. I see the central aim as being to engage the patient in talking about their inner world of unconscious feelings, conflicts and anxieties, to the extent that these can be deduced from the material available. I do not see it as a central aim of an assessment to engage the patient in a transference relationship if the assessor is not going to be the therapist. However, with some 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, which of course is true to some extent. But this seemed to be part of a scenario in which there is one expert and one fool.

I found increasingly throughout the first meeting that she evoked strong, and predominantly unpleasant, feelings in me. I felt pushed about and pushed out of my position as assessor. I felt abused by this and intruded upon by her contempt. Consequently, I felt I had little space to think, and I struggled with the feeling of wanting to get rid of her because she seemed to be demanding the impossible — immediate attention and care, on her terms, whilst implying that I was being impossibly cruel or stupid not to accede immediately to her request.

In the space between the first and second consultations, I could think about her anxiety, her fear of being rejected and turned away without help. She had told me that several friends had let her down badly and disappeared from her life; and she now felt totally isolated. Her recent illness began a year after her mother died. She had referred to an unsatisfactory relationship with her mother in childhood. She told a story of her mother giving her a painful injection, leaving her to cry afterwards alone. She conveyed her sense of a mother who could not tolerate or bear to understand her painful, frightening feelings and anxieties; so it seemed to make some sense to consider that she was reacting to me as though I were an unavailable and cruelly neglectful mother to whom she could never get through.

She had ended the first meeting by telling me she often felt suicidal, but assured me she was not telling me this to put pressure on me. She knew of the existence of the Clinic's waiting-list.

Second meeting. I began the next meeting by taking up what she had told me at the end of the first meeting in terms of her anxiety and uncertainty about the outcome of the assessment, expressed in her feelings towards me. She responded with a great deal of anger, telling me that I was blaming her for her illness, and making statements which left no room for her to respond other than in a yes-or-no way. I was somewhat startled by her outburst, and felt that her comments vividly described my experience of being with her. She got up to leave, dismissing me as worse than useless, as making her feel even more desperate. I had the fleeting experience of feeling like an intimated child with a tyrannical adult standing over me. Through her action she became like the cruel mother terrorising a fearful child. However, she did stay for the remaining part of the meeting, perhaps responding to my not retaliating by rejecting her as she expected.

Clearly for Miss B, the assessment process was extremely threatening, and her paranoid transference feelings clearly functioned as a resistance to any exploration of her difficulties. I felt attacked if I stepped outside a prescribed position — if I moved from accepting her views to inquiring into the causes and meanings of her suffering. It was therefore difficult to gain a detailed picture of the central unconscious conflicts, and to make a psychodynamic diagnosis, although her response to me suggested borderline psychopathology — and intense need and fear of contact with an object. As Joseph (1983) has pointed out, a patient in this state of mind is not interested in understanding. The priority is to get rid of into the therapist mental contents felt to be unbearable. In this situation, words are used, not primarily to convey information, but as actions having an effect on the therapist; and the therapist's words are likewise felt as actions indicating something about the therapist's state of mind, rather than offering insight to the patient.

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 assessment 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 inept 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 organisation, 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 *assidere* = ‘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 mobilised 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 separation and individuation in childhood and adolescence, and so on. Asking about work and relationships gives some information about the patient's capacity to relate to external reality and to gain pleasure and satisfaction from others. There are also fairly vital facts which may well not be related spontaneously, such as suicide attempts and fantasies, hospitalisations and breakdowns, drug-or alcohol-abuse, etc.

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 he began experimenting with drugs. He said he felt now that his continual smoking marijuana was killing him, but he felt better when he had a joint. I suggested that he was telling me about his suicidal thoughts. He replied they always had a romantic element to them, by which he meant he would imagine the reactions and the guilty sad feelings of those left behind. He had never made a suicide attempt. He said the real way to do it is to jump off a tall building, cutting your wrists; overdoses are just playing at it. He had plans to travel, which he likened to taking drugs as a means of escape. His talk of suicidal feelings and of wanting to escape his current way of life, the constraints of others, etc., indicated his fear of being overwhelmed by depressive feelings.

I thought that he was able to tell me quite a lot about himself, and his account showed evidence of some capacity for self-reflection. There were many references to his anxiety about intensely aggressive and violent feelings, and fears of intimacy. I commented on how he seemed to have his feelings well under control. He did not immediately respond to this, but at the end of the meeting he spoke of his fear that 'the lid might come off', as a result of talking in this way; and he might leave feeling very stirred up and disturbed. As he left, he told me he was as he predicted: feeling very angry.

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 out 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 wanting for 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

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 recalled the excitement she experienced at being able to control her body-weight in this way. She said the therapy had been helpful; she considered her eating was now under control. However, she also felt the therapy was dangerous. She felt the therapist encouraged her to let go, and whilst she recognised that she needed to keep control, and partially achieved this through arriving late to sessions, she felt the therapist was encouraging her to have a break-down. After six years of this therapy (once-weekly and sometimes twice-weekly), she left.

She had been married for eleven years. She initially described her husband as extremely supportive; she could not do her job without him. The traditional role-models were reversed: she was the breadwinner who frequently travelled, whilst he looked after the home. He was intelligent, but worked in a low-key job. At this point her negative feelings began to emerge. They have no sexual relationship now. She described him as rather androgynous in appearance. He was rigid, and could be quite cruel to her; when she was particularly vulnerable and asked for help, he would say ‘No’. At other times he smothered her with attention. She went on to talk of a passionate affair with a work-colleague, which had ended recently, but which she clearly hoped might re-start. She also described this man as cruel towards her: getting her interested, and then rejecting her.

She thought some of her current difficulties were to do with her past ‘stuff’ that she felt she had to get to grips with. Her parents had moved frequently. She often wished as a child that she could be adopted, and when she went to friends’ houses she would try to find ways of staying and not returning home. She said her mother 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 had 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: ‘letting 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 so she had not had time to think about our first meeting. But she remembered
thinking with surprise that I had cut through so quickly to some important things, 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. Her comment 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

has on others. She went on to say that thoughts about her mother are in the back of her mind; her mother was a very
confusing person to be with. When I inquired about this, she said her mother always had her own version of events, and
she had not realised this until her previous therapist had pointed it out. Her mother would talk in front of visitors about
what a marvellous child she was; but when the visitors were not around, Mrs C felt constantly criticised by her mother and
that she could do nothing right. She had realised how much this feeling pervaded her thoughts in her current life. I
suggested that she was perhaps feeling this here too with me and that this might lead her to feel uncertain about engaging
in longer-term psychotherapy. She denied this. But she went on to say that she could be like her mother, adding quickly
that she did not think she was distorting things with me, but she was worried about how aggressive she could be to other
people. At times she wished she could be physically violent, though in fact she restricts herself to being aggressively
critical or cutting. I thought she was describing how quickly she could switch from being the vulnerable victimised child
to being the aggressor, and though she was to some extent aware of this in her other relationships, she was too anxious to
acknowledge it in her relationship with me, as though I would become the abusive and rejecting object.

Third meeting. She arrived ten minutes late, looking ill. I wondered why she went on working her evidently-ill state.
She replied that she had spent so much of her childhood being ill and she had only recently started not to be ill; that she
had to be feeling absolutely terrible before she would stop working now. She had just driven 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 allowing time and space for herself seemed to be quite an issue.

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 of 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 said 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 centred 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

she defends against through the use of manic defences, leading to acting-out her aggression. I think she projected onto her
husband aspects of her own passivity and sexual conflicts, leaving her feeling freer to engage in a sexual relationship with
another man, who, like her father, was not really available. In fact, the lover seemed also to be like her cruel mother with
whom she remains enmeshed in a sadomasochistic relationship. Clearly her fear of therapy, or rather of the therapist,
related to her fear of her mother, and her fear of ‘letting all the bad stuff out’, her murderous and sadistic feelings which
felt so life-threatening. Her fantasy of living along with a cat in a bright flat perhaps expresses her wish for a narcissistic
retreat from her fears of damage and fragmentation.

In the transference I seemed to be a potential rescuer, an idealised figure split-off from the persecutory mother,
perhaps an aspect of her father. This transference I think slightly blinded me to the warning signs she gave of the ways in
which she was entrenched in sado-masochistic enactments as part of her manic defences. Though she appeared to
appreciate my different thoughts about her, this was only up to a point. I think the process also increased her anxiety and
ambivalence about long-term therapy. Her agreement to be referred privately was probably on the basis of compliance with a potentially dangerous maternal figure. She never contacted the therapist.

Conclusion

In this paper I have illustrated something of my own approach to assessments. In the NHS we are acting as gatekeepers 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 misuse 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-and-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 destabilising her sense of psychic balance; or as my unwillingness to play my 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 interpretations to facilitate the process of exploration. Although with Mrs C the centrality of her manic defences and associated sado-masochistic pattern of relating needed to be interpreted more actively, this was not entirely successful, as I have illustrated. These elements of the assessment process emerged alongside what they were able to tell me about their history and development, thus allowing me to construct a psychodynamic diagnosis and formulation. This can then form the basis of engaging the patient in an exploration of their inner world and assessing their capacity and motivation to do this in the context of a therapeutic relationship.

Implicit in what I have said is my view that an assessment is to be distinguished from a therapeutic session, though there are of course elements common to both. I think it is necessary to be more circumspect in making transference interpretations in an assessment when the assessor is not going to be the therapist and the patient is going to have to wait for some time on the waiting-list. I also think that too exclusive a focus on the transference relationship in an assessment may leave many crucial areas of the patient's life unexplored, which could possibly jeopardise the efficacy of the therapy or the safety of the patient.

References