


David Stewart BMus DipMT RMTh
5 Upper Malone Crescent, Belfast.
The use of a pre-interview questionnaire helps with this sort of assessment, as important background information is already available. However, an alternative definition of an assessor, also given, fortunately, is a person called in to advise on technical matters. I think this latter describes the role much more adequately. The term ‘consultation’ may be more appropriate, although in the NHS the word ‘assessment’ seems to have stuck.

The psychoanalytic assessment is one of the most important and interesting aspects of our work. We are very privileged as psychoanalytic psychotherapists to be given this detailed and intimate access to the mind of a hitherto total stranger. For the patient it is often a completely new experience, which may be quite disturbing, exhilarating, relieving, or intensely intrusive and frightening or enraging. Learning about assessment and developing one’s own method and style is a vital part of psychotherapy training in the public sector. Assessment styles and philosophies encountered during the apprenticeship phase of NHS work, when one is trying to develop one’s own method, may differ considerably, and it is helpful to examine this. I want now to caricature slightly two very different styles of assessment that have important, and differing implications.

Dr A conducts an assessment interview in a way which approximates at first technically to an ordinary analytic session. The patient is greeted courteously but gravely, and subjected from the outset to an intense scrutiny, with the minimum of instruction, or measures that might be described as ‘putting one at ease’. They are invited by a brief word to begin wherever they wish, and then given absolute attention, but no automatic social responses are given, for example smiles or attempts to ‘chat’. Dr A works hard, and in a very detailed way, studying transference and countertransference and making some transference interpretations in order to deepen understanding. Often, very rapid, perhaps unnervingly rapid, access is gained to areas of vulnerability, for example depression or paranoia, or sadomasochistic patterns, which can then be examined in detail in the room. Later there will be some more direct questioning, to fill in important gaps in the emerging story. The way this story is told will be studied, and the patient may be invited to think about why certain topics, (for example, the relationship with the father), had not emerged before. The use of a pre-interview questionnaire helps with this sort of assessment, as important background information is already available.

Dr B, on the other hand, greets the patient in a more conventional social way, and tends to respond to some of the social cues where the patient seems to be inviting him to reassure them that he is a benign figure. Analytically speaking, the opportunity is not taken directly to explore the paranoid anxiety underlying this need for reassurance, and to expose the nightmare figure straight away in the transference. While
piercing defences, and potentially causing mental pain and upset, especially when we have before us a patient who is not in active pain and distress at that moment. It might also be mentioned here that just as we would not wish an inexperienced clinician to perform a dangerous and invasive medical investigation on us, so too we would want to regard psychoanalytic assessment as a relatively advanced procedure not to be practised by the novice without careful supervision and training.

Considerations of invasiveness may be less fraught when a patient comes in a state of obvious pain and anxiety such that interpretation is needed almost as an emergency procedure, bringing visible relief. This is often not the case, however, in a standard psychotherapy service (as opposed to a crisis-intervention service), as, by the time the appointment arrives, the crisis has often abated and some sort of defence is back in place. However, one tends to find that there are two broad categories of person in this respect. The person whose complaint, and whose presentation is an anxious, actively distressed one, or where the distress is only just below the surface and is easily reached; and the person whose presentation is in the form of the defence itself, possibly with reported episodes of breakthrough of anxiety, such as panic attacks, but presenting for assessment in the thoroughly defended, cut-off state. It is the latter category of person, rather than the former, who will dislike the opening up procedure of the interview most, and face us most with a dilemma. On the one hand we are being asked not to intrude, but we could say with justification also that we might be betraying the patient and colluding with the defences by not being invasive enough.

So, having set the scene a little by saying what I mean by 'assessment', I will ask the question of my title — Why Assess? Why do we perform this invasive investigative procedure on people? To start with, when would we decide from the start not to do it? Would there be circumstances in which we thought from the referral that it was likely to do more harm than good? I think this is bound to be so.

Case example: Mr B

A GP asked our Clinic to assess Mr B for psychotherapy. In the referral letter, it was mentioned that Mr B had received assessments in a number of places, including in the catchment-area mental-health team, the local psychology service and by a private counselling organisation. He had been extremely dissatisfied with the care he had received so far, and had lodged with the health authority a complaint about the local psychiatrist. He had also sent a series of angry letters to the head of the counselling service, complaining that the person he had seen had stared at him in an aggressive way, and demanding another interview with someone more senior, who would 'give him more feedback'. The referrer felt, she said, that the 'very special skills' of the Tavistock Clinic were needed to contain such a difficult patient, and that he needed long-term individual psychotherapy. We were asked if we could see him as an emergency, as he was causing considerable anxiety to his family and to the practice, which he visited almost daily in an anxious and angry state.

In my view, to offer this patient an assessment interview would have been provocative and unhelpful, and purely a reflection of omnipotence. The litigious, near-psychotic or frankly psychotic transference was clearly manifest without seeing the patient, and although an interview might have revealed all sorts of interesting pathology, it would have simply inflamed the patient and raised false expectations. The most useful way we could help was by a detailed and thoughtful telephone consultation with the GP about management of this highly disturbing situation.

Another example will be given now, of a patient of this sort who was offered an assessment, with potentially dangerous consequences.

Case example: Mr C

Mr C was referred to an outpatient psychotherapy clinic with chronic anxiety and depression, and again, the urgency of the referral was stressed by the GP, who mentioned that the local psychiatrists had seen him, prescribed antidepressants, but that the patient was no better. A disturbed and abusive childhood was referred to, but little more detail was given. The patient was sent the standard questionnaire, with the usual request to fill in as much as possible, and to get in touch if there were any difficulties. Mr C turned up at the Clinic in an agitated state the next day, and the receptionist asked the duty medical registrar to see him. Mr C had his questionnaire with him, and said that he was afraid to fill it in, in case the biro damaged the paper as he wrote. He had a number of other anxious preoccupations and the on-call clinician ended up spending an hour with him, even though she had intended to spend only ten minutes. He seemed very persecuted, but not frankly psychotic. He left in a calmer state, and managed to deliver the questionnaire by hand the next day. At this stage, the supervisor encouraged the trainee assessor to carry on and offer a formal assessment appointment. Mr C, unable to wait the two weeks for his appointment, turned up at the Clinic on two further occasions, needing to be seen by a duty person again before he would leave the building. The assessment interview itself, as might have by now been predicted, turned up copious disturbing, near-psychotic material, and the patient became fragmented in the unstructured setting to the extent that the assessor had to modify her technique rapidly. He formed an intensely dependent, idealising transference to her, which turned to a confused rage when it became evident to him that she was not about to offer him individual therapy herself, and was indeed trying to talk to him about how he might feel more secure in a hospital at this point. She felt in physical danger, and had to call on all her pre-analytic, social-work skills in addressing the residual sane part of his ego, and to encourage him to walk with her to the lift and then to go to the GP, to whom she spoke immediately.
These examples should not be understood as meaning that a disturbed individual who is unlikely to be offered outpatient psychotherapy should never be offered an assessment: often something very useful is to be gained from offering a psychoanalytic interview to someone with, say, a psychotic illness, in remission, or someone else in whom a dynamic formulation has to be made in order to inform management. It is important in such cases, however, to do preliminary work with the referrer and try thus to avoid raising unrealistic expectations.

So, why do we assess for psychotherapy? Why do we need to subject the patient to the sort of disturbing and intrusive psychoanalytic investigation that I have outlined. Why, after ruling out the more disturbed cases referred to above, do we not simply offer more or less everyone who asks for it a chance to engage in a therapeutic relationship, say on a first-come, first-served basis, if, as we know, rationing in inevitable? I do have some sympathy with the idea of erring on the generous side, of giving people a chance at psychotherapy, as long as they seem to want it and have been given as clear an idea as possible what it will involve. I would like to argue that it is not so much for us to say ‘who is suitable?’ (as in fact that is a surprisingly hard thing to do), but for whom would we think psychotherapy, at least in certain settings, was contraindicated, and either harmful or likely to be useless. I would like to suggest that there is a hierarchy of aims involved that we should be attending to in roughly the following order. I am borrowing here from Maslow’s (1954) concept of ‘hierarchy of needs’, where he considers the way in which for us as human beings basic survival needs have to come before more complex social and psychological requirements:

1. Patient and Therapist Physical Safety
2. Patient Mental Safety
3. Patient Privacy and Dignity
4. Indications for Patient ‘Suitability’
5. Training Needs of the Therapist
6. Economic considerations

Before going through these points in turn, giving some illustrative clinical examples, the importance of the context of the assessment interview needs to be stressed. Is the assessor working in a hospital out-patient department? Are they in the same building as acute wards or a day hospital, or are they in an isolated psychotherapy unit? What sort of psychotherapy is available: how long-term, how intensive, and what is the waiting list like? What other treatments are available elsewhere, in the NHS? outside?

The well-known dictum first do no harm has to be paramount, and this means it is important to try and avoid doing something that will make the patient’s situation fundamentally worse, either by the assessment itself, or by offering a particular treatment. I have already given examples of patients where considerations of physical safety, for patient and therapist, suggest that we should consider not even interviewing them, given the situation of a service that offers only outpatient treatment, and no

Case example: Mr D

Mr D asked his GP to be referred for psychotherapy, as he was frightened of his uncontrolled violence. He had spent several years in prison for a violent attack on a member of the National Front, during what had started as a peaceful anti-fascist demonstration. His friends included both hardened criminals with a hatred and grievance against society and others with a seemingly more hopeful and encouraging attitude, and this very much reflected a deep split within himself. He had spent most of his childhood in care, having suffered violent abuse from parents and step-parents, but there had been one supportive social worker with whom he had formed a strong bond, who seemed to have helped him to retain some sense of hope and ambition to make something of his life. In the unstructured assessment interview Mr D quickly became white and sweaty with fear, and felt attacked and judged by the therapist. He wanted to leave the room, but managed, with much active interpretive help from the assessor, to hang on to himself and have a conversation about what was happening. He was able to talk about his fears of violence and even acknowledge towards the end of the first interview, with fear and shame, when it was suggested by the therapist, a ‘fascist’ part of himself who was both a protector and a vengeful aggressor. In the second meeting, a week later, he reported much more anxiety in the intervening week, with impulses to violence to himself and others only just possible to resist. However, he remained adamant about wanting to explore things and try and change, and pointed out that nothing else had helped, and he felt at the end of the road. Having thought carefully about the options, the assessor decided that only a residential setting such as the Henderson Hospital would provide enough safety for Mr D, and indeed for the professionals working with him, who would inevitably become at some point the hated fascists in the transference.

My next point in the hierarchy, about mental safety, applies to the patient who had fears of harming the paper of the questionnaire with his biro. Any analytic investigation is inviting possible breakdown, and for many, some form of ‘breakdown’, major or minor, will be an inevitable, perhaps necessary part of the treatment process. That is, breakdown of the defensive structure, and emergence, break-through of the underlying grief, paranoid fear and so on. We have to consider carefully and responsibly for each person, what breakdown will mean for them — what will be its nature if and when it occurs? Will it, for example, mean a serious psychiatric decompensation? And if so, are there any structures in place to help contain this? Some people we see will have broken down already with emergence of anxiety, depression and unravelling of their everyday existence. They are often the people who will say, ‘I’m afraid I’m
going to have a breakdown', who can often be quite helped by being told in some way or another, 'Well, actually what you are describing now is your breakdown, and this could already be as bad as it will get'. Others will come in a more defended state, and report episodes of depression, or panic; and part of our role is to try to uncover this in the work itself, as healing in a new way, with the potential for development, will not, in our way of thinking, be possible until the breakdown they are describing 'out there' has occurred in some form in the context of psychotherapy itself. We do aim, however, in outpatient treatment at least, to provide a therapeutic setting where the breakdown will be contained within the treatment, enough for the patient to be able to continue his life outside. This is where I think we have to be very careful in prescribing the right treatment. If psychotherapy is to work, it is a useful rule-of-thumb that the worst that the patient has experienced will occur in the treatment at some point. Thus, a patient with a history of manic or severe depressive episodes, however apparently sane and thoughtful in the assessment interview, will be bound to break down at some point in the psychotherapy, in the context of the therapeutic relationship (maybe precipitated by a break, for example), unless the therapy remains at a superficial, non-analytic level, at which we would question why we were doing it anyway. This is another good argument, I think, for invading enough in the assessment interview to try and show the patient, there and then, albeit in a small way, what this breakdown of defences, and breakthrough of anxiety and disturbance, is like, so that they can make themselves as informed a choice as possible. It is essential for the assessor to try and gauge what is the minimum therapeutic setting which will be needed to contain this inevitable breakdown, keeping the patient safe. The therapist must also feel contained enough by the setting they are working in, without fears about how the patient will react hampering their freedom.

Case Example: Miss E

Miss E was referred with a long history of recurrent mania, for which she had spent at least half of the last five years in hospital. The ward doctor, who felt strongly that there was a part of the patient who could think and wanted to work on herself, referred her to the psychotherapy department within the same building. The assessor, after careful consideration and discussion with colleagues, agreed with the ward doctor, and she was taken on for once weekly therapy by the psychotherapy senior registrar. The ward and the walk-in 'Emergency Clinic' downstairs from the psychotherapy department were informed that she was starting treatment. Miss E's disturbance quickly became focused on the therapy and the therapist, and episodes of breakdown continued intermittently as before, but now focused around transference issues. The impression that therapy was making her worse was inevitably created, and the tolerance of the Emergency Clinic staff, in particular, who often had to deal with an angry and histrionic, or very excited and disinhibited patient who arrived downstairs after her sessions, was stretched to its limits. There were often mutterings about those precious psychotherapists upstairs who did not have to do the dirty work and pick up the pieces. However, it became evident gradually over the next two years that Miss E's breakdowns were becoming more circumscribed, and shorter in duration, and that she had taken to asking for help as she felt herself deteriorating, instead of, as before, being brought in by police or friends in an excited, triumphant and inaccessible state. She also at times now required brief admission and close supervision during periods of depression.

Such a patient would not have been able to be contained in an institution geared only to out-patient work. In fact, to have offered treatment in such a non-containing setting would have transgressed my first two rules about physical and mental safety.

To move on now to the third point in this hierarchy, patient privacy and dignity. Patients may sometimes come to us having an idea about psychotherapy being soothing, primarily giving relief from pain, or consisting of question and answer sessions, with advice-giving or education. Similarly, there may be quite a utopian idea about what may be readily achieved in treatment. There is often a lack of knowledge amongst referrers and patients about the differences between different psychotherapeutic approaches. As has been mentioned, it is important that a patient should leave an assessment interview having an idea about the nature of the process to be undertaken, its intrusiveness, and its likelihood of exposing the patient to pain in the form of guilt and shame, for example. In contrast, an approach that is basically educational in nature, such as behavioural or cognitive therapy, will allow the patient largely to retain his defences, and protect his privacy to a much greater extent. It may be considered, however, that paradoxically the patient is being subtly infantilised far more in such pedagogic procedures than in an analytic approach.

To some people, their narcissistic structure or their fear of what is within is such that they are simply not prepared for the sacrifice of privacy involved in psychoanalytic work, and I think we should be able to let them make an informed choice about this by the way we work in an assessment interview, that is, by trying to show them a little of what the work involves; and then, if necessary, talking to them about what might be a more bearable, albeit more palliative, procedure. However it may seem right first to try to address and challenge a resistant part of the patient, which may be trapping a more voiceless, desperate part, in a pathological structure. If we feel we have done this to the best of our ability, the choice really is then the patient's, and it is a choice they should be allowed to make with dignity, with ourselves leaving the door open always for future discussion and review.

In the same way, a patient with a serious disease who cannot face a major operation, but opts for symptomatic relief, has a right to this, and once we have given as much information as we can about the situation to the patient, in as understandable a form as possible, it is no longer our business what course is chosen, although we also have a responsibility still to protect the patient's dignity and help him to make alternative
plans, rather than simply washing our hands of him or her in a smug or moralistic way. I think the many people who drop out during the assessment process, or during the early phases of psychotherapy, are often saying 'No' to the painful and disturbing intrusion involved, at least at this stage in their lives and their illness. This should be respected, but it is more helpful if this can be addressed openly in the interview, rather than leaving the patient angry and humiliated, or feeling a failure and with nowhere else to turn later.

Case example: Mrs F

Mrs F was referred by a child-guidance team who had been seeing her with her little boy, who was wild and destructive, as it was felt that she needed help in her own right. The referrer in his letter, called Mrs F 'a charming lady' who in addition to her difficult child was burdened by a difficult husband as well as an intrusive and critical mother. In the assessment interview, after an initial charming greeting and attempt to engage the assessor socially, which was hard to resist, Mrs F became resentful and suspicious in the unstructured setting of the consultation; and uneasy, even outraged, at the invitation to start wherever she liked. She demanded questions which she could answer, saying that she was accustomed to talk to the doctor about her little boy, and that the assessor's approach was rude and unreasonable. It seemed to the interviewer that she (the interviewer) was probably predominantly Mrs F's mother in the transference, and that criticism was expected, and indeed experienced, from the interviewer unless she dispelled this artificially by actively presenting herself as a good, benign figure, as there was huge pressure on her to do. Attempts to explore this dynamic were largely unsuccessful, and met with incomprehension and anger; but the assessor sensed that Mrs F was underneath depressed and despairing. She talked to Mrs F about her mixed feelings about exposing herself, and this was acknowledged. It seemed that for Mrs F to reveal to herself and others her own depressed and also wild, critical or 'difficult' side was at present unbearable. In the second meeting, Mrs F said that she had decided against psychotherapy, and was going instead to join a support group for mothers whose children had attention-deficit disorder. Her present solution to her problems was discussed and acknowledged by the assessor, who left the door open for a further consultation in the future.

To come now to 'indicators of suitability'. We often jump too quickly, I think, to putting this at the top of the list of reasons for the assessment process. In this paper I have been trying to come at this same issue from a different angle. I would say that the patient who has got to this stage of the assessment, who we have satisfied ourselves is not in physical or mental danger from treatment, who has not shied away from the invasion of privacy involved, has indeed begun to look like someone who could benefit from our work. I think it can be relatively easy, with experience, to get a sense of who might do well, but it is harder to say categorically that someone is unsuitable, and would not do well, or at least harder than we might like to think. As many do, I dislike the use of 'analysability' criteria of a didactic sort, as one can become suspiciously near to accepting only responsive and rewarding people for treatment. The irrelevance prognostically, on the whole, of psychiatric diagnosis is commonly accepted, much as we realise the irrelevance of social class, ethnicity, level of education and so on. Psychological-mindedness, or emotional literacy, has a separate dimension from all of these, and sometimes the most disturbed and chaotic people can have some liveliness or curiosity or strength about them that is absent in a more ostensibly sane person. It is possible also to talk about 'motivation' for treatment in a way that attempts to gauge something prematurely, and can even be slightly moralistic. Realistically, motivation may be something that can sometimes only emerge through the patient finding out by experience in therapy what is or is not bearable or worthwhile for him.

However, I do think we should, when thinking of likelihood of benefit, be trying to attend to the question of whether this particular patient might be making a useful sacrifice of time and effort in taking part in the particular treatment that is on offer at one's institution. For example we may judge that a very schizoid, or markedly perverse, stuck, person, may be wasting their time coming to once-weekly individual sessions, and may need to be told this. It may sometimes be that we would recommend more intensive treatment if possible, and options of low-fee, more intensive treatment schemes run by training organisations may be discussed. It may in such situations not be that the patient is necessarily 'unsuitable for psychotherapy' per se, but that we are the ones lacking, or failing in not being able to provide the specialist, intensive treatment that we would recommend for this person. We may also sometimes be recommending a group for a patient, even though they might strongly prefer the idea of once weekly individual treatment, which we judge will just get stuck and repetitive and offer less opportunity for change. There is often a point in the interview where the treatment of choice from our point of view may not be at all what the patient had envisaged. I think one of the functions of an assessment interview should be to enable us by the end to give an informed view to the patient, and to lay before them all the options available, with our opinion as to which is the most appropriate, and why. This is the point at which, I think, the less structured, reflective work of the session over, we need to become quite openly the professional who is advising and giving an opinion, and this aspect of the work is vital, and something to which the patient is entitled.

My penultimate point is about training needs. In practice, is one of the inevitable answers to the question why assess? 'Because we need to find suitable training cases?' Many of the organisations where we work have to take in to account the needs of our therapists who may be simultaneously training in psychotherapeutic skills. There is often a tension here, as new therapists will want patients who are accessible, and who will attend regularly and not cause too much trouble. Increasingly, of course, our patients are people with severe personality disorder, and we are often working at the limits of treatability. I think in the NHS, (as distinct from non-NHS
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 commercialised 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 sadly 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 and the therapy processes, 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 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 commercialised 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.

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Dr Jane Milton
Tavistock Clinic
120 Belsize Lane, London NW3 5BA.

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