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PSYCHOTHERAPY ASSESSMENT: THEORY AND PRACTICE

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SUMMARY

The history and developments in psychotherapy assessment are reviewed. Suggestions for an extended assessment of several sessions derived from the clinical experience of a District Psychotherapy service are put forward with clinical illustrations. The advantages in terms of flexibility, and the ability to embrace the range of factors involved as well as the influence this has in generating a sense of containment in the patients, are discussed. The implications of this approach on technique, and its differentiation from ongoing psychotherapy, are highlighted. It is suggested that assessment should be seen as an entity in its own right, with its own clinical technique.

INTRODUCTION

Assessment for psychotherapy forms a large part of the clinical work of a Consultant Psychotherapist, but it raises more uncertainty and anxiety than any other subject in psychoanalytic psychotherapy. The assessment interview is likely to be the first exposure patients have to a psychoanalytic way of thinking and is therefore a critical experience for the patient. It is at the interface between a psychotherapy clinic and other health-care agencies, and therefore plays a crucial role in defining the relationship between the psychotherapy service and the various referring agencies. Since it has numerous functions, and is multi-layered, it is not surprising that it is a subject that raises a wide range of questions. Its very breadth poses problems about how to manage such a diffuse process.

The Diagnostic Approach

Present thinking about assessment is based on the psychoanalytic literature, although several authors have noted that there is a relative paucity of this. Freud himself did not devote a paper to assessment for psychotherapy, but made a series of comments and clinical hints in several of his papers (Freud 1904, 1912, 1913, 1915, 1922).

Initially, recommendations were based mainly on diagnostic classification; and the early literature (Jones 1920, Reich 1933, Fenichel 1945) is concerned with elaborating and extending the conditions amenable to treatment by psychoanalysis. The

emphasis on diagnosis was reflected in the training programmes in which an obsessional and an hysteric formed the basis of the training experience.

Subsequently, it was recognised that diagnostic listings were an insufficient guide to patient selection. Glover (1954, 1955) highlighted the link between the person and his symptoms, and the importance of identifying the developmental stage in early life when the illness originated. He thought that a patient's accessibility to treatment depended on determining the fixation points in his or her development. These points indicate the stage to which the patients would regress, and therefore the type of defences they might employ. Glover did, however, consider that the degree of accessibility would be the same for any given diagnostic category.

Knapp (1960) reviewed one hundred analytic cases, and Zetzel (1968) did the further work of dissecting the varying response of hysterics to psychoanalytic treatment, firmly demonstrating that diagnostic categories alone were insufficient. This led to a shift of emphasis to other factors, such as: aspects of personality; recognition of the intimate link between symptoms and patient; the nature, origin, and type of anxiety; and the resulting defence (A. Freud 1936, Baker 1980). Emphasis was also placed on the relationship between the patient and the assessor, and factors internal to the patient scrutinised, such as motivation and the capacity for constructive synthesis of the analytic experience (Namnum 1968, Limentani 1972, Malan 1973).

The history of the selection of patients and the underlying concepts were critically reviewed by Tyson & Sandler (1971); and the methodological deficiencies in the search for significant factors in assessment have been pointed out by several authors. These were summarised in three major reviews: Bloch (1979), Erle & Goldberg (1979), and Bachrach & Leaff (1978). Bachrach & Leaff identified no fewer than 390 separate prognostic factors in the twenty-four studies reviewed.

Issues of Technique

Vigorous debate continues concerning the technique of assessment, the key issue being the degree of the assessor's activity. The classical approach is based on the patient's free associations and slow unfolding of material (Erle & Goldberg 1979, Kuiper 1968, Shapiro 1984). The rationale for the classical technique is that a more active intervention by the assessor would bypass the patient's ego, resulting in the obscuring of resistance as a dynamic force.

Prompted by ideas of widening the scope of psychoanalytic treatment to include borderline and psychotic patients, Stone (1954) challenged the prevailing orthodoxy and suggested a more active approach. There has been debate about numerous other aspects of assessment. For example, whether the assessor should take a formal history from the patient; since the history will inevitably change in the course of psychodynamic treatment as aspects of it are recovered and defences are relinquished. In almost half the cases, Erle (1979) reported a change in diagnosis from the initial assessment due in part to important historical information uncovered during the analysis.

The effect of an assessment interview involving an active approach on the relationship of the patient with the assessor, and its implications for the transference,

have been considered; and concern expressed that a powerful transference relationship to the assessor will be induced which will complicate the patient's transition into treatment. Similarly, the function of the assessor, and the extent to which he or she should adopt a broader role by recommending treatment, have been raised; together with the question of how to reconcile this with the nature of psychoanalysis which is to empower patients to take greater control over their lives and greater responsibility in making decisions. This question reflects the conceptual difficulty inherent in psychoanalysis, as it is both a specific treatment method and a body of thought used for the understanding of psychopathology. 'Treatment' implies an active process. Freud suggests that

> ...therapeutic success .. is not our primary aim; we endeavour rather to enable the patient to obtain a conscious grasp of his unconscious wishes.

It would appear then that the

> ... psychoanalyst is in the paradoxical position of seeing a cure as a desirable by-product of the process of analysis but a by-product nevertheless (Tyson & Sandler 1971).

The literature indicates a trend towards a greater activity in the assessment process, with more emphasis being placed on the activity of diagnosis in the widest sense and the active searching-out of information. Stone (1954) considered it important to derive information from the longitudinal history of the character and pattern of the patient's relationships with people in general and his or her life-situation. Waldhorn (1960) discusses the relative importance of a broad range of factors. Zetzel (1968) emphasised the examination of early relationships in the developmental history, an approach further elaborated by Busch (1986). Referring to the selection of training cases, Baker (1980) holds the view that primitive defence mechanisms (splitting, projective identification, denial, primitive idealisation, omnipotence, and devaluation) are the root causes of ego-weakness and underlie everything referred to in the literature as constituting contraindications for psychoanalysis.

Kernberg (1975) emphasises the importance of the diagnostic approach, particularly with the borderline and narcissistic disorders. Several authors (Steiner 1976, Schubart 1989) stress the elucidation of the unconscious transaction between the patient and the assessor as being key elements of the transference. Malan (1979) focuses on the importance of the psychodynamic formulation and the transference; and Hinshelwood (1991) has further developed the psychodynamic formulation which he considers the most important function of assessment. This formulation is based on three levels of object-relationships:

(i) the current life situation;

(ii) the infantile object-relationship as described in the patient's history or hypothesised from what is known; and

(iii) the relationship with the assessor which to all intents and purposes is the beginning of a transference. This approach corresponds to the development of the

'Core Conflictual Relationship Theme' by Luborsky's 1990 research group (Luborsky & Crits 1990). This group has developed a method which attempts to formalise the process of formulating the transference by a guided analysis of relationship patterns.

Returning to the clinical setting, Coltart (1988), who gives a very clear account of her approach to assessment, stresses the importance of the assessor working actively as an integral part of the process. She places particular emphasis on the assessor's capacity to form a treatment alliance, to be psychologically minded, and the ability to link relief of psychic pain with self-knowledge. Diatkine (1968) agrees, and indeed suggests that a silent assessor may encourage latent masochistic desires in the patient.

Several authors consider that the assessor has a responsibility to the patient beyond making a judgment about whether the patient is suitable purely for psychoanalysis or psychoanalytic psychotherapy, and that part of his or her role is to make a recommendation of the most appropriate treatment (Limentani 1972, Tyson & Sandler 1971, Pollock 1960). This introduces the whole domain of the context and the wider environment as a critical factor in determining the nature of the assessor's function, thereby affecting some of the characteristics of the assessment process.

The value of a trial period as part of the assessment process has been discussed (Diatkine 1968, Tyson & Sandler 1971). It was argued that it is of limited value, since it is likely to foster the splitting off of various aspects of the patient's problems or pathology in the trial period, and that important material may be consciously or unconsciously withheld. There is also the debate regarding the mechanism of referral. Should patients be screened by questionnaire? should there be initial consultation work with the referrer? or should the patient first be seen and the appropriate course of action then be decided?

Trends in Clinical Assessment

This historical review of the literature indicates that there has been a move from a formal medical model based on diagnosis to one that increases emphasis on the nature of the relationship and the transactions between the patient and the assessor within the assessment interview. Similarly, there has been greater appreciation of the context in which the assessment takes place. These changes have in turn influenced the role of the assessor, leading to a tendency for the assessor to be more active and to have a broader range of functions. The search for significant individual factors in assessment has however been unfruitful; the methodological deficiencies have been succinctly pointed out by Meltzoff & Kornereich (1970). The question of who will profit from psychotherapy is undoubtedly complex, because examination of any single patient variable in relation to outcome accounts for only a small portion of the total variance.

These changes in technique reflect developments in theory, evolving from drive and structural theory towards the more contemporary object-relations theory. Bachrach & Leaff (1978) demonstrated this trend in their review, pointing out that,

with the exception of transference, all but three of eighty-two references to object-relations have occurred since 1960. The concept of therapeutic alliance was introduced into the analysability literature by Levin (1960).

Developing a personal theoretical position

The assessor needs to have his own theoretical and clinical model to act as a foundation and to facilitate the use of clinical intuition (Coltart 1988). He should therefore have an internal model of psychic change and an understanding: of where he places himself on the continuum between insight and corrective emotional experience; of whether his theoretical position is towards deficiency or towards conflict as the main generator of psychopathology; and of the nature and importance of transference (drive v. object-relations theory). The assessor should also have developed his own position regarding recommendations for treatment.

MY CLINICAL VIEWPOINT

In this section of the paper, I set out the assessment technique that I have developed. My approach has been derived from previous work but is also based on my own clinical experience of two thousand assessments. This experience was largely obtained from running an outpatient psychotherapy service. The clinical service we offer is of psychoanalytic psychotherapy, and the modalities of treatment available are individual therapy, group therapy, and marital therapy. The psychotherapy clinic is a discrete clinic in its own building in the grounds of a Psychiatric Hospital. It is part of the National Health Service, and the psychotherapy offered, as part of the NHS, is without charge.

Aspects of the Referral Process

Most patients we see have long-standing difficulties, and a history of involvement with other caring agencies. It follows that most have been in some form of therapeutic relationship with another agency from which the referral has been made. It is also important to consider the dynamics of the referral and how this affects the existing therapeutic relationship. This may be in the primary health-care system with the General Practitioner, in the Community Mental Health Centre with a member of the community team; or in the secondary system in a psychiatric outpatient clinic.

One cannot assume that a patient referred for psychotherapy understands what is being offered and what will be required of them.

It may well be that an experience of a transaction in the primary-care setting has triggered off some type of anxiety in the relationship and thus precipitated the referral (Balint 1957). Elucidation of such a dynamic might suggest that a more effective mode of intervention would be to support some important on-going work or transaction that is taking place in the primary health-care system rather than to take the patient into the clinic for treatment.

A study of general-practitioner patterns of referral to a psychotherapy clinic (Cleary 1987 - personal communication) illustrates the complexity of the referral process. She found that the patients who most consistently engaged with a clinic were those whose GPs were not interested in, knowledgeable about, or believers in psychotherapy. What became apparent was that this cohort of patients was highly motivated and had specifically requested referral to a psychotherapy service. In this same study, there was also a cohort of referrers who referred a high number of patients who subsequently failed to engage in therapy. The study revealed that this cohort of referrers were themselves in psychotherapy and tended to have an idealised view of psychotherapy, which had a powerful influence on their practice.

Another complex issue that emerges when one is trying to understand the referral process is: who is identified as the index patient? It is useful in this context to have some notion of family dynamics, since it is highly complex and uncertain whether, for example, the parent should be referred into an adult service or the child into a child-and-family service as the index patient. In a similar way, one partner in a marriage might be referred as the index patient and yet it may emerge in assessment that seeing patient and partner as a couple would be the most useful therapeutic approach. Thus, awareness of the nature of the referral pattern, the family context, and the system from which the patient has been referred, all have important implications for the assessment interview.

There are also the subtle processes whereby the assessor finds himself being either invited or pushed into various attitudes, such as being the better doctor or therapist, devaluing a colleague's work, or being invited to rescue the patient, all of which are important aspects of the referral dynamic which need to be considered. Assessors are more vulnerable to these influences if they themselves have a personal therapeutic vacancy which then has the potential to influence their objectivity (particularly in private practice).

ASSESSMENT TECHNIQUE

The technique in our clinic is based on offering the patient several sessions. In my experience three is about the average; but for more complex and difficult cases it could be six sessions. The important components are:

(a) an analytic type of experience

It is my practice always to invite the patient in the first session to bring whatever they wish to bring, facilitating the possibility of free association. This permits a rigorous scrutiny in the here-and-now of the interaction between the patient and the therapist, particularly the nature of the contact at the affective level and the degree of access to the patient's inner world. The presence and quality of emotional contact in the session is important, as well as the patient's capacity to think and understand. It is also an opportunity for the assessor to point things out in the here-and-now and to monitor the reaction of the patient.

Mrs A worked hard bringing relevant material, wishing to be helpful and to please the assessor; thus in the transference being the good child, either pleasing or appeasing the parent figure. Exploration of this dynamic revealed her avoidance of conflict, which was linked to the experience in her childhood of a confrontation between her parents and the death of her father shortly afterwards — a psychic catastrophe resulting in extensive obsessional and depressive difficulties.

Mrs B, a borderline patient, presented similarly. There was however a different affective quality in the session — a sense of her being programmed to speak. Like Mrs A, she sat tensely on the edge of the chair. Exploration revealed that she concretely experienced her mother telling her to '**Behave – or else**!' This led to an understanding of her attacks on her partner, whom she transiently experienced as a threatening and frightening parental figures.

Another example is of the schizoid patient who brings a series of dreams and fantasies for analysis which may be a manifestation of the wish to flee from his or her difficulties in the external world, and seek psychotherapy as a refuge.

A further clinical presentation which perhaps is more frequent in a psychotherapy clinic closely linked to a general psychiatric service is the patients who present their neurotic difficulties, but who split off, disown, and project the psychotic part of the self. These patients may seek psychotherapy to maintain their own defences regarding their fear of psychosis or their previous history of psychotic breakdown. Such patients are difficult to assess, particularly if one has no prior knowledge of their psychiatric history. A clue to such a problem could be the feeling in the assessor of something missing, or of a discrepancy between the patients' presentations and their difficulties in the external world. To elucidate such a dynamic requires an active attempt on the part of the assessor to locate the split-off aspects of the person (Rosenfeld 1978, 1987).

Mr C, a young professional man, complained of sexual and relationship difficulties which he attributed to conflicts about his religious beliefs. The sessions with him had an affectless quality to them, while at the same time I felt bored into by his gaze. Exploration eventually led to his disclosing that he had recently resigned from his job because of a sudden eruption of psychotic and persecutory experiences.

This example highlights the importance of scrutinising one's own affective response to the patient and in identifying the countertransference.

Evaluation of the history

It is my practice to take a history from the patient. This is usually not in the first session, but varies, depending, to some extent, on how the patient copes with an unstructured first session. If his or her anxiety levels increase continuously in a counter-therapeutic way, beginning to take a history may relieve this tension. This degree of anxiety is important to note because it might indicate that the patient

could not cope with the demands of the unstructured setting of psychotherapy. The history-taking is from the psychoanalytic perspective: the assessor tunes himself into the affective qualities of the people described, rather than focusing on the factual information; this can be known but quite split off in terms of emotional meaning. Idealisation, for example, often reveals itself in the manner and the way a parent is spoken about. Similarly, it is of note when important family-members are not mentioned; or are mentioned, but colourlessly, in a way that makes it impossible for the assessor to form a picture of them in his own mind.

Other factors that the assessor is looking for in his history-taking is the nature of the patient's personal relationships and the developmental history from the psychological perspective. The pattern of interpersonal relationships may indicate, for instance, separation problems; or it may reveal a repetitive failure and a compulsion to repeat old behaviour patterns without conscious awareness (Klauber 1971). In this way one can also pick up other clues, such as splitting and dissociation.

History-taking is a very important activity: not only because it actually reveals a lot of important and helpful information if one is carefully tuned in to what the patient presents, but because it helps in indirect ways too. There is an educational component for many patients. Implicit in history-taking is the idea that present problems are rooted in the past. The patient is being invited to think consciously about his or her past; and the possibility is brought up of making links between present and past. Finally, the patient's ego-capacities are mobilised in the service of understanding psychic difficulties.

Mrs D, a 32-year-old woman from another country, who had lived in the UK for ten years, was referred by a physician when no organic cause could be found for her severe back-pain. The pain developed after the failure of several intense relationships with her male partners and rejection by her father when she was feeling very vulnerable. She described all the men in her life in idealised terms, including her father, and treated me in a similar way, totally trusting me immediately. The consultation began with the future potential for dramatic disillusion. Her move from her mother country could be understood as an attempt to maintain her idealised internal relationships whilst dissociating herself both externally and internally from a whole range of complex and painful affects. When this had been pointed out to her she was able to explore the underlying difficulties which she had been defended against.

EVALUATION OF EGO-STRENGTH

The process of evaluating the patient's ego-strength is of fundamental importance, as is the nature of his or her defences. That information is central for making diagnostic and prognostic predictions. What the assessor is looking for is the capacity of the patient to tolerate anxiety, and to tolerate the stress and inevitable frustration which is part of the psychotherapy process. One is also looking at the patient's ability to appreciate the experience of being understood and make constructive use

of it; rather than mobilise envy of the assessor's contribution and the wish to spoil or dismiss it. It is also important to examine the patient's ability to contain affects and to hold the therapeutic experience within his or her mind. A most reliable way to make such difficult judgments is to monitor what happens both within and between sessions. For instance, it may be perceived during the process of assessment that each of the three assessment sessions offered is experienced as a first session, leading to the conclusion that nothing has survived in the intervening period between sessions. This would be important information when making a judgment as to whether once-a-week therapy would be useful. It also raises the complex questions of both frequency of sessions and length of therapy, something that I will return to later. The assessment of ego-strength relates to the patient's capacity to contain intense states of anxiety or panic attacks. It involves gathering information to ascertain whether the patient has had to resort to manoeuvres designed to relieve his or her distress, such as alcoholism, over-eating, medication, or visits to the GP to demand instant relief.

The **Table** below summarises the main factors that I consider should be addressed in the assessment.

ADVANTAGES OF THIS APPROACH

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. It also follows that the technique embraced in such a comprehensive venture will vary at different times during the assessment. By having a structure of several sessions the assessor can adopt a more analytic stance at a certain point in the session, to encourage free association and rigorous examination of the interaction that takes place between the patient and the assessor. At other times, one can take a history from a psychodynamic point of view where one is functioning in perhaps a more active cerebral and diagnostic capacity. It is essential to address both the empathic emotional and the diagnostic aspects in the assessment.

From the assessor's perspective he is able to offer an interpretive experience to the patient and monitor the response, thus forming a judgment as to whether the patient can benefit from a psychoanalytic approach. It is important to differentiate the patient who can be understood by the assessor from the critical factor of the patient's capacity and motivation to use such understanding for the resolution of his or her problems. By spending a considerable amount of time with the patient one is also able to get a feel for the child within (this is a mental representation of the child's subjective experiences and their significant relationships) and for this to contribute to the psychodynamic formulation.

From the patient's perspective he or she has an experience, probably for the first time, of what psychotherapy is going to be like; so, within the structure, the trial element is included. This offers the patient an opportunity to reflect upon the experiences themselves and enables the assessor to make judgments about their

Table Core factors in assessment for psychotherapy

Referral process

Does the patient want to come?

Needs of the referrer (eg becoming overwhelmed by the patient)
Fantasies of the referrer (eg idealisation of therapy)
Patient carrying projected parts of another (eg aspects of parent or partner)

What does the patient want?

Clarify in relation to psychoanalytic psychotherapy (eg understanding and alleviation of mental illness, promotion of growth and development, symptom removal)

Educational aspect

The patient having an opportunity to experience:

a psychoanalytic approach
the exploration, understanding and reformulating of the presenting problems

Addressing the core aspects of the Psychoanalytic Assessment and its unconscious determinants

The psychodynamic formulation:

the internal relationship to the child within
how to repair damaged internal objects
identification of defences and disavowal

The Trial aspect of the assessment

Monitoring reactions within and between sessions (including regressive potential, risk of breakdown)
Further elucidation of defences
Capacity and will for growth

Treatment recommendations

Negotiating treatment recommendations with the patient
Matching patient's needs to what the service can offer
Is the clinic the appropriate setting? Or if there is some other on-going therapeutic work, should this be encouraged or supported?
Should one refer the patient on to a specialised agency? Or as a possible patient to a training programme?

Letter to referrer

Psychodynamic explanation and informed advice

personal motivation and whether they wish to participate in this psychotherapeutic approach. As a result, the patient becomes involved in the decision-making process and is not just the passive recipient of advice which, by its very nature, reinforces the individual in the parent/child role as the child receiving help and advice.

From the perspective of a district service offering a variety of therapeutic approaches, the individual response of the patient can be very helpful. For example, phobic difficulties can be approached psychoanalytically or more symptomatically. By giving individuals an analytic experience in the assessment, followed by discussion of the possibilities for therapy, one becomes able to determine and clarify whether they wish to understand themselves, and struggle in an analytical way, or whether they wish to have symptomatic relief and cannot cope, or do not wish to cope, with the great demands of better understanding themselves and their internal worlds. In this way one can come to a mutually agreeable decision about whether the patient wishes to have psychoanalytic psychotherapy, or wishes to elect for something like behaviour therapy.

A frequently-expressed anxiety about the assessment structure I have described, is that the patient will develop a very powerful transference to the assessor which will complicate the transition to establishing a working relationship with the therapist once a vacancy arises.

My experience has not borne this out. While there is much scope for fantasy to develop in a long, one-off intensive assessment session, over several sessions it is possible to work on this dynamic. This enables the patient to get a more realistic view of the assessor and of the frustrations of the therapy process. My view is that several sessions usually reduce the possibility of omnipotent and idealising transferences developing or being potentiated; and, if anything, the extended assessment is more facilitating when it comes to developing a working alliance once the therapeutic vacancy arises.

The availability of several sessions provides an opportunity for the assessor to metabolise the dynamic process of the assessment and to utilise the familiar experience of discovering something further while reflecting on the session or when writing it up. This is particularly important for borderline patients, since one has a greater opportunity to process and then verbalise a primitive communication (Bion 1962).

Mr E is a patient who had great difficulty in being able to attend the assessment, citing work-commitments and important meetings. When he did finally come he repetitively conveyed to the assessor that the assessment was making inroads into his valuable time and his important responsible job. The assessor was left feeling immobilised and belittled, and found himself responding in a stilted and rather wooden manner. It was only after the session had concluded that it was possible to metabolise this experience and come to an understanding that the patient was unconsciously causing the assessor to experience inadequacy and that the woodenness was a reflection of his rage and his hatred of the dependent aspect of his personality. It was possible to test this hypothesis in the following assessment session, resulting in the material about suicidal ideation which from time to time erupted, fracturing his rather grandiose way of functioning.

Miss F, aged 23, requested therapy, complaining of depression and relationship difficulties. She was quite contained in the session; but, afterwards, without the assessor knowing, she engaged the secretaries and then the cleaner, asking for advice and support. She also spent considerable time physically in the clinic, causing the staff to feel she was trying to make it her home. Such information, fed back to the assessor, regarding not only the limits of the session but Miss F's relationship with the staff and facilities within the clinic and her use of other agencies, was not only important in terms of suitability for treatment, but it was useful over the assessment period in establishing the limits of a containing structure which is necessary if meaningful psychotherapeutic work is to take place (Bleger 1966). This definition of limits can be seen as an alternative to the negotiation of a formal contract with the patient prior to treatment (Selzer *et al.*) Our practice with such patients is to establish a shared care arrangement, so that day-to-day management and medication is managed by either the psychiatric team or the GP. This enables clear boundaries to be established, and the concept of (symbolic) parents working together is available as a dynamic to explore in the therapy.

A further consequence of the multi-session assessment process is that patients on the waiting-list for a therapeutic vacancy are much more contained during this waiting period, and more reflective about their difficulties. I feel that this is due to the patient's experience with the assessor and the opportunity to form a relationship to the clinic as well as to the assessor, which helps to develop a sense of containment. This reflects the development of a split transference to both the clinic and the assessor (Main 1989) which relieves some of the pressure on the assessor to be the sole container of the patient's emotional difficulties. This is of particular importance in the case of the more disturbed patients, such as those with borderline disorders, where the function of the clinic as a container is an important part of the therapeutic work that enables the therapist to have more space to work with the patient.

An issue little discussed in the literature, is the relationship of frequency and length of therapy to its outcome. To conduct an assessment over several sessions enables the assessor to gather information on the patient's reactions to the intervals between sessions. A highly dependent, anxious patient may well feel contained for two to three days after a session, and then begin to display extensive symptomatology. This would suggest that twice-weekly or more frequent therapy is indicated and that less frequent therapy is likely to be ineffective. A patient with well-organised obsessional defences that allow some access towards the end of a session, but who returns to the next session with his or her defensive structure unmodified, is unlikely to be helped in a once-a-week time-limited therapy. Similarly, a patient who has suffered considerable trauma in childhood may need the continuity of a lengthy therapy, and may show no obvious change in the first year, which is the conventional time-limit of many therapies.

These clinical problems, and the matching of clinical need to resources, are of increasing importance with the advent of audit and in considering outcome data.

Some further considerations

One of the questions that arises from undertaking extended assessments is their relationship to brief psychotherapy, since three-to-six sessions is considered by many to constitute brief psychotherapy (Davanloo 1978, Sifneos 1972). In the extended assessment it is possible to make certain conflicts and wishes conscious that were previously unconscious, and to identify certain aspects of transference that have arisen in the assessment and to offer an interpretation. In my opinion, it is important to distinguish what can be achieved in the assessment process from some of the claims that are made in relation to brief psychotherapy. While it is true that on occasions the assessment itself has such impact as to be all that is required, I do not believe that it is possible in three-to-six sessions to effect a significant and durable intrapsychic change in the majority of people we see. It is my view that what an extended assessment can achieve is a significant increase in the patients' awareness of the unconscious pattern of relationships in their internal worlds and the resulting pattern of maladaptive relationships and transactions in the external world. It enables them to use their ego-function in the service of thinking about, and hopefully thinking about in a new way, some of the difficulties they experience. This, coupled with the experience of being understood and taken seriously, has an important therapeutic impact in giving patients a sense of hope. It is also a method by which they can achieve a greater mastery of their difficulties.

CONCLUSION

This paper explores a wide range of issues relating to assessment. The literature conveys the complexity of the problems, the various controversies with respect to technique, and the wide range of factors that have been considered to be important. The quest for accurate prediction in such a complicated area has within it a considerable degree of omnipotent fantasy. This parallells notions of total resolution of the transference, rather than a more realistic notion of modification. The assessment has numerous functions and is multi-layered. It can therefore benefit from an approach using several sessions. This structure enables the goals of assessment to be achieved, and allows freedom of movement within the assessment process (Symington 1983). Hence, a more analytic stance is possible at a certain point. At other times, one can take a history from a psychodynamic point of view where one is functioning in perhaps a more active cerebral and diagnostic capacity. The essence of the process is the ability to integrate these two basic aspects of the assessment process. Within this structure, I believe, it is possible to encompass the range that is required. It can be seen, from what I am proposing, that the technique adopted is very different from the actual therapeutic situation, where one is func-

tioning as the analyst or therapist. The assessment is therefore a discrete process, with its own technical characteristics, and should not be confused with psychoanalytic technique (A. Freud 1965). The consequence of this is that in the optimum set-up the assessor should not be the person who is considering taking the patient on for therapy, as these two activities are separate.

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