CHAPTER ONE

Assessment for psychoanalytic psychotherapy: an overview of the literature

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"I must however make it clear that what I am asserting is that this technique is the only one suited to my individuality; I do not venture to deny that a physician quite differently constituted might find himself driven to adopt a different attitude to his patients and to the task before him."

Freud, 1912e, p. 111

The idea that those seeking psychoanalytic treatment need to be carefully selected by analysts was first proposed by Freud (1904a, 1905a, 1912e, 1937c). On the basis of a meeting, variably called an assessment, a consultation, or an evaluation, the analyst makes an assessment of the prospective patient. If the patient is considered suitable for psychoanalytic psychotherapy, a referral will be made. The number of works cited in this chapter is testimony to the thought and effort that this idea has generated.

While this chapter includes most of the main papers in the field, it does not claim to cover all the material on the subject. Few of the papers are recent—only four of those most quoted having...
been published in the 1990s—and while it is not obvious why this is so, one could speculate that the whole area of assessment rather than becoming clearer has, in some way, become more blurred. It is, however, a field that has grown somewhat haphazardly: authors have written papers in which terms have been loosely used, in which their ideas have not been related to those of others, and in which questions that seem very fundamental are not raised. Throughout what is now nearly a century of work and thought, a virtual morass of work has burgeoned, punctuated at intervals by review articles that seem to attempt to bring attention at least, and a little order at best, to some of the confusions and loopholes.

What seems to be an omission in most papers is an explanation of why an assessment should be done for a treatment such as psychoanalysis. Of course, in the case of selection of patients for supervised analyses and of candidates for training, the need for assessment appears more obvious. However, few authors seem to express their views about the consequences of not assessing patients in this way, although it would seem that there are tacit understandings. Stone (1954) was quite unusual in saying that analysis should not be undertaken in cases where the prognosis looks bad or the personality cannot tolerate it. Similarly, Zetzel (1968), in describing patients whom she considered unsuitable, says that the risk inherent in such patients entering psychoanalytic therapy is a passive dependent transference and serious problems in the terminal phase.

Another omission in most papers is any definition of the process called psychoanalysis; again, for the most part there is tacit agreement about what is meant. It is a serious omission since the rationale for assessment must hinge on the nature of this treatment, and on the demands and rigours of the experience. No single definition seems adequate, but it may be important to recognize that developments in the theory and practice of psychoanalysis have interacted with thinking on assessment.

However, the purpose of this review is

1. To give some account of the work that has been done in the field of what will be called “assessment” in this chapter, with, once again, the unspoken recognition that this is a predictive task. To put it crudely, what are the aspects that need to be thought about in order that both the patient and the analyst can engage in this process called psychoanalysis or psychoanalytic psychotherapy? The main aspects described here are the qualities of the patient, the personality of the analyst, and the patient—analyst match. This account has a historical perspective in that an attempt is made to look at various aspects of assessment and how these have evolved over time.

2. To describe various aspects of the process of assessment. Very few authors define this process, but Pollock's definition (1960) that the purpose is “patient evaluation and suggestions for further procedures” is one that covers the assessment process to be discussed here.

The papers in this review are clinical and research studies, and both of these areas have their strengths and weaknesses. Some of the papers deal with referral to qualified analysts and some with referral to candidates training in psychoanalysis—that is, supervised analyses. One of the limitations of this overview is that constraints of space prevent the comparing and contrasting of these various aspects. Having taken into account this limitation, it is worth noting the comment of Bloch (1979) as regards the research:

The immense volume of research in the area of assessment has yielded little of practical value and the impact of research on clinical work has been minimal. [p. 205]

As regards supervised analyses, these papers could perhaps be considered comparable to the others on assessment in many ways. One very obvious difference is the context for which the assessment is made. This very general point will be addressed at the end of the chapter in terms of the factors that impinge on the course of an analysis.

For the purposes of this chapter in relation to the treatment that is being considered, Hinshelwood's (1995) approach is followed: in making assessments, his view applies to psychoanalysis as well as to an intensive psychotherapy based on the psychoanalytic method. The terms psychoanalysis and psychoanalytic therapy are used interchangeably.
Patient qualities

The early search for the criteria defining the psychoanalytic patient

The early descriptions of patient qualities provide evidence of a state of confusion that still continues to be the case. As Baker (1980) said, "In scanning the psychoanalytic literature it is possible to reach the conclusion that psychoanalysis is suitable for everything and nothing" (p. 355). (For excellent reviews of the earlier literature, the reader is referred to Tyson & Sandler, 1971, and Erle & Goldberg, 1979.) From the earliest times, Freud (1904a, 1905a, 1912e, 1937c), outlining his views of the symptoms, qualifications, indications, and contraindications of the prospective psychoanalytic patient, considered it important to look beyond the diagnosis or illness to the whole personality. Chronic cases of psycho-neuroses without very violent or dangerous symptoms were considered the most favourable for psychoanalysis. He excluded psychoses, states of confusion, and deeply rooted depression, although at that time he held the view that, by suitable changes in the method, this contraindication could be overcome and that there could be a psychotherapy of the psychoses. In looking beyond the patient's illness to the whole personality, he emphasized intelligence, ethical development (i.e. persons of a reliable character), and those under 50. Over the age of 50, the mass of psychical material, according to him, was no longer manageable, the time required for recovery being too long and the ability to undo the psychical processes beginning to grow weaker. In addition, patients should come to treatment because of their own suffering, not because of the authority of a relative. Tyson and Sandler (1971) quote the work of Jones (1920), who lists certain diagnoses for patient selection such as hysteria, anxiety hysteria, conversion hysteria, and mixed neuroses, but the deciding feature was that the predominant anxiety arises from the later infantile genital phases of development. Included amongst other diagnoses in the "moderately accessible" category was the average organized obsessional neurosis and obsessional character, and some sexual perversions, having their roots mainly in pregenital layers of development. Those diagnoses linked most closely with psychotic structures and psychoses were included in the "slightly accessible" category, of which he says endogenous depression is the most favourable and the pure paranoias the least. The use of the term "accessible" (although not new, as it was used by Freud) added a further dimension to the issue of assessment. Glover's use of the term was linked to the transference: the earlier the fixation points, the more tenuous is the positive transference bond and the less accessible is the patient to the opening-up process. Accessibility has been elaborated as a concept by others, in particular, Tyson and Sandler (1971), who in their paper suggest that it appears to be related to the factors that go into the making of a treatment alliance. This is discussed in greater detail in later sections.

Authors such as Fenichel (1945) and Glover (1954b), while offering lists of diagnoses, added their views on the important characteristics of the personality behind the diagnosis that should be considered, and they furthered the idea that the qualities of the person behind the illness were important and that diagnosis alone was an inadequate guide to patient selection.

Fenichel (1945) included hysteria, compulsions and pregenital conversions, stuttering and psychogenic tics, neurotic depressions, character disturbances, perversions, addictions and impulse neuroses, and psychoses, including manic-depressive psychosis and schizophrenia. This notion that the diagnosis is linked to the person was also emphasized by Glover (1954b), who took into account personality, life style, and the developmental stage of early life in which the illness could be seen as primarily rooted. He based his diagnoses on a developmental approach—for example, anxiety hysteria having its origins between 4 and 5 years of age, obsessional neurosis between 3 and 4, and psychoses in the first three years of life. Glover assigned his list of diagnoses to three categories: accessible, moderately accessible, and slightly accessible. In the "accessible" category, he included such diagnoses as anxiety hysteria, conversion hysteria, and mixed neuroses, but the deciding feature was that the predominant anxiety arises from the later infantile genital phases of development. Included amongst other diagnoses in the "moderately accessible" category was the average organized obsessional neurosis and obsessional character, and some sexual perversions, having their roots mainly in pregenital layers of development. Those diagnoses linked most closely with psychotic structures and psychoses were included in the "slightly accessible" category, of which he says endogenous depression is the most favourable and the pure paranoias the least. The use of the term "accessible" (although not new, as it was used by Freud) added a further dimension to the issue of assessment. Glover's use of the term was linked to the transference: the earlier the fixation points, the more tenuous is the positive transference bond and the less accessible is the patient to the opening-up process. Accessibility has been elaborated as a concept by others, in particular, Tyson and Sandler (1971), who in their paper suggest that it appears to be related to the factors that go into the making of a treatment alliance. This is discussed in greater detail in later sections.
method screened out those who might otherwise be selected for psychoanalytic therapy. He did describe certain conditions that he considered to have the “least part” in psychoanalysis. Firstly, there were psychoses, addictions, and perversions, which were considered problematic because they compete with the therapy in terms of providing relief from painful tension. Secondly, there were those psychosomatic problems that may be indicative of the severity of psychoses. However, in his paper “The Widening Scope of Indications for Psychoanalysis” (1954), he made a plea for the classical technique in some instances to be modified to accommodate certain patients:

My own clinical experience and observation lead me to believe that too great approximation to the mathematical ideal in certain references is antitherapeutic. [p. 574]

He goes on to say that there may, in some instances, be a need for deviation because it may be impossible for some patients to work with total emotional detachment. However, the deviation should not be too great and should be seen as a technique, not as a personal gratification or as a panicky fear of rule breaking. Stone’s paper can be understood mainly in terms of widening the scope of psychoanalysis—that is, being somewhat more flexible in method—to include those patients who formerly might not have been taken into treatment.

However, psychoanalysis may legitimately be invoked and indeed should be invoked for many very ill people, of good personality resources, who are probably inaccessible to cure by other methods, who are willing to accept the long travail of analysis without guarantees of success. [pp. 593–594]

There is also the sense in which he widened the scope to thoughts about not only the analytic method but the role of the analyst in the analytic task. This is discussed in later sections. The idea that diagnosis on its own can be misleading was one highlighted in a paper by Zetzel (1968), “The So-called Good Hysteric”, in which she described four categories of patients who had been diagnosed as hysterical. These patients were differentiated from one another on a variety of criteria—developmental, their defences, their work and academic achievements, their birth order in family of origin. Most interestingly, she marked out those whom she termed the “so-called good hysteric” in terms of the following criteria: absence or significant separation from parents in the first four years of life; serious pathology in one or more parents, often associated with a broken or unhappy marriage; serious and prolonged physical illness in childhood; a continuing hostile dependent relationship with the mother, who is seen as devaluing and rejecting; and, finally, an absence of meaningful and sustained object relations with either sex. She was perhaps one of the first to consider the role of the patient’s object relations—not only the early, but also the current object relations—as being important.

The early work mainly addressed the issues of diagnosis but also, more generally, patient qualities behind the diagnosis. Terms were, however, not defined, the purpose of assessments was unclear, and by 1971 the field had become complex if not confusing. The paper by Tyson and Sandier in that year addressed both these issues. They wisely entitled their paper “Problems in the Selection of Patients for Psychoanalysis”, thereby avoiding the very pitfalls into which others had fallen: namely, using in a loose way such terms as indications/contraindications, suitability, accessibility, and analysability. “Indications”, they suggested, were “signs and symptoms”, whereas suitability was more to do with the qualities and capacities of the patient. Assessment for treatment, according to them, depends more on criteria of suitability than on indications. They suggest that instead of talking about the suitability of the patient for the treatment, it is more appropriate to talk about the suitability of the treatment for the person. Perhaps there is greater hope for the individual if suitability is understood in this way, with there being possibilities of other treatments that may offer something of more value to this person. The notion of accessibility, referred to earlier, was also used by Freud (1905a) in terms of whether analysis could reach and influence the patient. This is understood in terms of what has come to be known as “psychological-mindedness”—the capacity to think in psychological terms, to see connections between events and feelings in himself. Tyson and Sandler (1971) understand accessibility in terms of the various components necessary for an adequate treatment alliance i.e. the capacity to tolerate a certain amount of frus-
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In addressing the issue of accessibility, the area of assessment is broadened, from the diagnosis and the person behind it, to the patient in the context of a psychoanalytic treatment.

Tyson and Sandler also discuss the term “analysability” frequently used in papers, a term that they regard as having disadvantages because it obscures the distinction between whether the analyst understands the patient and whether the patient can benefit from the analytic procedure at any time. It also perhaps introduces the thorny problem of the aims of psychoanalysis and the issue of how one might judge the success or otherwise of an assessment, let alone an analysis.

Tyson and Sandler’s paper, then, very usefully reviews the literature up to 1971, taking as their framework Freud’s criteria of suitability:

1. The upper age limit set at 50 by Freud was increased by subsequent writers, notably Abraham (1919), who suggested that the age of the neurosis was more important than the age of the patient. Tyson and Sandler themselves conclude that “an assessment must take into account the changes due to age in the individual patient rather than the simple factor of age itself” (p. 220).

2. Intelligence or education, it is suggested by Tyson and Sandler, should be considered more in terms of whether or not the patient can develop a treatment alliance and a sufficient degree of insight.

3. As regards moral and ethical considerations, Tyson and Sandler, while quoting authors such as Jones (1920) and Bibring (1937), suggest (as apparently did Fenichel, 1945) that a patient with one type of moral problem may be acceptable to one analyst and not to another. In such a case, they indicate that the analyst should not try to set aside feelings but, rather, should refer the patient elsewhere.

4. Freud (1905a) had suggested that the patient should be motivated by the fact that he suffers from his symptoms but then

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later (1926d [1925]) identified secondary gain—that is, drawing as much advantage from the symptoms as possible. Tyson and Sandler warn that some patients may have so much to lose in the form of secondary gain that analysis may not be a viable proposition.

Tyson and Sandler’s paper brings together the early thinking and usefully makes distinctions between formerly undefined terms, as well as reviewing the literature in the way outlined above. Their paper also draws attention to the complexity of the assessment process, indicating that any recommendations for psychoanalytic treatment need to take into account the qualities of the patient but also the possible treatment alliance and the patient-analyst match. In spite of the growing awareness of the complexity of the assessment task, the search continued for those patient qualities that would identify the ideal patient for psychoanalysis. Tyson and Sandler comment that the so-called criteria of suitability represent ideal conditions and that “It would seem that we may be in the paradoxical position of finding that the patient who is ideally suited for analysis, is in no need of it!” (p. 227).

The continuing search for patient qualities

Considerable work, both clinical and research, has gone into the search for patient qualities, and Waldhorn’s (1960) dictum “sick enough to need it and healthy enough to stand it” encompasses both the notion of the diagnosis as much as the person behind it. In a similar vein, Greenson (1967) suggests that a diagnosis may not tell us much about the healthy resources of the patient and that even perversions and borderline diagnoses have “varying degrees of healthy resources. Yet it is their supply of assets, not the pathology which may be the decisive factor” (p. 53). He goes on to suggest that what needs to be assessed is the patient’s endowment in regard to the specific demands of psychoanalytic therapy, which is a time-consuming, long-range, and costly therapy and by its nature is very frequently painful. The search has, therefore, continued for the qualities that reflect both the pathological and the healthy aspects of the patient. (It is perhaps worth noting that
Bachrach & Leaff, 1978, in their review of the literature, listed 390 individual but widely overlapping items that different authors thought important in predicting analysability.)

Categories of Patient Qualities

It is important to note in the work that is described below on the categorization of patient qualities that a variety of methods of assessment were used. These have been described by Bachrach and Leaff (1978) as follows:

1. clinical interview, with emphasis on life history—in recent times emphasis has been placed more on the experience within the interview itself;
2. diagnostic psychological testing (Kernberg et al., 1972);
3. meeting of a committee to make decisions, which is used mainly in supervised cases for training;

Not only are there these variations in methods of assessment (which has been touched on above), but variations in the purpose of assessment. Limentani (1972) considered assessment from three different points of view—of private patients, of supervised cases, and of candidates for training—and indicated that there needs to be a clearer definition of the purpose of assessment in these terms.

Bachrach and Leaff (1978), in their extensive review of the literature, described qualities of the patients in terms of the categories outlined below, which are used here as a framework. Examples are given, but because of limited space these are not exhaustive but are aimed at giving some sense of the thinking and its evolution over time.

- Adequacy of general personality functioning: including all references to adequacy of adaptive functioning, severity of illness, severity of symptoms, diagnosis, ego strength, reality testing, sublimatory potentials, adaptive regression, defence, thinking, intellectual abilities, and capacity for verbalization

Diagnosis, severity of symptoms. Some of the thinking in this area has been discussed above, but there are subsequent views that are worth noting. Greenson (1967) suggested that psychoanalysis was contraindicated for the various forms of schizophrenia and manic-depressive psychosis, but the case was questionable for such disorders as impulse neuroses, perversions, addictions, delinquencies, and borderline cases. Klauber (1971) expressed wariness about patients with psychosomatic complaints without other conflicts, and those with hypochondriasis. More recently, Coltart (1987) has pointed out that the term character disorder has been elaborated and that there have been advances in the theory and treatment of severe narcissistic disorders. She expresses, however, some reservations about depression with a kind of affective flatness and projective mechanisms, which should make one consider a concealed narcissistic disorder, as well as about a tentative diagnosis of the false self. However, she says that other situations formerly regarded as not suitable for selection for psychoanalysis—for example, psychosomatic states, delinquency, psychotic signs or behaviour trends, too long periods of previous treatment, very high levels of anxiety and tension, patient older than the therapist—may all be dealt with by psychoanalytic therapists who have an interest in, and extended knowledge of, a particular area of disturbance. The implication is that psychoanalysis may be a treatment of choice for a far greater range of patients than formerly thought. Garelick (1994) notes a trend away from diagnosis to the nature of the relationship and transactions between patient and assessor.

2. Psychological-mindedness. This has been described in various ways by different authors: a capacity for self-observation or self-appraisal as opposed to rationalization (Stone, 1954); an ability to take a distance from his own emotional experience (Namnum, 1968): the ability to carry out ego functions that are in contradiccion to one another, such as in free association, and to regress in thinking but also rebound from regression in his relationship to the analyst; the ability to have resilient and flexible ego functions (Greenson, 1967); the ability to think in psychological terms; and, finally, the ability to see connections between events and feelings
in himself (Tyson & Sandler, 1971). Sashin, Eldred, and Van Amerongen (1975), in an attempt to rate the usefulness of specific factors in the reports of individual evaluation interviews on patients accepted for supervised psychoanalytic treatment, found that there was very little inter-rater reliability on the criterion of psychological-mindedness. From clinical interviews, however, Coltart (1987) expressed the view that if the patient shows a lively curiosity and a genuine concern about internal reality and

if he can make a tenuous link between the idea of relief from psychic pain and an increase in self knowledge, and then shows some real pleasure in finding out some tiny thing about himself in the initial interview, this is one of the best criteria for the analytical approach. [p. 23]

3. Ego strength. According to Kernberg (Kernberg et al., 1972), good initial ego strength is correlated with degree of improvement. Sashin et al. (1975), in the study mentioned above, found low inter-rater reliability on this criterion of ego strength. Baker (1980), in a paper on suitability for supervised cases for training, approached the question of ego strength from the perspective of primitive defences, suggesting that their widespread presence is an ominous sign, the more so sometimes when they appear to be in the service of ego stability. He goes on to say that the successful operation of such defences can mask the ominous signs of ego weakness, such as the capacity to tolerate anxiety and the precarious mastery of impulse control.

1. Early object relationships. This was emphasized by Stone (1954), who took a longitudinal history and considered the character and pattern of relationships with people. Aarons (1962) suggested that a high initial quality of interpersonal relationships—that is, the person’s earliest object relationship—may provide a reliable basis for an assessment of his analysability. Object constancy and the capacity for differentiation of self and object representation was emphasized by Huysted, Lower, and Escott (1975). Others (Knapp, Levin, McCarter, Wetment, & Zetzel, 1960; Zetzel, 1965; Namnum, 1968) have all noted the importance of the capacity for object relations. Sashin et al. (1975) noted that those who left their analysis prematurely (within six months or even after three years) had a poor relationship with the same-sex parent. However, Kantrowitz et al. (1989) in contrast suggests, on the basis of a research pilot study, that the level and quality of object relationships is not predictive of outcome.

2. Object relations within the assessment setting. Stone (1954) suggests that the patient’s reaction to the examiner is of importance and should be noted. This aspect has been given more attention recently. Klauber (1971) suggests that it is primarily the quality of the rapport formed as a result of glimpsing the emotional and intellectual process that will enable the patient and the consultant to judge whether the patient can make further use of the experience. In his view, the assessment is

based on a complex assessment of defences and motives and arrives at a richer and profoundly relevant picture of the personality extending far back into the history of the patient. The most important thing is for it to take account of the intensity of the compulsions to repeat old patterns of behaviour, both within and outside the analysis. [pp. 150–151]

Hinshelwood (1995) considers, in addition to infantile object relationships and the current life situation, that it is essential to take into account the relationship to the assessor. Ogden (1989) sees the patient’s history as being conveyed unconsciously in the form of transference–countertransference experience. This, he says, is the patient’s living past, the set of object relations established in
infancy and early childhood which has come to constitute the structure of the patient's mind both as the content and context of his psychological life.

- **Motivation**

Although motivation has been regarded as an important variable in selection of patients by some (Aarons, 1962; Greenson, 1967; Knapp et al., 1960; Sashin et al., 1975; Tyson & Sandler, 1971), Kernberg (Kernberg et al., 1972) did not regard it as playing an important role. Similarly, Kantrowitz (1987) said that not only was it difficult to evaluate but it was also not predictive of outcome.

- **Affect organization, including references to availability of and tolerance for anxiety, frustration, and depression**

Authors have referred to this area in a variety of ways. Stone (1954) emphasized a capacity for patience and deliberate tolerance of unavoidable suffering. Zetzel (1965) wrote of the capacity to withstand anxiety and depression, Kernberg (Kernberg et al., 1972) of a high initial anxiety tolerance, and Tyson and Sandler (1971) of a capacity to tolerate and recognize affect. Once again, Kantrowitz et al. (1989) suggest that affect availability and tolerance are not predictive of successful outcome.

- **Character qualities**

This has been described in different ways by various authors: the need for a high degree of honesty and integrity (Greenson, 1967); the need to be reliable in the first place (Klauber, 1971); the need to have moral awareness and integrity (Coltart, 1987).

- **Superego factors**

This would include factors to do with a harsh superego, need for punishment, self-deprecation, and a history of reactions of unworthiness to successful achievements, which obviously would be regarded as less favourable when considering assessment. This was described in terms of deprecation and self-castigation (Stone, 1954), low self-esteem (Zetzel, 1965), or basic deficit in self-esteem (Huxster et al., 1975).

### Demographic factors

Age has been discussed above. Other factors such as occupation and life situation were considered relevant by Stone (1954). However, Bloch (1979) suggested that age, sex, marital status, educational achievement, and socioeconomic status were not of prognostic relevance. Huxster et al. (1975) noted that achievements in school and work were important, as did Coltart (1987) who suggested that the person who fails at everything will fail at analysis as well.

- **External factors**

Greenson (1967) suggested that prospective patients should not be in the midst of a life crisis. According to Klauber (1971), it is advisable to be wary of those who are making their own or someone else's life impossible. Bachrach and Leaff (1978) listed the following qualities:

Taken together these studies suggest that persons most suitable for classical psychoanalysis are those whose functioning is generally adequate; they have good ego strength, effective reality testing and sublimatory channels, and are able to cope flexibly, communicate verbally, think in secondary-process terms, and regress in the service of the ego with sufficient intellect to negotiate the tasks of psychoanalysis; their symptoms are not predominantly severe, and their diagnoses fall within a "neurotic" spectrum. Such persons are able to form a transference neurosis and therapeutic alliance, are relatively free of narcissistic pathology, have good object relations with friends, parents, and spouses, and have been able to tolerate early separations and deprivations without impairment of object constancy; they are, therefore, able to experience genuine triangular conflict. They are motivated for self-understanding, change, and to relieve personal suffering. They are persons with good tolerance for anxiety, depression, frustration, and suffering and are able to experience surges of feeling without loss of impulse control or disruption of secondary process mooring of thought. Their character attitudes and traits are well-suited to the psychoanalytic work, i.e. psychological mindedness. Superego is integrated and tolerant. They are...
mainly in their late twenties or early thirties and have not experienced past psychotherapeutic failure or difficulties. Of all these qualities, those relating to ego strength and object relations are most important. [pp. 885-886]

The above quotation gives what could be thought of as the definitive catalogue of characteristics of the ideal patient, but as early as 1960 Knapp et al. said the following after describing their study of a review of 100 supervised cases:

Certainly our work suggests the impossibility of treating patients as an aggregate of unrelated and separate qualities and the difficulty, not to say impossibility, of carrying out most studies of this kind by evaluation of patients alone. The attributes and experience of the analyst, the establishment of the analytic situation, and finally, the development and resolution of the transference neurosis must all be taken into consideration. [p. 476]

Perhaps most telling of all is the comment by Bachrach and Leaff (1978)—which is still applicable—that the majority of studies fail to indicate the evidence for their conclusions, the data upon which they are based, the populations referred to, selection biases, and, in general, the extent to which one investigation may truly replicate another. Very few studies specify what is meant by psychoanalysis; furthermore, as the work of Kantrowitz et al. (1989) indicates, it is questionable whether there is good agreement about the meaning of terms used. It would appear from the papers described here that there is far from total agreement; in particular, the work of Kantrowitz et al. (1989) questions some of the clinical findings. It is probably still true to say, as Bachrach and Leaff (1978) suggest, that the quantitative findings are superficial and those that are clinical are limited from a methodological point of view.

However, at the end of their very comprehensive and lengthy review Bachrach and Leaff (1978) do conclude that the studies of all kinds, despite their limitations, indicate a considerable degree of agreement about the qualities deemed to make a person a suitable candidate for psychoanalysis: the better the pre-treatment level of personality organization, the more favourable the prospect.

Bearing all this in mind, and the tremendous amount of work and effort that has gone into the establishment of those patient qualities that would make a person a suitable candidate for psychoanalysis, it would seem that, as Garelick (1994) suggests, there has been movement away from diagnosis and that the search for individual factors has been unfruitful. The growing trend is towards the nature of the relationship and transactions between patient and assessor. Reservations about the emphasis only on the patient’s qualities have been growing, and there is an increasing awareness of the importance of the role of the analyst and the analytic fit in the outcome of the analysis. Since the qualities of the analyst and that of the analytic match are even more difficult to assess than the patient qualities, much less attention has been devoted to them.

The personality of the analyst and the patient–analyst match

Freud (1905a) himself acknowledged the role of the analyst’s personality in the analysis:

It is not a modern dictum but an old saying of physicians that these diseases are not cured by the drug but by the physician, that is, by the personality of the physician, inasmuch as through it he exerts a mental influence. [p. 259]

As early as 1938, Clara Thompson wrote a paper entitled “Notes on the Psychoanalytic Significance of the Choice of Analyst”, saying that pertaining to the analyst’s part in the collaboration is the more glaringly inadequate. One seldom finds an account of anything that suggests the differences in personality of various psychoanalysts or the significant entering of the analyst’s personality in the whole protracted process. Many analysts, however, must have failed with some patient who did better elsewhere; must have carried to completion some patient who had failed with a preceding analyst. If one knew practical psychoanalytic experience only from the papers printed, one might be tempted to assume that the analyst as a personality in reality does not exist, that he never says anything, that he
never leaves the impress of his opinion on the patient in any way, that he never makes any mistakes, that in short, he is not human but a fountain of completely detached wisdom in no way affected personally by anything which goes on. [p. 205]

This question of the personality of the analyst was considered by Stone (1954), who in his discussion of the analyst himself suggested that the analyst needs to know his own capacities (intellectual and emotional), special predilections, interests, and emotional textures, since “he may profoundly influence prognosis, and thus—in a tangible way—the indications” (p. 592). In the same journal issue, Anna Freud (1954) wrote what she considered were “technically subversive thoughts” (p. 619):

But—and this seems important to me—so far as the patient has a healthy part of his personality, his real relationship to the analyst is never wholly submerged. With due respect for the necessary strictest handling and interpretation of the transference, I still feel that we should leave room somewhere for the realization that analyst and patient are also two real people, of equal adult status, in a real personal relationship to each other. I wonder whether our—at times complete—neglect of this side of the matter is not responsible for some of the hostile reactions which we get from our patients and which we are apt to ascribe to “true transference” only. [pp. 618–619]

Frank (1956), in writing about what he described as the “standard technique”, made the point that in his opinion psychoanalysis is a “subjective, solipsistic science, and I do not think we can shun our personalities in discussing technical matters” (p. 282). In a similar way, as mentioned before, Knapp et al. (1960) emphasized the importance of recognizing the attributes and experience of the analyst.

In 1968, Waldhorn, writing on the “lessons from the second analysis” suggested that, in those cases which by all reasonable evaluations appear suitable for analysis but prove to be incompletely or unsatisfactorily analysed,

...
analyst to appreciate certain value systems, customs, and attitudes: "Without such appreciations by the analyst, things might be misunderstood or thought of as having undue pathological significance" (p. 365). In addition, he says that patients may have strong views about the attributes of the analyst which may be defensive but, if regarded only in this way and not respected, may lead to an unsuitable match between analyst and patient, and the analysis may therefore fail.

In the paper by Waldhorn (1968) and the response to it by Liberman (1968), the match between patient and prospective analyst is regarded as a crucial factor. Liberman, taking up the issue of fit or match, offers a suggestion that more information on the question of fit could come from unpublished qualifying papers and points out from his own supervisory experience how differently a patient may react depending on the way he is focused by the analyst (p. 363). Shapiro (quoted by Kantrowitz et al., 1989) cites the fit between the analyst and patient as the most important element in the training analysis unless the initial pathology is too severe for steady progress to occur.

The neglect of this area and the relative paucity of information is pointed out by Bachrach, Weber, and Solomon (1985):

It is in the area of what transpires in the analytic dyad, i.e. the analytic process, the quality and effectiveness of interventions, the effect of countertransference, and the suitability of the match between analyst and analysand where effective formal methods of investigation are most lacking and most urgently required. [p. 387]

The referral for the assessment

The referral for the assessment is not often explicitly considered as a factor in the assessment although it is sometimes alluded to in an oblique way. For example, those patients who are sent by relatives, or indeed sometimes by professionals, and who attend the assessment meeting only because of being sent, are often seen as patients who are unlikely to engage in the analytic process. Freud (1904a) saw it as a contraindication if a patient submitted seeking treatment because of a relative’s authority. Aarons (1962) did not see it in this way, suggesting that the fact that they had come to the assessment was sufficient motivation. In the same year, Pollock wrote a very comprehensive paper entitled “The Role and Responsibilities of the Psychoanalytic Consultant”, in which he covered many aspects of the whole assessment process and saw as significant the issue of how the patient gets to the consultant. He emphasized how details of the referral may yield important clues as to the patient’s motivation, anxiety level, and resistance patterns, as well as fantasies, expectations, and goals. Along the same lines but nearly thirty years later, Garelick (1994) makes very similar points about the importance of attending to the context of the referral, the nature of the referral pattern, and the system from which the patient has been referred. Hinshelwood (1995) adds another perspective to this issue, suggesting that object relationships in the form of transference and countertransference may often be discerned before the interview in the manner of the referral itself:

Thus, the referral is often made on the basis of the referrer’s unconscious awareness of a specific relationship. It is a kind of “acting out” on the part of the referrer who is caught up unconsciously in one of these object relationships I have been
Conducting the assessment

The earlier writers such as Stone (1954), Waldhorn (1960), and Zetzel (1965) tended to take a longitudinal history. Garelick (1994) suggests that one of the important and, perhaps, controversial issues is the activity of the assessor that involves searching out information as opposed to using a technique of free association and the slow unfolding of material. Schubart (1989) and Shapiro (1984) recommend using an associative procedure from the start, evenly suspended attention, and not extracting information. Klauber (1971) and Coltart (1987) seem to adopt an intermediate position giving the patient something of the analytic experience, but at the same time they do not advocate sitting in silence.

Klauber's view is that in the consultation or assessment meeting the role is more an advisory one, directed to the functioning ego of the patient, since such an important decision needs to be made with powers of judgement in operation. Coltart's (1987) view is that

This may involve some questioning, some interpretation, some link making comments, sympathy expressed only in your whole attitude of extremely attentive listening, and some concise summarizing of your own views towards the end of the interview. [p. 26]

Ogden (1989) tries to give the patient a sense of what it means to be in analysis. He does not favour taking a history, since his view is that

a patient's history is not a static entity that is gradually unearthed; rather, it is an aspect of the patient's conscious and unconscious conception of himself that is in a continual state of evolution and flux. [p. 191]

Garelick (1994) provides a detailed account of his assessment technique, giving the patient an analytic type of experience, taking up issues in the here and now, monitoring the reaction of the patient, and identifying one's own countertransference. He advocates not taking a history initially, although he might do so to relieve anxiety. The history taking would serve to make links revealing the pattern of the patient's interpersonal relationships, separation problems, and a compulsion to repeat. He regards this as potentially educational for the patient, conveying some understanding that the past links up with the present. Hinshelwood's view (1995) is that assessments for psychoanalytic psychotherapy should be no less psychodynamic than psychotherapy itself, and he values making interpretations, even transference interpretations, for two reasons: firstly, the patient's response gives some idea of suitability and psychological-mindedness; secondly, it is a good preparation because it gives a taste of psychotherapy.

One or more meetings

The question of whether there should be a "trial analysis" was a concern in the early days. Freud (1912c) saw the question of trial analysis as sparing the patient the feeling that an attempted cure had failed, but it was also a way of taking a sounding to get to know the case and decide on the suitability for psychoanalysis. It was favoured by Glover (1954b), though not by Greenson (1967): "only the actual experience of a period of analysis can safely determine whether a patient is suitable for psychoanalysis" (p. 55). Tyson and Sandler (1971) point out some disadvantages, such as the patient having started analysis and, therefore, being eager to continue. Trial analyses seem no longer to be an issue, although the question of a single interview as opposed to extended assessments remains a controversial one. Pollock (1960) was opposed to extended interviews, as he said that this interfered with the transference. This particular dialectic between those who advocate extensive interviews and those who think that this interferes with the natural development of the analytic process is one pointed out by Bachrach and Leaff (1978) in their major review. Coltart (1987) appears to conduct single diagnostic interviews, although Garelick (1994) favours extended assessments for the following reasons: the assessor can have a more analytic stance, the patient can have
more of an experience of what psychotherapy is going to be like, and the patient is likely to be more involved in the decision-making process. While there is an anxiety expressed by some that a strong transference will develop, Garelick believes that it works towards facilitating a working alliance with the next therapist, and it enables the assessor to metabolize, process, and verbalize primitive communications.

Referring on

If the view were taken that the role of the assessor is only to make an assessment of the patient, then this issue of the referral process should not be included here. If, however, a broader view is taken that any assessment of the patient’s problems and qualities for psychoanalytic therapy depends not only on these problems and qualities but on the analyst and the match between patient and analyst, then consideration of the referral process is essential. Thompson (1938) considered the referral important, as did Pollock (1960). He, as mentioned before, considered that value systems should be taken into account, as well as patient preferences, which may have some validity and may not always be resistance. Pollock recommended that reality factors should be considered such as availability, economic range of the patient’s resources, and the geographical location. Beyond that, if possible, other considerations are age, sex, marital and parental status, experience, and culture. If there is time, the prospective analyst’s temperament and blind spots should be taken into account.

Pollock is aware, as well, that there may be occasions when the relationship between the assessor and the prospective analyst can stir up performance anxieties in the analyst. He also points out that the manner in which the information is given to the prospective analyst is important and should be done in such a way that the future analyst is free of a sense of loyalty and obligation. It is of interest that, at this early stage, such sensitivity can be shown when considering the possible impact of complex variables on the course of an analysis. Tyson and Sandler (1971) quote Fenichel (1945), who suggested that a patient may be suitable for one analyst and not another. They themselves suggest that the analyst himself might feel reluctant, and then it is important to refer the patient elsewhere. Klauber (1971), in pointing out the tremendous responsibility in recommending someone for an analytic treatment, indicates one hazard:

an underlying conflict of value systems between patient and analyst may cause a permanent discontent which the patient is unable to articulate and which may force him to make painful psychic adjustments that can only gradually be thrown off after the analysis is ended. [p. 142]

Coltart (1987) tries to match the patient with a therapist, being aware of colleagues’ capabilities and special talents, believing as she does in the process of matching, since some therapists have gifts for some sorts of patients and others for others.

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The attention to these factors highlights the complexity of the whole process of assessment and that making a judgement at the start of the analytic process to recommend treatment is a risky one, with a whole range of factors impinging on the analysis: the qualities of the patient, of the analyst, of the match between the two, of the process of assessment from before the patient appears at the assessor’s door to when he is referred on.

Conclusions

To make a recommendation for psychoanalytic therapy is a serious and at times risky decision. It is serious for the patient, because of the investment of time and money, as well as carrying the potential for difficult and painful experiences. At worst, it can be a damaging experience, considering the effect on the very deprived patient of the frustrations of the analytic setting and/or the effect of the stripping of fragile defences. It is also an investment on the part of the analyst. To conduct an analysis where little progress is made, or which is an experience too difficult to bear, and can become interminable, should also be avoided.
It was said at the beginning of the chapter that an assessment is at some level a predictive exercise. In making such a prediction, it initially seemed wise to base it on those factors that seem most easily assessed, and in the case of psychoanalytic psychotherapy those have been patient qualities. As has been noted, these qualities burgeoned into hundreds, and while the value of this work has been questioned, it has brought to attention the importance of considering not only the diagnosis but, as Freud said, the personality behind the diagnosis. Both the unhealthy and healthy aspects need consideration, and the conclusion that object relations and ego strength are the most important make considerable sense in terms of the analytic task that the patient faces. This involves the capacity to form a transference relationship, and of course such a relationship will have the quality of earlier relationships. Furthermore, the capacity to both experience and reflect on this relies to a large extent on the ego strength of the patient. At the point of assessment, the qualities of the patient are the factors that seem most available as evidence for making the prediction. This, as has been indicated, is far from being the whole story, and the course of the analysis can be affected by the personality of the analyst as well as the match between them. While assessors may try to select and match, there are few satisfactory ways of evaluating these factors except in a post hoc manner. Of course, other factors may impact on the course of the analysis, such as the process of referral. In addition, there have been changes and developments in the assessment process itself, with a greater focus on the object relationship in the here and now, the transference, and the counter-transference.

These are, of course, broad generalizations and, as mentioned earlier, are based on both clinical and research papers. Both types of paper present difficulties: clinical papers may struggle with definitions, whereas research papers, in an attempt at rigour and clarity, may filter out the meaning. Some of the papers have addressed the issue of selection for supervised analyses, none of which seem to add much to the question of how the selection of such prospective patients differs fundamentally from other patients, although the paper by Baker (1980) is extremely useful in providing some guidelines for recognizing some very vulnerable patients. Many of the same considerations seem to apply to supervised cases, and the question of “staying power” so that students can complete their training is one that Limentani (1972) considers is overemphasized. There are particular considerations in a training experience that may influence the course of the analysis, such as the nature of the referral and the supervisory experience (Epstein, 1990).

A serious methodological problem in this field relates to the issue of outcome. Some of the papers are based on work in which it has been possible to make some judgements at the end of the analyses, but there are problems in defining what is meant by a completed analysis (Erle & Goldberg, 1979). It was also difficult to distinguish between the development of the analytic process and therapeutic benefit, the latter sometimes occurring without the former (Erle & Goldberg, 1984).

One of the most difficult problems and perhaps most obvious omission is the vagueness and confusion about the definition of psychoanalysis (Erle & Goldberg, 1984). Sometimes the impression is given that this treatment is rather like standard medication taken in the form of tablets, and indeed this was referred to by Frank (1956) as the standard technique. Stone (1954) had tried earlier to address this problem, suggesting that some patients should be selected but that there should be deviations of some kind in the technique to accommodate their needs. Frank (1956) suggested trying to cast the net wider and, by modification of the treatment technique, make it available to patients who otherwise could not be treated by psychological means. He goes on to say:

I believe that in the group of narcissistic character disorders, particularly if they are deprived, the standard technique is contraindicated. Neither the nursery of children nor the human condition itself, as such, has the psychological climate of the synthetic artificiality of the really nonneutral but pretending-to-be-so analyst. I wonder whether the standard technique itself ought not to be humanized. [p. 280]

In their review, Bachrach and Leaff (1978) also point out this limitation in the literature and do not give any specific definition of classical analysis because such a definition is not included in most papers. Perhaps this raises the very difficult question that Erle and Goldberg (1979) also raise, as to which modifications of the
basic model are consistent with an acceptable concept of analysis. However, as Coltart (1987) points out, there have been advances in technique and in theory—as evidenced by the work of Steiner, Kernberg, Kohut, Symington, and others—on borderline and narcissistic disorders.

While there are limitations in the use of terminology and of methodology, there have been advances in the field of assessment. These include the recognition that an assessment of patient qualities on their own is not enough, that the other aspects of the equation—the analyst, the fit between the two, and the nature of the model of psychoanalysis—all need to be taken into account. There have also been advances in the way in which the assessment meeting itself is conducted, with more emphasis on the transference and countertransference and the notion of giving the patient some sense of what is to come in the analytic experience. This is both an advance and a reflection of the changes in psychoanalytic thinking: that is, that the patient is an active participant in the assessment just as he is in the analysis—part of a dyad, not the passive recipient of a recommendation or interpretations.

The way in which this review has been structured, singling out aspects of the assessment procedure for consideration, mirrors the problems in this field. The ingredients can be—if not measured—taken out and prepared, looked at, criticized; but in the final analysis any assessment is a combination of all these aspects, put together in a particular way by a particular assessor. To articulate that is an impossible task, influenced as we know we are by intuition, not to say by our own unconscious processes.

CHAPTER TWO

Where referrals come from and some links with general practice

Judith Barnard

"Would you tell me please, which way I ought to go from here?"
Lewis Carroll, Alice's Adventures in Wonderland

The public view of psychoanalytic psychotherapy is mixed with much understandable confusion, and within the profession there is often fierce debate on theoretical differences. On reflection, it is rather remarkable that there are so many individuals working with therapists in a reasonably settled and painstaking endeavour to understand themselves. The majority of these people discover that therapy provides them with an opportunity to explore and alter the rigid patterns of their lives. Sometimes it takes a long time to begin; one person had the telephone number crumpled up in a pocket for four years before yet another crisis pushed him to find the courage to ring the organization. There are obviously many different contacts and networks through which therapists are found, but in this chapter I try to outline the various ways in which people come to the Clinical Service of the British Association of Psychotherapists (BAP).