WHY ASSESS? PSYCHOANALYTICAL ASSESSMENT IN THE NHS

JANE MILTON

SUMMARY

The author outlines an approach to assessment, or as she prefers to call it, psychoanalytic consultation, in the Health Service. This involves giving the patient an experience of the analytic process, which they can then assess in a way, while the assessor gains information about a number of categories that can be thought of hierarchically, which inform the advice given the patient and the referrer about management and treatment. The safety of the patient is paramount, as psychoanalytic psychotherapy is a powerful and disruptive treatment. However it is argued that, on the whole, 'suitability for psychotherapy' should be on the basis of exclusion rather than involving the patient passing a sort of 'suitability test'. The latter may enable public psychotherapy services to deny the incompleteness of what they are able to offer.

Before the question of the title 'why assess?' there is another question — what is a so-called 'assessment' — what do we as psychoanalytic psychotherapists in the NHS mean by assessment?

It is important not to start off with too narrow a focus. When I am referred a patient for an NHS assessment, I try and keep in mind that I am not just doing something called 'assessment for psychotherapy', especially not just 'assessment for psychotherapy here in my institution', but I am conducting a psychoanalytically-informed interview with someone so that I can get as good a picture as possible in this limited time, of their inner world and the way it functions, and try to understand the nature of the distress they are presenting with. This will then help me to comment to the patient and the referrer about a number of things, only one of which is their so called 'suitability for psychotherapy'. The patient will, simultaneously, have the opportunity to assess the nature of the psychoanalytical process, and think about whether or not this is an investigation they wish to proceed with. The referrer, the patient, and often, it has to be said, the Institution where one works, may well see the whole enterprise as a sort of test that the patient will pass or fail; be accepted or rejected for the local treatment on offer. This can causes one subtly to adopt a style of communication with the referrer that is mutually unsatisfactory — 'your patient

---

This paper (and the next one by Joan Schachter) originate from an APP conference on Assessment for Individual and Group Psychotherapy in the NHS, held on 26 October 1996, at the Tavistock Clinic.
Dr A's strict neutrality ensures that any such threatening figure immediately appears in the transference, Dr B feels that it is wrong, perhaps unacceptably intrusive, to expose the patient to these sorts of anxieties in an assessment, arguing that he is not going to be the therapist, and that the patient may have to wait a long time for treatment after this interview. He prefers to discuss the patient's more paranoid anxieties in the 'there-and-then', rather than the 'here-and-now'. Thus he centres the interview on active history-taking, asking the patient about the details of their symptom, to supplement what is already known from the questionnaire. He is, in the main, talking to an observing part of the patient about the distressed aspect of them, while Dr A through his analytic neutrality, brings the disturbed part of the patient to life.

Having done hundreds of such interviews myself now, experimenting with different ways, and thinking about what I think I am trying to do and why, I now find myself at a point on the scale joining Drs A and B, tending more towards Dr A. Although I run a greater risk of offending and upsetting patients, at least in the early part of an interview, my personal view is that I do them a better service by not responding to their social cues, and thereby engaging more directly with their disturbance. After all, by maintaining neutrality and working in the transference, we have the opportunity often of becoming quite a fresh and unexpected figure in the patient's life. This is because, in a normal social encounter, the patient will be free to project the unreal, internal fantasy figure on whoever he meets, and the other person will tend to respond automatically to the patient's unconscious cues to become such, or alternatively bend over backwards to become a reassuringly opposite figure. The analytic assessor, by his hard work in resisting such pressure, remaining neutral and instead interpreting, will sometimes unexpectedly be revealed as a more three-dimensional and alive person to the patient, and often help the patient for that hour or two at least, to come more alive and three-dimensional themselves, to see things in a new way, and to be freer to think. Garelick (1994), in his comprehensive review of the subject of assessment, recommends that one assesses over at least two sessions, allowing time initially for this sort of unstructured approach, and then allowing time later for essential information gathering omitted up till now, and is my own practice increasingly.

Thus, when I talk about my model of assessment, or analytic consultation, which I know I share with many, I am talking about an invasive procedure or investigation. In medical terms, 'invasive' is a term describing investigations that mean breaking into the body in some physical way. So listening to the chest, or taking an X-ray, are not very invasive, but taking a sample of fluid from a body cavity, or putting a tube into the lung, or opening up the abdomen to examine how far a cancer has spread, are invasive. Invasive procedures should not be done unless there is a good reason, and there is no other option for example with some sophisticated form of scan, because they tend not only to be painful, frightening and inconvenient for the patient, but they inevitably involve bodily disruption and some danger. So we have to have a good reason to do a psychological investigation that tends to break in to the inner world,
piercing defences, and potentially causing mental pain and upset, especially when we have before us a patient who is not in active pain and distress at that moment. It might also be mentioned here that just as we would not wish an inexperienced clinician to perform a dangerous and invasive medical investigation on us, so too we would want to regard psychoanalytic assessment as a relatively advanced procedure not to be practised by the novice without careful supervision and training.

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

So, having set the scene a little by saying what I mean by 'assessment', I will ask the question of my title - 'Why Assess? Why do we perform this invasive investigative procedure on people? To start with, when would we decide from the start not to do it? Would there be circumstances in which we thought we should do it? We could help was by a detailed and thoughtful telephone consultation with the GP about management of this highly disturbing situation.

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

Case example: Mr C

Mr C was referred to an outpatient psychotherapy clinic with chronic anxiety and depression, and again, the urgency of the referral was stressed by the GP, who mentioned that the local psychiatrists had seen him, prescribed antidepressants, but that the patient was no better. A disturbed and abusive childhood was referred to, but little more detail was given. The patient was sent the standard questionnaire, with the usual request to fill in as much as possible, and to get in touch if there were any difficulties. Mr C turned up at the Clinic in an agitated state the next day, and the receptionist asked the duty medical registrar to see him. Mr C had his questionnaire with him, and said that he was afraid to fill it in, in case the biro damaged the paper as he wrote. He had a number of other anxious preoccupations and the on-call clinician ended up spending an hour with him, even though she had intended to spend only ten minutes. He seemed very persecuted, but not frankly psychotic. He left in a calmer state, and managed to deliver the questionnaire by hand the next day. At this stage, the supervisor encouraged the trainee assessor to carry on and offer a formal assessment appointment. Mr C, unable to wait the two weeks for his appointment, turned up at the Clinic on two further occasions, needing to be seen by a duty person again before he would leave the building. The assessment interview itself, as might have by now been predicted, turned up copious disturbing, near-psychotic material, and the patient became fragmented in the unstructured setting to the extent that the assessor had to modify her technique rapidly. He formed an intensely dependent, idealising transference to her, which turned to a confused rage when it became evident to him that she was not about to offer him individual therapy herself, and was indeed trying to talk to him about how he might feel more secure in a hospital at this point. She felt in physical danger, and had to call on all her pre-analytic, social-work skills in addressing the residual sane part of his ego, and to encourage him to walk with her to the lift and then to go to the GP, to whom she spoke immediately.
Why Assess? Psychoanalytical Assessment in the NHS

Case example: Mr D

Mr D, a 40-year-old man referred for psychotherapy, was frightened of his uncontrolled violence. He had spent several years in prison for a violent attack on a member of the National Front, during which he had started as a peaceful anti-fascist demonstration. His friends included both hardened criminals with a hatred and grievance against society and others with a seemingly more hopeful and encouraging attitude, and this very much reflected a deep split within him. He had spent most of his childhood in care having suffered violent abuse from parents and step-parents, but there had been one supportive social worker with whom he had formed a strong bond, whose memory seemed to have helped him to retain some sense of hope.

Mr D was able to talk about his fears and even acknowledge, towards the end of the first interview, with fear and shame, when it was suggested by the therapist, a part of himself who was both a protector and a vengeful aggressor.

In the second meeting, a week later, he reported much more anxiety in the intervening week, with impulses to violence to himself and others, only just possible to resist. However, he remained adamant about wanting to explore things and try and change, and pointed out that nothing else had helped, and he felt at the end of the road. Having thought carefully about the options, the assessor decided that only a residential setting such as the Henderson Hospital would provide enough safety for Mr D, and indeed for the professionals working with him. The well-known dictum, 'First do no harm,' had to be paramount; it was important to try and avoid doing something that would make the situation worse, either by the assessment or the treatment. The well-known dictum, 'First do no harm,' had to be paramount; it was important to try and avoid doing something that would make the situation worse, either by the assessment or the treatment.

Mr D could not be trusted to participate in psychotherapy; he was egocentric. The relationship of therapist to patient and the effect of this on the therapy were the focus of some discussion with Mr D, who was reluctant to enter into this kind of relationship. His therapist suggested that he see a psychologist for a series of interviews before deciding whether he could be trusted to participate in psychotherapy; he was egocentric.

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

Case Example: Miss E

Miss E was referred with a long history of recurrent mania, for which she had spent at least half of the last five years in hospital. The ward doctor, who felt strongly that there was a part of the patient who could think and wanted to work on herself, referred her to the psychotherapy department within the same building. The assessor, after careful consideration and discussion with colleagues, agreed with the ward doctor, and she was taken on for once weekly therapy by the psychotherapy senior registrar. The ward and the walk-in 'Emergency Clinic' downstairs from the psychotherapy department were informed that she was starting treatment. Miss E’s disturbance quickly became worse. It was still possible to make her feel contained and protected, and the tolerance of the Emergency Clinic staff, in particular, who often had to deal with an angry and histrionic, or very excited and disinhibited patient...

who arrived downstairs after her sessions, was stretched to its limits. There were often mutterings about those precious psychotherapists upstairs who did not have to do the dirty work and pick up the pieces. However, it became evident gradually over the next two years that Miss E’s breakdowns were becoming more circumscribed, and shorter in duration, and that she had taken to asking for help as she felt herself deteriorating, instead of, as before, being brought in by police or friends in an excited, triumphant and inaccessible state. She also at times now required brief admission and close supervision during periods of depression.

Such a patient would not have been able to be contained in an institution geared only to out-patient work. In fact, to have offered treatment in such a non-containing setting would have transgressed my first two rules about physical and mental safety. To move on now to the third point in this hierarchy, patient privacy and dignity. Patients may sometimes come to us having an idea about psychotherapy being soothing, primarily giving relief from pain, or consisting of question and answer sessions, with advice-giving or education. Similarly, there may be quite a utopian idea about what may be readily achieved in treatment. There is often a lack of knowledge amongst referrers and patients about the differences between different psychotherapeutic approaches. As has been mentioned, it is important that a patient should leave an assessment interview having an idea about the nature of the process to be undertaken, its intrusiveness, and its likelihood of exposing the patient to pain in the form of guilt and shame, for example. In contrast, an approach that is basically educational in nature, such as behavioural or cognitive therapy, will allow the patient largely to retain his defences, and protect his privacy to a much greater extent. It may be considered, however, that paradoxically the patient is being subtly infantilised far more in such pedagogic procedures than in an analytic approach.

To some people, their narcissistic structure or their fear of what is within is such that they are simply not prepared for the sacrifice of privacy involved in psychoanalytic work, and I think we should be able to let them make an informed choice about this by the way we work in an assessment interview, that is, by trying to show them a little of what the work involves; and then, if necessary, talking to them about what might be a more bearable, albeit more palliative, procedure. However it may seem right first to try to address and challenge a resistant part of the patient, which may be trapping a more voiceless, desperate part, in a pathological structure. If we feel we have done this to the best of our ability, the choice really is then the patient’s, and it is a choice they should be allowed to make with dignity, with ourselves leaving the door open always for future discussion and review. In the same way, a patient with a serious disease who cannot face a major operation, but opts for symptomatic relief, has a right to this, and once we have given as much information as we can about the situation to the patient, in as understandable a form as possible, it is no longer our business what course is chosen, although we also have a responsibility still to protect the patient’s dignity and help him to make alternative
Jane Milton plans rather than simply washing our hands of him or her in a smug or moralistic way. I think the many people who drop out during the assessment process, or during the early phases of psychotherapy, are often saying 'No' to the painful and disturbing intrusion involved, at least at this stage in their lives and their illness. This should be respected, but it is more helpful if this can be addressed openly in the interview, rather than leaving the patient angry and humiliated, or feeling a failure and with nowhere else to turn later.

Case example: Mrs F

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

To come now to 'indicators of suitability'. We often jump too quickly I think, to putting this at the top of the list of reasons for the assessment process. I have been trying to come at this same issue from a different angle. I would say that the patient who has got to this stage of the assessment process is not in physical or mental danger from treatment, and she has not shied away from the invasion of privacy involved, has indeed begun to look like someone who could benefit from our work. I think it can be relatively easy, with experience, to get a good feel for one's own work in this regard, and it is not always clearly addressed in one's educational training. When there is a feeling that a particular patient is not presenting a risk, and that the issues to be addressed are likely to be within one's therapeutic competence, then this is a useful indicator to begin to think about treatment planning. In the case of Mrs F, and I have described above, we were able to acknowledge the mixed feelings she expressed and treat this with care in the consultation, and open the door to further exploration in a subsequent session.
training institutions where the situation may be rather different), we must realise that training needs, given that we are trying to train people to work in the public sector, are more confluent with service needs than might at first appear. The supervisor has a vital role here, in helping the trainee extract something valuable from the experience of treating a great range of patients.

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

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

REFERENCES


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