Assessment for Psychoanalytic Psychotherapy  
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What is Psychoanalytic Psychotherapy?
It is a treatment modality that focuses on the patient’s subjective experience and deals with those experiences within an interpretive process, as these experiences are mobilized and expressed within the psychotherapeutic relationship. This broad definition recognizes that both patient and therapist contribute to what emerges between them and in each of them as they experience one another. The patient approaches the therapist and the treatment setting with a series of implicit and explicit expectations for help and expresses these, more or less, directly. The therapist in turn, also approaches the treatment setting with her own implicit and explicit ideas regarding the nature of the psychopathology and the process depending upon what theory or theory she holds, and therefore relates directly or indirectly in a particular manner with the patient. Both patient and therapist also have their hidden motives, which each brings to the therapy setting.

So, psychoanalytic psychotherapy is a situation which 1) optimally creates a climate for patient and therapist to become engaged, so that the hidden layers of their respective personalities become activated in the treatment process, as each brings to the situation their own internal representations of their own life histories; and 2) in which the therapeutic conversation aims at encompassing increasingly more of what the patient experiences on a level that is not immediately available to his awareness.

To create a proper climate for such an engagement is thus a pre-condition for being able to experience more fully, to lift into awareness and make part of the conversation, what would otherwise remain un-experienced and therefore unspoken.

The process therefore broadly consists of:

1. The establishment of a good therapeutic relationship- through empathic attunement, while listening for the emergence of certain themes.
2. Assessment of the patient’s presentation within that relationship
3. A Psychodynamic Formulation of this presentation
4. Ongoing attunement to present and past experiences
5. Increasing Conscious Awareness by understanding, explaining & amplifying
6. Linking experiences in the here and now and within the relationship
7. Linking present and past experiences, in an empathic manner
8. Understanding repetitions both in the relationship and in the outside, past & present.
9. Making the Unconscious Conscious, in the same listening, understanding and explaining attitude (interpretation)
10. Dealing with loss, separation anxiety and abandonment
11. Dealing with the issues of bringing therapy to an end
12. Termination

Referral
The therapeutic relationship begins from the very first contact. Each one influences the other, as expectational fields are created, and as each one’s internal representations are activated. Not every patient makes you feel good, or makes you feel needed. However you will form first impressions, depending upon how you feel after that first contact, perhaps on the telephone.

It is important to take a few sessions to assess the patient, in order that you have sufficient grasp of what the patient is about, what has brought him to therapy, and how you might help him. The manner in which you start may differ from person to person, a mixture of questions, statements and tentative reflections will help establish a balance in which the patient begins to feel comfortable. The therapist may want to ask more questions, take notes etc and this must be made evident to the patient at the beginning. The patient must be alerted to the fact that you will not be taking notes after the assessment sessions. It is not a good idea to have your face buried in your notes to the point where you are not in contact, or to ask too many questions, cutting off the patient. A balance must be found. Some patients may not let you have a word to say, in which case you may have to actually say “I want to ask you a couple of questions before we go further, or before we finish today”.

**The process must be our primary focus (the content matters)**

1. What he says to me
2. How he says it to me
3. How I experience him
4. How I experience him experiencing me (transference)
5. His expectations of how I will receive what he is saying (countertransference)

   . Will I listen?
   . Will I understand?
   . Will I be critical?
   . Will I reject him?
   . Will I be angry?
   . Will I hear him?
   . Will I be burdened by him?
   . Will I impose my own values?
   . Will I take control?

**The Therapeutic Relationship**

The therapist will want to know what brings the patient to therapy, his current circumstances, his past history, and his developmental experiences. How he handles adversity, how he coped in the past, and how he deals with situations currently as in close relationships become important.

The process will be influenced by both patient and therapist, as we listen to the unfolding of the patient’s story – his current difficulties, his current experiences, and his past. As we hear about his past experiences we begin to understand some of the feelings that are
generated in the relationship in the here and now. How does he describe significant relationships? Is the past being recreated in the present? Does he clarify or contradict himself? What is the flow if any of the conversation? We will begin to clarify some of the above statements and develop answers to the above questions.

The therapist has an important role in whatever is being played out. How he relates, what he expects, whether he idealizes or devalues the therapist, whether he is agreeable or disagreeable, angry or punitive, controlling and dismissive or dependent, these are being co-created in the relationship. The therapist’s manner of reacting and responding to the situation will become and continue to be very important. The therapist may feel idealized, needed, devalued, controlled or dismissed. Whatever she feels must be dealt with appropriately, and negative feelings taken note of and bracketed, and worked with later in supervision, or/and in personal therapy.

**How does the patient describe his developmental experiences with significant others?**
- Are they idealized, and can he support it with anecdotes, or can he not, or does he contradict himself?
- Are there no references to significant other/s and no memory of certain times?
- Are his memories fragmented? Is his language fragmented?
- Are his memories confused in space and time, in time present and past?
- Are they devalued? Or are they dismissed as being unimportant?
- Are they those of accommodation and compliance with a significant other?
- Are they of a care-giving nature?
- Are his memories potentially traumatic, with the appearance of anxiety/fragmentation?

**What are his earlier experiences about?**
- Are they about longing and disappointment?
- Are they about isolation, neglect or abuse?
- Are they of avoidance and confusion?
- Are they about ambivalence?
- Are they all bad? Or are there some good experiences?
- Are there some good significant relationships in his history?

**The further task on the part of the therapist is:**
1. To gain further access to the patient’s subjective experience.
2. To understand that experience in a contextual manner
3. To communicate that understanding in the service of further development
4. To facilitate the relationship

**The therapist can do this by:**
1. Respecting the patient’s vulnerability
2. Accepting what he says to you
3. Offering a place of safety and security, a secure base
4. By being dependable as to time and place, adherence to the frame
5. By maintaining boundaries
6. Being non critical and non-judgemental
7. Being empathically attuned, aligned and understanding
8. Using language that is resonant with the patient’s language

The therapist who is attuned, in fact begins to use as sessions go on, similar language to the patient – the more the therapist is experienced as attuned, the more connected she feels with the patient. The therapist cannot expect this to occur all the time, errors are bound to happen, mistakes made, the past is going to colour the present, particularly in the early stages while the relationship is being established. Apologizing to the patient for an error in understanding, or a lapse in concentration helps to reconnect.

Disruptions & Disjunctions
The therapeutic relationship is co-constructed, therefore the therapist reactions and responses will have a direct bearing on the continuing relationship, and breaks (disruptions/disjunctions) such as coming late, failing to attend, silences when the patient had been hitherto talkative, threaten the relationship, and must be examined within the relationship.

Therapist reactions must be looked at:
1. Do I feel good when I am idealized?
2. Do I reflect/overly reflect his idealization of me?
3. Do I remain passive to his idealization?
4. Do I distance myself from his idealization?
5. Do I recoil at his hostility?
6. Do I become defensive when he is hostile?
7. Do I respond to hostility as if I have been attacked?
8. Do I respond appropriately, and not take things too personally?

The severe borderline patient can make the therapist feel a multitude of feelings, positive and negative, and it is important to be aware of such feelings at the start.

Further aspects of assessment:
Both therapist and patient interact at multiple levels of consciousness, and while the therapist is consciously aware of her subjective experience of the patient, she is also taking note of signs and symptoms, and the ways in which he relates those experiences, and expresses his distress. You may find that the patient uses certain defense mechanisms. Elaboration of complaints or symptoms, when and how they started, precipitating events if any that may have triggered for example a depressed state, are explored, self harming behaviour, drug use and abuse- illegal and prescribed what makes the patient feel better if any, their supports, their living arrangements, family, their work, friendships, strengths, motivations and aspirations are all explored. If any particular aspect of the patient’s history needs to be more accurately assessed it should be done in an empathic way, in order to help the therapist deal with the patient’s needs, sometimes immediate.
There may be times when the therapist is confused and is unable to get an assessment done in the way she would like to. It must be remembered that the presence of multiple self states, and therefore disorganization in the presentation, is pathognomic, and must be registered as such and worked with, in order to reach a place where more clarity can be obtained.

**Defense mechanisms** were initially thought to be ways in which the person kept from awareness his sexual and aggressive drives, and managed conflict. The contemporary view is that these are unconscious mechanisms are initially protective and adaptive and serve their purpose well i.e. prevent overwhelming fragmentation etc but as they continue to be used, they prove to be maladaptive and unhelpful to the patient. The therapist must become aware of the defense mechanisms that the patient uses, but not interpret them. The various defense mechanisms and the purpose they serve are described.

**Affect** and its expression needs to be taken notice of. Is the affect dissociated from the experience that he is talking about, or is it incongruent with what he is talking about. Is there no expression of affect? These need to be registered, as they are important, and need to be attended to later on in therapy.

**Non verbal** communication must be taken note of both the patient’s and that of the therapist. Important clues may be obtained from non verbal ways of interacting, and the therapist must be aware that the patient may be attuned to her non verbal expressions.

It is possible to describe a patient as stimulus entrapped when he is unable to punctuate his conversation, but rather it is filled with anecdotes, with fragments of experiences that bear no connection to one another, that are unrelated, and are filled with events, happenings (chronicles) and the outside, which tell you nothing about the patient’s feelings, needs and wants, or is totally caught up with body sensations, problems, symptoms etc.

**Summary**

At the end of assessment, the therapist must be familiar with the patient’s presenting problems, his living circumstances, significant others, social supports, work, partner, children, does he go back to an abusive environment, does he go back to a solitary home, is he itinerant, whether he is depressed or suicidal, whether he has made attempts in the past, and whether they have been impulsive, or were they dealt with, the presence of excessive anxiety, is he showing evidence of a psychosis, whether he takes medication, and/or drugs. The presence of dissociation and depersonalization must be taken note of. She must also have some knowledge of his background. This may take a minimum of three sessions.

**Formulation**

The therapist must contain her own anxiety in this process, and be able to help him at the end of this time, with some feedback on her understanding of his problems. In order to do this, the therapist must be able to formulate what she has heard, in psychodynamic terms, taking care to feed back the positive aspects of the patient’s personality, achievements.
and functioning, and the nature of current problems in the light of personal history, relationships and experiences. The therapist must then make an offer of help to the patient, and see if the patient is accepting of that offer, before a contract is made.

Psychodynamic formulation will be dealt with in another session.

Confidentiality
The therapist must also assure the patient of confidentiality as much as possible, even when she needs to contact a third party, such as a mental health worker, a general practitioner or psychiatrist. The patient must be made aware that there are circumstances when confidentiality will have to be breached to some extent, if the need arises, depending on the type of problem, and depending on the reasons for referral. The exact nature of these reasons needs to be spelt out at the very beginning.

Medication
Sometimes a patient comes to psychotherapy having been on medication for some time. In such circumstances it is wise to get in touch with the prescribing doctor, and get to know the reasons for the prescription. It is unwise to take patients off their medication because they are unhappy to be on it, or because there is no evidence of need for them to be on it. Suggest to him that it can be looked at during the course of therapy, and dealt with appropriately in course of time.

Suicidal ideation
A depressed patient who expresses his need to die, whether he has plans or not, must be encouraged to explore his current circumstances, and whether he is actively suicidal and therefore whether he needs to be in a place of safety. If a seriously depressed patient refuses the offer of hospital admission, attempts to have him contact you or a nominated person, a hospital casualty, in times of need, would be helpful. A seriously suicidal person would require admission, particularly when he does not have the safety of a caring other/family or environment. Chronically suicidal patients must be understood and contained within the relationship, because such patients generally do not benefit from hospitalizations, the latter often turning out to be too frequently unproductive and detrimental. Each patient must be assessed on an individual basis, and when in doubt, seek help – sometimes it is better to err on the side of caution.

Integrating Medication
The prescribing of medication must also follow similar guidelines, and be introduced within the relationship in an empathic attuned manner, rather than in a gesture of hopelessness or despair. This is particularly true when medication is introduced in the course of therapy.

The patient must be a collaborator, within the treatment relationship, and his knowledge and consent must always be obtained. It is rare to have to hospitalize a patient against his will in psychotherapy when these guidelines are adhered to, and if it does happen, the patient must be told about it, and supported even if he refuses.
Non Medical Practitioners

Non medical practitioners will do well to have a working knowledge of diagnostic categories, and of using a psychodynamic formulation after a few sessions of assessment, in order to work with severely disturbed individuals and provide evidence of best practice to themselves and to their patients. Similarly it would be helpful for practitioners to have some knowledge of major classes of drugs, antidepressants, antipsychotics, anxiolytics and tranquilizers. Medicos should be aware of the patient’s physical condition, drugs he takes for medical conditions, and their possible interactions with other prescribed neuroleptic medications. They must also order investigations to rule out co-occurring conditions which may complicate the mental state of the patient, if that is necessary. They may integrate these various aspects of treatment within the psychotherapy relationship, or they may split the treatment with another medical practitioner, in which case they stay in contact, with the patient’s permission.

Therapists need to look after themselves:

1. Do not take on too many borderline patients
2. Have a mix of patients in your practice, particularly if you are a new clinician
3. Belong to a group for peer supervision/discussion
4. Be aware of your own functioning, have your own therapy
5. Patients can be anxiety provoking, difficult, confusing, take to regular supervision
6. Take regular breaks from your practice
7. Continue to up-date by reading, discussion, seminars, conferences
8. Maintain boundaries at all costs, while you offer the patient safety and security
   make sure that you are safe too
9. Do not take on a patient who frightens you, who is known for violence, and whom you feel very uncomfortable with
10. Do not tolerable frank abuse
11. Therapists must value their work, and be paid for it, do not undervalue your services, at the same time, do not over value them.
12. Maintain your rooms adequately, be punctual, dependable and warn about your absences in advance, making adequate provision for your patients, when you are absent.
13. Talk about failure to attend, on time, or not at all, failure to pay fees, sooner rather than later. Expect certain behaviour from your patient, as you would want him to expect of you.
14. Get his informed consent if you wish to tape your sessions, if you want to present him at an open seminar, if you wish to write about him in a journal. Having done so, also make sure he remains anonymous by changing some of his details, and identifying information.
15. Non medical therapists will find it helpful to acquaint themselves with general practitioners in the area, the patient’s psychiatrist if any, services in the area, hospitals etc as this information will be helpful in times of need.
16. The aims of supervision are to help the therapist help the patient, and in the process understand herself, and improve her knowledge. Supervisees must take the responsibility of making sure that their supervisor does just that. Supervision is not therapy for the supervisee, and care must be taken not to turn it into a
therapy session, though there will be times when there is need to look at some of the therapist’s interventions with reference to their own dynamics.

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