THE PAPER

Stimulated by the frequent observation of gross occurrences of symptomatic behaviours in assessments for psychoanalytic treatment, and by the lack of basic and technical theories that would permit understanding and intervention, the author mounted a private study.

The paper begins with definitions and clinical descriptions of the phenomena under study, and proceeds to a literature review. That is followed by an extensive description of the methodology that was conceived and developed over several years. The study itself is then described in detail, as the author first developed and tested his "Basic Theory" for an understanding of the phenomena, then his "Technical Theory". In the latter section of the paper, an investigation into the technical significance of the phenomena is outlined, and this is followed by a description of the development of a theory of intervention.

Forty-one (41) cases were studied, thirty-seven (37) of which were new assessments. Scientific principles were applied throughout.

In addition to stimulating interest in the significance of symptomatic behaviours in assessment - in particular, into their technical aspect - the author hopes that the paper will contribute to further advancement in the areas of:

1. The development of research methodologies that permit intimate access to the psychotherapy process
2. The application of the Scientific Method to psychoanalytic practice and research
3. The application of metapsychology to clinical practice
4. The assessment process, (in particular, theory of Technique of Assessment - a neglected subject)
5. Analyzability as relative to technique of assessment
6. The motivation of the unmotivated
7. The clinical presentation of Character Disorder in assessment
8. Criteria for selection of type of psychotherapy
9. Cost-effectiveness in application of treatment

NOTE: The following outline is provided for readers interested in research design, in this case, the logical sequence of explorations determined as the study developed.

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Dear Friend

Peering suspiciously
Out of dark eyes
'Neath thick, wet, black fur
I washed upon the beach,
Cast there
From a sea of violent creatures,
By a violent wave

You offered me breadfruit
And thus began
My metamorphosis

I. INTRODUCTION

A. Stimuli for the Study

The initial stimulus for the following study was the observation over thirteen years of psychotherapy practice, that patient symptomatic behaviours of various kinds frequently intruded upon assessments for the psychoanalytic psychotherapies (including brief psychotherapy, psychoanalytic psychotherapy and psychoanalysis). Such behaviours were of gross or subtle nature. They were sometimes sudden and immediate in appearance. They were capable of pervading the entire assessment. And they were always disruptive of efforts to gather and collate the essential data of assessment, in spite of the conducive atmosphere of consideration, respect and helpfulness that the consultant provided. They possessed an emotional quality and appeared not to be prompted by the realities of either the consultant's behaviour or the realities of the assessment process. They also appeared to demand an interventive system

that the psychoanalytic psychotherapies did not teach, if indeed there was a body of theory pertinent to the situation.

The second stimulus for the study was the finding, upon extensive review of the literature on assessment and related subjects (e.g. analyzability), that such phenomena appeared never to have been systematically studied. Only fragments of the subject had been given attention, and that was generally of an empirical rather than a scientific nature.

B. Symptomatic Behaviours Defined

The behaviours in question warrant being characterized as "symptomatic" because they are not realistic responses to the actual assessment situation and the real object of the consultant, but are the outward expression of pathological psychological processes. When held up to the light of the real situation, they prove to be evidence that an internal process has operated to cause distortion of the consultee's incoming perceptions. They do not themselves reveal the process, but they can be said to be symptomatic of it. Like the pain in the abdomen that is a "symptom" of underlying processes within it, they are "symptoms".

C. The Descriptive Properties OF Symptomatic Behaviour

From a descriptive point of view, the behaviours under discussion can be of a vastly varying array of types. They may be in the form of lateness for the interview, unusual facial expressions, physical signs of anxiety, questions to the consultant, physical actions, requests, statements, responses to questions, emotional outbursts, communication difficulties, assumptions about the consultant or the assessment, and so on. In each case the factor distinguishing the act from realistic actions of a similar type, will be its incongruity in relation to the real stimuli coming from the real object and the real clinical situation.

D. The Metapsychological Properties of Symptomatic Behaviour

Any piece of symptomatic behaviour, regardless of specific individual content, can be described in terms of its metapsychological properties. That is, it can be described in terms of its Topographical, Structural, Economical, Dynamic, and Genetic features.

It is helpful in approaching an understanding of the general metapsychological properties of symptomatic behaviours, to bear three

points in mind. **One** is that a basic prerequisite for the act to take place is that at least one problematic transference has been set in motion. That is, the mental representation of the consultant must have become distorted, in the form of the mental representation of a pathological internal object, or part-object, from either an Ego, Super-ego or Ego-ideal structure that is either fully or partially developed. (While sometimes the corresponding underlying fantasy of the consultant will appear to have properties of the patient's self representations, and thus to be considered a "projective identification", further study will reveal the deeper, primary role of transference from an object). A **second point** is that when an action takes place, it is the ego, or a portion of it that acts, and contained within the action will be material evidence of the ego itself, the id, and the two suprastructures, as well as the ego's relationship to those structures. The **third point** is that the ego may exist in different segments that may be in contradiction to one another**. [Note: 2014 later discovered to be in different, developed SELF_organizations, each with a segment of the original, total ego - e.g. Defense Self, Observing Self, etc.]**

With regard, then, to the general metapsychological properties of symptomatic behaviour, the **"Topography"** of the act will describe its conscious-unconscious properties. That a piece of behaviour has taken place, makes the internal process potentially observable to an observing portion of the patient's ego. And when such an observation is made, a greater or lesser portion of the underlying psychic activity will be found to be conscious, upon enquiry by the consultant.

The **"Structure"** of the behaviour will describe the presence or absence of a self-observing ego, in relation to the particular behaviour. And if an observing ego is present, the Structural dimension will describe the degree to which the behaviour is in ego-syntonic or ego-alien relationship to the observing portion. A further delineation of ego in terms of a "Healthy Ego" and "Pathological Ego" may be made, because the symptomatic behaviour (that is a manifestation of pathological ego) is found to be in either ego-syntonic or ego-alien relationship to the observing ego. Symptomatic behaviour that is ego-syntonic to an observing ego, indicates pathology of the observing ego.

The **"Economic"** point of view will describe the relative sizes and strengths of the various structures, both pathological and healthy, and the amount, type and source, of the energies available to each. It poses, for example, a different prospect for treatment if the primary motive for it in that portion of the ego seeking it; (a) derives its energy from aggressive drives set in a matrix of hatred towards a parent and a rival sibling, or (b) what presents when the ego seeking the therapy is driven by energies derived from neutralized

Libido set in a matrix of loved and loving relationship to an idealized parent and regretted aggression to a hated sibling.

The **"Dynamic"** perspective will describe the readiness with which shifts in dynamic balances occur, the directions they pursue, and the stimuli under which they take place. Such shifts can often be observed directly in the assessment interviews (e.g. brief expressions of drive cut short by defense generated by fear).

The **"Genesis"** of the behaviour will describe the infant-child neurosis, with its fixations and fixating factors, and the subsequent aberrant development of the ego (in relation to the real objects of the parents) that has produced character pathology, when it is present. It will also describe and explain the effect of that early-developed neurosis on the formation of symptoms, in this case the symptomatic behaviour in the assessment.

The above five points of view may then be combined to provide a total metapsychological picture of the behaviour. The consultant practised in such a process of metapsychological analysis will find that the various types of symptomatic behaviour will have specific metapsychological properties. If he develops an intimate familiarity with the clinical application of metapsychology, it will not be an uncommon experience to find that a quick breakdown of a piece of symptomatic behaviour early in an assessment reveals the entire structure of the neurosis - sometimes including its genesis before the historical material has been provided.

Examples of symptomatic behaviours and their metapsychological analysis, will be provided in Section IV to follow.

[Comment, August, 2013: As I re-read the above material from the start, I am stuck by: (a) how clear and detailed the basic theories described were by that time in my career; (b) how little of Freud's development of metapsychological *concepts* (unlike some of his *theories*) needed work to validate or reject them; (c) how many hundreds of times I have tested his provable theories to this day using concrete patient material; (d) how easy the concepts and validated theories are to teach and be learned; (e) how unlike they are of anything I was taught in supervision; (f) how what I was taught was what to do, not how to formulate with tested basic theory; (g) how curious it is as to why the profession at large has been rejecting Freud's great start to the creation of a real science; (h) how interesting it is to find the profession accepting so many varieties of disparate theories;

(i) how many of those contain elements of mystery with no suggestion of a means of exposure]

II. THE LITERATURE ON SYMPTOMATIC BEHAVIOUR IN ASSESSMENT

Several problems are posed for the psychotherapy researcher who wishes to review all that has been written on his specific topic of interest, and to define those of its sub-topics that are as yet unknown. The **first** problem encountered is that writers on psychotherapy often make no reference to the subject of the paper in precise scientific terms, so that a literature search of the topic using titles, whether it be a search of indices of relevant journals or a library-assisted computer search, may cast up little information. The **second** problem is that scientific enigmas in psychotherapy are seldom studied scientifically in phase-specific periods of development of the profession's theories, so there is often no clearly developing line of investigation of a given subject that exists to be readily apprehended. A **third** problem is that from a scientific-research point of view, many articles are useless in that they propound ideas that are personal, and are put forth without the corroborating, hard scientific data that would make them trustworthy. A **fourth** problem is that the literature is filled with too many papers, many of which, upon close scrutiny, duplicate others.

The author, with some experience using the computer search, eschewed that approach, and relied on indices combined with continuing interest in the subject over the years, and an up-to-date access to prominent journals and books. Searches of indices, in addition to those made in preparation for the study, were carried out for several courses and workshops to various psychiatric and psychoanalytic bodies, over a period of eight years.

No articles on this specific subject were found. Articles on assessment were largely of two types. One was of the "How-to-do-it" type, and generally derived from the empirically-determined experiences of the various authors. Such articles are sometimes clinically valuable, but one must distinguish them from scientific researches that aim to successfully discover, test and prove the theoretical principles underlining unexplained clinical phenomena, and the technical principles that would direct systematic intervention. The other common type of paper in the realm of assessment, was one that addresses itself to those patient intrapsychic factors that bear on the analyzability of cases. Some were of course, also quite valuable clinically. Anna Freud's

Metapsychological Assessment of the Adult Personality. The Adult Profile (1965) is a good example of this type.

In addition to a lack of research into the specific subject of this paper, other related gaps were found in the various studies on assessment and analyzability. There appeared to be no articles that looked upon the matter of analyzability as *relative to technique*, and none that especially addressed themselves to the question of the relative relationship between analyzability and the technique of assessment. Those papers that did approach the question, did so from the (scientifically-speaking) "wrong end". They' raised questions about the effects of various differing techniques (such as single or several interviews, use of psychological tests, and so on), upon the determination of analyzability (e.g. Waldhorn, 1960), when a scientific approach would demand that they begin at the observational end of the scale. Real science would insist upon observation and description of problematic phenomena first, with the development and testing of logical technical hypotheses to deal with them following later.

One recent article did deal with a sub-category of the subject of this paper, and it did so in an exemplary scientific fashion that was not common. It was the paper, "Some Effects of the Consultation-Referral Process on Subsequent Analytic Work", by David Hurst (1980). In it, Dr. Hurst began with the pure curiosity that the scientist has in the observed phenomenon. He did not engage in personal conjecture about his subject, and he did not move towards premature conclusion without study, but kept opening the descriptive side of the subject to the scrutiny of colleagues.

III. THE METHOD OF' STUDY

A. General Problems of Methodology and Suggested Solution

a. Introduction

The psychotherapist who wishes to do scientifically-valid research in a specific area, must address himself to several general problems of methodology that remain to be solved in the profession before he can create a viable method for the particular study. Many psychotherapy research methods have been reported, e.g. Bergin and Strupp, 1972, Luborsky and Spence, 1978, Chassan, 1979. To the experienced practitioner, the results, such as those summarized by Luborsky and Spence, have been disappointing, the impression being

created that the methods are crude while the subject is infinitely subtle and complex. At best they have told the clinician what he has long known. At worst, they have been based on faulty theoretical and clinical premises that sent the researcher on a wild-goose chase for explanations of phenomena that do not exist.

b. Criteria to be Met by an Ideal Methodology

Any methodology that aims to enable detailed, viable, scientific study and conclusion to be made about the workings of psychotherapy, must fulfill certain criteria, namely:

1. Provide full and detailed access to the significant data of the subject - the patient material, the subjective experience of the therapist, the therapist's formulative processes, and the outcome of such formulative processes in the interventions.
2. Provide access to such phenomena, as they exist in exact interacting relationship to each other. And, because two of the processes, the therapist's subjective experiences and formulative endeavours can take place at an unconscious level, the method must permit them to be brought to consciousness.
3. Make possible, verbatim recording of the total data in interaction, and therefore, of a recording "in vivo", because the enormous amounts of data that rapidly oscillate from one field to another, are of such a magnitude as to make accurate after-recall beyond even partial reach of the human mind and its memory capabilities.
4. Reduce to an absolute minimum, the effect of the methodology itself as a variable influencing the psychotherapy.
5. Assure that analysis of data is objective. This requires that the sources of common biases be removed or reduced. They fall into three categories, theoretical, clinical, and personal, and they may occur in either the clinician himself, if he is the researcher, or in an outside observer.
6. Allow for a means of communication of the total scientific data, (i.e. the observed data, the processes of hypothesis-formation and testing, and the validation processes) to the scientific community, where it must pass the tests of "comprehension" and "capability of duplication", in order to permit a final acceptance of the study's theoretical conclusions. In fulfilling this criterion, the method must

not permit any transgression upon the clinical, ethical and legal requirements of confidentiality in the treatment situation.

[2013: Most of the points above are directed at identifying and eliminating potential situational variables (the consultant/therapist and his behaviour being central) that can influence the patient's spontaneous behaviours and turn them from their natural evolving path. That is, they are aimed at creating a stabilized, purely functional set of external circumstances against which the consultee/analysand's perceptions can be assessed for their objectivity or otherwise. I see that I elaborate this point in the paragraphs that follow.]

c. Limitations of Methodology Set by the Criteria

With the above criteria in mind, certain inferences can be made about some of the features that will be necessary in a methodology that could meet them.

It is obvious that on-the-spot access to the full range of data can only be privy to the therapist himself. Only the crudest-of-crude access to observation of the therapist's mental processes can be obtained by the outside observer, and the process of external observation itself, introduces such seriously complicating variables that it threatens to negate the therapy's natural course. The therapist wired for skin temperature and heart rate could reveal- signs of his emotional fluctuations, but no knowledge of the corresponding mental processes could be gathered. And for him to speak to a tape-recorder or an investigator during the session would be impossible.

It is also obvious that if those mental processes that are unconscious must be made conscious, then the therapist, if he is also to be researcher, must successfully develop new ego capacities that will permit him to:

1. Listen
2. Consciously formulate
3. Observe himself
4. Suspend conscious formulation and enter into primary process experience when indicated by the self observations
5. Do self analysis

all in rapidly alternating sequences.

The development of such capacities will require special concentration in two areas. Skill with conscious formulative processes will require lengthy study and practice in the conscious application of proven metapsychological theories to clinical work. The development of a capacity for self-analysis will require that such tested theories be used as reference points against which the analyst can identify aberrant subjective activity in self. Then a protracted period of willingness to voluntarily inflict suffering upon a resistant self must follow. (Calder, 1980, has provided a good description of the problems facing the clinician who would do self-analysis.)

It is further obvious that verbatim recording of the data, if it is to include all the information about on-the-spot interactions, must be made by the therapist, and made by means of the pen. Research can, of course, be done using only recordings of the patient material and the spoken interventions, and access to both can be had through the one-way screen or through audio or audio-visual recordings. Such methods must, however, content themselves with half of the process remaining inaccessible, and they generally introduce variables into the treatment situation that are of the "serious" variety. Marziali (1982) has referred to that matter, and most therapists, including the author, who have used the methods, can attest to the major complications that they can introduce into treatment.

d. The Variables Introduced to Treatment by the Method - Problems and Solution.

The introduction of the above methodological ingredients into the treatment situation runs the risk of negating a further essential aim of the methodology - namely, that it be capable of reducing, to insignificant influence, the effect of the variables that the method itself introduces into the natural course of the treatment

The rapidity of introduction of method bears on that potential problem. Any sudden introduction of such methods would throw the fine balance of the therapist's clinical mental activities into utter disarray, with severe dangers being posed for the treatment. An ego already straining in its clinical efforts could not persist in its new and rewarding goal if several enormous tasks were quickly thrust upon it. If the therapist's work ego is to undertake such additional functions, he must introduce them to himself gradually.

Another factor that bears on this potential problem, is the question of whether or not the about-to-be-engaged elements of method conflict with the

therapist's motives, ideals or techniques. A successful incorporation of the methods proposed above, requires that such conditions do not apply. Indeed the counterpart of this point is that successful incorporation will be enhanced if the methods prove helpful to the clinician's treatment. And that, in fact, is a distinct possibility for some clinicians. For example, having conscious awareness of his unconscious mental processes can most certainly add to his control of the treatment and the pleasure that brings. Successful self-analysis, is also helpful in that it opens the door to confident handling of that ubiquitous foe of the clinician's efforts, "Countertransference", and undoes unhappiness in life beyond the clinic. But what of on-the-spot verbatim recording? Can it be a clinical asset? The author has found that, if the clinician experiments with on-the-spot *written* recording as a potentially useful clinical tool before any thought to use it for research purposes, then:

1. Research motives and ideals that could interfere with those of a clinical nature, can be avoided.
2. A natural sequence in the development of clinical expertise may permit it, and the other elements of method, to find their phase-specific place.

As the therapist attempts conscious formulation, he turns to metapsychological analysis of phenomena in the clinical situation. He also encounters subjective intrusions and excursions that beg for self-analysis. And as he develops such capacities in the analytic situation, if the researcher is an analyst, the written record can actually prove to be a clinical asset by freeing the ego from its major memory efforts. Should he wish to refer back to a word, phrase, or statement that was made earlier in a session, he will have it at his fingertips.

As the various methods become incorporated into clinical practice and eventually become a matter of course, then a solution to many of the methodological problems of subsequent researches will have been found. All of the material has been obtained and recorded, and future researches have only to turn to it

e. Analysis of Data - Problems and Solution

The need for an objective analysis of data poses a number of problems. It is well known that theoretical biases abound in psychotherapy. It is also well-known that clinical biases, especially in the therapist, are common. It is with great sympathy that we must look upon the trend in therapists to see "success marching" where "failure actually treads", such are the enormous

pressures of the clinical situation upon a human mind of dubious suitability to ever master them all.

The personal biases that can be the source of problem are also well-known, but they are less discussed. Third-party-observer biases such as envy and jealousy directed towards successful peers of the same professional community, are powerful spectres in the background of collaborative efforts. And less well known, are personal biases in the clinician himself. But there are other categories of factors. Intrapsychic conflicts like those that result in excessive modesty, for example, can prevent the researcher from being able to objectively analyze his own work.

A common attempt to meet the criterion of objective analysis of data, has been to put the function in the hands of an outside investigator. Whether analysis is done by the therapist or a third party, potential problems of approximately similar magnitude exist with each method, and the third party introduced into on-going therapy always sets in motion important complications for the treatment.

Marziali's report (1982) describes techniques used (in the Psychotherapy Research Unit of Toronto's Clarke Institute) to reduce such complications by assuring that the researcher and the therapist share theoretical views and that they have established a positive colleagueship and a mutual personal respect. Such conditions do not, however, assure that the unconscious processes set in motion by the research arrangement, can be identified and harnessed, even by those who have been analysed. To move, as subject or object, from friendly colleagueship to intimate observation or self-exposure, poses no mean task for the egos of both parties, because each party essentially either allows in, or is allowed into, the other's unconscious torture chamber, very private bathroom or much secret bedroom. It is not out of order to consider that perhaps years of effective self-analysis by both parties might be necessary in order to overcome the manifold sources of potential unconscious interference that are stirred.

This author prefers a technique whereby the data analysis is done by the clinician as part of his clinical task, and the scientific method is used as part of the clinical endeavour. That is, he prefers a method whereby the clinician formulates and predicts, using his formulations to give weighted forecasts, and tests the predictions by the observation of subsequent patient material. The process can be applied equally to the provision of proof of the accuracy of formulation, and the demonstration of accuracy of intervention.

Accuracy of formulation can be repetitively demonstrated using subsequent patient material, without any interventions to raise questions about the possible effects of suggestion. And when this process is recorded verbatim, the accuracy of that analysis of data is available for confirmation by a third party. By this method, the process of investigation has been harnessed to the therapist's ideals for clinical expertise. The research records have been made before the research hypotheses have been developed, and *they* will be developed from the scientific observations in the clinical work. The clinician, so motivated to develop himself as a clinician, cannot readily be suspect of varnishing his data for purposes of professional aggrandizement.

f. Communication of Data - Problems and Solution

Constraints upon the direct communication of detailed, actual treatment material are of three types: clinical, ethical and legal. Efforts to deal with them have generally involved getting patient permission, and disguising case material, and usually both have been combined. The former approach always introduces complications into treatment – more so while ongoing, but still so even when finished. The latter, by itself is rarely a sufficient safeguard, if direct clinical material is to be published in at least a reasonably verbatim form. The researcher, as a result, often hangs in limbo on the issue, and he may have great difficulty ever settling it. The author's solution to the problem is still in the form of a proposal. It has, however, adequate safeguards built in to assure that on the one hand, no patient risk is entailed, and on the other, no scientific element of confirmation is omitted. A description follows.

The material of day-to-day psychotherapy work – material, formulation, analyst subjective state - is "dry stuff" when a "work sheet" is examined. Such a record, of course, usually carries not a single element of identifying data because the contents are symptoms and technically determined (and it is only in the background of the process that the parties get to know and like each other). It is doubtful if one could be picked out of several such records by the patient himself. And if only pertinent segments of those records were used, and descriptive elements changed without losing the meta quality of the actual process, only a record of scientific proceedings, i.e. of the patient's treatment and the therapist's work, would remain. Such an account could then be provided to selected colleagues, with the further precaution that any actual or potential contact with the patient had been ruled out. And with some explanation of the organization of the work sheet, such colleagues could verify the validity of the science used and attest to the method's duplicability. Such a

procedure would then allow for the results of the study to be published, with indications that they had been corroborated, and without the necessity for clinical material beyond brief excerpts used for illustration.

Although this part of the method has not yet been carried out in the case of this particular study, the author, who is considerably familiar with the application of the scientific method to psychotherapy practice, considers that its essential requirements have been met. Strict scientific process has been applied, and exact on-the-spot documentation has been recorded. The details would be easily explainable to any worker accustomed to the application of tested metapsychological theory to clinical work. And for those not thus familiar, instruction could be given.

B. Specific Problems of Methodology

The psychotherapist-analyst who would be researcher, who has prepared himself through a clinical development of this type over some years, can then come to the specific piece of research with:

1. Extensive familiarity with the application of '"Basic Theory"[1] to an understanding of the clinical phenomena.
2. Reliable, proven knowledge of, and expertise in, the principles of intervention or "Technical Theory".
3. Essential elements of sound research methodology built into his every-day clinical practice.

It can be readily appreciated then, that the investigator has only the specific problems of methodology remaining to be solved. He is, indeed, in a position comparable to the rather blunt physicist described by the philosopher-scientist, Pierre Duhem, (Hansen, 1961, p.16), who portrayed the following scene:

> "Enter a laboratory, approach the table crowded with an assortment of apparatus, an electric cell, silk-covered copper wire, small cups of mercury, spools, a mirror mounted on an iron bar: the experimenter is inserting into small openings the metal ends of ebony-headed pins; the iron oscillates, and the mirror attached to it throws a luminous band

[1] This is a reference to the Metapsychology of psychoanalysis as comparable to the "basic science" theories of the natural sciences. To be elaborated later.

> upon a celluloid scale; the forward-backward motion of this spot enables the physicist to observe the minute oscillations of the iron bar.
>
> But ask him what he is doing. Will he answer, 'I am studying oscillations of an iron bar which carries a mirror?' No, he will say he is measuring the electric resistance of the spools.
>
> If you are astonished, if you ask him what his words mean, what relation they have to the phenomena he has been observing and which you have noted at the same time as he, he will answer that your question requires a long explanation, and that you should take a course in electricity."

With respect to this specific research, the therapist-researcher came to the task with considerable clinical familiarity with the various forms of symptomatic behaviour, from his experience with analytic treatments. It included their identifying features, their metapsychology, and their technical significance.

Having decided to study the phenomena in assessment, he then determined the significant spheres of observation in addition to assessments themselves. One was that of the treatment analysis, because experience reveals that assessments eventually return to being the subject of analysis, and the significance of the events in them come to be understood in terms of their deepest unconscious roots.

The other field of observation was that of failed or failing analyses – cases of impasse states and of unilateral premature terminations. That field was chosen because one aim of the research was to determine the technical significance of the symptomatic behaviours under investigation. That is, the researcher wished to determine the presence and importance, or otherwise, of a lack of basic and applied theories of the assessment situation in such cases.

The author then considered the problem of recording the data of assessment in particular. In that area, some degree of scientific problem was encountered. Unlike the treatment situation with its use of the couch, the consultation did not permit the consultant to do his recording in process, in detail and verbatim. He was limited to recording recalled excerpts and conclusions after sessions. As a consequence, then, the "hard data" component of his material for presentation to colleagues was removed. To establish the method and its validity, he had to rely on immediate memories of <u>pieces</u> of data recorded at once. Colleagues would be asked to accept that the same demonstrably valid processes of observation, formulation and

intervention as had been used in analysis, had also been used in the assessments.

IV THE STUDY

A. Introduction

The study has been broken down into two parts, the "Basic Science" aspect and the "Technical" aspect. This is in keeping with the view that the psychoanalytic psychotherapies can be sciences in the order of the natural sciences that have both a body of "basic theory" to explain the natural phenomena, (in analysis - slips, dreams, transferences, anxiety, etc.), and a body of "applied theory" to allow for systematic intervention and influence with such phenomena. In the psychoanalytic psychotherapies, those theories are, respectively, "Metapsychology" and "Theory of Technique". In most natural sciences, they are referred to as the "Basic Science" and the "Applied Science".

B. Basic Science or Metapsychological Aspect

a. Description of the Case Material

Thirty-seven (37) new consultations were studied over a period of three years. The study also included seven (7) analyses that were well advanced in treatment (with good therapeutic alliances and histories of symptomatic behaviour in assessment), and four (4) analytic cases with histories of symptomatic behaviour in assessment and outcomes of premature termination. Only the findings in new consultation group are included here.

Referral Source	**Type of referral**	**Number**
Psychoanalyst, Psychiatrist	After formal assessment	8
	After casual contact	1
	For consultation on impasse	1
Self	Phone book[2]	19

[2] The therapist is listed as "Psychoanalyst, Psychiatrist". The cases involved in the study were those requesting a psychotherapy type of treatment. General psychiatric cases were excluded.

Friends	2
Return of brief psychotherapy cases	6

b. Frequency of Symptomatic behaviour

Of the 37cases studied, only one showed an absence of observable symptomatic behaviour in the assessment. In that case, as later demonstrated by the treatment that followed, there had been considerable control of such behaviours in the first meeting.

c. Descriptive Aspect

A large variety of behaviours was found, but even in this small sample of cases, similar behaviours were observed in different patients, and there did not appear to be potential for an infinite number of types. The following examples were taken at random from the study:

1. Two episodes of observable and reported anxiety in the first assessment interview, and the statement: *"It took me a year to come. I came because I'm desperate."*
2. On the phone, in reply to a request for a brief description of the problem: *"I'm not homicidal, if that's what you mean."*
3. A phone message left with the answering service to call: *"Genevieve".*
4. Nervously, and with a partially-inhibited querulous look at the start of the first interview, the statement: *"I don't know if I have a problem, or if I will grow out of it."*
5. On the phone, fifteen minutes before the first interview: *"I'm at Avenue Road and St. Clair. Is it Warren and St. Clair?"* "No, it's Russell Hill and St. Clair."
6. Upon entering, five minutes late for the first interview: *"Sorry I'm late. I forgot and drove past your office."*

d. Diagnostic Conditions for Occurrence

There was a regular association between the symptomatic behaviour and the diagnosis of Character Disorder. The character problems were of varying

degrees of severity. Symptom-Neurotic symptoms were present, or absent, and did not bear a similar relationship to the behaviours.

In each case, the consultant had been approached and engaged in a symptomatic manner similar to the consultee's problematic engagements with other objects. Frequently, the symptomatic behaviour was found to be related to a "chief complaint" of a characterological nature. For example:

> In case #1 above, the patient reported that she regularly procrastinated in preparing reports to the board in her job as an executive of a large insurance firm, and that she was often late for appointments.
>
> When the treatment (Psychoanalysis) was started, she came late for sessions.

e. Metapsychological Conditions for Occurrence

The metapsychological factors that were directly correlated with the occurrence of these phenomena in assessment were similar to those applying in cases of Character Disorder.

At least a portion of pathological ego (P.E.)[3] was found to be in ego-syntonic relationship to genetically-determined, negatively deformed mental representations of current objects. This P.E. occupied a larger or smaller portion of the total ego. It usually co-existed with healthy ego (H.E.) of miniscule or large proportions, but sometimes no H.E. was present, and the ego engaged in everyday activities, including the assessment, was found to be entirely pathological.

The P.E. sometimes revealed the presence of a split within it, with the part in presentation in everyday life employing various defenses to prevent assertions of impulse behaviour by the other part. The defenses that were

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[3] The author has omitted discussion of the relationship between the "ego"; as this descriptive term is herein used, and the concept of "self". While the issue is a very important one, the amount of clinical material required to illustrate the author's view has made its inclusion in this paper impossible. **[2013: This connection, not confirmable in 1982, was confirmed much later.]**

used varied with the character types. And that, in turn, as expected, was related to the significant fixation levels in the different cases.

The Genetic dimension revealed that there was a regular association between the occurrence of symptomatic behaviour in assessment, and significant degrees of character pathology in the parents. Actual pathological interactions with the parents were found to have occurred repetitively in childhood as a result of the parental character-symptom liabilities, and often the interactions had continued into adulthood. When early traumata and consequent fixations had occurred, characterologically-determined pathological parental responses to the child's subsequent *defensive* efforts, (which were often of a manipulative type), contributed further to the development of character symptoms in the child. Then that development determined that immediate problematic transferences to subsequent objects in the adult were frequent, and the consultant in the assessment became included in the pattern.

No traumata or fixations in selves without significant character pathology in the parents were found in any cases in the study. Relatively-normal metapsychological conditions in parents can exist and usually result in a relatively symptom-free character in the child, with a varying degree of susceptibility to minor symptom neurosis being a possibility.

Space does not permit illustration of all of the above points. One example will be provided to show how the H.E. and the P.E. may present clinically, and how they may be detected. Case #1 will again be used:

> **The patient, a 29-year old married woman from the nearby town of New Toronto**, displayed the following ego structure.
>
> The ego segment involved in the request for treatment was entirely pathological. Its response to the idea of treatment involved the experience of "anxiety", and the effect of that upon it was to cause it to "wait a year" , and come only when pressure of reality made the need "desperate". The anxiety could be understood as the outcome of unconscious pressure from a repressed id or ego-id segment, upon an ego in relation to a feared introject, (or introjects) in the Super-ego
> and/or the Ego-ideal.

That this ego responded to the idea of assessment with procrastination, indicated that there was a transference to the consultant deriving from the suprastructure introjects. It also indicated that the ego that was seeking treatment held this transference-determined view of the consultant in an ego-syntonic mode, and that it was therefore a pathological ego.

That that anxiety occurred in the first interview in relation to the consultant, was further indication of such. That the patient, however, neither behaved in keeping with, nor voiced actual fears of, the consultant, indicated that this ego segment (that might be called a "defence ego" segment) that has become engaged in the defense against the repressed id, or ego-id segment, (that might be called an "impulse-ego" segment), was not operating at a conscious level.

That the patient was, to large degree, able to engage in the work of the assessment in a manner free of conflict with the consultant, indicated that there were ego functions that were, in Hartmann's terms, (1958, p.8), "conflict-free". It is important to note, however, that this did not imply that there was a large segment of neutralized ego-id, ready for immediate alliance in the treatment task. In point of fact there was none.

This metapsychological breakdown was immediately confirmed without any significant intrusion by the consultant in the subsequent assessment interviews and early analytic sessions that followed. Immediate acted-out defense behaviour of intense degree characterized the first sessions. With analysis of that, the repressed (impulse), side was unveiled and it proved to be an ego-id segment full of hate and raw, primitive aggression. The patient had had no awareness of the "creature-like" being that inhabited the deeper strata of her psyche.

C. "Applied Science" or Technical Aspect

a. Investigation of the Technical Significance of Symptomatic Behaviour in Assessment

1. Factors Suggesting a Technical Significance

A number of observations and experiences of other authors strongly contain the germs of implication that symptomatic behaviour in assessment might be of considerable technical significance. It was surprising to this author then, to find that the subject had not been systematically investigated, and that a technical theory to work with these phenomena had not been developed.

In the fifties, the British analyst, Edward Glover (1955), referred, *almost in passing and without seeming realization of its importance*, to a phenomenon *during* <u>*treatment*</u> that *this* author later found to be a major problem <u>*at its very start*</u>. It was a technical complication resulting from the non-recognition of clinically-operative (acted-out) negative transferences. Glover reported that non-recognition and non-intervention with such transferences *in treatment* could lead to states of impasse.

He described the metapsychological basis for the effect and essentially explained that, without illumination and interpretation of such transferences, the negative mental representations of the analyst became regularly associated with all of the various real elements of the analyst's behaviour, (e.g. his greetings, interpretations, etc.). Then a subsequent transference-determined distortion of the analyst's real behaviours took place, and the distorted mental representations were internalized in memory.

The result was that the deformed representations of the real analyst built strength in the suprastructures and the ego, and became indistinguishable from those of the original pathological introjects of the parents and siblings. Then for the therapist to explain that the patient's acted-out transferences were "unrealistic behaviours caused by transference-determined fantasies rooted in infant-child experience", became a doubtfully possible or even well-nigh impossible solution to the problem. And the further effects of this lack of basic and applied theories were such complications as impasse states, rudderless analysis, depression, suicidal conditions, and other dangerous forms of acting out.[4]

Although Glover did not recognize the process he described in the <u>*consultation phase*</u> of treatment, he was, to this author's knowledge, the only researcher who provided a stimulus for that finding, so it has been named the "**GLOVER EFFECT**". One area in which it can be more readily identified

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[4] Kernberg (1975) has reported what appears to be a similar phenomenon in his book on Borderline States, although without apparent reference to Glover.

during first sessions, is in the consultee's immediate responses to interventions aimed at the delineation of early resistances. Close attention to such responses reveals concrete indicators of the phenomenon, and alertness to its signs is warranted. If it is missed, all behaviours of the analyst are incorporated into transference-determined, pathological mental representations of him that were in effect before the first meeting, and a silent clinical chaos settles in. In this author's experience, for example, the Glover Effect can be responsible for more *apparent* Borderline situations than what might be found in cases diagnosed in terms of symptoms not driven by it. The acting out that it produces can even lead therapists to define identifiable cases of stabilized character disorder as "Borderline", when the behaviours are the unsuspected result of large gaps in the profession's clinical theory of technique. **[See Note]** The common technical adage in work with so-called "Borderlines", i.e. "Interpret the negative early", can be regarded as an empirically-discovered element of technique based upon this theoretical principle.

[Note, 2013: The above development was a strikingly-early, very-key theoretical finding repeatedly confirmed and elaborated from new researches (e.g. the "Multiple Transference theory") to-day, but ignored and rejected by the profession as a result of: (a) the developing bias against Freud's Metapsychology; (b) the movement away from science; (c) the avoidance of self analysis and the question of *"Why no analysis is ever complete?"*; (d) the increasing trend to endorsement of the scientifically-hopeless "interactive subjectivities" conceptions that dominate the field to-day.]

Wilhelm Reich's (1950) study of Character Analysis, also strongly contains the seeds of inference about the importance of recognising and intervening with symptomatic behaviours in assessment. He reported the frequent association between early strong resistances in analyses and character symptoms. He advocated technical concentration on such, and cited the fact that non-intervention early could lead to impasse and other problems. He also encountered much professional opposition to his technical injunctions.

In this author's opinion, although analysts continue to refer to his work as seminal, a systematic analysis of character-related resistance, based on his findings, is far from being a routine procedure in the modern day analyses of Character Disorders. One flaw, in Reich's effort that may have played a role in its pragmatic neglect, is the imprecision of his metapsychological analysis of the clinical phenomena he addressed. The illusion was created that a

conclusive technical theory had been developed, when, in fact, a great deal of metapsychological investigation remained to be made.

In addition to the nucleus of suggestion contained in Glover's and Reich's observations, (that might be phrased as, "*If such processes can operate <u>early</u> in analysis and have such severe effects, why could they not begin in assessments?*"), many other observations on assessments themselves point to the significance of technique with symptomatic behaviours occurring in them. Included are: the unexplained, polite, indirect and unsuspected deferral of treatment after one or two assessment interviews; sudden rages and non-return; the cancelled first appointment, and so on. One case some years ago that stimulated this author's interest in this area of study, developed as follows:

> **Ms. V, a single young English immigrant, in Canada for five years,** was referred informally by a psychiatrist who was a casual-acquaintance. The patient had asked her for help with an unspecified personal situation. She called for an appointment, indicating that she had a problem that was "getting her down"', and that she wished to see the consultant, to find out if analysis was indicated.
>
> To the analyst, the assessment interview was unremarkable. The patient outlined the problem, that involved guilty feelings over an ……. with …. ……. ……. . The total picture was one of a ……. Character Disorder of mild-to-moderate degree, with many indications for a good prognosis with analytic treatment.
>
> At the end of the consultation, the patient asked the consultant if he would recommend analysis and he said he would. She thanked him, explained that she wished to clear up some time issues, and said that she would call back in a week. She then phoned to say that she would call later, but she never did and never returned.
>
> One and one-half years later, the author came face-to-face with the person while walking along a crowded street in a small vacation town north of the city. She was shocked, became instantly frightened, and fairly ran away in the opposite direction. It was obvious that the assessment had set an intense, unidentified, dynamic situation in motion, but he did not know what it was. It took years, and the

study of many subsequent assessments before he could systematically piece the elements of the assessment responsible for the behaviour together.

2. Hypotheses to Determine the Technical Significance of Symptomatic Behaviour in Assessment

a. The Initial Technical Hypothesis

Based on the above suggestions and observations, an initial technical hypothesis was formed as follows:

- Given that symptomatic behaviour occurred commonly, at least in the author's case sample, and
- Given that some forms of such behaviour, upon metapsychological analysis, were symptomatic of an ego entirely pathologically involved in the assessment, and
- Given that the presence of such a pathological ego implied that an ego-syntonically-held transference to the therapist was in effect and would be acted out,
- Upon identification of such phenomena, if an interpretation is not made, immediate evidence of the Glover Effect, as revealed by the consultee's behaviour and associations, should be observable.

This proved to be an abundantly confirmable hypothesis, as one example of several will illustrate:

> **Mr. B, an insurance executive, and native Torontonian**, was given the Consultant's name after assessment by a psychoanalyst colleague. He called for an appointment, asking for an analysis.
>
> At the end of the first interview (that was amicable and overtly uneventful), and while walking out the door, he enquired about fees. The author politely recommended deferring discussion to the next meeting. He then came late to it, and scowled to himself as he entered the office. He did not speak, at first, of what was an apparent, decidedly ego-syntonic, negative transference reaction to the last exchange. On a reality basis, however, the deferral of the fee matter could not have accounted for the response.

b. The Second Technical Hypothesis

It was further hypothesized that:

- Given that the Glover Effect would only apply to instances of acted-out, ("operative") negative transferences, and
- Given that symptomatic behaviours could arise from a segment of the ego that was not the portion of the ego motivated towards treatment and involved in the assessment,
- There ought to be demonstrable instances of symptomatic behaviour, the metapsychological breakdown of which, would not suggest that the Glover Effect would ensue, and where indeed it could be proved not to follow.

Again this could be readily demonstrated. One example will be provided:

> **The patient earlier cited, (case #5, "Descriptive Aspect"), a middle aged artist**, who called before the first assessment interview, having gone to the wrong area, showed surprise and embarrassment in response to the behaviour. He readily entered into conjecture as to what the reasons might be, and revealed that the act was from a segment of ego that was alien to the portion of ego in search of treatment and interaction with the consultant. The consultant was readily perceived on a reality basis. The patient, then, with minimal assistance, began to sketch in the features of the acted-out, transference-determined fantasy, and went on to discover the genesis of the behaviour.

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c. The Third Technical Hypothesis

It was still further hypothesized that:

- Given that the Glover Effect, early in analysis, could result in impasse, and
- Given that the earliest manifestation of such an effect could be in assessment,
- Then instances of the phenomenon in assessment, when unrecognised or without intervention, ought to be capable of producing impasse, and,

- Evidence of such should be discoverable in those analyses in which impasse states have occurred, and in which successful analysis has eventually been possible.

And once again, the facts abundantly illustrated the truth of this hypothesis. The following case illustrated the point:

> **Mr. T, a 35 year-old computer engineer from the United States**, early in the author's career, was referred after full assessment by an analyst for analytic treatment. He said that he wanted analysis to free himself from a lack of assertiveness in work. In the first assessment interview, he made a slip, noted by the analyst, but neither inquired into by him, nor observed by the patient. While talking of his enthusiasm about the idea of an analysis, he said "I really think it will be very **un**helpful".
>
> During the work, he developed a protracted resistance involving a recurring wish for direction in response to an ego-syntonically-held view of "direction" as the analyst's real responsibility. While progress in certain areas of transference resistance appeared to be made, and paralleled by progress in life outside the analysis, a return to the "direction" situation always ensued, and an atmosphere of enigma around it prevailed.
>
> Real analysis eventually became possible, however, and four years later it was brought to light that the analysand had entered treatment under duress. The analyst and analysis had been immediately incorporated into an ego-syntonic negative transference in which the analyst had been ordered to "Make him productive!", by a boss who had also acquired the significance of a transference object. It was revealed that, in accepting the patient for treatment, the analyst had been perceived to be responding to this fantasied demand from the boss, and no mention had been made of that situation in assessment. Indeed the particular structure of the neurosis, as later discovered, had determined that an enthusiasm for analysis was to be the dominant attitude in assessment.
>
> During the period of eventual successful analysis of this case, numerous instances of the analyst's real behaviour were found to

have been incorporated into this transference fantasy. The analyst's real behaviours had been perceived in terms of it, and the period of gradual resolution of the situation was a lengthy one. The patient encountered great difficulty in grasping the demonstrable fact that fantasy elements had produced distorted perceptions of the analyst's actions. When, for example, the sources of current ego-syntonically-held transferences were being tracked, it was common for the patient to say, "*Well of course I think that! You must remember two years ago, when you said .... ".*

d. The Fourth Technical Hypothesis

It was further postulated that:

If unrecognised and uninterrupted instances of the Glover Effect could produce impasse dissolvable upon later recognition and successful analysis, then

- Continuing unrecognised instances of it should be capable of resulting in unilateral terminations, and
- Subsequent examination of such endings, if possible later, should reveal that they were linked with the Glover phenomenon.

Once again this could be shown to be so. The following example helps to illustrate the finding:

A thirty-five year old single woman, (Case #3 "Descriptive Aspect"), left a phone message to "call Genevieve". She explained that she had consulted a clinical psychologist who had recommended analysis and suggested this consultant.

She was seen in one assessment interview, during which there was clear evidence of a hysterical character **(see Note**), and abundant evidence of an Oedipal fixation **(see Note)** in the genetic dimension of the case. Analysis was arranged. As the patient went to the door, she said, "I do hope that you will call me 'Genevieve', doctor".

The subsequent work gradually moved into an impasse state involving an acted-out negative maternal transference that was totally

resistant to formulative assistance. Input was met with reports of earlier instances of the analyst's behaviour that were "proof" that he did hold the attitudes ascribed to him. The patient secretly became engaged and pregnant, and left the analysis.

Subsequent behaviour in a second consultation revealed the continuing presence of the negative ego-syntonic maternal transference, and the patient reported that she had experienced a rapid return to the original symptomatic state, after having left before.

It then became clear that the request to be called Genevieve had derived from an undetected operative transference from the mother to the previous consultant and repeated in the analysis with this author. "Aggressive impulse" and "negative super-ego" components of the internal conflict with the mother featured in the material, and the request for first-name familiarity emerged to be a manifestation of acting out by the "defense" segment of the P.E.

e. The Fifth Technical Hypothesis

- Given that symptomatic behaviours in assessment that are potentially capable of producing the Glover Effect when not recognised and not intervened with, can have the aforementioned results, and

- Because the *assessments* in such cases contain the same features of an unrecognised acted-out transference responsible for such results in *treatments*

- Then such conditions in assessment should be capable of producing the same effects at an earlier point, namely in the assessment itself.

Once more it was readily possible to demonstrate that when such a situation existed, it was commonly associated with resistance to assessment, chaotic assessment, and unilateral, premature termination of assessment. The following case illustrates one such effect:

In the case of the Toronto insurance executive previously cited, (b) 1 – "The Initial Technical Hypothesis", while the analyst recognized the signs of symptomatic behaviour in the second

interview (a scowl), he did not intervene. The patient appeared to engage in the assessment work of the second interview, but while leaving, he unexpectedly cancelled further interviews and said that he needed to reconsider treatment. He then left and did not return.

3. Theoretical Conclusions

It was concluded that certain symptomatic behaviours, upon psychological breakdown, can be shown to be evidence that the ego segment of the patient motivated for treatment and engaged in assessment, is a pathological one. Such a metapsychological condition implies that an immediate ego-syntonically-heId transference is in operation and being acted out. If this situation goes unrecognized, and/or unaddressed, the Glover Effect can take hold. And that can result in one or another of:

In assessment:

Resistance to assessment

Chaotic assessment

Unexplained sudden unilateral termination of assessment.

In treatment:

Protracted, unexplained resistance

Impasse

Chaotic therapy

Unilateral premature termination of therapy

Other serious forms of acting out (e.g. suicide threats, attempts)

Mistaken re-categorization of diagnosis as “Borderline”

Endless “analyses” in name only

(b) Development of a Technical Theory for Systematic Intervention

1. Psychoanalytic Theory of Treatment as a Source of Hypotheses

On turning to the development of a technical theory that would allow systematic intervention in assessment, the author first considered that psychoanalytic technical theory would be a logical place to look for the seeds of hypotheses about technique. Several elements of that theory bore on the matter. The concepts of the "acted-out transference" and "resistance" were important. The whole body of knowledge of the principles underlying systematic intervention with resistances was important. That included the selection of the type of resistance to be interpreted, the level to be addressed (based on the concept of the layering of resistances), and the types of intervention (e.g. acknowledgement, affirmation, query, clarification, construction of fantasy from behaviour, introduction of reality, confrontation, etc.) that would be most suitable.

It was well known to the author that analysands may begin to behave in keeping with unrealistic fantasies of the analyst based on transferences very early in analysis. The phenomenon had been described in various terms such as "transference reaction", "floating transference", "spontaneous transference", (G1over, 1955), "character armour", (Reich, 1950), and a host of other terms such as the "background .... receptivity" of the patient (Lichtenberg, (1982).

He also knew that the transference fantasies behind such acting out could be: (a) conscious or unconscious, and ego-syntonic, or ego-alien; (b) sources of "resistance", and obstacles to the patient's progress. He then further knew that, under such conditions, intervention, and only correct intervention, would effect change; and that the outcome of such would of necessity be that the patient came to see the outlines of the underlying fantasy, fill in its details, make it ego-alien, replace it with realistic perceptions of the analyst, and **[2013:** use the, then-real, analyst to assist with the permanent dismantling of conflict with the internal objects**]**. He knew, too: that to carry out the required technical procedures, the analyst had to be familiar with the clinical presentations of four types of resistance - from Ego - defense, transference, secondary gain; Superego, Ego Ideal, Id - and that each would involve a transference fantasy and a certain structure that had developed from it.

Then, with regards to intervention, he was aware: (a) that the analyst must first note the form of presentation of the resistance, and, based on his knowledge of the structures of the various types, find the specific contents of each as they are revealed by the material; (b) that such work would then lead

him back to the delineation of as much detail of the transference fantasy as would be possible for him to construct; (c) and that it would not be surprising to find more than one transference, and find them in layers (topographic dimension).

And, still further, to discover the point at which he would necessarily have to apply his intervention, the author knew: (d) that he should consider a principle that lay beyond the commonly-held technical maxim, "Defense before Instinct" and take the view, "*If defense is present, what is its motive?*"; (e) and that he should intervene with the specific transference fantasy responsible for that *motive* that made *defense* necessary.

It was then clear that:

- Given the similarity of the symptomatic behaviours in assessment to the acted-out transferences commonly presenting early in the analyses of character disorders, and,

- Given that a well-developed and tested body of technical theory existed for intervention with the latter, and that part of this, i.e. accurate formulation and intervention, had been proved to be the only technique effective with such transferences,

- Then this segment of the technical theory of *treatment* ought not only to have potential value in a theory of intervention in *assessment*, but should to be found to be indispensable there.

2. Problems in the Direct Application of Technical Theory of Treatment

The author's next step was to take note of the fact that there were elements in assessments that made at least the direct application of these technical principles of treatment an uncertain, if not impossible possibility. He then considered them as follows:

- The suitability of the case for treatment has not been determined, and good clinical sense demands that treatment not be undertaken without assessment.

- Patients commonly do not know, to adequate degree, what treatment realistically involves, and they are often unable to give assent to it immediately.

- A consultee mandate to treat has not been given.

- Immediate effort to establish a temporary arrangement to treat, in the cases under discussion, routinely becomes the source of a Glover Effect and as such, becomes a potentially serious threat to the assessment.

3. Summary of the Total Demands upon a Technical Theory for Assessment

The next step in the author's thought was to set out in summary form the total demands that an adequate assessment would make upon a technical theory. He considered that it must:

- Allow for interpretation of technically-significant symptomatic behaviour to be started at once, in order to prevent the Glover Effect and its negative influence upon assessment and treatment.

- Not produce a disruption of psychic homeostasis beyond what the patient has implied consent for

- Enable provision to the patient of information about the realities of treatment, in order to allow him to later make an informed decision about undertaking it.

- Allow the consultant to have free access to all relevant conscious material, in order to determine type of psychotherapy and prognosis, and have adequate formulative preparation for therapy, if it ensues.

- Enable an agreement to be struck upon the practical issues of time, holidays, missed appointments and lateness, as the treatment itself and insurance-plan requirements might demand.

4 Theoretical Solution – A Modification of Treatment Theory of Technique for Application in Assessment

With further thought and experimentation, the author found that the theoretical problem, posed by at least some apparently incompatible demands upon a technical theory of assessment, could be solved in the following way:

a. Intervention Essential

He first determined that interpretive work would definitely be applied when technically-significant symptomatic behaviour was in evidence. He considered that no theory of technique could be deemed viable if it were to permit factors known to be capable of destroying both assessment and treatment to operate without challenge.

b. Instruction to Include Elements of Free Association

In order to have reasonable access to the material associated with symptomatic behaviours, he included a degree of free association in his initial directions to the patient. When patient and consultant had met, and when it was apparent that no initial severe reaction in the patient prevailed, the consultant, along with his invitation to talk about the reasons for the consultation and him/herself, suggested that the most useful way to proceed would be to *try* to speak of things as they came, and that if intervening thoughts came, to include them as well, rather than deferring them for the sake of the narrative.

c. First Level Types of Intervention

In consideration of the patient's right to have no interference with psychic homeostasis before treatment had been offered and accepted, the author determined that first level types of intervention would be used, and that they would be directed at the very surface of the transference structure within the behaviours. By this approach, the patient inclined to defense could continue do so.

For example, with situations in which the patient reported anxiety in the assessment, the consultant's intervention would be a question, not a statement. It would be offered tentatively, and directed at the very surface of the material (Motive for Defense), i.e. the question, *"Is it possible that you have some troublesome ideas in your thoughts, about how I will respond to what you tell me?",* can be met with, *"No, I have no ideas that you'll dislike me, doctor."* It is a different and much problematic matter however, when input referring to Drive (e.g. Aggressive type) such as, *"You resent being in a position of needing my help and it makes you angry with me"* is made.

In the latter case, repressed material is forced into the consciousness of a necessarily defending ego engaging a critical and threatening object

believed to be the consultant. There is a disruption of defense homeostasis that is irrevocable, in an ego far from being in a position to accept treatment and not yet voluntarily in collaboration with an interpretive process for its own end.

The subjective experience is like that of the house-holder who called the electrician to get a quote for a faulty bedroom outlet, and returned from a brief excursion to find a great hole in the bathroom wall with circuits ripped out.

d. Reliance upon Clinical Skill in Application of Metapsychological Analysis - Essential

The author realized that intervention in assessment, especially when applied necessarily early in assessment, would require extensive skill in the metapsychological analysis of symptomatic behaviour, a skill acquired through study, practice and repeated testing. He reckoned that, in contrast with the treatment situation, the consultant would be required to make rapid formulations of behaviour, with little or no knowledge of the patient's developmental history. As the author came to think of it, the consultant would have to be "nimble" (metapsychologically-speaking) in the presence of symptomatically-significant behaviour.

e. Defense Response to Intervention - A Guide towards the Surface of the Structuring of Transferences

Unlike the blind man who felt the elephant's haunch and thought that the animal began there, the consultant was familiar with *the metapsychological implications of a defense response to interventions in treatment,* and he used such responses as guides towards the surface of the transference structure of the symptom. Then further observations directed at the *motive for the defense*, regularly turned up an even more-surface transference, the signs of which could be noted and addressed.

Then non-responsiveness to such *further* efforts often led to evidence of gross, transference-determined misconceptions of the treatment and motivational problems related to them. They, in turn, could be addressed until the motivation was laid as bare as the consultee's engaging ego would permit. In some cases, respectful exposures of pathologically-derived motivations with a measures of their genetic origins were able to

mobilize healthy segments of ego and allow progress towards treatment. In others, disinterest in such input doggedly persisted in spite of further formulative efforts, and motivational systems inconsistent with the realities of treatment emerged to observation. And as the objective realities of analyst and situation began to press home in a series of still-consultation sessions, i.e. as the consultees learned what the work required and that the consultant was invulnerable to being an outlet for displaced aggressive drive, they left during assessment to seek another form of treatment, or a neurotic relationship outside such.

f. Information about Treatment Provided as Process Develops

To provide the prospective patient with knowledge about the realities of treatment - its aims, methods, requirements - the consultant discussed such issues in an informational way at points in the assessment where they became relevant. If for example, a patient came late, or missed an assessment interview, he explained what the twosome could most usefully do to contribute to the goals of consultation and of possible subsequent treatment.

It was not uncommon to find that such input was immediately incorporated into a transference that was acted out, so the consultant shifted attention to that phenomenon and the details of the transference fantasy became exposed. It might have been “his” “desire to dominate”, or (if the matter of fees was part of his explanation) “his” “greed”, and so on. Then clarification of the positive realities in all cases went hand-in-hand with delineations of the significance of the transference for the consultee’s goal to be free of symptoms.

Sometimes, however, the behaviour was continued, so the repetitions were noted and hypotheses created to a point at which one proved valid enough to provide the consultee with a tentative description of the situation. And sometimes there were no hypotheses that held up to testing, and we were faced with an original research, the length of which could not be determined.

g. Consent to Treat Obtained as Assessment Process Develops

With the alternating sequences of process – “collection of material, symptomatic behaviour, intervention, instruction, contractual

arrangement, repeat" - the consultant obtained the patient's tacit consent for the work at intervals as the process developed. Each new consent allowed him to proceed to the next phase. In some instances where the consent had not been made explicit, and was not clearly evident, he enquired directly, describing the further course that the assessment would, of necessity, be taking in order to allow the patient to give informed permission.

h. Decision to Treat - Evolves and not Arbitrary

At each point of the assessment at which negative prognosticative P.E. factors were unveiled, the work done with such enabled the patient to separate out and mobilize any dormant significant H.E. segments that he possessed. The patient thus had the opportunity to respond positively to the work and move closer to treatment. In this way, decisions about treatment evolved, and were based on the inherent potential for successful treatment that existed in the case itself. The risk of an elimination of cases that appeared unsuitable because the treatment potential lay dormant and unrecognized, was avoided by the method. The consultant was never faced with s a common requirement in conventional assessments, that of having to make an uneasy, arbitrary decision to begin or end, knowing that it is based on prognosticators of uncertain validity.

i. Indicators for Successful Termination of Assessment

The author found that as the assessments moved successfully through the sequences outlined, the reasons for seeking treatment, the current life situation and the developmental history were gradually provided in significant detail. He came to realize that when a consultant had arrived at the point where he was not left wondering about any element of data, the assessment was over. At that point, treatment could be discussed, a decision (of "yes" or "no" to treatment, and if "yes", with the present consultant or not) could be made by the consultee. And if all answers were in the affirmative, as the consultant had obtained all *he* had needed to confirm the suitability of analysis, mutual arrangements could be established.

That type of successful end-point for him was routinely paralleled by a similar sense of completion by the patient. He had provided the essential

information. He knew from experience what treatment would be like. He understood (as much as possible at that point) what a successful treatment would require of him. And he knew that both parties sought sensible and realistic decisions when necessary during process.

j. The Principle of 'No "Unanalyzable Parameters" In Assessment

Throughout the development of his technical theory, the author was guided by Eissler's (1953) treatment principle that no parameters of technique would be used that could not be subsequently analyzed, and he extended the principle to include the assessment. His reasoning was that, by this approach, those patients with pathological motivation who elected to leave the assessment or defer treatment, could have uncomplicated access to resumption of the work, should reflection, an exhaustion of other unrealistic avenues to cure, or future life events so dispose them.

5. Types of Outcome

As the study developed and the consultant began to apply his technique with increasing dexterity, the author began to observe three general categories of outcome to the assessments. They will be described, and brief clinical examples taken at random will be provided for illustration.

a. Self-Selection Out of' Assessment'

Those cases with intractable disinterest in the realistically-necessary work of assessment and treatment, selected themselves out during assessment. This was not generally done directly, because of the *transferences of defense* that remained operative and untouched by the consultant's work. A message was left. A polite excuse was offered.

In such cases, the consultant was satisfied that ultimate situations of permanent impasse in treatment had been prevented, and the consultees had been given full opportunity to decide with a minimal waste of time and effort. He also considered that an unsuspected positive internalization (of greater or lesser strength) of the realistic object of the consultant had taken place, and that it would continue to exert *some* positive influence after contact was broken.

For example:

A young, professional, married, East Indian woman was referred by a psychoanalyst who had been unable to see her. The patient explained at once that she had discussed psychoanalysis with a mature friend who had been analysed, and that she had had a bad reaction to some things her friend had said about the treatment. She explained that she wished to see the consultant in order to find out if the reaction had been due to the analysis, the friend or herself. She then enquired as to whether she could ask questions and said they would be directed at the consultant's attitudes towards racial prejudice.

The consultant recognised two elements of symptomatic behaviour at once. The first was the query, *"Can I ask questions?"* From the metapsychology of questions he knew that the patient had two fantasies of his response, and as a differentiation of the real analyst from both had not yet had time to derive from reality, he concluded that an operative transference was in effect. He then provided the relevant information about how the request could be most helpfully addressed, having in mind the one side of her transference in which he would say "No" to "asking questions", in some informative verbal and gesticular detail.

The consultee then ignored the input, bypassed *that* transference and took the matter into her own hands with the imagined refusing consultant, and went on to ask a question anyway, *"Just what is your attitude to racism?"* , she said, and knowing that a second transference (e.g. *"Whether you like it or not, I am going to do it*[?]", he offered further explanation of the transference phenomenon and how such queries could help her with her above-stated problem, but her response was half-hearted. Then towards the end of the meeting she: (a) said, *"Is this what analysis is like?"* (obviously distasteful of it as she assumed it to be); (b) followed that with, *"This is the same as what happened with my friend!";* (c) postponed further interviews and did not return. She had answered the question she had posed. The problem was not her friend or her, it was real analysis. But it was not correct.

During the meeting, the material provided, made it readily apparent that the approach to the consultant was rooted in character pathology, and that that, in turn, would have had origins in pathological interactions with a character-disordered caregiver/parent. It was also clear that the symptomatic behaviour was directly related to her chief complaint.

Although a small segment of H.E. was indicated, the patient's course broke on the side of the P.E. She sought to establish interaction with the consultant that would be determined by a P.E. segment of "defense" origin. When mutual interest in this segment was advocated by the consultant, she wavered briefly in decision, then unwittingly settled with, and went away with, the wrong answer, i.e. "herself".

b. Entry into Psychoanalysis or Psychoanalytic Psychotherapy

Several cases entered into psychoanalysis or analytic psychotherapy after assessments lasting from one to several sessions over weeks or months. The treatments had varied outcomes. Some went on to successful treatment. Others, with mutually-understood uncertain prognoses due to questionable motivation, moved quickly to self-termination when the realities of treatment were engaged. Still other cases, motivated for treatment by incapacitating symptoms, improved structurally and symptomatically after work of six months to year, and deferred further treatment. The latter cases were readily distinguishable from those of premature termination in which no therapeutic engagement and consequent structural change had occurred. Some such cases also returned later for continuing treatment.

For example:

A single woman of thirty-five, a nursery school teacher in a suburban school, contacted the consultant through the phone book. She had informally sought direction from her supervisor, a mature and sensitive person who gently suggested treatment.

Symptomatic behaviour was in evidence in the first half of the first meeting. There was embarrassment and suppression of affect, and indication that such symptoms were of the most technically-significant kind. That is, the ego involved in assessment was totally pathological, with contents conscious, and no observing or healthy segments. Intervention was begun in the second half of the interview, with good response. Transference fantasies were brought out and geneses found. Then, after an assessment lasting ten sessions, during which transferences were acted out and identified, and the other elements of technical theory were applied, the consultee asked for, and entered, an analysis that proceeded successfully.

c. Evolution of Cases of "Natural Brief Psychotherapy"

To the author's surprise, some cases evolved in assessment into what he began to think of as cases of "Natural Brief Psychotherapy". Without planned advance termination, and through work with character-disorder-related symptomatic behaviours, these people progressed rapidly to intense transference engagements and new object experiences, with rapid relief of symptoms and elective termination.

They were generally ones in which character pathology, begun in a setting of pathological responses from the parental objects, was repeated without relief in settings of similar responses from all subsequent objects. The early work with the transference, in place of a repetition of such experiences, had resulted in a new experience of obviously profound significance for the psychic structure. The course of the work and the results were similar to those reported by workers in Brief Psychotherapy such as Malan (1976) and Davanloo (1978). Of particular interest to the author was the apparent inherent potential for brief therapy that some people possessed, and the capacity that the consultative method under development had for tapping it.

The finding appeared to have value for researches into criteria for the determination of choice of psychotherapy type.

For example:

A forty year-old engineer, who described his symptom as a "negative view of life" that regularly resulted in complaints by family, employers and friends, got his directions to the office confused and went to the wrong street.

In addition to the symptomatic behaviour described, other such behaviours that became manifest immediately proved technically significant upon metapsychological breakdown. Some information and instruction about "fantasy" was given within minutes of the opening of the session, with good response. And ego-syntonic transference fantasies were defined, with some genetic roots coming forward.

Then, over a period of ten consultation sessions, acted-out transferences appeared, and interfered with the person's ability to engage in the process. They were identified and formulated in detail, and powerful, much-feared aggressive affects were released to useful expression for a first time. He then experienced immediate relief from the chronic

symptoms of the chief complaint, and made a happy reconciliation with his estranged family, following which he elected to stop our work. And it was evident that a constructive change in his internal structure-processes had taken place.

"Well begun
Is half done"

Aristotle
Politics, Book III, Chapter 9

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