CHAPTER FIVE

The assessment interview

There is a moment in the story of Frankenstein when the monster comes face to face with his pursuer, and begs him to listen to his sad story. The response of the pursuer encapsulates an essential dilemma of psychotherapy:

> You may easily imagine that I was much gratified by the offered communication, yet I could not endure that he should renew his grief by a recital of his misfortune. I felt the greatest eagerness to hear the promised narrative, partly from curiosity and partly from a strong desire to ameliorate his fate if it were in my power. Mary Shelley, *Frankenstein* (1818)

On the face of it, assessment for group analysis involves a conversation between therapist and patient about one of them: the patient.

The process of assessment is, however, a mutual one. The prospective group member is assessing the therapist as much as the other way round. The term 'assessment' implies the capacity to make a rational judgement. The would-be group member should be assisted in the process by being given an explanation of the method, purpose and rationale of group-analytic therapy. This explanation is tailored to the specific needs of the patient. It should include a cautionary account of the demands and complications of group therapy as well as its possible uses and benefits. In addition to giving an account of group therapy in general, some therapists like to give a flavour of the particular group which the person might join.

There are a variety of ways in which the assessment interview can be conducted. The two of us compared notes on this:

Liesel: How do you receive the person who walks through the door?

Harold: I extend myself in a friendly fashion. When it comes to receiving patients, I have known some psychotherapists to be like children in matters of etiquette. They forget to say hello. Or perhaps they omit it intentionally because they regard it as bad technique to indulge in any welcoming pleasantries. The principle of inscrutability is sometimes invoked in the belief that one shouldn't do anything which might cause a ripple on the pool of the transference.

Liesel: Like you, I believe that nothing is lost and much is gained by extending a warm, friendly welcome.

Harold: Let me now present you with a typical scenario. A 45-year-old woman has been referred to you by her general practitioner. She enters the room and you see before you a tired-looking, tense, worried, depressed woman. How do you begin your interview?

Liesel: Of course she is not quite new to me. I will have had some previous information about her, probably through a referral letter or some other form of communication from her GP. If she is one step ahead of the GP and has referred herself, there would have been some contact with my secretary, who would have told me who she is and what she wants.

Harold: OK, let's say you've had a letter from her GP describing

lining her family situation rather briefly. That's all the information you have.

Liesel: The file will be lying on the table between us and I would be introducing myself and telling her that I've had this referral from her GP. I would then invite her with words such as 'Let's talk now and see how I can be of use to you. Just tell me whatever you wish to.' I would ask a minimum of questions, in fact I would try to ask none at the beginning, and allow her to structure the interview. I would ask permission to take notes. To the best of my memory, my note-taking has only been queried twice, and in both cases it denoted a fear of misuse of the written information. If this happens it is essential not to jump to the conclusion that one is dealing with a paranoid personality. This may indeed be the case, but it is more likely that the fear is based on previous experience. One patient had actually suffered from the misuse of data given by him in a similar interview, and the request for information about what would happen to the notes I was making was, in the light of his experience, reasonable rather than pathological.

Harold: I have to say that I take it for granted that note-taking is part of the assessment interview, so I don't even draw attention to it. It is too much to expect the therapist to retain the wealth of detailed information and impressions in mind without making notes.

Now let's suppose that our patient begins to talk in a slow, hesitant way about her difficult relationship with her husband. Would you encourage this and allow this theme to develop with her?

Liesel: I would certainly listen very carefully. I would neither encourage nor discourage it. What I would try to do is to establish a relationship – in which she will take notice of me as well as I of her. In that sense I would make observations about her present state in the 'here-and-now' of the interview situation. I might say, 'You sound sad to me, you sound tired'. I would make some reference to the depressive state in which I experience her now. I would describe my experience of her in this session and see what she makes of it.

Harold: It's not uncommon for patients to begin to cry as they start

Liesel: That's difficult. I certainly would accept her tears for a while, but then I would intervene with a question. I might explore the tears. I would see them as a symptom – no, not actually as a symptom – I would see the tears as a defence against what lies below the tears, and I would make remarks which would encourage her to penetrate the tears and get down to a deeper layer of the exploration of her feelings and her existence. It would be very important in this first interview to get on to her relating more of what I would call her social history, which means, for instance, her culture and family of origin, and so on.

Harold: As far as the social history is concerned, I have in my own mind a sort of blueprint of what has to be covered during the first session. I think of two strands of dialogue which have to be woven together by the end of the interview. The first is a conversation about her symptoms: in other words, what she regards as the problem areas in her life, both interpersonally and in the way she feels. The second strand is about the rest of her life, the 'non-problem' to use Caroline Garland's phrase (Garland, 1982). I would try to find out whether she can imagine connections between the two. That's going to be important if she joins a group. I want to conduct a tour of her present and her past, in that order.

Liesel: That seems to me a little over-structured. It may be that this is unobtainable in the first hour of one's meeting a new person. If so, I would point out just how much we have left undone and how difficult it is to get down to her history and her problems, and I would suggest another diagnostic interview, which, in my experience, is gratefully accepted.

Harold: Yes, I also sometimes find that I have to extend the assessment process, but I still try to get a comprehensive history during the first meeting. I find it all too easy to get drawn into an emotionally powerful narrative before we have got anywhere near to working out a shared understanding of the next step. She is giving me a lot of information, but there is also a lot of information I have to give her, about the nature of group therapy, and my group in particular. I also want her to go away with some new thoughts about herself, and with a sense of hope.

Liesel: I can see that your approach is more complete, and therefore has to be more structured than my own would be. Would you think that our patient can take all this in this first encounter with you?

Harold: Maybe not, but I imagine that she will reflect back on our meeting, and I would expect her to hold on to some facts as a way of deciding whether she wants to come back at all. I feel that I owe her an informed opinion of her predicament by the end of our first meeting. Or else I have to give her good reasons for meeting again.

Liesel: In your scheme of interviewing, how do you lead from the symptoms into the social history?

Harold: I usually find that I have to initiate a clear break between the emotionally driven account of the symptoms and the rest of the history. I might say something like: 'Let's leave this area for the moment. It will help me to understand it better if you can tell me something about other areas of your life.' I would then probably follow that up with a specific question such as. 'Who are the other important people in your life right now?'

Liesel: I probably do it differently and I am beginning to wonder whether this has to do not only with our two different personalities, but also the fact that you are male and a doctor and I am female and non-medical. It seems to me from your description that I present a more receptive, maternal figure in the first interview and that you present a paternal demanding figure and that both are equally justified. They influence the structuring of the first interview, but I think the end result is probably the same, because I very much agree that one has to get down to the practicalities of the treatment situation of the 'here-and-now'. One should not allow too much of the material to pour out in these interviews, if only for the reason that too powerful a transference can be established in this first interview, when after all the patient will eventually have to share you with seven others, and if the relationship is too intimate and too maternal this can result in difficulties when the patient is introduced into the therapeutic group. This could give rise to resistance to the group and a demand for individual therapy.

Harold: Getting the balance right between the patient's need to tell her story and her need to learn about herself isn't easy.

And she also has to know what she is letting herself in for if she decides to join a group.

Liesel: I always keep in mind our analytic purpose, which is to develop a relationship in which needs can be expressed through the transference, initially towards the therapist and then towards the group as well.

Harold: OK, let's get back to our hypothetical patient. Suppose you conclude from her story that she idealizes her family. I might venture something to the effect that she might be seeing her parents through rose-tinted spectacles. She denies this, defends her parents and leaves you feeling that you have trespassed on sacred territory. Do you try to re-enter this area in another way?

Liesel: We are talking about unconscious defence mechanisms. I may be inclined to make a mental note of her defence, but I might leave it at that for the moment. There are various techniques for testing defence mechanisms. By the way, some of them are quite questionable. Many years ago a candidate for group-analytic training was invited to an interview by the training group analyst for his placement in a therapy group. As he came into the room the interviewer carried on writing and didn't look up at all. The candidate waited a few minutes and then said that he had limited time at his disposal, and could the interview please start. Later, the therapist told him that he had behaved like that to see how he managed his defence against rising anxiety. We would not proceed in such a manner ourselves, would we?

Harold: At what point do you begin to reflect your opinion back to the patient?

Liesel: I see this as happening all the way through the interview, whenever I offer trial interpretations. Collectively they form what you might call an opinion.

Harold: Again, I think we have a difference in emphasis. I also offer trial interpretations along the way, but I feel a kind of obligation to bring things all together near the end, with some kind of summation or formulation which I can deliver to the patient. Perhaps that's my medical training at work again.

Liesel: I would like to add to what you are saying about a formu-

not only her but the group which she might or might not join. As I am experiencing her in the first session, I am wanting to see whether she fits in, in the sense that she will not be isolated in the group, whether some of her problems are presented by other patients in the group, whether she fits in age-wise and personality-wise. However, as one is inclined always to feel that a newcomer might disturb the group and not get what she or he needs out of the group, the first picture is usually a cautious one, rather than an over-optimistic one, in my experience.

Harold: As you continue to talk to this woman then, what factors would make you feel more optimistic about her potential to make use of the group? You note that she has already reacted rather negatively to your early tentative interpretation which attempted to link her symptoms to her tendency to idealize her family.

Liesel: The main factor would be whether I feel that we have managed some kind of working relationship, whether I can reach out to her and she can reach out to me, whether we can actually, in the deepest sense of the word, communicate. If we can, there is no reason why she should not be able to communicate in the group with other people. However, it could be that the group at that moment is in a depressive state, and depression tends to prevail over all other moods. In this case I would be very hesitant to introduce her at this moment to this particular group. I might suggest a number of individual sessions to prepare her and at the same time work to prepare the group for her entry at a time when it has got over the worst part of its depressive state. What I'm saying is that the timing of entry is almost as important as the personality of the new group member, and they have to be fitted one to the other. If a fit is not possible in the group which you have in mind, it helps to be working with other therapists in a network or practice which can provide a pool of groups, so that another group can be found for her.

Harold: So far we've talked about a prospective group member whose presenting problem lies in the area of mood. She wants to feel better. Let's think about another example, of a person who presents with a pattern of behaviour which

is unable to complete an important research project. As the months have gone by he has become increasingly tense about this, but is unable to overcome the block and he has no idea about what might lie behind it When you meet him you get a sense of someone who is quite emotionally cut off.

Liesel: Despite the note of doom around that phrase 'emotionally cut off', he might very well be a suitable group member. He can communicate, but he has no idea why he fails in such a specific area, which at the same time is vital to him. The chances that he can come off the description of his symptom and slowly peel off the various layers and get to the bottom of it, are best served in a group, to my mind better than in individual therapy, because of the varied input and the free association of the other group members.

Harold: And now a third example, where the presenting problem seems lodged within a difficult interpersonal relationship: a 35-year-old man who is in a state of emotional turmoil because his wife has threatened to leave him. He is terrified of losing her and this has made him increasingly possessive. It is she who has urged him to seek therapy. She sees it as his problem and will have nothing to do with therapy herself. He expresses the hope that therapy might somehow save his marriage, but he also realizes that he needs therapy in his own right, regardless of the impact on his marriage. When you meet him it is difficult to get him to talk about anything other than his relationship with his wife.

Liesel: A presenting problem like this immediately calls to mind the possibility of couple therapy, but if, as you say, his partner will not lend herself to that, and it is clear that he wants therapy for himself, I would seriously consider him for a group. A positive feature of his presentation is that he sees his difficulty as being located within an interpersonal relationship, albeit a dominating and incapacitating one, but the very fact that he is experiencing his relationship in these terms bodes well for his group analysis. The group, by encouraging him to talk about his relationship and resonating to the emotional issues which it stirs in them, would help him to become more detached and less driven

and therefore more able to think about the other relationships in his life.

Harold: What about a related problem, the case of a man who has been given an ultimatum by his wife: 'Go and get some therapy for yourself, or I will leave you'? His own preconceived view of therapy is highly sceptical, but he is desperate and 'will do anything if it will help'.

Liesel: In such a case I ask myself whether the person will stay in the group if for any reason the pressure from the partner is off. One man comes to mind whose wife had actually left him, and he came into the group and did good work. Then she came back, whereupon he left the group. So, although the motivation was urgent at the time, it was not strong enough for him to gain the insight that it was his own personality that was deeply engaged in the interaction. So the moment the pressure was off he actually withdrew from therapy.

Harold: Would you test a person's capacity to make use of analytic thinking by asking for a dream ?

Liesel: I might under certain circumstances. I'm thinking of a patient who came for group therapy after prolonged individual psychoanalysis, and he already had knowledge of the psychoanalytic process. There was no need to lead him on to the royal road of dreams, it was a familiar route for him. I might ask a less 'sophisticated' patient, 'Do you sleep well, and do you dream a lot?' Often I then get a dream. I do not directly ask for a dream to be related, but I would show that I am interested in dreams and receptive to them. To me, the relating of a dream implies psychological-mindedness. What do you think of that as a construct?

Harold: The ability to see a dream as significant indicates psychological-mindedness to me, and I would regard this as a good indicator of the person's ability to use an analytic group. I would be more doubtful about someone who stays with a very concrete narrative and seems unhappy in the medium of symbolic thinking.

Liesel: How important do you regard it to find out about previous therapy?

Harold: I like to find out what steps the person took to reach me, and whether there is a history of previous experience of

therapy. I also have no compunction about asking how the therapy was experienced. I think that often a negative experience will have coloured this person's attitude to current possibilities. I particularly want to know on what note the therapy ended. If the therapy is still ongoing, I would want to redirect the person back to the current therapist to clarify the appropriateness of a transition, and to open up the possibility of an exchange with the other therapist. Let's now assume that you regard the person as suitable for your group. How do you begin to prepare that person for the act of joining?

Liesel: First of all, I make an effort somehow to make clear my belief that group therapy is the optimal treatment for that person. It's important, when one holds this view, to actually put this across, because often group therapy has an aura of being second-best, that is to say less 'deep' than individual therapy, cheaper, convenient for the therapist, and so on. I recall a supervision group where a supervisee, an experienced psychotherapist, replied to a telephone request for therapy with: 'I have no vacancy for individual therapy, but I can take you into a group.' The implication is that group therapy is being offered *faute de mieux*. It's important to dispel the myth of 'second-best', and to make it clear that in choosing group therapy for this particular person the therapist has given due consideration to other methods of therapy. It's then also necessary to talk about the therapeutic contract, which means regular attendance and all the other obligations attached to joining and leaving the group. I tend to give the person a written statement about what is expected. This is often mislaid or forgotten later on, but at least it is a bond between the therapist and the group member. It is, so to speak, a kind of 'transitional object' which the patient takes home and keeps. Having ascertained fairly early on in this briefing that the time and day of the group are convenient, I explain about the 'slow-open' nature of the group. I reply cautiously to questions about how long it is likely to take, but I make it clear that it is not a short-term treatment . On the other hand I do not overstate the time. I remember someone coming into the group and making it quite clear that she was certain that

would be quite wrong to say that this was too short. This woman is now in her fifth year in the group. It was quite important to allow her to set her own targets at that time and change these targets while she was in the group. I am therefore not dogmatic about the time it takes, but I make it clear that this is a process aimed at deep and fundamental change. This also brings in a sense of hope.

Harold: I agree with all of that. I think the patient's first reaction to the suggestion of group therapy is important. Many patients say that they would like to think about joining a group, but they want some individual sessions first. Even if they don't put words to this, I sometimes propose it as an option, and I find that it is often readily accepted. Other patients are so keen to get on and join the group that they even want to dispense with the initial assessment meeting. This raises the possibility that they could be unconsciously devaluing the therapist or the opposite: an unconscious terror of being alone with the therapist, as is sometimes the case with people who have experienced childhood abuse.

Liesel: When would you not take someone into a group?

Harold: What you say about a particular group having to be right for a particular individual is the only way I can think about the question in general. Having said that, some patients are too narcissistic to be capable of identification with the other group members, others are too needy to be able to contemplate the sharing of attention which a group demands. Some individuals with too severe an ego-weakness may react negatively to the emotional currents in the group. Patients with poor impulse control may find the challenges posed by the group situation too much. I also think that people whose lives are dominated by rigid belief systems are unlikely to tolerate change. When I am in doubt I find that the therapy of choice generally declares itself to the patient after a few individual sessions.