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Assessment in psychotherapy

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What is psychotherapy assessment for?

Assessing a patient for psychotherapy is often seen as mystifying. This is not surprising given the diversity of opinion, even among experienced clinicians. In this chapter we will outline some of the basic concepts and skills and aim to provide a framework. This framework can be summarised as two main decisions: first, the appropriateness of any psychological treatment approach; and second, the choice of which particular psychological treatment method. These decisions involve knowledge gained from research (evidence-based practice) and views based on systematic clinical experience (practice-based evidence).

There are two distinct processes occurring during assessment. The first is idiographic; a unique formulation is being drawn that captures the essential features relevant to this person. The second, nomothetic, process draws inferences relevant to this individual from good quality research with similar subjects. Evidence-based medicine (Sackett *et al.*, 1998) is one attempt to bring these processes closer together (Margison, 2001). The clinician tries to construct a well-designed question that is relevant, and perhaps unique, to an individual and then uses strategies to search the literature for information relevant to that question. The knowledge-base for answering questions with regard to psychotherapy assessment is far from ideal, but is more extensive than some critics would allow (for a detailed review see Roth & Fonagy, 2005).

In an ideal world there would be simple tools for carrying out an assessment. The tools would be accurate in predicting both positive and negative effects of therapy. Despite many attempts there has been little progress in developing an assessment tool able to make accurate predictions across a range of patients and conditions (Mace, 1995). Tools have been of little use, perhaps because they are often used 'without conceptual or logical justification' (see Bloch, 1979). Evidence-based guidelines are a sophisticated attempt to draw on the best available literature and to use 'expert consensus' methods (such as Delphi techniques) to synthesise the best way to tackle a clinical problem. These approaches have been difficult to

implement and are expensive and time-consuming to produce. Critics have also pointed out that bad guidelines may be worse than having no guidelines at all (Woolf *et al*, 1999). Despite the limitations of the subject areas covered by good quality guidelines, they need to be considered as an integral part of assessment when they are available.

In reading this chapter, it is assumed that the description of assessment will supplement other methods of evidence-based medicine such as literature searches and evidence-based guidelines. The essence of assessment is in evaluating a person's strengths, weaknesses, desires and motivation. The skill in carrying out an assessment is in balancing all of these elements, while considering the best of several approaches to therapy. Doing this within a conversation that is both personally engaged and professionally detached is demanding. Assessors may believe that their approach is the best approach. Their assessment of a new patient may therefore focus on establishing whether the individual is suitable for treatment by their own approach, rather than on considering which approach of the many available would be best for that individual.

This chapter deals with a wide range of psychotherapeutic approaches. First, underlying principles relevant to any interview are detailed. Second, some of the strategies that are specific to the main modalities are considered briefly: cognitive-behavioural, systemic and psychodynamic-interpersonal. Integrative approaches that draw on several traditions to tailor an approach that is designed for a particular individual are also discussed.

To do this, the strategies used in an assessment interview have been summarised. We then discuss assessment in relation to formulation skills. Finally, a simplified decision model that summarises the main points is presented.

How to do an assessment interview: conflicting roles and expectations

It is crucial to distinguish between two quite different purposes of an assessment. The first has sometimes been called 'brokerage'. Here the therapist is acting as a guide, helping the patient come to the best decision about whether to undertake therapy and, if so, which approach might be most suitable. This requires the assessing therapist to know a fair amount about the range of therapies and their indications, and something of the local situation (for example, where to find different types of therapy, or in some cases, alternative approaches, including social and psychopharmacological). This process requires different skills from the second type of interview, where the therapist is assessing for a particular type of therapy.

A psychotherapy interview needs to provide structure within a freely flowing conversation. Such a narrative allows connections to become apparent. The interviewer may, however, need to deal with a relatively high level of uncertainty and anxiety. Finding out whether the patient can tolerate this ambiguity while exploring painful areas is in fact one of the issues being

assessed. In a single interview the assessing therapist is trying to balance the need to take a social and psychiatric history while also modelling something of the actual therapeutic experience. Sometimes the interviewer manages to get to the heart of the patient's distress remarkably quickly. Paradoxically, this can make the subsequent task of the therapist more difficult because the patient has unrealistic expectations of being 'understood' to an almost magical degree.

Malan (1979) gave a succinct account of the main points to bear in mind throughout the assessment interview. These have been rephrased to highlight some key points that apply across different modes of therapy (see Box 1.1).

Assessment before the interview

Even before the assessor meets the patient a lot has happened. There is often a substantial therapeutic effect from just making contact. The need to maintain this initial 'mobilisation of hope' leads to the first conflict for the assessor. Should the therapist make contact as soon as possible, even if there is then a delay before the definitive therapy is offered? Or, should the therapist wait until the initial interview can be followed by therapy with no further delay.

One possible compromise is to have an initial few meetings as a form of very brief therapy, leading to a formulation and advice, while waiting for the definitive therapy, if that is still needed (Aveline, 1995).

Many departments send a preliminary questionnaire for the patient to complete before the interview, which typically covers similar ground to the interview, sometimes supplemented by standardised measures of symptoms and interpersonal problems. The Symptom Check List–90 Revised (SCL–90R; Derogatis, 1983) and the Inventory of Interpersonal Problems (Horowitz *et al*, 1988) are commonly used, and recently there has been the development of

Box 1.1 Checklist of tasks to consider in any assessment (after Malan, 1979)

Think psychiatrically:	Diagnosis, symptoms, medication
Think psychodynamically:	Triangles of conflict and person
Think psychotherapeutically:	Make forecasts and predictions
Think practically:	What is possible even if the ideal is unavailable?
Take care of the session:	Create and maintain rapport
Take care of the patient:	Avoid pointless anxiety
Be wary about your impact:	Watch the effect of your interventions, now and for the future

Box 1.2 Pros and cons of using a questionnaire

Advantages

- Extra detailed factual information available
- To understand the patient's hopes and expectations before meeting
- Style of filling-in reflects the patient's defence style
- Initial information is free of the interviewer's own bias
- Questions reflect the importance given to feelings, relationships, hopes and expectations
- To some extent, motivation and commitment can be checked

Disadvantages

- Questionnaire feels impersonal
- Patients feel uncomfortable writing down very sensitive information, for example, about abuse
- Postal security may not be perfect
- Written format tends to compound the existing bias against some patients with learning difficulties, who are not fluent in writing, where English is not the first language and in those with visual disability
- Savings in establishing motivation have to be offset against patients who are alienated by the questionnaire and do not respond

the Clinical Outcomes in Routine Evaluation (CORE) assessment instrument (Barkham *et al.*, 1998). The use of initial questionnaires has been summarised by Mace (1995), and some key issues in using questionnaires are given in Box 1.2.

Some of the problems can be reduced by stating that the patient can still be seen if they cannot complete the questionnaire, having a space where the patient can say 'there is something I cannot put in writing', and by careful phrasing of sensitive questions.

*Opening the interview***Presenting problem**

The presenting problem can sometimes be specific, but may be much more diffuse (for example, a loss of direction, poor or unstable sense of self), masking other psychiatric difficulties.

Example

A 35-year-old woman, working as a successful computer analyst, started the interview by describing how she had been feeling empty, despondent and lacking direction about her future. She had not felt herself to be depressed but the interview helped her to trace the vague feelings of unease back to an earlier point in her life when she had been less successful than her sister who it turns out had just had a child, while the patient remained childless.

This highlighted for the patient that she faced a difficult choice between her role as a woman gaining self-esteem from her job, in conflict with a possible

role as mother. She was then able to talk about episodes when she would feel hopeless and worthless and had considered suicide. She had felt ashamed to admit these feelings just as she had been unable to tell her parents how desolate she felt as a child.

This brief account shows how a vague presenting problem can be transformed into a much clearer area of conflict within the assessment itself. Sometimes the problem remains diffuse until much later and the assessment will then focus on the patient's capacity to engage in exploring the symptom.

Expectations

It is important to grasp the patient's understanding of the interview purpose and any areas of hopeful or negative expectations. 'I just want to be happy' is one of the least useful responses as it implies a positive expectation but a passive approach to the treatment.

Feelings about the interview

This leads on to the way the patient feels about the assessment, for example feeling exposed or anxious.

Example

A 36-year-old man started the interview looking particularly anxious even though a pre-treatment questionnaire had not suggested that he was prone to anxiety. When asked he commented that he had felt anxious in the waiting room and connected this feeling with a habit his father had of keeping him waiting before beating him with a steel ruler.

This exploration would have been useful simply to put the anxiety in context so that the patient can turn to the ostensible problem. However, as is often the case, the anxiety could be linked to the presenting problem. Here, the problem was of angry outbursts at work. The assessment led to a focus on rage towards junior colleagues at work being a replay of earlier relationships, with him unwittingly taking on the role of 'father'. Different approaches to therapy might highlight different aspects of this scenario: unwanted thoughts and actions, awareness of role conflict, managing a demanding job with insufficient support, making links between past and present. So, even in a generic interview, the strategy the assessor adopts may subtly lead to particular recommendations.

Gathering information

Presenting problem

As discussed above, it is often possible to move from the patient's feelings about the interview to the current difficulties they are experiencing. Why has the patient come for help? Why at this point? Are there any recent precipitants?

Historical factors

These are 'woven' into a personal narrative that can focus on anecdotes, which are then linked into themes. This section of the interview needs a careful balance between being comprehensive and structured on the one hand, while allowing the patient's own links to emerge naturally.

The main headings are the same as in a psychiatric history. For early life cover, as a minimum, family atmosphere, family history, separations and illnesses, school adjustment, friendships and experiences of bullying or abuse.

From adolescence there are the themes of sexual development, risk-taking and eventual separation. In adult life there are the themes of sustained sexual relationships, children, work, leisure and dealing with the ageing process in oneself and the ageing and death of parents. 'Mid-life' is a developmental point rather than a chronological one, when successes are re-evaluated and failures seen either as irrecoverable or assimilated.

In late life there are often themes of separation, illness and loss, either experienced personally or vicariously, or there might be themes of new-found creativity, independence and wisdom. This assumes that there are developmental themes in every individual's life, which are, in turn, linked to family themes, and to the broader culture in which the person lives.

A common error is to take a history assuming that developmental hurdles are locked to particular ages. It is common to face rivalry issues in adolescence during examinations, but these are often replaying themes from the time of starting school. A different opportunity for this theme to be played out might be the time of becoming a grandparent, which may lead to rivalry with one's own child. Although the history may emerge in a chronological sequence, the key task is to form themes from the relationship anecdotes. As will be discussed later, the different modes of therapy require somewhat different approaches to these themes, but in the assessment phase it is generally useful to gather a number of anecdotes and suggest linking themes.

It is best to see which themes emerge naturally, although there are traps related to our own prejudices, for example, reluctance to see someone from an ethnic minority as having to deal with envious attacks on their career success, or reluctance to see a male patient struggling with conflicts about how to nurture a child. Resisting stereotyping is always difficult, but perhaps especially so if the assessor is trying to form a 'story' of the patient's life. Patient and assessor are subject to a series of 'plots' (i.e. presumptive beliefs about the meaning of situations), which are especially subject to cultural bias.

Relationship history

The previous narrative will have covered various relationships in passing. In this section it is helpful to gain a detailed account of several key figures, again by getting the patient to recall significant stories about important people.

The quality and duration of the relationships, and ways of dealing with loss should be covered. Examples need to cover prototypes of relationships, for example, authority, peer, sexual, care-giving, and even 'casual' acquaintances.

Types of attachment pattern

Bowlby's work highlighted the importance of attachment types. In adult life these early patterns persist and can be brought out through the anecdotes mentioned earlier, particularly of parents and close family members. Abnormal relationship patterns are either intense, clingy and dependent; aloof and disconnected; or alternations between these two. In contrast a mature style can tolerate separation and ambiguity (see Holmes, 1996; Bartholomew, 1997; Mace & Margison, 1997). The research on attachment, through the introduction of the Adult Attachment Interview (Main & Goldwyn, 1995) led to the observation that the narrative style of the patient's accounts (rather than the content) was the most important information in assessing attachment style. Further studies (Sachse & Strauss, 2002) of attachment type (using a different taxonomy of avoidant, ambivalent, mixed insecure) in group therapy show less powerful predictions based on the attachment type, but meaningful links between therapeutic factors and attachment type. For example, avoidant patients rated group-linked change factors such as cohesion as least helpful, although the overall effectiveness of the group was not markedly less. This is an example of research evidence being consistent with, and supportive of, an underlying theoretical model, but of little value in helping a patient to make a choice about treatment.

The interview itself will display many of the key elements of relationship style through tone of voice, posture and gesture. This can be merely noted or brought into the discussion (although this needs tact as it can be intrusive and even persecutory to draw attention to your observations). The ability to experience 'basic trust' is fundamental in relationships and the patient's difficulty with this may become obvious in the interview.

Psychological mindedness and capacity for symbolism

There are several ways in which this appears in the interview, for example, the patient may talk about a dream and the dream may be seen to connect with the relationship themes already touched upon. The patient may use metaphor (with a greater or lesser degree of awareness of its multiple meanings) (Guthrie, 1999).

With some patients, exploring personal connections with characters from plays, films, television or books can carry the links further.

Coltart (1988*a,b*) suggests that psychological mindedness can be identified through the following factors:

- a history that deepens and becomes more coherent
- needing little prompting to give a story the patient seems able to relate to

- bringing up memories with appropriate affect
- awareness of an unconscious mental life
- a capacity to step back and observe reflectively
- a wish to take more responsibility for the self
- imagination
- capacity for achievement and some realistic self-esteem.

It will be clear from this list that suitability for psychotherapy is often taken to mean conditions predicting success in psychoanalytic psychotherapy specifically. It might be more accurate to see the absence of these predictive factors as indicators that other forms of therapy might be more appropriate. Recent studies on psychodynamic interpersonal psychotherapy suggest that the therapy might be beneficial even when the person is not psychologically minded (Guthrie, 1999).

McCallum, Piper and colleagues have investigated the relationship of psychological mindedness and alexithymia with therapy outcome in interpretive and supportive group and individual therapies. Both features do predict outcome (McCallum *et al*, 2003).

Assessing motivation

Motivation is notoriously difficult to assess (Bloch, 1979). Without at least a minimal agreement to attend sessions, therapy is clearly impossible. Beyond this, it seems that motivation may be as much a function of social compliance as a rational statement of intent.

Example

A 45-year-old man with a history of alcohol misuse and violence to women was denigrating the female therapist by calling her 'chick' and dismissing her suggestions, and by saying that 'therapy was for dickheads'.

The therapist felt the urge to make a 'clever' interpretation about his fear of his own sexuality (which would have been justified by the content of the interview). Instead she realised that this would have had the effect of merely making him look stupid (a 'dickhead') and instead chose to focus on how strange and even frightening the situation was for him. Eventually he talked about his need for alcohol to feel in control and accepted the suggestion of a support group to help with his violence to women and a planned detoxification from alcohol.

Therapists might be inadvertently biased towards accepting patients for therapy who are submissive and dependent, rather than dominant and assertive. This is to confuse motivation with compliance. This may lead to a refusal to take on apparently 'difficult' patients who are opinionated, dismissive or contemptuous of the therapist. In theory, therapists might acknowledge that being disdainful is a defensive manoeuvre to protect self-esteem, but it is still used as a reason for patients to be judged beyond therapeutic help.

Sometimes it is not possible to have a 'trial of therapy' to assess motivation because the patient may need several months to develop even

basic trust, but it is sometimes possible to make a judgement based on previous commitment to therapy, and the ability to talk about the therapist as a separate person, whether the therapy was helpful or not.

Understanding problems and expectations of change

This section picks up whatever the patient had said at the opening of the interview and extends it in the light of what has been discussed so far. It is essential to explore the patient's model of what is wrong. Sometimes there is a natural style of thinking that favours either practical problem-solving or the exploration of an event's meaning.

Sometimes it is appropriate to agree with the patient's view, for example, by suggesting a rational and practical way of tackling phobic anxiety by exposure treatment. Alternatively, the patient may welcome the opportunity to explore the meaning behind a particular symptom. This might be the case for a patient coming for therapy at a point where those habitual ways of coping have collapsed and an alternative model is welcomed.

The assimilation model (Stiles *et al*, 1988) suggests that problem domains move through a fairly predictable sequence, from 'warded off' through 'painful' to 'problematic' to merely 'puzzling' and finally, 'mastered'. There is some support for the belief that psychodynamic therapies tend to be strongest at the unassimilated end of the spectrum, where the patient may only know in vague terms what is wrong. Further along the spectrum cognitive-behavioural techniques are powerful, as they are focusing on solutions to problems that are already clear and relatively circumscribed.

One of the most difficult problem areas to tackle is the belief that symptoms are caused by a physical illness. Here the problem may be clear to the patient, but its underlying nature and origin may be stereotyped within a disease model, despite repeated failure. Somatisation is amenable to various psychotherapeutic approaches (Guthrie, 1999) but the clash of models needs careful negotiation.

Example

A patient referred from the gastrointestinal clinic with irritable bowel syndrome was insistent that her abdominal pain and swelling was proof that there was a physical cause. The engagement in therapy was reliant on the therapist meeting the patient for a long first interview, where links, expressed in bodily metaphors like 'full up to here' and 'gutted', were explored. She seemed to give the therapist the benefit of the doubt and attended sessions and continued to explore the links between her bodily and psychological distress.

Resilience and robustness of defences

Throughout the interview the patient will have been displaying a characteristic defensive style and describing it in the anecdotes elicited earlier. Asking about times when the patient felt overwhelmed and how they then coped can develop this. The therapist may need to prompt with suggestions about previous defensive strategies such as cutting off from people, drinking more, working too hard and turning against friends.

In the patient's story there will usually be a good indication of the ability to tolerate change and there may also be clues to particularly difficult defensive strategies, such as the tendency to see the responsibility for problems in the other person. Maturity of defences is somewhat similar to 'ego strength', although it has been hard for clinicians to agree on its meaning (Lake, 1985).

Dealing with significant loss and the ability to mourn should be a specific focus. The pattern of a person's coping with issues of separation and loss can help the therapist predict how these themes will emerge, and be managed, in the therapy.

A hierarchy of defence and regression

There have been several attempts to categorise defence from the early clinical descriptions of Anna Freud to more recent questionnaire and standardised interview methods. One of the most useful is the model developed by Vaillant (1986), summarised below. One of the strengths of this model is that it was linked with a large follow-up of college students and the predominant defence was clearly linked to the subject's life adjustment.

Vaillant makes the important point that defence can be clearly constructed as a hierarchy, but that there is usually overlap in any particular person, and the person's defences might shift depending on the current life stresses. This tendency to 'regress' to coping strategies that originate at an earlier point in life can be 'regression in the service of defence', or a 'malignant' state that can lead to prolonged dysfunction. The proneness to malignant regression is sometimes picked up in the history from an account of the patient worsening and increasing self-harm after admission, when the removal of responsibility pushes towards a regressed state.

Vaillant's hierarchy (Box 1.3) is a helpful framework to understand the level of avoidance of feelings. However, it is meant as a guide and the assessor needs to look for the overall style and avoid simply trying to find examples of each.

Sedlak (1989) has illustrated the importance of a particular defence called disavowal, which means an ability to tell the therapist that something desperate has happened, without the ability to connect with the affects that belong to this experience. Patients with this difficulty have been dismissed in the past as 'hysterical' and manipulative.

Sifneos described an important state that may be either a defence or represent a developmental block in his concept of 'alexithymia' (Nemiah & Sifneos, 1970), which means literally having no words for feelings. On first sight it appears that this state must preclude any attempt at exploratory work. Some patients can learn to develop a 'feeling language' (Hobson, 1985) if the assessing therapist tries to model the use of metaphor in a sensitive way.

Box 1.3 Vaillant's hierarchy of defences

Mature defence

- Anticipation and objectivity planning ahead for painful times
- Suppression 'getting on' without denying the difficulty
- Altruism meeting needs through service to others
- Sublimation accepting difficulty but focusing on another activity as a substitute
- Humour expressing distress in an oblique way to 'see the funny side'

Intermediate defence

- Repression memory lapses, inexplicable naivety
- Reaction formation feelings or behaviour diametrically opposed to an unacceptable impulse or feeling
- Displacement avoiding conflict by expression towards a 'substitute'

Immature defence

- Passive aggression ineffective expression of anger to others or directed against the self
- Hypochondriasis somatisation of feelings and conflict
- 'Acting out' allowing an unconscious impulse to be expressed to avoid the associated feelings
- Dissociation a temporary and drastic loss of identity or personal action, e.g. conversion symptoms, fugues
- Projection attributing unacknowledged feelings to others
- Schizoid fantasy avoiding relating and substituting gratifying fantasy

Primitive defences

- Splitting, delusional projection, denial distortions of reality which are psychotic or bordering on psychosis

Coming to a decision*The patient's own preferences*

Some patients may have quite explicit requests (such as wanting 'psychoanalysis') that may be carefully thought through or may be based on misconceptions. The patient may also have strong feelings about the possibility of working in a group, or working in a structured way (for example, keeping diaries and reviewing homework). These beliefs and prejudices need to be disentangled and put in the context of the rest of the interview and the resources actually on offer. There have been

systematic attempts in research to look at the interaction between patient 'aptitude', type of therapy, and outcome (Aptitude Treatment Interaction (ATI) paradigm: Shoham & Rohrbaugh, 1995). As Shoham points out, the paradigm has been used extensively but the results are still ambiguous. She suggested that the most important area to explore in 'aptitude' might be relationship style, rather than the demographic and personality variables studied in most research to date (Garfield, 1994)

One particular aptitude, or sometimes preference, is the ability to work in a group setting (Knowles, 1995). Dealing with the fantasy that group therapy is a diluted form of therapy rather than a different method of exploring needs careful handling so that the patient can see what the option actually involves.

Preferences about the gender, age, or ethnic origin of the therapist are sometimes difficult to clarify. They may be expressions of social preference, or they may reflect a carefully considered position, or they may be part of a defensive stance. The evidence is equivocal about the impact of social similarity on outcome but the preferences may at least need discussion if mismatches are not to interfere with the development of the therapeutic alliance. However, the balance of evidence suggests that ethnic origin and similarity between patient and therapist in ethnicity do not have a powerful effect in predicting therapy outcome (Maramba & Hall, 2002).

Double-checking for problems

Psychotherapy assessments run the risk of overemphasising psychological and relational issues. Part of the argument for maintaining the role of the medical psychotherapist is to pick up medical and psychiatric complications. Almost as a routine, the usual screening questions for the main psychiatric syndromes need to be followed.

This can lead to a sudden shift for the therapist, when the attempt to understand an odd experience becomes suddenly reframed as a possible physical illness such as epilepsy. Experienced assessors seem to have a capacity to be attending closely to the patient's immediate experience while at the same time monitoring and sifting the evidence. Box 1.4 suggests some key issues to consider when weighing up the risks of therapy.

Assessment for specific forms of psychotherapy

The account of assessment given above is drawn strongly from the psychodynamic–interpersonal approaches. Some of the points are specifically relevant to psychodynamic therapy, but many are relevant to any form of assessment. However, there are additional factors that need to be taken into account when assessing with a view to other models of therapy.

Family therapy

Therapists use methods that assess typical communication patterns and, through analysing these, develop strategies to encourage more adaptive

Box 1.4 Checklist for assessing the risk of therapy

- Is there any history of alcohol or drug misuse?
- Is there any history of impulsive behaviour (overdoses, self-harm, violence, sudden avoidance by moving away)?
- Find out the point of maximum disturbance in the person's life (as the therapy might reactivate comparable levels of difficulty)
- Were there any problems in a previous therapy?
- Who is responsible for prescribing and monitoring any concurrent medication?

family function (see also Lieberman, 1995). (Family therapy is covered in Chapter 11.)

Behavioural therapy

In behavioural therapy a formal approach known as behavioural analysis describes the antecedents, behaviours and consequences (ABC) under study and identifies target behaviours whose frequency is to be increased or decreased, and assessment may involve specialised observational techniques. (See also Chapters 6 & 7.)

Cognitive therapy

Cognitive therapy takes a broadly similar approach (including diary keeping) but focuses on dysfunctional cognitions and uses homework tasks to assess the conditions that alter the intensity and frequency of these dysfunctional beliefs. The assessment interview might include many of the features described earlier, particularly the development of good therapeutic alliance, but the focus in the assessment is on errors of thinking, as originally outlined by Beck *et al* (1979). (This is covered in more detail in Chapters 6, 7 & 8.)

An interesting synthesis of cognitive and interpersonal approaches from Safran and colleagues (Safran *et al*, 1993) has led to an empirical approach to selection for cognitive therapy with an interpersonal focus. Although this work was originally focused on cognitive–interpersonal approaches, the principles are, again, of wider applicability. They listed 9 areas (summarised in Box 1.5) to be explored and then rated in order to predict whether brief cognitive therapy might be an appropriate treatment. It will be apparent that many of the themes are variations on the approaches outlined earlier, but focused on the factors that have been shown to predict outcome in brief cognitive therapy. It could be argued that they are primarily a list of good prognostic features for any therapy, but the method uses particular ways to probe in the interview to gain maximal information about specifically cognitive aspects.

Box 1.5 Assessment of suitability for brief cognitive therapy

Accessibility of automatic thoughts	Enquire about thoughts and also images; try 'here and now' assessment of negative thoughts with therapist; attempt to distinguish thoughts from feelings
Awareness and differentiation of emotions	Probe a particular episode for quality and intensity of feelings; ask the individual to describe as if 'here and now' the detail of what happened
Compatibility with cognitive rationale	How far can the patient see and accept the cognitive conceptualisation of distress? Is it compatible with their health beliefs?
Acceptance of personal responsibility for change	Can the patient take responsibility, within a collaborative alliance, for homework tasks, monitoring progress and carrying out suggested procedures between sessions?
Alliance potential (in session evidence)	Openness in the interview, and ability to stay with uncomfortable material with the therapist
Alliance potential (out of session evidence)	Ability to confide, and develop meaningful relationships
Chronicity of problems	How long the problem has been present
Security operations	These are strategies to 'ward off' anxiety with habitual strategies (e.g. controlling the interview, changing topic, being vague or even evasive, intellectualising). Continue despite being drawn to the patient's attention
Focality	How circumscribed is the problem?

Psychodynamic psychotherapy

Many of the general points raised earlier about assessment in general are drawn from psychodynamic thinking. Coltart's views (see above; Coltart, 1988a, b) summarise the features that are associated with psychological-mindedness of a sort which is conducive to psychodynamic work. Garelick (1994) and Milton (1997) have presented views about the essential features of an assessment for psychodynamic therapy. Milton makes the point that 'consultation' is a better word because the potential patient is being given an indication of the nature of the therapeutic experience. Hobson and colleagues showed that an unstructured interview with little prompting or reassurance from the assessor brought out the characteristic communication patterns that allowed reliable distinction between depressive and paranoid-schizoid functioning (Hobson *et al*, 1998). Some psychodynamic approaches use a formulation to focus the therapy (for example, see Guthrie, 1999) and are particularly relevant for brief approaches (Marmor, 1979; Hoglend *et al*, 1992). Box 1.6 lists the advantages and disadvantages of psychodynamic psychotherapy.

Group therapy

A significant difference in assessing for any type of group approach is that the impact of the patient on the rest of the group must be considered. For example, a patient with antisocial personality traits might make positive changes in a group setting where there is the possibility of confronting some exploitative strategies. However, this could be at a considerable cost to the other group members and the group as a whole (Knowles, 1995). Similarly, patients who attend while intoxicated may significantly disrupt the work of the group and may need to be excluded. However, problems that can be played out and understood in a group setting might be amenable to change within a 'social microcosm'. Mild social inhibition and anxiety are positive indications, whereas extreme social anxiety makes this approach impractical. Sometimes a resistance to see problems can be challenged by confrontation within the group. A trial of suitability has been developed by setting up group interviews, although this has not been used extensively. The assessment usually involves a preparatory stage of a 'role induction' interview.

Knowles (1995) suggests that the emotional level of functioning of the individual is crucial. This is distinct from the level or intensity of disturbance. She gives an example of a patient who was unable to tolerate the affront of having to share in a group, and that this led to a regression to a developmental level when he was narcissistically wounded by a badly-handled late adoption.

Therapeutic community

The assessment for in-patient and therapeutic community programmes is another highly specialised form that typically draws on a wider range

Box 1.6 Factors for and against psychodynamic psychotherapy**Pros**

Patient factors

- Able to express feelings verbally
- Able to tolerate a range of feelings
- Wanting change rather than symptom relief
- Psychologically minded; introspection, curiosity, and reflection
- Ego strength; consistent, tolerance of stress, flexible range of defences
- Able to carry on life out of therapy
- Basic object relatedness; basic trust and at least one meaningful relationship

Psychodynamic formulation

- The central problem can be understood in psychological terms

The interview

- Can see relationships in feeling terms
- Some link between key outside relationships mirrored in sessions
- Reasonable level of rapport maintained
- Some ability to explore early transference links and trial interpretations

Symbols

- Can work with dreams and fantasy
- Can link historical and personal material to dreams and fantasy images
- Not over-reliant on fantasy and able to keep reality of interview in mind, as well as fantasy

Therapist factors

- Therapist able to cope with the degree of disturbance expected and countertransference aroused by the interview

Cons

- Uncontrolled 'acting out' (e.g. alcohol or drug misuse, repeated self-harm)
- Previous maximum level of disturbance very severe (e.g. psychosis or past history of severe regression or 'acting out')
- Insufficient environmental support
- Firmly held non-psychological theory of causation
- Previous evidence of dependency in therapy

- Marked schizoid or paranoid elements in personality
- Marked passivity
- Circumscribed symptoms seen as stable derivatives of conflict
- Severe resistance including denial and evasion

- Patient looking for an intellectual understanding of conflict
- Unrealistic expectations of therapy as a 'magical answer'
- Difficulty with basic trust
- Rapport difficult to develop

- Unable to see things in 'as if' way
- Blurring of fantasy and reality
- Cannot see the point of links between past present outside and 'here and now'

- Therapist feels overwhelmed by material

of assessors, including patient members of the community, as well as the therapeutic team (Denford, 1995). Essentially, Denford suggests that the criteria for an in-patient community are broadly the same as those for out-patient settings. As for group therapy as an out-patient, there are some patterns of behaviour that are so disruptive to the structure of therapy that the patient cannot use this type of therapy. The threshold may vary between units, but the exclusion is primarily based on the expected risk of harm, physical and emotional, to other members of the community. Clearly, the issue of resources plays a part in assessment for a very intensive programme. There is likely to be an implicit or explicit 'filter' so that referrals tend towards the more severe, treatment-resistant end of the continuum. Many in-patient units have very detailed assessments to check whether the huge investment of time involved in an admission is worthwhile (Dolan *et al*, 1990). This might involve an initial screening interview with completion of several assessment schedules followed by meetings with residents and the community as a whole.

The above comments should be seen as no more than a brief note about some of the additional approaches and strategies that may be appropriate for particular modes of therapy. For fuller consideration of the particular strategies used see the references and the relevant chapters in this volume.

Assessment in relation to formulation

Whatever the type of therapy, there is an argument that the assessment needs to be linked to a case formulation. There are a number of advantages of incorporating a formulation as the basis of a treatment plan (Aveline, 1980; Perry, 1987; Hinshelwood, 1991; Crits Cristoph, 1992; Tillett, 1993). There has been a substantial body of recent research showing that case formulation can be reliable, and that there are advantages in maintaining a focus. However, slavish adherence to a formulation, particularly where the therapist has a rigid, self-critical personal style, has been shown to be associated with poorer outcomes (Strupp, 1993). Accurate and timely interpretations, however, in the context of a stable alliance and linked to an agreed formulation result in better outcomes (Joyce & Piper, 1993).

The advantages of a formulation stated in Box 1.7 mainly refer to brief therapies where the goals can be agreed and made explicit. Malan (1979) pointed out that some goals could not be made consciously available until the therapy had taken place. He suggested that an alternative in psychoanalytic therapy is for the therapist to set goals (the psychodynamic significance of which need not be made explicit to the patient). The goals should have a specific relationship with the underlying unconscious theme leading to the main symptoms.

Example

A 21-year-old man had experienced difficulty with a male supervisor. The assessment led to an understanding that the man was seeing the boss as a

Box 1.7 Advantages of a formulation**Conceptualisation**

A formulation draws together descriptive, evaluative, causative and predictive factors. The information from the assessment interview is sorted under different headings that allow a conceptual overview, leading to recommendations about the optimal treatment.

Stable focus

It is very easy to lose sight of the main therapeutic focus; in brief therapy by moving onto different themes without resolving any, and in longer therapy by losing sight of any therapeutic goal.

Sets limits

The therapist may come under immense pressure to meet unrealisable dependency needs and an agreed formulation helps as a reference point to avoid extending the therapy in response to countertransference pressures.

Predicts blocks, resistance and likely transference.

The therapist can easily feel at sea in the middle of a therapy and a formulation can help by predicting likely areas of difficulty.

Sets goals

The formulation process can help to specify goals in advance. In focal therapy these are usually explicit goals agreed between therapist and patient.

father-like rival, which is characteristic of unresolved Oedipal issues. Most models of therapy would set a goal of better work adjustment, but a specific dynamic goal might be derived from an understanding of the conflict. So, a goal might be set of being able to collaborate with the boss and to feel admiration and identification with him, reflecting what is expected in successful resolution of the Oedipal phase.

A formulation can function, then, as an 'anchor point' for the therapy. From this anchorage it is possible to work in two complementary ways. First, it is possible to keep the formulation in the back of one's mind while attending to the free flow of conversation. Second, it is possible to review progress periodically to check that the conversation is still focused on the agreed goals.

A good example of the use of formulation as a main element of a therapy is cognitive analytic therapy (Ryle, 1990) (see also Chapter 5). This uses particular concepts such as the target problem procedure, traps, snags and dilemmas, reciprocal role procedures and systematic diagrammatic reformulation as tools to keep focus on the main, recurrent issues that cause difficulties. The structure involves four initial sessions leading to a narrative and/or diagrammatic reformulation. This then provides a framework (with therapeutic opportunities described as 'exits') for the

remaining sessions of work (typically 8–20), ending with ‘goodbye’ letters that summarise and consolidate change.

Working from a cognitive analytic therapy perspective, Denman (1995) summarises the key issues in making a formulation. She suggests that they help in initial management (overall suitability and type of therapy), but also have a function later in the therapy to ‘guide the treatment plan, focus interventions [and] help predict the evolution of treatment’ (Denman, 1995: p. 169).

There are other comparable approaches including the core conflictual relationship theme approach of Luborsky (Luborsky, 1990). This delineates a central wish/fear theme from the patient’s account of typical relationships. There is also the Weiss and Sampson’s plan diagnosis system from the Mount Zion group (see Silbershatz *et al*, 1989). Although working from a psychodynamic perspective, their model of formulation has some similarity with cognitive interpersonal therapy, in that there are ‘irrational pathogenic beliefs’ that hinder the realisation of goals. In the cognitive-behavioural tradition, Persons (1991) described ‘schema focused cognitive therapy’, which has many elements in common with Safran’s approach (Safran *et al*, 1993) to predicting the effects of cognitive therapy. Persons’ view was that the correct unit of analysis in reviewing outcomes of therapy should be the assessment plus the therapy, and that diagnostic groups are of little value, or are actually misleading to practitioners.

Elements of a formulation

A formulation pulls together the information from the interview into a coherent form. The goals can be specified in a hierarchical way. Early goals include amelioration of distress and the restoration of hope; intermediate goals involve symptom improvement, then improved social and occupational functioning, improved relationships; and finally, long-term goals include evidence of enduring change in the sense of self and ‘being in the world’. As far as possible, the formulation should state explicitly the goals in practical and unambiguous terms, focused on what would be different in their everyday interactions, rather than vague hopes for change such as ‘feeling better’. Questions for the formulation are shown in Box 1.8.

A simple guide to assessment

The patient will often fulfil the ‘criteria’ for several approaches. In this situation the assessor will draw out the patient’s preferences and link them with therapy availability. The simplest algorithm has considerable merit.

Always try to recommend:

- short before long
- safe before risky
- inexpensive before costly
- effective before unproven before discredited
- patient-chosen before imposed.

Box 1.8 Questions for the formulation (after Aveline, 1980)**Causes and effects**

- Which stresses and why the reaction? (Recent precipitants such as losses?)
- Are there any re-activating factors? (Current stress that links to early life experience?)
- Meaning of symptoms? (How does the person make sense of their predicament, for example with spiritual values?)
- How are the symptoms handled? (Coping and defence style?)
- What is the biological and social substrate? (Early and late predisposing factors?)

Maintaining factors

- Are there advantages to keeping the symptoms?
- Are there any vulnerabilities of self in relation to others?

Factors promoting change

- Are there disadvantages and limitations from the symptoms?
- Is there an openness to change?
- Can the consequences of change be predicted?
- What is the individual's motivation and expectation of change?

Making predictions

- What is the likely outcome?
- How is the alliance likely to evolve?
- Are there potential threats to the alliance?
- What are the goals in different domains?
- What resources are needed (e.g. number of sessions)?

With such simple principles the task of assessment should be very simple. Even if assessment is, in practice, more complex, these simple 'rules of thumb' have surprising utility in managing a safe and effective service (see Fig. 1.1 and Box 1.9 for a more detailed expansion of these 'rules').

Below, in Tables 1.1*a* and *b* there is a more sophisticated model that attempts to look at factors which might maintain safe practice and also differentiate between indications for different types of therapy. It should be noted, however, that the summaries are based on very limited evidence. They should be seen as a summary of current practice rather than guidelines. Few of the statements made could be supported with the substantial body of evidence expected for a practice guideline.

For example, studies have shown that cognitive therapy and family interventions are highly effective in schizophrenia, but they have been slow to appear in routine practice (Margison & Mace, 1997). Many of the treatment decisions implied in Tables 1*a* and *b* are wrongly based on the

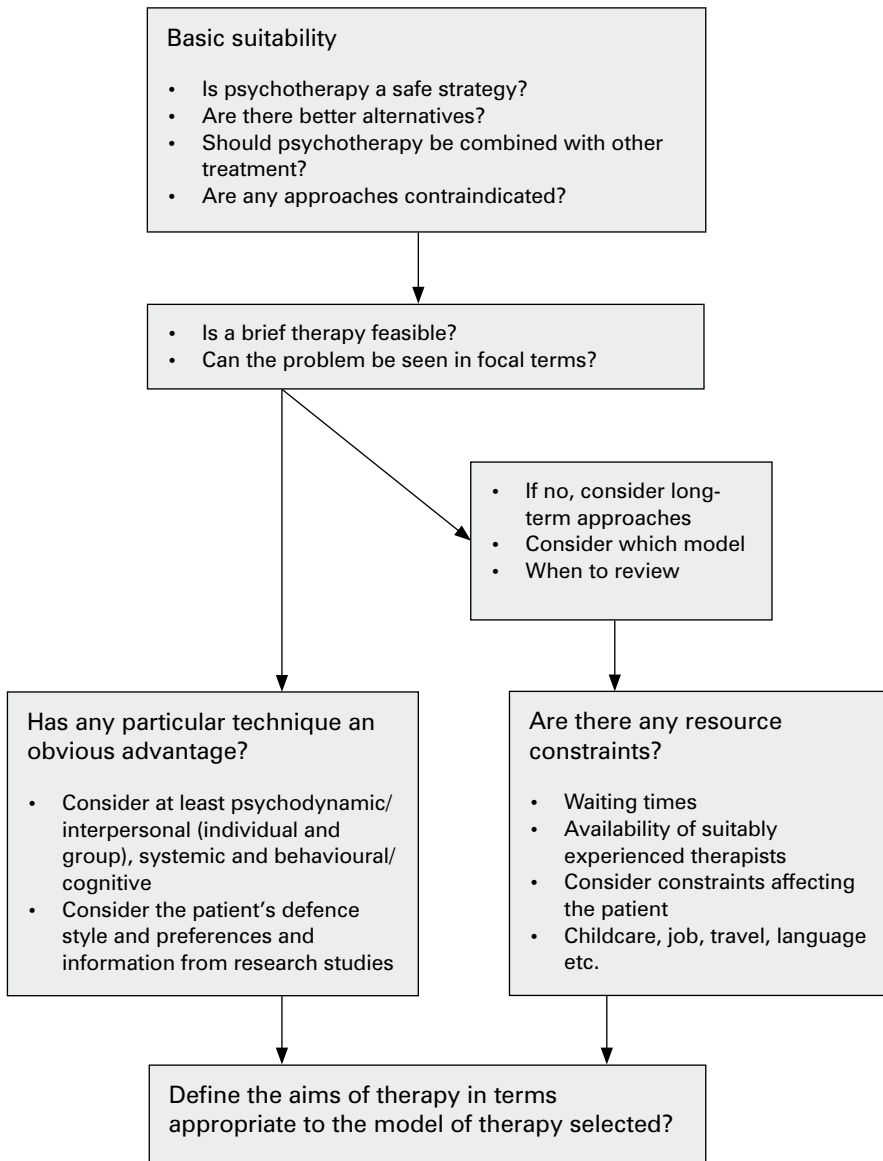


Fig. 1.1 An overview of the assessment process

Box 1.9 Key questions in assessment

- What format (group, individual, couple, family, other)?
- What depth/intensity?
- Which techniques (psychodynamic, behavioural/cognitive, systems)?
- What frequency of sessions?
- How many sessions expected? Open-ended or fixed?
- Balance of support versus exploration?

assumption that psychological treatments are relevant solely for neurotic illnesses and perhaps personality difficulties.

Moreover, studies of clinician behaviour suggest that decision-making about therapy is linked to allegiances and availability of preferred therapies in the clinician's department (Skynner & Brown, 1981; Margison *et al.*, 1998).

The final point of the interview should be to check that the patient has followed what has been offered and knows what will happen next. Frequently the anxiety of the interview situation impairs the patient's ability to process this information. Some departments confirm in writing the main issues, the decision about therapy and the likely waiting time.

Conclusions

This chapter has focused on the clinical aspects of assessment. Ideally, this 'art' of assessment (Storr, 1979) would be balanced by the application of scientific knowledge (Svartberg & Stiles, 1991; Mace, 1995; Beutler, 2001). This chapter deals with the paucity of evidence about assessment by providing clinically-relevant guidance, but there is still a significant gap between what is derived from empirical studies and the knowledge base for clinical practice. For example, in a very large study of over 4000 patients using survival analysis and clinically significant change measurement, Hansen & Lambert (2003) showed that 15–19 sessions were needed to achieve a 50% recovery rate (across various therapies and various diagnoses), but this type of information, although valuable in planning services, is difficult to apply to individual patients.

The growth of evidence-based practice and the use of clinical guidelines may transform the way that assessments are carried out. Currently, integration of the clinical and research approaches to assessment requires particular commitment on behalf of the assessor. Recent advances such as those described earlier from Lambert and colleagues (Hansen & Lambert, 2003) and Beutler (2001) are coming to a new level of sophistication, although not yet in routine practice outside teaching centres. For example a group in Germany has established a computer-assisted feedback system to

Table 1.1 a Summary of factors to consider in assessment where the individual therapy model is favoured

Factors favouring short-term therapy	Favouring integrative, structured brief therapy (e.g. cognitive analytic therapy)	Favouring cognitive-behavioural therapy
<p>Favouring short-term dynamic therapy</p> <p>Clear treatment goals which can be expressed as a focal conflict</p> <p>Patient active in establishing focus</p> <p>Acceptance of limited treatment goals</p> <p>Recent change rather than a chronic state</p> <p>Problems 'Oedipal' in type (competitiveness, anxiety in sexual relationships, conflicted triangular relationships and authority problems)</p> <p>Sufficient basic trust to tolerate frustration in therapy</p> <p>Ability to work with an explicit time limit</p>	<p>Need for concentrated work on an avoided theme (e.g. post-trauma, unresolved grief)</p> <p>Problem linked with typical stressors, characteristic patterns of relationships and repeated self-limiting themes</p> <p>Themes tend to be complex and interactive rather than discrete</p>	<p>Problem can readily be expressed in terms of abnormal cognitions and/or behaviours</p> <p>These maintain specific patterns of dysfunction (e.g. depression, anxiety, eating disorder)</p> <p>Problem already partly clarified</p> <p>Patient does not use defences to keep the problem out of awareness</p> <p>Absence of overwhelming relationship themes (e.g. dependency, control) that would prevent the development of a therapeutic relationship</p>
Factors that may favour long-term therapy		
<p>Severe personality difficulty and early developmental failure</p> <p>Lack of definable conflict area and problems difficult to clarify</p> <p>Goals expressed in terms of general interpersonal function (e.g. problems with intimacy and control)</p>		

Table 1.1b Summary of factors to consider in assessment where the non-individual approach is favoured

Group analytic therapy	Family and marital therapy	Therapeutic community
<p>Generally suitable for a dynamic approach</p> <p>Conflict themes can be seen in interpersonal terms</p> <p>Difficulties expressed in group settings</p> <p>Tendency to avoid responsibility for change by trying to rely on others</p> <p>Capacity to work with confrontation</p> <p>Ability to tolerate a group setting without severe anxiety</p> <p>Individual therapy difficult because of diffuse personal boundaries, or limited capacity to initiate exploration</p>	<p>Problem can be seen to involve several family members (or couple)</p> <p>Evidence of scapegoating or labelling of patient within family</p> <p>Patient and family (or couple) recognise a shared problem and wish to work collaboratively</p> <p>Problem transcends the presenting patient and may involve systematic splitting within the family</p> <p>Problem presented as a couple or family issue</p> <p>Presenting patient enmeshed in a complex system and vulnerable (e.g. a child patient or a patient with psychosis)</p>	<p>Patient otherwise suitable for a dynamic approach, but where regression is likely</p> <p>Structured, stable boundaries cannot be maintained in individual or group therapy</p> <p>Life circumstances make prolonged 'time-out' feasible</p> <p>Problem severe and disabling</p>

correct therapist errors at assessment and subsequently these models have been acceptable to patients and therapists (Kordy *et al*, 2001). The central part of the system is an 'alarm' function, signalling a possible deficit of the psychotherapy provided on the basis of the standard evaluation of treatment outcomes for large numbers of patients, against which this individual is measured. Such systems are currently experimental, and may go against the grain for many who see psychotherapy as an art. However, the weakness of our current methods of prediction needs to be acknowledged and, as yet, further evaluation of these emerging models is required.

To improve patient care clinicians may wish to revise the simplified models we have presented in the light of emerging research findings and also to challenge some of the assumptions we have made. However, the algorithm and boxes may be valuable in applying therapeutic knowledge to day-to-day practice.

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