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Point of View

The Assessment of Psychological-Mindedness in the Diagnostic Interview

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In the last paragraph of his paper 'A defect in training', Yorke (1988) has a sentence which serves as an excellent link to the opening of this paper – "For all their importance, empathy and awareness of patients' anxieties do not in themselves amount to psychological understanding". In his paper, he had made a plea for more psychoanalytical psychology to be included in a general postgraduate psychiatric training, and I am in complete agreement with his cogently-argued case.

However, I want to concentrate on a particular aspect of this point. When an experienced psychoanalyst is carrying out a diagnostic consultation with a view to assessing a patient's suitability for analysis or analytical psychotherapy, he is exercising his own skill and psychological-mindedness in this intensive exploration. The prospects of a successful treatment will be greatly enhanced if he finds the patient is 'psychologically-minded' – whatever the presenting complaints, or however unpromising the superficial impression.

Therefore, I would like to detail some of the qualities of this feature, with a view to offering some guidelines to colleagues who are still learning their technique. Because of the value of brief lists for the purpose of consigning to accessible memory, I shall lay out these points in an approximate order of discovery, rather than of importance, under two main headings. Nevertheless, it should be remembered that the whole may be larger than the sum of its parts.

The history

The diagnostician should look for:

1. The capacity to give a history which deepens, acquires more coherence, and becomes texturally more substantial, as it goes on. This may happen in a rambling, and not necessarily consecutive way. Indeed, a very tidy, chronologically exact history without diversions, or patches of *apparent* inconsequence, may suggest a constricted, over-anxious or very heavily-defended mind.

2. The capacity to give such a history without needing too much prompting, and a history which gives the listener an increasing awareness that the patient feels currently related in himself, to his own story; properly – if unhappily – the product of the connective aetiology of his life's circumstances. A history which has to be coaxed, dragged, or frequently prompted by the assessor does not show much potential for the development of further free associative ease, and also suggests severe inhibition, anxieties, or cast-iron resistances. Here, there is a strong implication that the assessor himself can effectively use a disciplined, well-judged capacity to maintain quite a lot of silence – often for longer than the patient either feels that he might want, or is socially accustomed to. However, I am *not* referring to a stultifying, unhelpful silence which may be experienced by the patient as frustrating to the point of sadism, and which, in inexperienced assessors who are aping an ill-digested model, may actually be so.

3. The capacity to bring up memories with appropriate affects, and some sense of how both these, although perhaps not easy for the patient, may relate to his present state of suffering.

Developments in the interview arising from the history

4. Some awareness in the patient that he has an unconscious mental life. There are people who cannot tolerate, and stoutly deny, that they have an unconscious – especially if it may contain 'outdated' material which is powerfully influencing their current feelings, behaviour, and thought-processes. Such people are unsuitable candidates for the analytical approach. It is extremely important, therefore, to assess the capacity both to allow for the existence of these as-yet unknown powerful influences, and to hope that with skilled assistance from another, they may become known, accepted, and transformed.

5. Some capacity to step back, if only momentarily, from self-experience, and to observe it reflectively – either spontaneously, or with the help of a simple interpretation from the assessor, who should make opportunity for this sort of intervention. In the presence of psychological-mindedness the use of such an intervention should lead to a more mobile recognition by the patient that he may be able to tolerate, even welcome, and *use*, a new light on the darker, more hidden side of his internal reality, with

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its wishes and conflicts. The intervention, in other words, is a subtle directive towards the unconscious, and contrasts with interventions on other levels and with other aims, which come under the heading of advice, counselling, or guidance to behavioural change. These belong more to the realms of the already conscious ego, and of external reality: cognitive therapy is more of this nature.

6. A capacity, or more strongly a wish, to accept and handle increased responsibility for the self – the whole realm of the unconscious, its affects and effects, and the 'maturational' processes (Winnicott, 1965.) This is also a crucial factor; psychoanalysis has little to offer to the patient who only desires to be rid of his own irrational suffering through the work of another person. A passage in an assessment interview arising from some tiny interpretation or enlightening, new-angle comment from the assessor, in which the patient experiences a tiny insight, some relief, a movement; or in which a link, however tenuous, is made between a slight easing of psychic pain and a fractional increase in self-knowledge – these are reliable pointers to the existence of psychological-mindedness. Moreover, they are promising signs for the development of true dynamic work in treatment, and the establishment of the therapeutic alliance.

7. Imagination. A totally unimaginative person may find it hard to dream, to use or understand metaphor, to elaborate – or even to have – a fantasy.

8. Some capacity for achievement, and some realistic self-esteem; he who fails at everything fails at analysis. The sort of achievement I refer to here does not necessarily include anything very great; areas in which to look are those of work, and/or an important good relationship somewhere along the line.

9. Overall impression. This has to be the last ingredient. The presence of several, and preferably all, of the foregoing criteria tells the assessor that he is with someone who is psychologically-minded. Absence of them will add up to an overall impression of a character who may be socially and intellectually sophisticated, and a competent personality (although probably with some alien-seeming symptoms), who nevertheless does not show and is not likely to develop psychological-mindedness. There is something deeply recognisable, but ultimately not fully definable, about the assessor's experience of a thorough, intense, working consultation with a pyschologically-minded person.

Pitfalls

Our own trained capacity for creative silence needs to be kept in context:

> The accurate forecast of the patient's behaviour before therapy has begun is a challenge to the diagnostician who *nevertheless* has the means of eliciting evidence of the patient's capacity to move freely within his own psyche. But he will do this only if *he* is prepared to *move freely within the interview situation*, so that he can induce fluid responses in the interviewee. The silent and inactive evaluator who clings faithfully to the psycho-analytic model of behaviour (i.e. behaviour during the course of a long psychoanalysis) will obtain only a partial, if not distorted, picture of what he is meant to be observing (Limentani, 1972).

An interviewer should not behave like a caricature of an analyst. This 'model' hardly speaks, does not make interventions, makes no clarifying comments or statements toward the end, may deliver himself only of a weighty interpretation directed at a deeper unconscious, which mystifies the already frustrated and probably frightened patient, and never varies this 'technique', whoever he is with. One of the excuses for this type of behaviour is that it 'brings out the patient's anxieties'. Of course it does. This 'goal' is wheeled out as if it were some Aristotelian cathartic ideal in its own right, but it is nothing of the sort. Aristotle was referring to the art of dramatic tragedy, enshrined in a whole play. There is no drama if the consultant does not speak or work; the only tragedy will be a traumatised patient (I see several in subsequent consultations every year) whose last state is worse than his first. The work required of the interviewer entails drawing on all his own skills and talents, in fact his whole personality, insofar as he trusts in its unselfconscious value to serve his professional aims in a creative, flexible way. He does not have to make the patient too comfortable, dispel all his anxieties, or offer solace or exaggerated hopes; these are the dangers when the interviewer *only* has "empathy and awareness" at his service (Yorke, 1988). It is his job to create and consolidate an ever-deepening rapport, and keep it going. In other words, to deploy as extensively as he can the structure *he* has created on the foundations of his own psychological-mindedness.

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