

Assessment of Suitability for Psychotherapy

II. Assessment Based on Basic Process Goals

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Part II of this paper presents an outline for the assessment of suitability for psychotherapy based on the patient's ability to participate in the basic tasks of the therapeutic process and provides a coherent approach to this complex and difficult task. Several factors, such as therapeutic interaction and relational history, influencing the patient's ability to form a productive working relationship can be assessed clinically and are well supported by research. Others, such as motivation and supportive life circumstances, although less supported by research, still appear to be clinically important. Influences on the ability to create a model of the patient's psychopathology, such as introspection, circumscribed focus, and some aspects of the model itself, are supported by limited research but important for some therapies. There is little research on trial interventions, though these remain a crucial assessment dimension for short-term therapies, particularly. Countertransference, although traditionally not viewed as part of assessment, is actually an important tool that has been validated by research.

Part I of this paper outlined the value of careful psychotherapy-suitability assessments, and described a process involving the traditional history and diagnosis, the creation of a model of psychopathology, and evaluation of the patient's ability to engage in the therapeutic process. Part II discusses this third component in detail, structuring the discussion around the basic tasks of the therapeutic process (1): productive working relationship, patient-model factors, trial interventions, and countertransference.

PRODUCTIVE WORKING RELATIONSHIP

The patient's capacity to form a stable and viable working therapeutic relationship began to be recognized as an important predictor of outcome in the psychoanalytic literature of the nineteen-sixties and seventies (2). It became a central suitability criterion for brief psychotherapy, where the therapeutic alliance must be established rapidly, there are limited opportu-

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nities for it to develop, and the patient must also be able to disengage rapidly (3).

A number of assessable factors will influence the formation of this relationship. *Motivation* affects the patient's use of the relationship as a vehicle for learning in the treatment (4). Direct assessments of the *quality of the therapeutic alliance* and evaluation of the underpinnings in the patient's *relational history* are also valuable. The patient's *life circumstances* may determine whether they can maintain the therapeutic relationship, so it is also included in this category.

MOTIVATION

Motivation has traditionally been important as a criterion of suitability though the supporting research has not been consistent. It is a complex, multidimensional construct which includes the motivation to change, the capacity for insight, self-understanding, and active participation. Aspects, such as willingness to make sacrifices, the initial level of distress, the desire to relieve suffering, secondary gain from the illness, taking personal responsibility, realistic goals, positive expectations of therapy, and the curiosity to understand oneself, seem conceptually related and are often included. Two additional factors, less clearly conceptually related, are psychological-mindedness and honest communication (2,5). Cognitive therapists use some similar ideas to assess suitability, though they do not categorize these as part of the motivation construct. This includes accepting personal responsibility as an active agent in the change process, using the therapeutic relationship as a vehicle for self-exploration and viewing the goals and tasks of therapy as relevant (6). There is little agreement on the meaning of the term, and many researchers have defined it so broadly that it becomes synonymous with suitability. It seems difficult to rate reliably, particularly in patients with personality disorder who are difficult to assess regarding their motivation to change (7). Motivation is not a static quality and may be modified by therapeutic actions in some cases at the start of therapy (5). High initial motivation is essential for brief psychoanalytic psychotherapies (8–11). It is also critical for group psychotherapy, where the specific motivation for group is most important (12).

Motivation is a short-term predictor of outcome. Frayn (13) found patients with poor motivation, as reflected in a lack of commitment to understand self, and insufficient suffering to bring about a desire for change, to be more likely to terminate prematurely. It is associated with premature termination from group therapy as well (12). Some motivational factors also contribute to the prediction of outcome in cognitive therapy

(14). As expected, it does not predict long-term dynamic change at two and four years after brief therapy (15).

Determining a patient's motivation is highly inferential, but there are ways to achieve a fairly clear sense. Is the patient motivated internally, or by some external source? This is often clarified when we know why the patient presents now. Those who seek therapy as a condition of probation, or under pressure from a spouse generally do more poorly than those who recognize that they have a problem, and are uncomfortable with themselves (4). Freud (16) stated that his method was not applicable to "people who are not driven to seek treatment by their own sufferings, but who submit to it only because they are forced to by the authority of relatives" (pp. 263-4), and this still applies to most therapies.

Patients' attitude about therapy can often be elicited by asking how they feel about the prospect of starting. In what way are they motivated to use the relationship? Many troubled patients will be motivated to meet with the therapist and have a relationship that satisfies their needs, but this is not the same as using the relationship as a vehicle to learn and change. Patients must accept personal responsibility for change and actively participate. Passive recipients looking for an external solution, such as medication, do poorly, as do those looking for a magical solution or for the therapist to give them the answer to their problems. What is their theory of the cause of their problems? The rationale of the particular therapy should be compatible with patients' beliefs about what is wrong. Patients should view the basic model, tasks, and goals of therapy as relevant and potentially valuable. Those who believe in another model, such as a biological one, are more likely to have a poorer outcome (4,6,14,17). Patients' motivation will often be specific to a particular type of therapy, so that it is high for a therapy, such as marital therapy, while being low for others, such as cognitive therapy, group psychotherapy or psychoanalytic psychotherapy. Do they think therapy will help and if so why? What are they hoping for? An optimistic expectation predicts better outcome (18). It is also helpful to explore how our patients view their role and that of the therapist. If they have unreasonable expectations, can they develop more realistic ones? Psychoanalysts have suggested that patients who have unrealistic fantasies about therapy, based on the wish to deny reality, to be dependent, out of envy or based on competition, will do poorly in psychoanalysis (2). When patients have been previously involved in therapy, the course of therapy and the reasons for termination should be explored in detail, as it often results in information clarifying their motivation. It also contributes to

understanding their relationships and their ability to form a therapeutic alliance.

QUALITY OF THE THERAPEUTIC ALLIANCE

Direct assessments of the patients' interaction with the evaluator became a prominent assessment dimension during the seventies with the development of brief psychoanalytic psychotherapies (8). Patients who cannot engage and disengage rapidly are not good candidates for brief focal therapy (10,19,20). The alliance-forming ability is also important in longer-term therapy, where it affects the initial therapeutic process, and may determine the length of therapy required and its eventual outcome.

Many studies support the quality of the therapeutic relationship as a predictor of outcome. Luborsky and his colleagues (21) reviewed eleven earlier studies, all of them showing significant correlations of .2 to .5 between measures of the therapeutic alliance and outcome. Their own study of weekly sessions in the drug-counselling, cognitive-behavioral, and supportive-expressive psychotherapy of methadone-maintained opiate addicts substantiated this, with strong correlations between measures of the patients' view of the helping alliance in the third session and several measures of outcome at seven months. The patients' preference for the therapist has also been associated with outcome (18), as have patient and therapist assessments of their positive contributions to the relationship in brief therapy (22). The quality of the therapeutic alliance is regarded as the most reliable predictor of psychotherapy outcome by cognitive therapists (6), and has been found to contribute to this prediction (14). The ability to establish a therapeutic alliance is also important in group psychotherapy, where patients must be able to establish a working relationship not only with the leader, but with other group members. Assessments of the patients' ability to form a therapeutic relationship, the ability of the therapist to empathize, and his/her overall liking of the patient, predict premature termination within 16 meetings of outpatient group. Those who interact well with the interviewer are more likely to succeed in long-term or short-term group therapy. Patients who are spontaneously hostile or require prodding in the assessment are likely to drop out prematurely (12).

The therapeutic alliance is an interactive product of patient and therapist characteristics (21). It reflects the match of therapist and patient and is particular to that therapeutic dyad. The common clinic routine of patients being assessed for therapy by one person and seen in therapy by yet another is best avoided for this reason. Safran and Segal (6) assess the in-session alliance potential by evaluating their ability to connect and experience

resonance and mutual warmth with the patient. A poor therapeutic alliance may be reflected in lack of trust, lack of confidence in therapy, negative attitudes about the interviewer or the interview, guardedness, irritability, and lack of engagement or involvement. A good therapeutic relationship will be reflected in the patient feeling understood. The patient should be involved in a flexible, genuine and honest fashion.(1,2,4,5) Hoglend and colleagues (7) correlated flexible interaction with dynamic outcome four years after brief focal psychotherapy. The patient's use of defenses, or what the cognitive therapists refer to as security operations (17), may of course interfere with genuine involvement, and it is then important to test whether this can be altered with interventions as I will note later. Inability to establish rapport may reflect the therapist's limitations as well. Cognitive therapists include such issues in the concept of the therapeutic alliance, though we will examine them separately under the psychodynamic concept of countertransference.

RELATIONAL HISTORY

Many psychotherapists have noted that the ability to form a productive working relationship will depend on the patients' previous experience of relationships, and their internal object relations (2,6,8,9,11,23). Many research studies over the past fifteen years support the history and experience of relationships as a predictor of outcome, especially in short-term dynamic therapies, though I will review only a few of the most recent ones. It predicts both short-term events, such as premature termination, and long-term outcome. Frayn (13) has shown that patients with previous positive relationships with parents, teachers, bosses, and therapists are less likely to terminate psychodynamic therapies prematurely. Those who show low levels of object relatedness, reflected in disinterest, chaotic or absent ties, exploitive involvement or the tendency to be self-involved, are more likely to drop out. Interpersonal relationships, characterized by mutuality, gratification, stability, and seeing others as whole autonomous persons rather than as need gratifying, are correlated with outcome after four years, but not after two years of brief focal psychodynamic therapy (7,15,24). There was a strong interaction between quality of interpersonal relationships and treatment length on dynamic change (24). Piper and his group (25) used scales with multiple dimensions resulting in five levels of object relations to rate the lifelong pattern of relationships in interviews. Those with high-level object relations had the best outcomes in brief therapy, as shown by an additive effect for therapy and high-level object relations.

Clinically, a major component of assessing the complex internal rela-

tional models of the patient, which we term object relations, involves assessment of the quality of the patient's interpersonal relations, or the out-of-session indicators of alliance potential (6). Sifneos (8) and Davanloo (11) suggest that the patient should have had at least one meaningful relationship. Several aspects appear to be important, including the ability to confide, intimacy and trust. The relationship should have been a sustained one, and afforded the possibility to resolve conflicts. There should be a pattern of intimate relationships with mutual respect, a capacity to genuinely invest in others, and acceptance of the limitations of any single relationship. Relationships with parents, siblings, sexual partners, coworkers, and confidants should all be examined. Evaluating previous therapeutic alliances is particularly important. Idealization or devaluation of previous therapists is a poor prognostic sign for some therapists (2,17). How conflicts are handled in all these relationships, and how they end is also important.

Although patients with problems in relationships should be considered for group therapy (26,27), those with relational problems characteristic of antisocial or schizoid personality will often be unable to participate in group therapy appropriately, and their inclusion in a group can be destructive to the patient and/or the group. Patients who are so conflicted about intimacy in interpersonal relationships that they withdraw, show pervasive dread of self-disclosure, disclose promiscuously or make unrealistic demands for intimacy tend to drop out prematurely, and are often thoroughly discouraged. Those who are obviously unable to tolerate hearing the problems of other group members, are unable to share the therapist, lack interpersonal sensitivity, or tend to be satisfied with themselves and overestimate others' opinions of them, all tend to profit less from the group experience. Conversely, patients who are impulsive or who intellectualize may do better in group than in individual therapy (12).

SUPPORTIVE LIFE CIRCUMSTANCES

Patients with inadequately supportive life circumstances do poorly in therapy. Those who lack time, appropriate finances, work support, or family support are more likely to terminate prematurely (13). Patients in the midst of a life crisis, such as intense conflict with another, acute physical illness, severe financial difficulties, impending failure in work or school, or a chaotic work situation, are thought to be better suited to crisis intervention than intensive therapy (12,28). However, these criteria do not seem to apply to short-term therapies that include initial problem-solving approaches, as do interpersonal and cognitive psychotherapy. Those in crisis

are more likely to terminate group therapy prematurely, though they may be suitable for a crisis group or specialized problem oriented group (12). Patients who are likely to be forced to terminate prematurely by life circumstances should not be accepted for group, and this is good advice for other psychotherapies as well.

PATIENT MODEL FACTORS

In order to work effectively with our patients, we must develop an understanding of the way they operate psychologically, thereby creating a model of their functioning. We require information, the collection of which is profoundly affected by the patients' ability to introspect, their psychological-mindedness, and their acceptance of patterns as maladaptive. The efficiency of therapy is affected by the ability to focus on a particular problem, and by the ease and speed with which the therapist can create an initial model or formulation. Some specific features of the model will have prognostic implications for some therapies. Patients' introspection, psychological-mindedness, circumscribed focus and early formulation, acknowledgement of maladaptive patterns, and other specific details of patients' psychology, contribute to the ability to create a patient model.

INTROSPECTION

Creating a model of the patient's psychological functioning relies on the patient's ability to observe him/herself and report on inner experience, a skill known to psychoanalytic therapists as introspection. Research support for this outcome predictor is rather limited however. Limitations, such as disinterest, lack of self-reflection, lack of awareness, and thoughtfulness, make premature termination of psychodynamic psychotherapy more likely, as does lack of affect availability reflected in denial of affect or memories, or in secretiveness (13). Cognitive therapists assess similar skills when they evaluate their patients' ability to give a detailed description of problem situations and events, the automatic negative thoughts and emotions associated with these, and the accessibility and differentiation of emotions in the session, that contribute to the prediction of outcome in cognitive therapy (6,14,17).

Ideally, patients should be able to communicate emotional significance and meaning (1). Observing and communicating thoughts, feelings, and actions are all important, with requirements differing according to the type of therapy. Psychoanalytic therapists, such as Strupp and Binder (4), emphasize the application of introspection to an interpersonal and particularly a transference focus, whereas others view the focus on dreams and fantasies, or the ability to free associate by speaking spontaneously and

continuously about inner experience as important (2). The ability to introspect can sometimes be learned within months to years given adequate underpinnings, so it may be less crucial in longer-term therapies. It is also state dependent and assessments made under conditions of high anxiety, serious depression, external threat, or inadequate therapeutic alliance will often not be accurate or reflective of these abilities under other circumstances.

PSYCHOLOGICAL-MINDEDNESS

Psychological-mindedness reflects the patient's ability to work with the psychological concepts of a particular therapy. Aside from some research in group psychotherapy, there has been little recent research on this outcome predictor. Yalom (12) notes that patients who deviate from the group through lack of psychological-mindedness, as reflected in their emphasis on external factors, are often unable to participate in the group process, are excluded by the group, and do not do well. Lack of psychological-mindedness predicts dropout in brief analytically oriented group therapy (29), where understanding the conflicts of others promotes acceptance in the group for filling this therapeutic role. The type of psychological-mindedness should match the particular therapy used, and if the interviewer is familiar with multiple approaches, the patient's ability to work within these can be tested. For individual therapies, this is best tested through trial interventions.

CIRCUMSCRIBED FOCUS AND EARLY FORMULATION

Brief therapies pursue a circumscribed focus or chief complaint, which is agreed upon with the patient (6,8,10,20,30). Several somewhat independent, but highly interrelated, aspects appear to be important in finding and maintaining this focus. An early formulation of the patient's difficulties is required to determine the focus and guide the first stages of therapy. This usually relies heavily on the therapeutic relationship, the patient's capacity for introspection, and psychological-mindedness. The ability to make an early, clear dynamic formulation was found to predict a better outcome in group psychotherapy but not individual therapy (31), perhaps reflecting the importance of other group members being able to achieve a thorough understanding of the patient's problems.

Agreement on the focus between the working parties will depend on the compatibility between the patients' view of their difficulties and the rationale of therapy. Both the therapist and the patient must then stick to this focus. Cognitive therapists label this patient ability to focus on a problem situation in depth, without straying to other topics "focality."

Patients with good focality are usually able to give—with or without prompting—an example of a recent situation where their difficulties are manifest, and are able to discuss this in detail (17). Their ability to explore the underlying issues that interfere with such recovery should also be tested. Some patients, particularly those with more severe forms of personality disorder, are unable to do this because of the limited relationship with the therapist, and the activity of defenses. Therapists may contribute to these difficulties as they may be unable to maintain the focus due to limited experience with focal therapies, or countertransference problems as we will note later.

Some research indicates that the ability to maintain an appropriate therapeutic focus predicts better outcome even in longer-term therapy. Patients with recurrent depression in the three-year maintenance trial of interpersonal therapy who were able to maintain a high level of interpersonal focus, had much longer intervals between episodes. The interpersonal-focus score correlated with the cognitive focus, but not the somatic focus typical of the medication clinic, suggesting that the former was a valuable psychotherapeutic focus, whereas the latter was not (32). Both patient and therapist characteristics are contributing factors.

The focus must relate adequately to the presenting problems. Malan (10,20) suggests finding the best focus from the material the patient offers in brief focal psychoanalytic therapy. A focus involving complaints that are chronic is less likely to respond to brief therapy than a more recent one. Malan has suggested that inevitable involvement in pervasive complex dynamic issues should exclude the patient from brief focal therapy. A circumscribed focus addressing problems that are “oedipal,” such as assertiveness with the same sex, ambivalence about genital sexual relations, and triangular situations, as apposed to problems that are more “oral,” such as dependence, trust, and separation, has been shown to predict a more positive outcome in brief focal psychodynamic therapy (7). Longer-term therapies may benefit from frequent renegotiation of the therapy contract. Examples include the Interpersonal Therapy treatment of dysthymia and the maintenance treatment of recurrent major depression as discussed in Part I of this paper.

Certainly, a variety of foci can be addressed by the different focal psychotherapies, and each approach works best when matched to the patients for which they are best suited. More recent psychodynamic approaches usually involve a focus on recurrent and repetitive patterns of interpersonal interaction that have been internalized and are maladaptive, and manifest in current relationships, particularly the transference. These

interactions may reflect wishes, fears, views, attitudes, and actions. Those that are prototypical become the focus, and those manifest in the transference take precedence over those outside the session, which, in turn, are much more important than those that occurred in childhood but are not currently manifest (1,4,18,33)

Another important variation of focal psychotherapeutic technique is the focus on a recent life event that has activated a clinical syndrome (33). Interpersonal psychotherapy with depressed patients, a variation of focal psychotherapy, attempts to focus on one or more of four problem areas associated with the onset of depressive illness: grief reaction, interpersonal disputes, role transition, and interpersonal deficits (34,35). Horowitz and colleagues (36) use a focal approach to destabilizing life events in patients with personality disorder. It can be applied to a wider range of character pathology and life events than traditional focal psychodynamic therapies. Cognitive therapists choose a focus involving automatic negative thoughts and the emotions associated with clinical syndromes(1, 14). Many types of group psychotherapy are also effective when adapted to a particular diagnosis or problem (12).

ACKNOWLEDGMENT OF MALADAPTIVE PATTERNS

We must keep in mind that therapeutic work, particularly that which is brief, will only be effective if patients can acknowledge that certain patterns are maladaptive, or dystonic with their view of themselves or how they wish to be. Often enough, this is not the case, particularly in certain clinical problems, such as personality disorders, where the symptoms and problems are "ego syntonic." These individuals are only suitable for therapy when they can acknowledge dissatisfaction with some major aspect of themselves. It is now widely recognized that, particularly for brief psychotherapy, patients must carry out much of the working-through process on their own in order to generalize from the therapy through trial and error (3). Some effects of brief psychotherapy are seen years after therapy has ended (7,15,24). Unless patients acknowledge that such patterns are maladaptive, and they do so increasingly throughout the therapy, they are unlikely to persist in making the appropriate changes.

SPECIFIC CHARACTERISTICS OF THE INDIVIDUAL PATIENT

Many aspects of the individual patient have traditionally been used as criteria of suitability or prognosis in psychotherapy, and some of these still seem very useful, if not well supported by research. Many of these have been discussed most clearly by Kernberg (23). The degree of "superego integration" as shown by the ability to abstain from the exploitation and

manipulation of others, as well as maintain honesty and moral integrity in the absence of external control, seems to have prognostic implications in the treatment of people with borderline organization. Such characteristics are necessary to utilize the therapeutic relationship effectively and to present an honest account of difficulties so that the therapist's working model is accurate. Patients without these characteristics are rarely good candidates for group therapy either, unless it is a homogeneous group under appropriate controlled conditions (12,26). Reality-testing capacity has implications for the success of psychotherapy as well, though this must be explored and tested in the interview with suitable interventions as we will note further on.

Although the general abstraction of "ego strength" is associated with a number of problems, as noted in Part I, the nonspecific manifestations of "ego weakness," such as poor frustration tolerance and impulse control, lack of anxiety tolerance, and lack of sublimatory capacity, as defined by Kernberg (23), are thought to have prognostic implications for psychoanalytic therapies (2). Frayn (13) associated poor reality testing, regressive potential, and indicators of poor impulse control, such as the loss of control in impulsive or antisocial acts, with premature termination. Similarly, poor anxiety tolerance, as reflected in increased symptoms or regressive behavior in response to increased tension, particularly the stress of the therapeutic process, may lead to the patient becoming worse rather than better, as sometimes evidenced by symptoms or behavior that intensify over the assessment period. Davanloo's (11) approach, which relies heavily on confrontation and re-experiencing affect, requires particularly good affect tolerance. Some believe that a good record of work or academic performance is required for successful outcome in short-term therapy (8,19). A good work or school record is also important in long-term therapy, and is often included in the concept of "sublimatory capacity," along with creative ability and the availability of sources of gratification (2).

A number of clinical response patterns may be difficult to treat with particular approaches. Sifneos noted a poor outcome in short-term therapy for patients with reactive depression following the loss of a loved one (3). Patients who tend to somatize are traditionally thought to do poorly in most psychotherapies, including group (12). Historical elements, such as the experience of childhood sexual abuse, may have implications for treatment as well. These individuals should be aware that they may get worse with treatment, and they should be supported in pursuing treatment, if and when they are ready, rather than in response to the now all too common social pressure.

TRIAL INTERVENTIONS

A good therapeutic alliance and a reasonably accurate working model of the patients' psychological functioning will be of little value if patients cannot utilize subsequent interventions to promote therapeutic change. Trial interventions are the best way of determining their ability to utilize these.

POSITIVE RESPONSE TO TRIAL INTERVENTIONS

Although traditionally emphasized by brief dynamic therapists, such as Davanloo (11), trial interventions are now widely accepted as part of the assessment process, though there is little research supporting them as an outcome predictor. Cognitive therapists use trial interventions when they test the accessibility of automatic thoughts and the awareness and differentiation of emotions. A similar approach is used in psychodynamic therapies, where access to such feelings and thoughts is equally important, though understood from a different theoretical perspective. We ask patients to give examples and describe problem situations in detail, as clearly and vividly as possible, avoiding generalization and abstraction until the full emotional and cognitive context of the unique personal meaning is clear (1). Safran and Segal (6, p. 252) probe with questions, such as: "What were you thinking in that situation? Do you recall what was going on in your mind?" They encourage patients to imagine their being in this situation while in the session. Similarly, they test the patient's ability to become aware of, and differentiate emotional states and notice fluctuations in these, including those occurring in the interview: "Do you remember what you were feeling? What was the feeling like? How strong was it? Is that different from how you normally feel? Can you get in touch with that feeling now?" Thase and Beck (37) help patients to identify automatic thoughts by asking what goes through their minds during strong emotional responses, visible mood shifts, or while imagining a troubling event. Such questions would be regarded by psychodynamic therapists as clarifications, and would focus on wishes and other interpersonal aspects of such thoughts, with further links made when possible by interpretations. These typically describe relationship themes (1,4,18), which are linked to defenses or to similar patterns in other contexts, such as between transference, the present outside of the session, and the past (38).

Responses to such questions, clarifications, and interpretations will reflect the patients' ability to decenter and observe their own thought processes, demonstrating their ability to introspect, psychological-mindedness, and ability to stick to a focus without too much interference

from either defensive processes, or the subjective experience of problems in the therapeutic relationship. Observing the patients' patterns of response and their creation of idiosyncratic meanings allows the therapist to create a good working model of the patients' psychopathological processes. Productive responses to these interventions will be predictive of response to that therapy be it brief and focal, or open-ended, as they indicate a greater potential to change in therapy, or a potentially shorter course of therapy.

Two specific categories of interventions must be considered in addition to the more general types of interventions; those addressing the therapeutic relationship or transference, and those addressing defenses or security operations.

MODIFIABLE DEFENSES

The modification of defenses through psychotherapy has been a central feature of psychoanalytic therapy, and the absence of inflexible, rigid defenses has traditionally been an indicator of suitability (2). Interventions with transactional, interpersonal defenses has become a key feature of psychotherapy with personality disorders, where they are used to maintain progress on a focus in brief therapy (36), or are central to the therapeutic process of change (23). The clarification, confrontation, and interpretation of defenses is part of Kernberg's Structural Interview for diagnosis and evaluation of suitability for psychotherapy. Clearly, defenses evident in the assessment may compromise the therapeutic progress, and trial interventions must be made to evaluate whether they can be dealt with successfully. This is especially germane to brief psychodynamic therapies, where time is more limited (10,20). Although cognitive therapists label these phenomena as "security operations," they are concerned with the same basic processes, and assessment of the degree to which they interfere with the therapeutic process and self-exploration contributes to the prediction of outcome (14,17).

Common behaviors reflecting these potentially problematic processes in the interview are avoidance, incompleteness, vagueness, lack of clarity, preoccupation with excessive details, circumstantiality, selective inattention, controlling behavior, tangents, and externalizing. Patients may present themselves in an exaggeratedly favorable light or discuss emotional issues in a distanced way. They may present inappropriate, contradictory or incongruent information. The earliest and most evident manifestation may be the interviewer's feeling of confusion or puzzlement, such as when what is verbally asserted contradicts behavior, or behavior that strikes the

interviewer as inappropriate. For example, denial may manifest as cognitive awareness while presenting an emotional response out of keeping with the normal human reactions one would expect in that situation. Such features can be explored most effectively by sharing the observation and drawing the patient's attention to this by statements, such as "I've noticed . . . have you noticed . . ." (6,23).

Such tactful, patient, nonaggressive confrontations are indispensable when assessing individuals for any type of psychotherapy (1,23,39). Clarification may demonstrate primitive defenses, contradictory self and object representations and decreased awareness of reality suggestive of severe psychopathology with clear therapeutic implications. What patients have not been aware of is brought to their attention, what they have taken as natural is questioned, and what has been experienced separately is brought together and, when possible, linked to current functioning in terms of symptoms or personality features (23). Suitable patients should be able to empathize with the interviewer's view, and not regress or show ongoing impairment of reality testing. Their functioning should actually improve, if only temporarily, in these areas. Unless there are reasons to do otherwise, such interventions should be made with all patients being assessed, including those being assessed for psychoanalysis. This approach should usually be avoided or stopped when loss of reality testing and psychosis is evident. Such confrontations will also be necessary to assess current and previous interpersonal relationships accurately. Therapists assessing or preparing patients for group therapy may find it helpful to confront denial when it is present, prior to placement in group, to see if such denial can be effectively confronted, as such patients may terminate prematurely when their denial is confronted by the group (12).

POSITIVE RESPONSE TO TRANSFERENCE INTERVENTIONS

Patients should be able to report on the therapeutic relationship. A positive response to interventions addressing the therapeutic relationship during assessment is important to some of both the open-ended (23) and brief or focal psychotherapies (4,6). The way in which the therapist will be able to work with the transference must match the type of therapy prescribed. At the very least, even if transference interpretations will not be a significant part of the therapeutic process, the therapist must be able to successfully contrast the transference with the actual relationship to maintain a working therapeutic relationship (1,23,36).

Cognitive therapists do not label this phenomenon as transference, but rather as the ability to work with patient-therapist relationship in the

here-and-now (17). Much as psychoanalytic therapists do, they focus on the patient's experience of emotion in the present, noting shifts in mood during the session and indicators of emotional discomfort with interviewer. They suggest exploring with questions, such as "What's your feeling about what's going on now?" or at the end of the session, "What was it like today?"

Ideally, in psychoanalytic psychotherapies, patients should be able to work with and experience the transference, concurrently modulate the depth and intensity, and maintain reality testing. Some patients showing intense and unfavorable transference responses may be suitable for long-term therapy, though most should be excluded from brief focal therapies. Provided the transference response can be worked with effectively, those patients showing conflict manifesting in the transference are thought to have more positive outcomes (10,20). The various types of short-term psychoanalytic psychotherapies differ in the emphasis placed on aspects of the transference, with some authors advocating waiting until it manifests as resistance, others emphasizing the transference-parent link, and still others interpreting this aggressively (3).

Group therapy should be considered for interpersonal problems manifesting with problematic transference that may interfere with successful individual therapy if the patient is a good candidate for group therapy otherwise (27). Confrontation by a peer in such settings is often received more readily than it would from someone, such as an individual therapist, who is perceived in a parental role. Transference can be experienced in relation to several others, in a more dilute fashion, where peers can assist in reality testing, and there are opportunities for gratification from others in the group.

COUNTERTRANSFERENCE

Monitoring and utilizing countertransference is the last of the four key tasks in psychotherapy, though it is pursued simultaneous to, and in conjunction with, the other three goals (1). It is a powerful predictor of outcome, with patients who are liked by the therapist tending to do better. Conversely, therapist negative feelings, including fear and guardedness, have been associated with premature termination (13). Therapist countertransference problems over being aggressive, ending therapy, and experiencing loss commonly lead to problems in brief therapies, most of which will require therapeutic approaches touching on these issues (3). Research shows that therapists who lack feelings of competence, or have concerns about damaging patients, are more likely to have patients break off treatment prior to termination (40).

Countertransference may affect the treatment through a variety of mechanisms. Therapists must be sufficiently relaxed and comfortable so that they are able to use countertransference in psychoanalytic psychotherapies as a tool in "role responsiveness" (41). The role assigned by the patient is accepted to some degree compatible with the therapy, but the therapist is also able to disengage and interpret this assigned role (42). Also, as I have noted before, countertransference has a major influence on the ability to empathize and thus affects the therapeutic alliance (1).

Patients who elicit negative or otherwise problematic countertransference, where this may be idiosyncratic to the particular therapist, should be referred to other therapists for consideration. Those who elicit negative countertransference but are able to participate in the group process without being excluded, and are otherwise appropriate for group, may be best treated in that setting (12).

THE CLINICAL USE OF SUITABILITY CRITERIA

Generally, research on these suitability criteria show correlations with outcome that are small, so that multiple factors must be combined to predict outcome. Similarly, when using these factors clinically, they should be used in combination rather than individually. Highly suitable patients will generally benefit from short-term therapy, whereas those with lower suitability, particularly with a history of poor interpersonal relationships, or with major personality pathology, will have a more favorable outcome with longer-term therapy (24). Certainly, the application of clinical judgment and expertise is required in the use of these criteria, and they cannot be used effectively in a checklist fashion where each has equal weight. For example, some patients will present a history of good interpersonal relationships, which in conjunction with a poor therapeutic interaction with the interviewer, and in the absence of other explanations, may be discounted as reflecting denial or other primitive defenses. Some factors, such as a negative countertransference response, can be so crucial to the success of therapy that it would be best for that therapist to not attempt treatment, and refer the individual to someone else. Patients who have almost no motivation for treatment, and are being seen because someone else expects them to be, are unlikely to be treated successfully, regardless of their suitability on other dimensions. In such cases, these factors are used more as exclusion criteria than as part of a set of inclusion criteria. As already noted, whenever possible, assessments should be done by the individual most likely to offer treatment.

Of course, with some individuals, suitability will still not be clear and

under such circumstances, Freud's recommendation (43) for a trial of therapy, is still a useful approach.

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