Practice Bulletin 7
Psychoanalytic Clinical Assessment

Psychoanalytic clinical assessment is the tool by which psychoanalysts assess all patients presenting to them and make diagnostic and treatment recommendations. Different aspects of this evaluation might be emphasized or de-emphasized by individual analysts based on customary practices of their profession of licensure (i.e., psychiatry, psychology, social work, etc.).

Psychoanalytic clinical assessment aims to clarify the nature of the patient's request for help and whether psychoanalysis is a treatment modality that can address these matters. The assessment aims to achieve a balanced understanding of the patient's relative strengths and vulnerabilities as they apply to concerns, signs and symptoms that are presented initially or emerge over the course of the assessment process. Psychoanalytic clinical assessment is usually conducted concurrently with the professionally skilled process of establishing the various essential aspects of a psychoanalytic therapeutic relationship, including mutual trust and confidence. The initial assessment process usually requires many sessions. It enables the patient and analyst to reach the necessary level of clarity to support a discussion of the advantages and disadvantages of a range of treatment approaches and to reach a mutually agreeable plan for treatment (S. Freud, 1940[1938]). A complete assessment process might require a trial of psychodynamic treatment for several months to evaluate the patient's capacity to benefit from an insight-seeking treatment. In some cases, a trial of psychoanalysis for a period of up to a year might be necessary to determine the appropriateness of the treatment plan.

This practice guideline describes a model for psychoanalytic clinical assessment that is consistent with the American Psychoanalytic Association's guidelines for clinical practice. It differs in some ways from other models of clinical mental health assessment. Given that each clinician will adopt a charting policy in consideration of the particular nature and setting of his or her practice, guidance is given to help clinicians select the information that might be useful or necessary for documentation of the clinical assessment, the resulting discussion of treatment options, and the treatment plan. This documentation can serve as an important part of the patient's confidential health care record.

Psychoanalytic education devotes extensive attention to the development of skills in assessing the degree to which psychoanalysis or modified psychoanalytic treatment is an appropriate treatment in a particular case. A usual pre-requisite for psychoanalytic education is the completion of training in a mental health clinical specialty in which the clinician has demonstrated a professional level of knowledge and skill in evaluating the mental health of individuals, considering differential diagnoses, and developing

appropriate treatment plans for patients. A detailed description of these educational processes and the corresponding assessment and evaluation processes that are mastered is beyond the scope of this guideline. This information is available from other sources. (APsaA, 1999; Etchegoyen, 1991; Kernberg, 1984)

A. Assessment of strengths:

A psychoanalytic assessment seeks to recognize the uniquely adaptive and maladaptive ways that the patient engages in the process of living, working, forming relationships and maintaining emotional attachments. The assessment considers the person no less than the presenting complaint. It seeks to understand how the presenting concerns, signs and symptoms mesh with adaptive strengths. It aims to recognize and understand the degree to which the patient possesses particular strengths that can favor positive results from psychoanalysis or modified psychoanalytic treatment. (Etchegoyen, 1991, p. 14; Greenson, 1967; S. Freud, 1940[1938]; Bachrach, et. al., 1991; Gray & Brauer, 2004) A few examples of these particular strengths can be summarized briefly:

1. Motivation: How clearly and seriously does the patient see the presenting problem(s) and how does this relate to the patient's determination to pursue an analytic effort at self-exploration? How stable is the patient's current life situation and how strongly is the patient (and the patient's parents or guardians in cases of minors) willing and able to invest the effort, time, and financial resources necessary for successful psychoanalytic treatment?

2. Potential for self-observation: How strong are the patient's capacities for introspective self-reflection, cognition, verbal communication, and expression of thoughts, feelings and fantasies?

3. Potential to withstand the tensions of analysis: How strong is the patient's capacity for impulse control and frustration tolerance? How effectively has the patient utilized prior treatment opportunities?

4. Potential to work analytically: To what degree does the patient show abilities for adaptive internal conflict resolution (e.g., via sublimation, grief and mourning, etc.), for maintaining a loving, caring investment in a human relationship in the face of some frustration (object constancy), for recognizing and experiencing others as both similar and different from oneself (e.g. self-object differentiation), and for reliable recognition of the difference between reality and fantasy (reality testing)? How strongly does the patient show the potential to analyze rather than avoid or mal-adaptively enact the anticipated powerful feelings, wishes, and urges that emerge toward the analyst?

Experience has led analysts to regard the presence of these strengths (or evidence that the patient has the potential to develop these strengths) as a good indicator that the patient can participate successfully in a psychoanalytic treatment process. In a particular case in which the assessment indicates that the patient lacks some of these strengths and appears to lack the potential to develop them, a treatment plan for modified psychoanalytic treatment (e.g., modifications of the frame of treatment, technique, frequency, etc.) might be considered. (Holt, 2002; Etchegoyen, 1991, pp. 529- 566; Greenson, 1967; Winnicott, 1965)

The assessment of developmental progress toward such strengths is an important aspect of psychoanalytic assessment of patients of all ages. (Horowitz, 2002; Richards & Tyson, 2000; Vaillant, 1993; Tyson & Tyson, 1990; Vaillant & McArthur, 1972) Psychoanalytic clinical assessment for children and adolescents considers this progress relative to chronological age along expected developmental lines. (A. Freud, 1965; Mahler, Pine & Bergman, 1975; Gedo, 1979) For example, a child's ability to express himself or herself through play is a positive indicator of the potential for self-observation. Since the active support of the parent(s) or guardian(s) is usually important for effective psychoanalysis and modified psychoanalytic treatment with children and adolescents, assessment of the strengths noted above is relevant for each of the adults expected to participate to some degree in the treatment process. For patients of all ages, the assessment of current adaptive style and/or ego defense mechanisms will provide information about the developmental level at which difficulties emerged or were consolidated. (Vaillant, 1993)

The process of psychoanalytic assessment considers the patient's current level of psychological, social, and occupational functioning. Also of interest is how the adaptations expressed in these various arenas represent unconscious compromises that integrate the patient's strengths and vulnerabilities. These adaptations can reveal how effectively the patient has engaged in his or her relational and occupational roles and achieved a measure of personal fulfillment despite psychological distress. Consideration of achieved adaptation also helps to differentiate the extent to which the patient expresses his or her distress through psychological symptoms as compared with behavioral symptoms, including ways he or she engages with others and with the environment. Furthermore, a consideration of these prior adaptations is relevant for treatment planning in the sense of how they may emerge, shape, and perhaps compromise the psychoanalytic treatment process. (See also reference to DSM-IV Axis V and VI in section B below.)

In addition to the strengths and vulnerabilities that the patient brings, the effectiveness of psychoanalytic treatment and the quality of the therapeutic relationship between patient and analyst are also determined by the levels of analytic skill, professional experience, and empathic capacity of the analyst. (Etchegoyen, 1991, pp. 50-59)

B. Assessment of weaknesses and vulnerabilities:

Psychoanalysts have not reached a consensus favoring a particular system of diagnosis, largely because no existing system is able to convey with accuracy and balance the full depth and breadth of the understanding gained from psychoanalytic clinical assessment. In some cases, psychoanalysts use existing systems or modify those systems to meet clinical needs. (Shedler, 2002; McWilliams, 1994, 1999; Gunderson & Gabbard, 1999)

It is beyond the scope of this guideline to consider the predictable effectiveness of psychoanalysis that might correspond to specific diagnostic categories. Past reviews, recent research, and works-in-progress address the effectiveness of psychoanalysis, review outcome studies, and advance the development of scientific methodology for psychoanalysis. Over time these efforts will help to link psychoanalytic work with some of the methodologies used by other sciences. (Bachrach, et. al., 1991; Fonagy, 1998; Gunderson & Gabbard, 1999; Seligman, 1995; Gray & Brauer, 2004)

Psychoanalysts might find DSM-IV diagnoses useful as one way to understand and summarize impressions derived from psychoanalytic assessment (Gray, 1996; APA, 1994); but a thorough assessment will go beyond the information that can be coded by this system. From DSM-II to DSM-III, this system shifted from a clinical perspective that described dimensions of mental and psychological functioning to a research perspective that focuses on objectively observable manifestations of experience and behavior that can be categorized into relatively discrete diagnostic criteria. From both general clinical as well as psychoanalytic perspectives, the current DSM-IV is limited in its ability to serve as an assessment instrument for mental health care in the real world. For example, Axis I categories are based on research diagnostic criteria that do not optimally account for individual variability. Furthermore, contrary to the specifically stated intent of the framers of the DSM-III and DSM-IV system, economic and sociopolitical forces have distorted the general use of the DSM system toward a "cookbook" approach that fulfills the notion that nearly all of life's troubles can be defined as "discrete and identifiable mental illnesses," can be clinically diagnosed, and can be addressed by pharmacological intervention alone. (Shedler, 2002; McHugh, 1999; McWilliams, 1999, p.1; Healy, 1997; APA, 1968; APA, 1980)

The current DSM system does not include information derived from psychoanalytic research methods and, with a few notable exceptions, ignores the accumulated knowledge from a century of psychoanalytic clinical experience. (APA, 1994; Gunderson & Gabbard, 1999; Fonagy, 1998) For example, the DSM-IV system does not account for unconscious aspects of mental functioning that are at the heart of the psychoanalytic treatment process. The DSM-IV perspective aims to confine its data to experience and behavior at the level of phenomena that can also be observed outside a therapeutic context. In contrast, a psychoanalytic perspective recognizes unconscious processes and unconscious meanings of experience and behavior as these become observable over the course of treatment. Some examples are intra-psychic conflict, defenses and their associated internal object relations, ego functions, the cohesiveness of the sense of self, the patient's subjective inner life experience, etc. (Schore, 2001; Gunderson & Gabbard, 1999; Wilson, 1993)

To illustrate the importance of these uniquely individual influences, trial interpretation is a method that is sometimes used during the psychoanalytic assessment process. Trial interpretation does not aim to reach specific diagnostic conclusions or meta-psychological determinations. Instead, this method aims to reveal a general sense of the patient's relative strengths and vulnerabilities, and how these might become manifest and be worked with in the analytic treatment process.

The DSM system has focused upon the patient's pathology and has tended to ignore the patient's strengths. Recognition of this limitation has led to the proposed addition of a new Axis VI to delineate adaptive styles and a defensive functioning scale as part of the scientific paradigm of the DSM system. If analysts choose to use the DSM system in their work with clinical cases, they might consider use of Axis V and Axis VI to convey a more balanced assessment than is possible in the current DSM-IV.

When psychoanalysis or modified psychoanalytic treatment is considered to be an appropriate treatment in a particular case, the benefits and risks of giving a "diagnosis" to the patient should be considered. Clinical use of "official" diagnostic labels tends to act as a suggestion that might become a new guiding aspect of the patient's sense of

self and might serve to alter the treatment process. In some cases, this suggestive technique might help a patient who feels fragmented to organize his or her sense of self enough to participate more effectively in treatment. However, the experience of being labeled with "the diagnosis" may create new defensive barriers that can block free psychoanalytic exploration and obstruct the treatment process. (Glover, 1931) In cases in which the clinician's judgment suggests that the risks of diagnostic labeling outweigh the benefits, the clinician might use alternative methods that avoid the use of current diagnostic labels to convey diagnostic information for use in treatment planning and charting.

C. Complementary and non-psychoanalytic approaches to assessment:

Psychoanalytic clinicians might also consider the published recommendations for assessment processes from the clinician's mental health specialty of licensure. These efforts, like the American Psychiatric Association's "Psychiatric Evaluation of Adults," represent thoughtful approaches to complex tasks, some of which might be useful when applied to the process of psychoanalytic clinical assessment in particular cases. (APA, 1995) However, some recommendations found in these sources conflict with essential features of psychoanalytic practice and require modification when applied to the psychoanalytic clinical assessment process. (Etchegoyen, 1991) For example:

1. In contrast to recommendations for psychiatrists (APA, 1995), psychoanalysts and psycho-dynamic psychiatrists should not be expected or required to conduct physical examinations. In most instances there is no need for them to collaborate with physicians who conduct physical examinations on their patients (also see item 2 below). When psychoanalysts are assessing and treating patients in hospitals, in residential treatment settings, or when a patient's capacity to communicate in support of his or her health care is severely impaired, with the thoughtful consent of the patient (or a minor's parent or guardian) the psychoanalyst might communicate directly with other clinicians to enhance the effectiveness of the patient's health care and/or maintain support for the patient's psychoanalytic treatment. In outpatient settings, specific information that the patient shares about their physical health, illnesses and injuries is integrated into the clinical psychoanalytic assessment.

2. Psychoanalysts should consider that the practice of obtaining health care records from other clinicians that treat or have treated the patient is not usually necessary for good psychoanalytic treatment and may have important unintended consequences. A direct request for such records from another clinician creates an outside record of the existence of the psychoanalytic treatment that may complicate or compromise the analytic treatment process. Since these records are likely to be disseminated throughout the health care records systems, their existence can trigger reciprocal requests for the patient's psychoanalytic health care record by outside parties. Such requests might pose serious risks to some patients and always pose a threat to the psychoanalytic treatment. (Cummings & Gray, 2003) If a particular need emerges for the analyst and patient to examine data about the patient's health care, the patient (or a minor's parent or guardian) can maintain privacy and confidentiality for the analytic treatment by acting as intermediary, obtaining and bringing copies of health care records to the analyst.

3. The utilization of psychoanalytically-oriented psychological testing has been shown to enhance and sharpen the psychoanalytic assessment process in three areas: (1) the assessment of analyzability, (2) the prediction of treatment outcome, and (3) the delineation of dimensions of change (or variables) by which treatment outcome may be measured. (Appelbaum, 1976; Wallerstein, 1986) Due to the scarcity of this resource, it has been part of the psychoanalytic assessment process in only a few practice settings. Continued positive results from use of this testing in these settings might lead to greater availability of this resource and support for its wider use.

4. The technique of psychoanalytic assessment aims to consider the person no less than the person's presenting symptoms, signs and problems. The analyst strives to work together with the patient in a flexible manner to facilitate the patient's free expression. The aim is to listen and observe the patient's presentation of inner and outer life experience at depths that include unconscious dynamic processes. (Etchegoyen, 1991, pp. 41-59) This technique differs from some recommended approaches for clinical evaluation that aim to gather and document answers to a standard series of questions regarding conscious behaviors and phenomena in order quickly to identify pathology according to specified diagnostic criteria. (APA, 1995; Kernberg, 1984)

5. Many diagnosis-based practice guidelines for mental health treatment limit their evaluation (and consequent treatment) to evidence that can be studied and empirically validated by double-blind, randomized, controlled trials and similar experimental methods. (APA, 2002) The approach of these guidelines tends to focus on one DSM-IV diagnosis at a time. However, in daily clinical practice, many DSM-IV diagnoses occur together. This reality complicates assessment and treatment far beyond the guidance derived from carefully-controlled experimental studies. (Shedler, 2002) Diagnosis-based guidelines tend to exclude the body of knowledge and the clinical methodology gained from over a century of psychoanalytic clinical experience in which patients are seen in the context of their real lives, each presenting a complex and unique mix of strengths and vulnerabilities. Therefore, guidelines that follow the diagnosis-based model often result in recommendations that are incompatible with a psychoanalytic approach to patient care. A recent study of data from over 900 completed psychoanalytic cases indicates that DSM-IV Axis I diagnoses (with psychotic disorders excluded) are not useful to predict distinctively the outcome of psychoanalytic treatment. However, more generally, this study revealed that a patient who shows an Axis II diagnosis (which might become apparent only after an extended clinical assessment) will require a more lengthy analysis to complete treatment than a patient who does not show an Axis II diagnosis. (Gray & Brauer, 2003) It is not appropriate to expect or require psychoanalysts to conduct psychoanalytic treatment according to the advice contained in DSM-IV diagnosis-based practice guidelines.

Sometimes clinical psychoanalytic assessments are conducted by clinicians other than the treating psychoanalyst. For example, psychoanalytic practice guidelines describe a confidential clinical psychoanalytic assessment that can be conducted as a second-opinion review, requested by a third party in the context of third party authorization and funding, or when the third party payer requests a second-opinion review in the event that psychoanalysis proceeds significantly beyond the usual length. . It is recommended that the second opinion consultant be an appropriately qualified psychoanalyst peer of the treating analyst, acceptable to the patient, the treating analyst, and the third party. In

this type of review, the treating psychoanalyst does not have written or oral communication with the third party. With the patient's informed consent, the consultant reports to the third party only as to whether psychoanalysis is or is not an appropriate treatment (i.e. no diagnosis, personal details, or other clinical information would be reported). (Council, 2000; Cummings & Gray, 2002)

D. Psychoanalytic charting considerations and methods:

Documentation of the clinical assessment becomes part of the patient's confidential health care record. This health care record should be filed securely by the analyst to protect the patient's privacy and confidentiality. The patient has a right to read and receive a copy of this record. The patient also has a right to waive confidentiality and privacy by giving a thoughtful consent (i.e. "informed consent") that directs the analyst to release this record to a third party.

A complete confidential health care record for CPT 90845 (psychoanalysis or modified psychoanalytic treatment) might contain the following items: (1) the appointment and fee-payment record of the treatment; (2) a note stating that a psychoanalytic clinical assessment process was conducted and led to a discussion with the patient of the advantages and disadvantages of various treatment options (specified) and to a mutual agreement upon a treatment plan (specified to include the frequency and length of sessions, an indication of whether the procedure is psychoanalysis or modified psychoanalytic treatment and reason for the choice of this treatment option, and a description of modifications or special features of the treatment plan); (3) notes to document the occurrence and reason for any major changes in the treatment plan or forms of treatment or recommendations by the analyst that the analyst considers to be outside the usual scope of psychoanalysis (e.g. prescription of medication, referral to a neurologist, etc.); (4) any third party correspondence and a note documenting the patient's thoughtful consent for this correspondence; and (5) a closing note at the end of treatment, or if treatment is interrupted or ends prematurely.

Psychoanalytic practice guidelines may help clinicians in developing policies and procedures for clinical documentation and charting of psychoanalysis. These guidelines recommend that analysts refrain from creating session-by-session progress notes. The guideline entitled "Charting Psychoanalysis" gives specific explanations for this recommendation that are relevant for decisions and policies about documentation of the psychoanalytic clinical assessment. In many cases, psychoanalytic treatment starts from the initial contact with the patient. Psychoanalysis is a single procedure from start to finish. For the construction of a psychoanalytic treatment plan, maintenance of strict confidentiality is vital and absolutely necessary if the patient is to feel safe enough to talk freely and openly with their analyst and express thoughts and feelings fully, without reservation (Gray & Cummings, 1997; Cummings & Gray, 2000, 2002, 2003). Confidentiality is defined as an understanding between patient and analyst that, absent patient authorization or legal compulsion , the analyst will not disclose anything about the treatment to anyone outside the treatment situation or take any actions outside the treatment situation based on what he or she hears inside the treatment situation. When this level of confidentiality is not afforded patients, the nature of the entire treatment process is changed. (Bollas & Sundelson, 1995) Reality-based fears about confidentiality infringement have been shown to lead patients to be less candid with

clinicians in the clinical assessment, treatment planning and overall treatment process. (Kremer & Gesten, 1998)

Acknowledging the importance of confidentiality, the Supreme Court of the United States (1996) has supported the psychotherapist-patient privilege on the basis that "effective psychotherapy…depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears", and that psychotherapeutic treatment supports the "public good." The Court specifically noted that "the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment."

A specific format for documentation of the clinical assessment is not included herein for many reasons. For the psychoanalytic assessment process that culminates in mutual agreement with the patient for the treatment plan, each analyst develops his or her own charting policy and methods in consideration of the analyst's practice and its setting. Many analysts appropriately establish a policy to refrain from officially charting the clinical assessment beyond a note indicating that the assessment occurred and was discussed with the patient in the context of the treatment planning process. Modifications are sometimes required to meet special needs in a particular case.

In some cases, the clinician might decide to chart details and/or conclusions from the assessment that strongly influenced the treatment planning. Since the records contained in a patient's psychoanalytic health care chart are discoverable for a variety of purposes, documentation of the clinical assessment should not extend beyond the information that the analyst determines is minimally necessary. (APsaA, 2002) Analysts are advised to chart only the minimum and necessary facts, with the understanding that the patient (or a minor's parent or guardian) might read every word of it during the treatment or after the treatment is finished. It is not necessary to chart facts about the patient's life history. If an outside party wants to know these facts, the patient (or a minor's parent or guardian) is a good source for this information and should be allowed to decide how to respond to a particular inquiry. Analysts are cautioned against charting speculative hypotheses, questions, formulations containing technical jargon, or other non-factual items. If such speculations are discovered by the patient and/or revealed externally, the psychoanalytic treatment process might be set back or slowed (e.g., via premature interpretation) and the patient's sense of well-being might be unnecessarily challenged. (Glover, 1931; Freud, S. 1940[1938])

When a psychoanalyst maintains a psychoanalytic health care record for a patient, materials related to the case that are stored separately from that official record (e.g. the analyst's working notes, process notes, or research notes) are more easily distinguished as property of the analyst and legally protected from discovery in most situations. HHS regulations pertaining to Federal law distinguish "psychotherapy notes" as separate from the patient's official health care record. (Federal Register, 2002; Gray and Cummings, 1996)

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