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Ego Function Assessment and Analysability

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For psychoanalysis as a system of therapy, analysability is probably the single most important concept and factor: it is but a synonym for curability, at least by that particular technique. Curability in general, as analysability in particular, is neither easy to determine nor an all or none proposition. With the possible exception of some acute infectious disorders, there is a quantitative spectrum of curability for most illnesses if the criteria are strict.

For an analyst then, it is important to be able to determine as soon as possible if a patient is analysable, to what extent, and with what likely vicissitudes to be encountered in the process. Even within the confines of the most classical model of analysis there must be allowance for individual differences, leave alone allowing such in the broadened scope of psychoanalysis. Therefore technical variations must also be contemplated as a function of the individual aspects of analysability.

Assessment of analysability intrinsically involves a prediction, namely that the patient is likely to respond to psychoanalytic treatment. Analysts have been somewhat reluctant to finesse this particular implicit prediction, as well as the many other predictions involved in each of the conceptual and methodological propositions basic to the field **(Bellak, 1961b)**.

Ego function assessment offers a systematic basis for prediction based upon past and present functioning. The more clear-cut the conceptualization and the planning of treatment, the more success one can expect, the less stalemate **(Glover, 1955)**, the fewer broken off analyses and fewer undesirable results.

The literature on analysability is replete with statements regarding the 'fragmentary and contradictory knowledge' **(Namnun, 1968)** and the 'lack of well defined criteria' **(Limentani, 1972)**regarding the indications and contraindications for psychoanalysis. Waldhorn's **(1960)** review of the subject speaks to 'the need for some better organized and precise approach'.

The specific role of the ego in the analytic process could be neither appreciated nor studied prior to the development of the structural theory. Before 1923 Freud conceptualized the goal of analysis as the lifting of repression and making the unconscious conscious. With the development of the structural theory these goals became the building of ego at the expense of id. This allowed Freud to consider '… the obstacles that stand in the way of such a cure' **(Freud, 1937)**. He spoke of an unfavourable alteration in the ego acquired in its defensive struggle as 'prejudicial to the effectiveness of analysis'. Freud was still primarily speaking of the ego as a structural entity. Nevertheless, a number of authors were concurrently defining this entity in terms of its functions **(A. Freud, 1936)**; **(Hartmann, 1939)**.

We have since had a continuation of the description and definition of the ego functions. Parallel developments have included a concern about the 'widening scope of psychoanalysis' **(Stone, 1954)** and a consequent increasing focus on the problem of analysability. The relationship between these areas of investigation has become more apparent. Nunberg **(1955)** has spoken of the significance of overall ego strength and particularly of the synthetic function in determining a favourable outcome. Waldhorn **(1960)** considered it logical above all to evaluate ego functions in assessing analysability. Aarons **(1962)**, as Nunberg and Hartmann had done previously, emphasizes the importance of the synthetic function in determining motivation for analysis. Namnun **(1968)** elaborates on this theme with the term 'the will to be analysed', which he sees as a manifestation of ego autonomy and capacity for mastery. He sees this autonomy as critical to the working through of the transference.

Shuren **(1967)**, in his paper on the pre-analytic

patient, describes how disturbances in separation and individuation lead to deficits in ego functions that can prevent a successful analysis.

A number of other authors have discussed the role ego functions play in the analytic process without specifying them as such **(Stone, 1954)**; **(Levin, 1960)**. Knapp **(1960)** found evidence suggesting that a team of 'experienced clinicians are able to assess suitability [for analysis] in advance'. Although ego strength was 'recognized as important' in the study, assessment of it 'was left to the interviewer's intuitive clinical judgment'. More recently Lower, Escoll & Huxster **(1972)** reported the high frequency with which 'good ego strength' was described as a reason for acceptance for analysis and the higher frequency with which 'poor ego strength' was cited as the reason for rejection.

We will address ourselves to evaluating specific ego functions concerning analysability and possible parameters to be introduced into an analysis for specific problems.

SYSTEMATIC EGO FUNCTION ASSESSMENT

A systematic technique for the evaluation of ego functions was developed by Bellak *et al*.**(1973a)** previously in a different context. A large research study of five years' duration concerned itself with the definition and rating of ego functions in such a way that clinicians serving as independent raters could agree to a statistically acceptable degree on the rating of 12 ego functions on either a 7 scale or on a 13 scale. These 12 ego functions were chosen after considerable preliminary work and carefully defined in a rating manual. Superego and drive

factors were also rated but were not statistically studied because of practical limitations (such as computer time) at the end of the study.

Figure 1

Ego function rating form

	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII
	Reality testing	Judgment	Sensè of reality	Regulat. & cont. of drives	Object relat.	Thought process	ARISE	Defensive functs.	Stimulus barrier	Auton. functs.	Synthet. functs.	Mastery–cmptnc.
13												
12												
11												
10												
9												
8												
7												
6												
5												
4												
3												
2												
1												

Ego functions

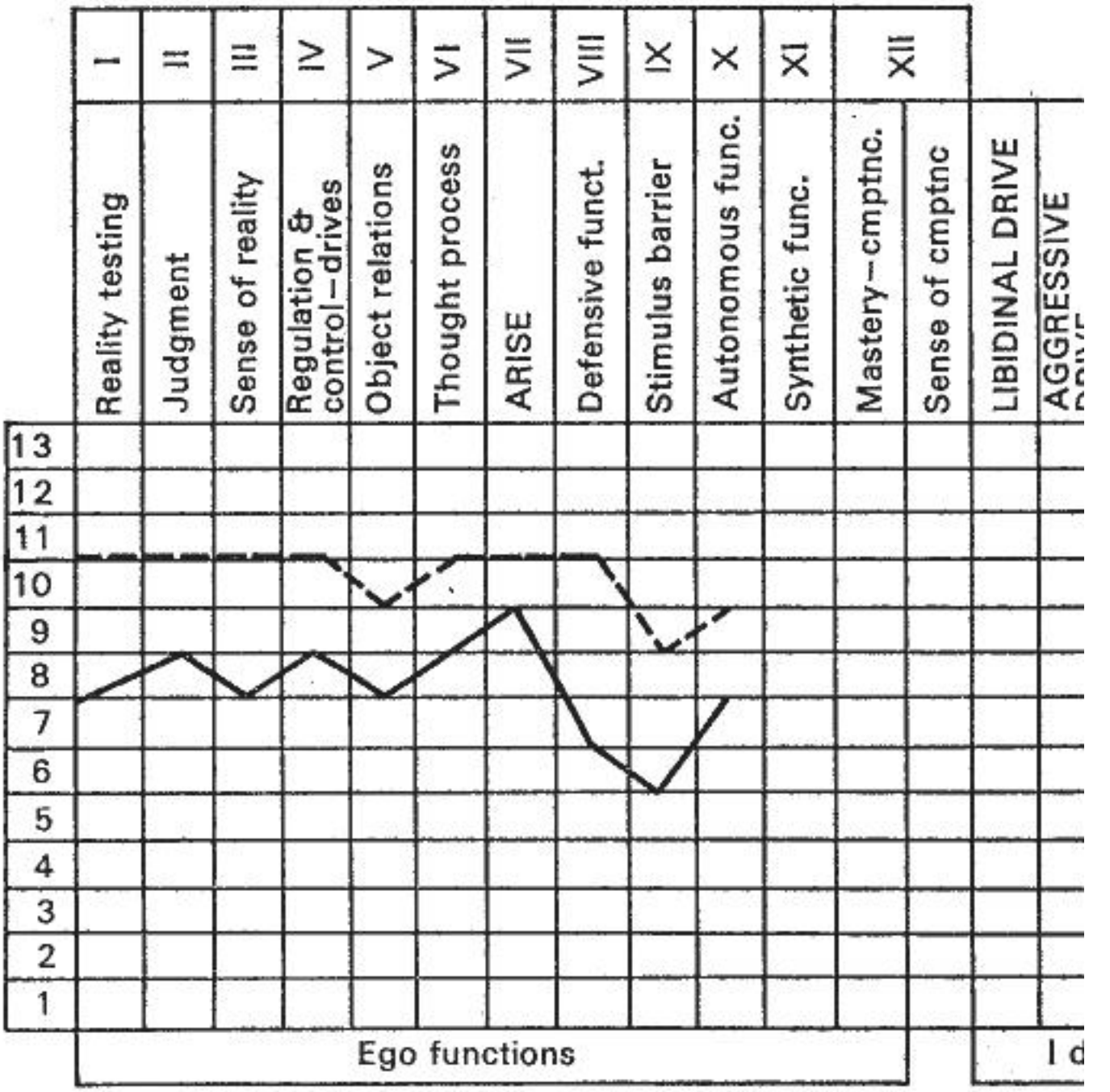
Figure 2

Ego function ratings at beginning and end of treatment

EGO FUNCTION ASSESSMENT

Patterns of ego functions
Research project
N.I.M.H. Grant #ROI MH 14260

Subjec
Group#
Rater(s



Levels of functioning:
Characteristic :
Therapist's rating ——before
----after

Figure 1 shows the basic rating form and the approximate *ranges* of normality, neuroses (and equivalent character disorders), borderline conditions and psychoses.

It was also shown **(Bellak, Chassan et al., 1973b)**that these ratings could be derived either from a two hour standardized interview or from regular sessions of psychoanalytic psychotherapy, and that the ratings correlated highly between these two sources. **[See Fig. 2.]**

An informal inquiry of the 12 ego functions should suffice most analysts for a systematic appraisal of these ego functions in relation to analysability. For those further interested in a systematic inquiry concerning ego functions, as well as the rating manual, information is available in Bellak *et al*.**(1973a)**.

THE EGO FUNCTIONS AND THE ANALYTIC PROCESS

Reality testing

Reality testing is considered here as a function that is distinct from sense of reality and judgement. Other authors have discussed reality testing as a component of a larger function, 'the relation to reality' **(Beres, 1956)**; **(Frosch, 1964)**. Nevertheless, the systematic study of the ego mentioned above substantiates consideration of reality testing as a separate function on phenomenologic grounds. We feel that such a distinction is warranted on genetic and meta-psychological grounds as well.

One principal component of reality testing concerns the perceptual and cognitive capacity

to distinguish internal from external stimuli. The loss of the capacity is most clearly demonstrated by one of its extremes, as in the formation of an hallucination. It is more subtly seen in illusions or other phenomena where the perception of external reality is significantly altered by an internal affective state.

A more common, yet more subtle form of confusion between internal and external stimuli occurs when contemporary external reality is perceived in terms of the internalized past, as when infantile fantasies or object representations determine the response to a here-and-now situation. Freud **(1924)** has discussed this loss of reality as a foundation of neurosis. It is a goal of analysis to repair such distortions and thus enable the individual to distinguish internal from external and past from present.

Other important components of reality testing include the intrapersonal and interpersonal validation of perceptions. This is largely a cognitive testing process. Intrapersonal validation refers to the check of data perceived from one sense against that perceived by others, as is lacking in hallucinations. Interpersonal

validation involves the comparison of one's own perceptions with those of others, as is lacking in delusions. Any idiosyncratic beliefs that become evident in the consultation must be thoroughly examined with regard to the patient's capacity to test and validate them.

Another principal component is inner reality testing: the analytic process works through an increasing focus on understanding internal reality. It requires a shift of attention from external to internal without losing the capacity to separate the two. The patient is expected to become increasingly aware of how external perceptions are influenced by internal states. The depth and accuracy of internal perceptiveness is related to what we call 'psychologic mindedness'. Impaired defensive functioning, as manifested by excessive use of denial or projected-introjective mechanisms, limits this perceptiveness and thereby limits the analytic results. Here as elsewhere, we have to keep in mind the interrelationships of different ego functions, and how strengths or weaknesses of one influence others.

Reality testing is integral to other aspects of the analytic process. Bellak's **(1961a)** conception of 'the oscillating function of the ego' can be considered as a 'macrofunction', contributed by both adaptive regression and reality testing. The adaptive regression allows for the suspension of secondary process, ensuing free association, and the emergence of previously unconscious material, while the observing reality testing function is required for the recognition and understanding of external and internal reality based on the data of the association.

Reality testing is also critical to the understanding and working through of the transference. At appropriate times the analysand must be able to distinguish internally from externally derived perceptions of the analyst. The regression that produces transference distortions must also be largely reversible at the end of the analysis so that functioning can resume in the patient's daily reality. Borderline and psychotic patients often continue to respond to the internal stimulation of the transference to the point where excessive and unmanageable acting out ensues. It is thus apparent that a parameter to be used in analysing patients with deficient reality testing is the modulation of the developing transference by the analyst. Rapid clarification and interpretation of severely distorted transference phenomena becomes indicated.

Judgement

The function of judgment refers to the ability to be aware of the likely consequences of intended or actual behaviour and is reflected by the extent to which manifest behaviour reveals such awareness. In this sense, judgement is a 'social' and 'conscious' function involving the ego's capacity to appreciate its interaction with external reality. Impaired judgement results in what is referred to as inappropriate behaviour, relative to a specific cultural setting.

Logic, which involves the awareness and understanding of cause and effect relationships, is integrally related to judgment. Although logic is generally an

aspect of 'autonomous functioning' and 'thought processes', it is relevant to judgement with regard to the individual's capacity to appreciate the external effects of behaviour.

The analyst must appraise the patient's judgement regarding the analysis itself. How

realistic are the patient's expectations of goals? How well does the patient appreciate the type of financial, geographic and temporal commitments that are being made? How well can the patient undergo the voluntary 'suspension of disbelief' which relates to the acceptance and awareness of the 'as if' **(Tarchow, 1963)**nature of the transferential relationship? It is such a faculty which permits, for example, the appreciation of and identification with theatrical drama without involvement to the point of running on to the stage to join the performance. Despite the regressive forces inherent in the analysis, a reserve of the function of judgement is necessary for the patient to synchronize the inner and outer realities of the analytic situation and thereby to respond accordingly.

Another significant aspect of judgment is its role in acting out. Patients with impaired judgment can be expected to act out in a socially inappropriate and perhaps harmful way. The consultation should evaluate judgment demonstrated by the behaviour a patient utilized to resolve past conflictual situations. Similar behaviour can be expected to be acted out during the analysis. In such cases the analyst may have to supplement the patient's deficiencies in judgment with the analyst's own awareness of the consequences of intended behaviour. This awareness can then become signal awareness for the patient at times when self-destructive behaviour would otherwise be imminent. (See also 'regulation and control of drives'.)

Sense of reality

This ego function will be discussed both in terms of its phenomenology and its dynamics. Phenomenologically it is manifested by the extent to which external events are experienced as real and embedded in a familiar context as well as the extent to which one's body and its functioning are experienced as familiar and belonging to the self. Depersonalization, derealization, *déjà vu* and dissociative experiences are all examples of defective sensing of reality. Another aspect is faulty self-esteem regulation because of the lack of a constant cohesive concept of self. The result here is that the patient's self-esteem is quite mutable because of its dependency on daily experiences and the opinion of others. We see these clinical phenomena most clearly in narcissistic personality disorders.

The sense of reality is dynamically and structurally determined by the degree to which an individual has mastered separation and individuation so that self and object representations are distinct. In so far as this developmental task has been

mastered, both self and object representations can remain 'constant' and relatively independent of changes in reality.

A question arises as to the distinction between sense of reality and reality testing. We have called both of these 'ego functions' and both deal with the ego's ability to distinguish internal from external and its 'awareness' of body boundaries. It is clear that the two functions are interrelated. There is, in fact, preliminary evidence from factor analysis that reality testing, judgment, sense of reality and regulation and control of impulses form a 'group' of functions whose strengths and weaknesses correlate closely in a particular patient (Bellak *et al*., 1973). However, one has to do with the way the ego senses and experiences reality, and the other with the ego's ability to 'test' these experiences against fixed internal percepts and ideas of what is real.

The degree of significance of disturbances in the sense of reality in assessing analysability has yet to be clearly ascertained. Nevertheless, defects here speak for an overall problem with what Beres **(1956)**and Frosch **(1964)**have described as 'the relationship to reality'. Patients who give a history of responding to stress by regressively losing ego boundaries with resultant perceptual distortions will presumably have this difficulty in the analysis. A particular difficulty could ensue in the transference where severe transference distortions occurring under the influence of a regressive refusion with the analyst could result in an unmanageable 'transference psychosis'. It is probable that parameters have to be introduced into the analysis of patients with severe defects in this function to maintain the existence of an observing ego, the working alliance and the patient's ability to test his reality. One such parameter is the analyst's 'lending' his ego to help the analysand perceive reality at times when it seems irretrievable.

Another parameter is the substitution of face-to-face sessions for the use of the couch. This becomes necessary for patients in whom disturbances in sense of reality readily produce depersonalized or derealized states associated with such severe anxiety that analysis of the state becomes impossible.

The use of the couch need not be an all-or-none proposition. The patient may be able to use the couch most of the time, but may need to sit up when feelings of depersonalization or derealization emerge to a disturbing degree. When the relevant problems are analysed, the patient is usually able to return to the couch.

Regulation and control of drives, affects and impulses

This function comprises the ego's coping with impulses impinging on it. It takes into account the directness of drive expression, the degree of frustration tolerance and the extent to which drive derivatives are channelled through ideation, affective expression and manifest behaviour. The latter closely relates to, and can overlap with, defensive functioning.

Impaired regulation of drives is directly related to a tendency towards acting out. Acting out becomes a too easily used means of remembering and, as such, an alternative to analysing and understanding conflicts *within* the analysis. Thus, in order for the analysis to progress, the frustration of not acting out transference wishes must be tolerated. The interpretation of the wishes within the analysis then results in a second loss and resultant frustration. As Tarachow **(1963)**points out, all transference interpretations result in a loss in that the patient must reaccept the 'as if' transference quality of the relationship. It is a difficult set of steps for the analysand to (*a*) first feel the impulses, (*b*) then renounce the gratification offered by acting them out, (*c*) bring the wishes into the analysis, (*d*) accept the loss that results from interpretation, and (*e*) use the interpretation to synthesize a new understanding and relinquish old object wishes.

Bellak **(1963)**, in describing the psychology of acting out, suggests a number of points in its treatment, some of which are directly relevant here: even at the beginning of the analysis it can be important to predict for patients who appear to have a tendency to act out that this is likely to arise, including their desire to interrupt the analysis. They may do this seemingly for external reasons or because of hostile feelings towards the analyst. It may be appropriate in the initial interviews, or early in the analysis, to point out to the patients the situations in which they are especially likely to act out and thus to increase their signal awareness. In this way an important therapeutic alliance can be established which may make the difference between a successful and an unsuccessful analysis.

Patients who give historical evidence of requiring immediate relief from anxiety or depression have analytic difficulties in this area. These are often the same patients who have histories of overstimulation and have constitutional or experiential deficiencies in stimulus barrier.

Patients who evidence deficient drive regulation combined with overtly gratifying symptomatology present particular problems. This relates to some of the difficulties encountered in the treatment of drug abuse and the perversions.

A parameter to be considered in dealing with weaknesses in this function is the addition of medication at times when excessive anxiety combined with deficient affect modulation has a particularly disorganizing effect. The amount and duration of such psychopharmacologic interventions must be carefully monitored so as to allow for an optimal affect as well as cognitive functioning level consistent with the analytic work.

Object relations

This is a complicated ego function which comprises both the degree and kind of relatedness to others. Specifically it involves the extent to which others are perceived as separate entities rather than extensions of the self and the extent to which present relationships are influenced and patterned by past infantile ones. The unifying principle is the degree to which the patient has mastered separation

and individuation and achieved object constancy.

Failures in the development of these spheres and object relations have particular effects upon an analysis. Failure to differentiate self from

object is the distinguishing characteristic of the psychosis, but is a more subtle manifestation of narcissistic personality disorders. In these narcissistic non-psychotic disturbances, the separation of internal self and object representations has occurred, and consequently the individual can distinguish internal from external reality (reality test). However, due to both incomplete mastery of separation and unresolved wishes for refusion, the narcissistic patient is liable to transiently *feel* external objects as extensions of the self. The result, in both psychosis and narcissistic disturbance, is that within the analysis, losses resulting from absence, silence, vacation and transference interpretations lead to a severe anxiety that recapitulates infantile separation anxiety.

Disturbances in object relations can lead to transference resistance or resistance to transference. In the former, the analyst is perceived and maintained as the projection of an all good idealized 'real' object. Analysis of this fusion would lead to a profound narcissistic loss. In the latter, the analyst is perceived as a powerful threatening figure via projective identification and such a transference makes a working alliance impossible. The severe forms of disturbance are classically seen in narcissistic and borderline conditions.

Kohut **(1971)**has specifically described the vicissitudes in object relations of the patient with a narcissistic character disorder and the analytic modifications and technical measures necessary to plan on. Kernberg **(1968)**has discussed parameters that may become necessary during the analysis of both narcissistic and borderline disturbances. Jacobson **(1971)**, in turn, has especially described the psychodynamics of the transference relationship of the severely depressed patient. In patients described by these authors, it is important to to be fully aware of all the factors that are likely to manifest themselves as problems of analysability at the earliest possible opportunity. In many cases the analyst must decide as to the feasibility of restructuring infantile object representations, as opposed to a less classical approach that would aim at internalizing a new object by identification with the analyst. Naturally, this is never an all-or-none phenomenon.

Less severely distorted object relations are seen in neurotic disorders and, prototypically, in the transference neurosis. It is through the transference that we have most direct access to an examination of how internalized mental representations from childhood influence current perceptions and object relations. This can be contrasted to the hypothetic optimal level of object relatedness in which the perception of external objects remains constant regardless of affectual or instinctual changes. It is of note that in order for an analysis to take place there

must be a regression in just this area. The patient must regress from his own optimal level of object relatedness in order to develop the transference distortions essential for an analysis. The limiting factor must be the level of individuation already achieved so that the transference distortions do not become symbiotic refusions or do not require the use of intransigent splitting, denial, idealization, or other primitive defences that make the transference unanalysable.

Classical theory of analysability has been somewhat divergent from actual practice. According to the most classical, and undoubtedly most gratifying model of an analysis, interpretation of the defences leads to the establishment of a transference neurosis. This transference neurosis is not only a renascence of the childhood neurosis, but also the somewhat varying model of the patient's conflicts and problems in general, reproduced like a laboratory preparation in the analytic setting. In this ideal situation, the interpretation of the transference neurosis leads by automatic generalization to a corrective therapeutic restructuring of the personality of the patient via this model. It is as if a calibrator were directly to transfer the learning from the small transference analysis model to the large, life-sized scale of all relationships.

The fact is, however, that a majority of the patients currently seen in western cultures rarely produce a classical transference neurosis unless they suffer from a hysterical disorder, possibly close to a borderline condition. While most patients do not produce a full-blown transference neurosis, they do so to a small extent from time to time throughout the analysis. It would be a mistake to consider a limited ability

to produce any kind of transference neurosis as a preclusion to analysis.

Thought processes

This function concerns the ability to think clearly and is most plainly manifested by the capacity to communicate one's thoughts in an intelligible way. Components here are the adequacy of processes which guide and sustain thought, such as attention, concentration, concept formation, language and memory as well as the relative primary-secondary process ratio in thinking.

Many of the components of this function interrelate with other functions. Memory and language, usually considered under the heading of 'autonomous functions', are considered here in so far as they have lost their autonomy and impair thinking. The ability to concentrate is also usually autonomous, but disturbances in concentration have a deleterious effect on thinking. This is irrespective of whether the disturbed concentration is secondary to marked anxiety, organic defect or clouding of the sensorium, or excessive pressure of thoughts. (Even the latter can have a number of causes.) Defensive functioning affects thinking as well, e.g. by the mechanisms of displacement, condensation

and projection.

Denial, as particularly described by Lewin **(1953)**, produces centrifugal thinking, while elliptical thinking occurs to an extreme degree in schizophrenics but may occur in minor degrees in all kinds of disorders of lesser pathology. Disturbances in thinking have traditionally been excessively related to schizophrenics. There is evidence that some schizophrenics do not have a thought disorder and some non-schizophrenics do (Bellak *et al*., 1973).

Especially noteworthy is an increasing awareness that mild neurological conditions, which in childhood probably manifested themselves as dyslexia or other learning disabilities with some soft neurological signs (minimal brain dysfunction), may also result in thought disorders under the impact of flooding by emotions. (Patients with such conditions not only need to be specifically diagnosed with regard to their analysability, but they also need, themselves, to understand the origin of their disorder.) Such patients may at times sound psychotic to themselves and others. A decreased tendency to be flooded by neurotic emotions will decrease their tendency towards confused thinking. At the same time, awareness and understanding of this tendency is essential. In this case a neurological deficit is contributing to poor control of drives and affects with a consequent disturbance in thinking.

Defects in the thinking process have clear-cut effects on the analytic process. Free association requires controlled regression of thought processes. The ego must be capable of oscillating in such a way that secondary process thought can take over to perceive and understand primary process material that has emerged. The analysand must be able to use attention, concentration, memory and concept formation in order to be aware of his associations, be capable of recalling them and, finally, be able to decipher themes and form concepts regarding his internal reality. *The capacity to think syllogistically is relevant here*. The analyst's use of, and the patient's understanding of syllogisms is critical to interpretation and insight.

Adaptive regression in the service of the ego

This function involves the two phases of the oscillating process described by Kris **(1952)**and Bellak **(1961a**and alluded to in the discussions of reality testing and thought processes. As Kris **(1952)**and others since have pointed out, adaptive regression is an essential aspect of the creative act and thus has a critical role in the analytic process. This function, firstly, allows for the relaxation of cognitive acuity and secondary process modes of thought to permit the emergence of more mobile preconscious and unconscious ideation and, secondly, involves the ego's capacity to interrupt and reverse the regression and return to secondary process thought. The third aspect of this function is the ego's capacity to utilize the regression adaptively by inducing new configurations and creative integrations.

Defects in any of the aspects of adaptive regression result in specific

difficulties in the analysis.

The obsessive-compulsive personality will have great difficulty suspending secondary process thought because of the anxiety produced by affects, instincts and the fluidity of cathexes. His

thinking will remain concrete. This same anxiety about the unknown (unconscious) will impair such a patient's ability to form creative and new integrations adaptively. The schizophrenic and borderline patients can readily regress to primary process modes of thought but have difficulties reversing the process. The anxiety resulting from the loss of control of the thinking process in such patients impedes the adaptive utilization of the regression as well.

The initial interview is an invaluable tool here. Can the patient fantasize? Is he aware of his dreams and how does he respond to them? Is the patient capable of the regressions called for in the appreciation of art, sex or humour, or are they felt as threatening and ego-alien? Alternatively, does the patient regress 'too readily' and not in the service of the ego? Does the patient evidence primary process thought in a structured interview? Is there a history of fantasies interrupting intended concentration in a disabling fashion or of a preoccupation with and 'being carried away by' fantasies?

Regarding the second phase of the oscillating process, the interviewer can investigate whether the patient has been able to use discoveries from dreams, fantasies or other regressed states for planned or creative actions. How does he go about problem solving? Does he discover imaginative solutions via ego regression or can he only approach solutions by rote learning?

Finally, the question arises as to how smoothly the patient can make the transition from the regression to control. Can the ego use regression and its controls in a complementary fashion that can lead to adaptation? A microcosm of this occurs in the consultation itself where the patient relinquishes usual inhibitions to speak of emotionally charged anxiety-producing material. The interview must attend to how the patient responds to this regression and to the thoughts it evokes. A patient who is able to regress in a limited fashion, who finds this pleasurable and, most importantly, a patient who can use the consultation to form limited yet *new* understandings about the self creatively, is demonstrating evidence for a positive prognosis—at least in regard to this ego function's contribution to the outcome of the analysis.

In many cases the analyst can help the patient modulate the degree of regression during an hour so as to achieve an optimal regressive level for adaptive utilization. In some patients medication can be considered which might decrease the effect of anxiety on the oscillating function. Excessive and maladaptive regression can be interrupted by the analyst's increased activity or by the

temporary substitution of face-to-face sessions for the couch.

Defensive functioning

We consider this a binary function that includes the extent to which defences are successful in reducing dysphoric affects such as anxiety and depression and the degree to which in turn the defences themselves adaptively or maladaptively influence ideation and behaviour. The formation of a hierarchy of defensive functioning, based on either the chronology of defence mechanism development or on particular levels of psychopathology, is an unresolved issue for psychoanalytic theory. We are concerned here with an empirical operational assessment of defensive functioning. We are concerned with the effectiveness with which the defences cope with drives and affects and the adaptability of the responses. Finally, we are concerned with the extent to which vicissitudes in this function facilitate or impede the analytic process. We must consider how deficits here can be identified during the initial consultations and what parameters are available for dealing with such deficits during the course of the analysis.

Incapacitating dysphoria will have a disruptive effect. Severe depression will result in retardation of thought and associations, as well as a general impairment of cognition. Excessive anxiety has an obvious disorganizing effect. Patients presenting such severe affective symptoms are often suffering from a failure of repression and necessitate, at least initially, a more 'supportive' psychotherapeutic approach. The use of psychoanalysis can be reconsidered later, but even then, the introduction of parameters that would help to bind dysphoria might be required.

Patients who bind their dysphoria but at the cost of maladaptation present the converse problem. The lack of anxiety and depression decreases the motivation towards analysis. The

alloplastic tendency lends itself to acting out. In the obsessive compulsive the defences of isolation and intellectualization, by preventing the emergence of affects, are mitigating against the development, awareness and understanding of transference feelings. Patients suffering from perversions or psychosomatic illnesses, because of the rapid discharge of affect inherent to their conditions, can be expected to present similar difficulties.

The more punitive defences produce the greatest reality distortions and are therefore the most difficult to analyse. A patient whose presentation reveals an extensive use of denial can be expected to be quite resistant to perceiving, much less analysing, the disturbing internal reality. The tendency to perceive problems as externally caused is associated with denial and projection and presents similar difficulties. This applies not only to overtly manic or paranoid patients but is also seen in what are often referred to as 'acting out' forms of character disorders. Finally, the borderline patient's tendency to split will be revealed in the

consultation by a history of defensive overidealization or denigration of significant objects. The transference distortions resulting from splitting are often intransigent to analysis (Kernberg, 1966, **(1968)**.

Stimulus barrier

This ego function also has two basic components: a receptive and an expressive one. The receptive is the individual's threshold for sensitivity to and awareness of sensory stimulation. The expressive component relates to how the individual responds to different degrees of stimulation with particular emphasis on whether coping mechanisms are adaptive or maladaptive. In the latter case deficient coping plus effective overstimulation leads to disorganization and withdrawal.

The receptive component includes sensitivity to internal and external stimulation with the common final pathway being impingement of the sensory nerves. Examples of internal stimulation include changes in body temperature, and visceral and muscular pain, while external stimulation includes light, sound, drugs and other forms of inanimate stimuli.

Drives and impulses can also be conceptualized as stimuli, albeit internal ones; however, sensitivity to and regulation of them is considered a separate ego function. Stimulus barrier is more closely related to the sensory motor nervous system than the psychological realm. It is only when we see failures in sensory threshold or in motor responsiveness to the stimuli that we get 'sensory overload'. It is at this point that drive and affect changes occur and the function of their regulation becomes operative.

As mentioned above, the expressive component concerns the individual's coping mechanisms to different levels of stimulation. A critical aspect of this is the individual's ability to regulate the stimulus threshold: one of the coping mechanisms towards stimulation is modulation and selectivity of attentiveness. This screening mechanism allows for adaptive changes in sensitivity to stimulation thus facilitating periods of heightened acuity, focused concentration and the general filtering out of stimulation necessary for sleep. Other aspects of the expressive component include the degree of cognitive and motoric adaptation to high levels of stimulation versus motoric and cognitive disruption. Persons with a low stimulus threshold plus poor coping mechanisms are easily 'overstimulated', leading to impaired sleep habits, concentration, mood and drive regulation, synthetic functioning, etc. It is thus clear that overflow from defects in this function can influence the other ego functions as well.

The ego's capacity to regulate stimulus input plays a critical role in the analytic process. The analytic setting is designed to reduce external stimulation and thereby promote regression and an increased attention to internal phenomena. The patient cooperates in this screening out of external stimulation. Patients with impairments here are easily distracted and such distractions can become a major

obstacle to the analysis. The emphasis here is not on the psychic meaning of such distractions, but that some patients lack the ego capacity to adequately screen out adventitious stimulation.

Patients with such impairments often give histories of daily experiences in which sensory overstimulation has led to disorganization. Not being able to cope with the impact of small children or of having to orientate oneself while

driving in a new environment are commonplace examples of this.

In this context we want to refer to the previously mentioned and too rarely recognized problem of adults who, as children, suffered from a minimal brain dysfunction and may still have, on the one hand, a low stimulus barrier and, on the other hand, some problems in orientation. Sometimes they are actually left-handed or ambidextrous and some have problems of orientation in space—more problems than they are aware of. For example, in instances where there was frequent marital discord because a spouse tends to get lost in driving to some destination, examination revealed that difficulties in telling right from left as part of a minimal brain disorder were responsible for the patient's poor sense of direction.

Another aspect of this is sensitivity to the effects of internal changes. How disorganizing does the consultee find the experience of pain or discomfort, or, in the case of women, premenstrual tension? The analysand must, rather than be overwhelmed by internal stimulation, have the capacity to perceive and utilize such stimulation in the service of self-understanding. Patients with strengths here can more readily understand the relationship between sensations that are perceived and their psychological meaning.

Conversely, the concept of a required minimal stimulation relates to this function. The classical example of deficient stimulation disrupting psychic functioning is in the sensory deprivation syndrome and persons vary in regard to their sensitivity to this. Patients requiring moderate amounts of stimulation to preserve psychic integration can be expected to derealize or have transient psychotic experiences in the sensory deprivation that is inherent to the analytic situation. Such patients may require a well lit room or increased verbal activity by the analyst to prevent such experiences.

A paradigm for the evaluation of stimulus barrier can be how the consultee deals with the task of falling asleep. Is sleep too readily prevented by minimal external stimulation? Conversely, has the lack of stimulation inherent to falling asleep required the use of hypnotic agents or the auxiliary stimulation of the television or radio? The dynamic significances of sleep disturbances are myriad. Nevertheless, a critical element is how well the patient can regulate the stimulus barrier to achieve the level of stimulation necessary for sleep and how this regulatory capacity will facilitate or impede the analysis.

Autonomous functioning

We are concerned here with the relative lack of impairment of what have been described as primary and secondary autonomous ego functions. Primary autonomous functions include perception, attention, intelligence, intentionality, memory, language, sensation and motoric expression. Secondary autonomy refers to habits, skills, and behaviour patterns that are either combinations of primary autonomous functions or have become secondarily autonomous by sublimation **(Hartmann, 1939)**, **(1955)**. Autonomy refers to the freedom from impairment of these operations by the intrusion of conflict, ideation, affect and and/or impulses. It takes into account a degree of resistance to regression and reinstinctualization that would result in such intrusions.

One can conceptualize the autonomous ego functions *as the tools the patient brings* to the therapeutic alliance to accomplish the analytic work. Deficits in these tools can severely limit the amount of work done. This is clearly true when we consider impairments in intelligence, language, memory and attentiveness, and their effects in the analytic process. The same is true for the complex patterns that make up secondary autonomous functions. What acquired intellectual and perceptual skills (which include communication, the ability to symbolize and understand symbols, etc.) does the patient bring to the analysis? To what extent are other major ego functions such as reality testing, judgment and thought processes operating free from conflict? How likely are these functions to regress and in what conflictual areas? A patient who develops severe anxiety with loosened associations when discussing overtly sexual material has such impairment of reality testing, thinking, object relations and his primary functions at such times that the capacity to perceive or understand the difficulties is lost.

We can always anticipate a degree of regressive instinctualization of what had previously been

autonomous functions during the course of an analysis. What we must consider are the autonomous starting points and the autonomous reserves the patient will maintain. This will help decide the kind and degree of effort and equipment the patient has available for the analysis. Persons who already suffer from inability to perform simple work habits or intellectual tasks, for whom such tasks now seem a burden and who have lost the ability to concentrate or communicate clearly, are usually not ready to start an analysis. In such cases a preparatory course of therapy is often indicated, followed by a reassessment to determine the capacities of autonomous functions to contribute to and withstand the rigours of an analysis.

Synthetic-integrative function

This function will also be described in terms of two principal components. The first is the capacity to integrate potentially discrepant or contradictory

experiences. Such experiences can be behavioural, psychological or both, and can involve thoughts, feelings, actions and perceptions. Psychological aspects include the ability to integrate: (1) apparently divergent self representations, (2) distortions between internally perceived object representations and externally perceived objects and (3) affects with incongruent ideation or internal perceptions. The resolution of such distortions plays a large role in reality testing, sense of reality and object relations as well as other ego functions. It is also crucial to the resolving of ambivalence.

The second major component of this function is the ability to interrelate and integrate psychic or behavioural experiences which need not be contradictory. This aspect of the function facilitates the experiences of connexions and continuity, and allows for planning and organizing operations. Psychologically it enables the perception of the relationship of past to present, mood to idea and percept to experiences.

As Beres **(1956)** has pointed out, the synthetic function's activity is ubiquitous in human thought and action. It works so closely with other functions that its examination in isolation is nearly impossible. This has been alluded to above. Nevertheless, the critical nature of this function's contribution to the analytic process makes such a dissection and investigation imperative. Without adequate synthetic integrative functioning, the reductive dissective aspects of the psychoanalytic process would lead to dissolution and psychosis rather than re-synthesis and ego growth.

The associative process by which the connexions occur also depends heavily on this function. Without it, the second phase of the oscillating function does not occur and free association becomes the loosened autistic associative process of the schizophrenic. The synthetic function allows for the linkage of initially casual associative data in order to arrive at causal and dynamic themes and understanding.

The psychoanalytic process is itself a dissociative experience: the patient is asked to observe himself and report on himself (Bellak, 1961). This involves both phases of the oscillating function, i.e. adaptive regression followed by synthesis. In some people with a poor synthetic function, the analytic process actually increases a tendency towards pathological dissociation. Having previously been self-observing in an unskilled way, they now substitute analytic self-observation. In the absence of a sufficient ego synthetic function, they are unable to utilize interpretations in a constructive way. They are primarily the people who do well intellectually, but are unable to integrate and synthesize the experience emotionally into the necessary gestalt that, indeed, is ultimately responsible for a restructuring of the personality. For that reason, insufficient synthetic function to utilize insight is a contraindication to analysis and calls for psychotherapy with limited associating, limited self-observing and other forms of intervention. Very often people who have been unsuccessfully analysed, with a specific complaint of

constant self-analysis and no symptom resolution, need postanalytic psychotherapy, specifically to undo the dissociative aspects of analysis.

Appraisal of this function during initial interviews should include evaluation of the frequency and severity of dissociative states. How well does the patient integrate affects with thoughts? How well has the patient been able to sort out excessive stimulation by specifically synthesizing the various stimuli to arrive at an understanding

of the specific situation? Patients with neurologic defects, particularly involving minimal brain dysfunction, may present difficulties here.

One parameter that can be introduced into the analysis of some patients would be the analyst's lending his own synthesizing function to the patient. The analyst could thus concretely review and synthesize significant elements of the session. The analyst would have to help the patient integrate the affective state and the thought content. The hoped for result would be a strengthening of the patient's own integrative function so that the patient could then carry out such processes independently.

Mastery–competence

This function relates to the individual's capacity to master his environment relative to his resources **(White, 1967)**. The resources are largely subsumed under the other ego functions, and by mastery-competence we are referring to how well an individual's ego assets are utilized in interaction with the environment. This function has three components: (1) objective performance relative to assets, (2) subjective sense of competency or expectation of success, (3) the degree of concordance between actual performance and expectation.

The third component is an aspect of self-esteem regulation and therefore involves the functions of object relations, sense of reality and reality testing. We also consider it here because the interaction between objective competence and subjective sense of competence has a definitive effect on an individual's mastery performance.

The mastery we are considering here is of the analytic task. In essence, we are considering how well an individual utilizes the analytic insights to work through and resolve conflicts. Difficulties with this late step in the analytic course explains a difference between patients who understand the infantile origins of their conflicts while continuing neurotic patterns, and patients who, by working through conflicts, become free to achieve behavioural and characterologic changes.

The preanalysis evaluation must assess this function and consider the potential analysand's sense of competency and its relation to actual achievement. Is the patient unrealistically grandiose or unduly pessimistic? Does he 'underachieve' and why?

Patients with character traits marked by strong passive and/or masochistic wishes become problematic here. The literature has considered these issues and the related topic of the negative therapeutic reaction **(Freud, 1937)**. The resistances that develop in such patients are usually considered in terms of their psychodynamic origins or manifestations in the transference. We are not minimizing such issues but are rather focusing on another perspective through which to view them: masochistic and passive-dependent character pathology leads to impairment of the ego's functioning, specifically in its capacity to achieve mastery and competence. We would predict that without a certain resource level of this function, regardless of the strengths of the other functions, a weakness in the so-called '*analytic utilization factor*' results with a consequent limitation on the potential analytic achievement. A corollary to this is that some relatively more disturbed patients who bring a particularly strong utilization factor to the analysis, as evidenced by a history of past environmental masteries, may be surprisingly good candidates for analysis.

SUMMARY

Systematic evaluation of ego functions for the assessment of analysability has been discussed. In concentrating on these aspects of the personality, evaluation of superego factors and, to some extent, drive factors have not been considered. Similarly, reality factors, specific maturational phase or general life situation, intelligence, various handicaps such as speech difficulties, hearing difficulties, congruence or incongruence of a given patient with a given psychoanalyst were also not discussed. It is in the nature of a paper that its scope be limited. In no way should this technical consideration be construed as a willingness or suggestion that factors other than ego function assessment should be ignored or considered unimportant, or even, less important.

On the other hand, we suggest that systematic

ego function assessment should be a valuable tool for all analysts. Though a very formal rating scheme, with detailed definitions, suggestions for inquiry and criteria for rating is available, it will be possible and sufficient for any analyst to engage in some clinical rating without much more effort than making a list of the 12 functions discussed, clarifying the definitions and some criteria for evaluation in his own mind and keeping list and criteria *as a frame of reference* in a clinical interview.

Of the ego functions discussed, stimulus barrier, mastery-competence and ARISE are the only ones somewhat less than routinely kept in mind by analysts. With regard to stimulus barrier, certain neurological or generally physiological factors and their effect on organizing ability—and its lack—were especially stressed. Minimal brain dysfunction was brought to special attention in this respect

with regard to thought processes, impulse control and some specific symptoms particularly.

Mastery and competence may be something of a new consideration for many analysts because, among other things, the concept does not come from strictly psychoanalytic sources. Nevertheless, we feel that it is an important aspect of analysability: mastery and competence seems to be autonomous enough to permit the conclusions that if someone shows mastery in his general life-style, he is likely to have a very good ability to utilize analytic processes—have a *good utilization factor*—and a poor one if the general life-style shows little mastery and competence. This fact seems to override degree of general pathology in our clinical experience.

ARISE (Adaptive Regression in the Service of the Ego), as originally formulated by E. Kris, needs merely be brought more fully to the attention of the analyst considering analysability because it may not have been sufficiently the custom to consider it for this purpose.

Above and beyond the usefulness of systematic and careful ego function assessment for analysability, we also wish to suggest such assessment for other purposes.

This is the era in which peer review is playing an increasing role, at least in American psychiatry and psychoanalysis. Systematic ego function assessment may be as good a way as any for systematic comparison of the status of many patients at the beginning, the middle and the end of an analysis.

Third party roles are also steadily increasing. Compensation by insurance companies, government and others makes a systematic evaluation as well as one based on criteria intelligible to lay people more and more urgent. Ego functions are behavioural variables mostly, which can be so understood, and an assessment can be given without violating intimate data or material very meaningful to the patient.

Finally, ego function assessment may be a useful and much needed research tool for analysts who wish to have a clearly defined basis for diagnostic assessment and the evaluation of therapeutic results by independent judges at different points of the treatment process.

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