Introduction

THE ideas that comprise my thinking here were originally organized in response to an invitation from James Barron to contribute an essay to an anthology entitled *Making Diagnosis Meaningful: Enhancing Evaluation and Treatment of Psychological Disorders* (1998). In fact, this book is a much-expanded elaboration of that chapter, with a different audience in mind and a more complex collection of aims that I try to articulate in what follows. In his letter about the proposed book, Barron raised questions about tying the diagnostic process more meaningfully to the actuality of clinical work, about the complex relationships between diagnosis and prognosis, about the extent to which diagnosis informs treatment, about relating diagnosis to developmental processes, and about the tension between diagnoses that seek descriptive specificity yet obscure the complexity of patients and diagnoses that capture complexity but sacrifice specificity.

I have pondered such questions for years. As succeeding editions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association (1968, 1980, 1987, 1994) have become increasingly objective, descriptive, and putatively atheoretical, they have inevitably minimized the subjective and inferential aspects of diagnosis on which most clinicians actually depend. Operating more or less invisibly alongside the empirically derived categories of the DSM is another compendium of wisdom, passed down orally and in practice-oriented journals: clinical knowledge, complexly determined inferences, and consistent impressions made on the harnessed subjectivities of therapists. In any individual case, these data coexist somewhat uneasily with whatever formal diagnostic label the patient has been given. One aim I have here is to represent that invisible, shared set of procedures and reflections.

ON THE SUBJECTIVE/EMPATHIC TRADITION

From the perspective of an empirical scientist, human subjectivity is generally considered a detriment to accurate observation. From that of the clinician, subjectivity allows access to knowledge about human beings that one could never have of other subject matter (one presumes that physicists rarely "empathize" with particles). Many contemporary psychoanalytic writers (e.g., Kohut, 1977; Mitchell, 1993; Orange, Atwood, & Stolorow, 1997) essentially define psychoanalysis as the science of subjectivity, in which the analyst's empathy is the primary tool of investigation. Much of what I cover in this book reflects this subjective/empathic orientation. There is an important place for clinical observations made from this perspective, especially when they are scrupulously amassed and repeatedly compared with those of colleagues.

Several years ago, I agreed to be a research subject for a doctoral dissertation investigating differences in diagnostic preferences between psychoanalytic and cognitive-behavioral therapists. I consented to "diagnose in my usual way" certain material that would be presented to me on videotape. The tape purportedly showed a patient describing certain problems. I was to view it and then fill out a questionnaire. My immediate and persisting reaction to the video was that the woman describing her symptoms was not a patient; in her relationship to the camera, there was a complete absence of the usual emotional atmosphere one feels in the presence of a suffering person asking for help. I was quickly aware that I could therefore not "diagnose" her in the usual way I make clinical assessments—namely, by empathic immersion in the subjective experience of the person seeking a therapist's expertise and the disciplined exploration of what she provoked in my own subjectivity. The first item on the questionnaire was "What was your first reaction to the patient?" I responded, "That she was an actress, not a real patient." The subsequent questions, which assumed that the videotaped woman was in fact a patient, were impossible to answer.

I called in the student and explained to her my problem. I had been asked to diagnose in my "usual way," but my usual way required me to feel the presence of a person who was really asking for help. I said I was not trying to be difficult, but I could not fit my usual style of diagnosis into the demands of the experiment. The researcher confirmed that the videotaped woman was an actress but asked me to imagine anyway that she was a real patient. I said I could not do this: Diagnosis for me is not a strictly intellectual exercise, responsive only to described symptomatology. In exasperation, the experimenter decided to exclude me from

her study, since I was not able to cooperate with her research on its own terms. The findings she later published simply omitted the assessment practices of therapists like me, who bring a more holistic, subjective, interactional sensibility to the task of understanding another human being.

Analogous omissions happen all the time with psychoanalytic data. Information is ignored because it is not "neat," objectively describable, full of discrete, observable behavioral units (cf. Messer, 1994). Therefore, it is no surprise that we have a lot of empirical data on cognitive-behavioral therapies and far less on psychoanalytic ones. Only a cognitively impaired individual could honestly conclude from this situation that cognitive-behavioral treatments work and that psychoanalytic therapies do not. We are missing data, but we are not in possession of data demonstrating that psychoanalytic treatments lack effectiveness. As George Stricker (1996) has remarked, we should not confuse the absence of evidence with the evidence of absence. What *can* be concluded is that we need to invest in the very expensive, complex, and creative research that psychoanalysis requires to establish its empirical status. Meanwhile, those of us who are already convinced of the efficacy of psychoanalytic work owe at least some account of our thinking.

In fairness to the critics of traditional therapy, there is ample evidence that psychoanalytic assumptions have often been mistaken (one thinks, for example, of some of Freud's more peculiar ideas about female sexuality), reflecting smug, culture-bound convictions that now look quaint at best, harmful at worst. Because of the limitations of lore, there will probably always be a healthy tension between the subjectively infused oral tradition and the objectively oriented syndromal one. Another source of tension is that practice often lurches ahead of research, for the simple reason that therapists, hearing from a colleague that a new technique can help patients, will try it before waiting for full empirical validation (the recent popularity of eye movement desensitization and reprocessing [Shapiro, 1989] or thought-field therapy [Callahan & Callahan, 1996; Gallo, 1998] come to mind here).

It is very difficult to do good research on conventional, long-term therapy, and few of us who feel the calling to be therapists also have the temperament of the dispassionate scientist (see Schneider, 1998, on the romantic tradition in psychology). We are not, however, indifferent to science. At least since the time of Spitz (1945), analytic practitioners have been deeply influenced in their practice and in their development of theory by controlled research, especially research in developmental psychology. Another aim of this book is to show how experienced ana-

lytic practitioners apply relevant research findings to the demands of formulating a case.

ON BEING A THERAPIST AND TEACHING PSYCHOTHERAPY AT THE TURN OF THE CENTURY

It is an irony of our times that at the point when psychotherapy has almost completely lost its stigma, at least in the middle classes, and at the point when a respectable literature on its effectiveness has accumulated (Luborsky, Singer, & Luborsky, 1975; Smith, Glass, & Miller, 1980; Lambert, Shapiro, & Bergin, 1986; VandenBos, 1986, 1996; Lipsey & Wilson, 1993; Lambert & Bergin, 1994; Messer & Warren, 1995; Roth & Fonagy, 1995; Seligman, 1995, 1996; Howard, Moras, Brill, Martinovich, & Lutz, 1996; Strupp, 1996), we are experiencing political and economic pressures that are demoralizing practitioners, discouraging clients from seeking help, punishing clinicians who are able to inspire patients' willingness to stay in treatment long enough to accomplish something enduring, and redefining as "therapy" a nonconfidential relationship that may be summarily stopped at any point (cf. Barron & Sands, 1996).

Becoming a good therapist is inherently arduous and time-consuming, but lately, the task has been complicated by anxieties among aspiring clinicians that they will not be able to practice the difficult art they have made so many sacrifices to master. As a teacher of therapists, I have seen evidence that these anxieties have been rising steadily in recent years. For example, in my introductory survey of psychoanalytic theory at Rutgers, I typically assign a paper asking students to analyze one of their dreams in classical Freudian fashion. Occasionally a kind of "class theme" emerges in the papers, often involving separation (students usually take this course in their first graduate semester) or self-esteem (not easy to maintain in graduate school). In a recent semester, almost half the analyzed dreams contained images of an intrusive, arbitrary, unempathic authority—hostile police officers, angry school principals, autocratic nuns, and the like. When I reported this pattern and asked class members how they understood its meaning, they associated immediately to their apprehensions about practice in a "managed care world" where some bureaucratic directive would suddenly override their clinical judgment.

If I had been writing this book fifteen years ago, it would not have the polemical edge it has now. We are in a period of painful crisis about

health care in general and psychotherapy in particular. There has essentially been a corporate takeover of the health care delivery system, and like most health care professionals, I am highly skeptical about the applicability of corporate and commercial models to the helping professions. Although I find it hard to imagine that there will ever be a time when people will not want to talk to highly trained others about their problems, if perfunctory, insincere, and frustrating interventions are represented as psychotherapy, it will not be many years before significant numbers of people will think they have "tried therapy" and found it wanting. They are unlikely to think about trying it again.

These realities make it even more compelling for therapists to do their job conscientiously and effectively. If a client is restricted to a short-term therapy relationship, it is more important, not less, to operate from a sound diagnostic basis. If the job the patient wants done cannot be done under the conditions that a paying third party insists on, it is up to the therapist to be honest about that and to know how to convey to the client an understanding of that person's particular psychology and its therapeutic requirements—to impart a dynamic formulation in ordinary language (cf. Welch, 1998). Communications of this nature can themselves be understood or misunderstood based on how astute the therapist is about the patient's overall psychology.

It is a common contemporary belief, especially among managed care personnel, insurance company executives, and some academic psychologists, that psychotherapy, especially psychodynamic therapy, is wasteful and ineffective. The research that has been cited in self-serving ways by many third-party payers to justify the most minimal interventions in the name of treatment has consisted mostly of studies in which time-limited, identical interventions are delivered to carefully selected, randomly assigned patients with simple diagnoses, whose progress is evaluated strictly according to the fate of the specific symptom for which they came to treatment (see Parloff, 1982; Persons, 1991). As Seligman (1996) has pointed out, such procedures differ markedly from psychotherapy as it is actually practiced. Conventional therapy is typically open-ended, with the patient influencing time of termination; it is self-correcting, in that therapists readily change their approach when something is not working; it often reflects the client's active and discriminating selection of a therapist with whom he or she feels comfortable; it usually concerns multiple and interacting problems rather than isolated symptoms; and the therapist's and patient's criteria for outcome include not just symptom relief but improvement in general functioning.

Complicating matters, the rift between academic psychologists and dynamically oriented practitioners, for which both groups bear some responsibility, has affected the undergraduate and graduate teaching of psychology. Notwithstanding a few friendly university departments, the settings hospitable to psychoanalytic scholarship have been freestanding institutes and hospitals outside the academic mainstream. Because most academic psychologists have had scant exposure to analytically informed practice, theory, and scholarly research, their comments to students about the nature of analytic treatment are often wildly misinformed. It is not uncommon for individuals who earnestly want to learn how to help people to come to graduate programs in psychotherapy believing that psychoanalytic practice is represented by a withholding and authoritarian doctor, a worshiper of the mythic Freud, who says nothing for the first six months of treatment and then tells the patient she has penis envy. One impetus to my writing this book is my concern to bring the analytic tradition and contemporary analytic theories into classrooms where psychoanalytic ideas may not previously have been well understood or welcome.

Analytic psychotherapy is not a set of techniques that operate independently of those who practice it. Relatively untrained people with good instincts and a good heart can be effective therapists. Highly trained individuals who lack ordinary compassion can be disastrous ones. The art of the clinician is difficult to teach and especially difficult to convey to skeptics. Some people who disparage psychotherapy have no temperamental affinity for the sensibilities it involves. A relative of mine, a higher-up in an insurance company, tells me that unless they have a vivid personal or family experience with mental illness, executives in his line of work view therapy as a sentimentalized racket, ingeniously designed for the enrichment of its practitioners.

I have been struck over time with how many critics of psychotherapy have had a disappointing experience in treatment. They may have been diagnostically misunderstood or have gone to an incompetent clinician or have seen an adequate person who was simply a poor fit for them. If they were to get a bad haircut, these people would doubtless have fired their hairdresser rather than attack the profession of cosmetology. But so much is at stake in psychotherapy, so much is risked by the patient, that one can hardly react to its failure with a shrug and a change of plan. Grievances by those for whom therapy has been either useless or damaging are understandable. Nonetheless, it is exasperating to those of us who practice this difficult art to see our work distorted and devalued, for whatever reason. I hope this book exposes some of

the difficulties, possibilities, and limitations of assessment and treatment in a realistic light.

Despite the fact that every therapist with a general practice treats only a small number of individuals suffering from each of the major kinds of psychopathology, by sharing knowledge, the therapeutic community has accumulated a vast amount of information about many conditions. Clinical experience generates many researchable questions; research will suffer if practitioners neglect to make explicit the premises from which they operate. I am trying in this book to convey ideas that the psychoanalytic community has developed over a century of conversations about patients, ideas that may be researchable in spite of not being fashionable in the current health care climate. I have also drawn on the existing research tradition in psychoanalysis, a tradition more substantial than many critics of psychoanalysis admit (see, e.g., Masling, 1983, 1986, 1990; Fisher & Greenberg, 1985; Barron, Eagle, & Wolitzky, 1992; Bornstein & Masling, 1998).

Although people of my generation have been chastised for having an attention span the length of a television commercial, I have seen no evidence that contemporary therapists are less eager than their predecessors to assimilate painstakingly accumulated clinical wisdom and clinically relevant research data. Yet given that market forces and academic politics are not always on the side of preserving complex and controversial truths, we can assume that therapists will continue to feel some isolation and will need to support one another in their shared knowledge and vision. I hope to contribute here to that supportive professional environment.

ORGANIZATION

The format of what follows is straightforward. After an introductory chapter on the relationship between case formulation and psychotherapy, there is a chapter orienting readers to the issues one faces in an intake session. The eight subsequent chapters address different aspects of psychoanalytic case formulation. Readers will be given rationales and procedures for assessing the patient's temperament and fixed attributes, developmental history, defensive operations, affective tendencies, identifications, relational patterns, methods of self-esteem regulation, and pathogenic beliefs. In all these areas, I try to show how knowledge of that feature of the person's psychology has implications for the therapist's approach to treatment. Those who wonder about my preferences

in terminology and tone are referred to the comments about my choices in the Introduction of *Psychoanalytic Diagnosis* (McWilliams, 1994).

From Chapter Four on, I typically begin each chapter with some definitional comments and a historical review of psychoanalytic theory that bears on the concept under discussion. Usually, that means starting with Freud. I hope the reader understands that I do not do this out of some knee-jerk homage to The Father. Rather, I think it is hard for new therapists to understand the evolutions and transformations of classical psychoanalytic theory into the contemporary world of diverse analytic viewpoints without having some sense of Freud's original hypotheses. After these grounding comments, I usually talk about other analytic ideas on the topic and finally discuss how what I have covered applies to the therapist's choices about intervention. I have been liberal with case examples so that otherwise sterile concepts can come alive in the reader's imagination.

Because the message it tries to deliver concerns the intimate connection between good formulation and good treatment, this book is as much about therapy as it is about assessment. Like many committed therapists, I have a tendency to be opinionated about psychotherapy and to be deeply influenced by my particular clinical experience. I suspect that a passionate, perhaps even evangelical, sensibility is not unrelated to a therapeutic calling, and possibly to therapeutic success. This sensibility does not always correlate with evenhandedness. Other clinicians may disagree with many of the inferences I draw here. Therapists work effectively from many divergent perspectives, on the basis of different but ardently held convictions. If, irrespective of disagreements, my writing stimulates reflection about the connections between a careful dynamic formulation and the psychotherapy that follows from it, I will be satisfied that I have made a contribution to clinical practice.

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