Psychoanalytic Case Formulation

…utifully written, uniquely accessible guide to the psychoanalytic understanding …al cases will be of immense value to students and practitioners of all theoretical …ions. I predict it will be among the most important and widely used books in this … years to come."

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Rutgers—The State University of New Jersey

…McWilliams has written a lucid and compelling work, a sweeping, eclectic inte… of psychoanalytic knowledge from its inception to the present day. This book … wonderful mixture of the practical and theoretical. It is an extremely valuable … for mental health professionals at all levels of expertise."

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McWilliams

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Nancy McWilliams

tive qualities if she had her obesity (and conversely, that she would avoid her mother's negative ones if she avoided being thin like her); (6) that she was still living in a posttraumatic mental state in which she saw others as potential molesters and blamers; (7) that the value system by which she had supported a fragile self-esteem as a teenager was now operating to deter her from enjoying and profiting from a normal degree of vanity; and (8) that whenever she lost a few pounds, she became unconsciously panicky that she would die like her father.

I should stress that it is only in retrospect that all these determinants and their therapeutic implications are so clear. Some of the features of this woman's psychology were among my original hypotheses, while others emerged during the therapy process, surprising both her and me. Usually, a therapist has a few interconnected ideas about the sources of a particular client's suffering and finds that while investigating in those areas, all kinds of other realms open up. A dynamic formulation is only the roughest kind of mapping of someone's individuality, but it is essential to have some kind of map before we invite a person into a terrain where both parties could otherwise get lost.

SUMMARY

Psychodynamic case formulation attempts an understanding of a person that will inform the direction and tone of treatment. It is a more inferential, subjective, and artistic process than diagnosis by matching observable behaviors to lists of symptoms. It assumes a concept of psychotherapy as involving not only symptom relief but also the development of insight, agency, identity, self-esteem, affect management, ego strength and self-cohesion, a capacity to love, work and play, and an overall sense of well-being. I have argued that an interviewer can generate a good tentative formulation of a person's personality and psychopathology if he or she attends to the following areas: temperament and fixed attributes, maturational themes, defensive patterns, central affects, identifications, relational schemas, self-esteem regulation, and pathogenic beliefs.

CHAPTER TWO

Orientation to Interviewing

BEFORE I go into the specific areas I enumerated in Chapter One as essential for understanding individual applicants for psychotherapy services, let me sketch out the underlying values and associated mechanics of clinical interviewing as I have come to view them. There are several good books available on how to do an intake interview, but few of them are oriented toward a specifically psychoanalytic understanding of the person coming for help. Moreover, most of them are concerned with the accurate labeling of a person's problem but not with the connection between a label and the establishment of a therapeutic relationship. That connection is the main focus of this book.

Readers who want a basic introduction to the traditional psychoanalytic approach to case formulation would do well to read Messer and Wolitzky (1997) on the topic. Those who have not been trained in clinical interviewing may find some help in the appendix in my previous book (McWilliams, 1994), where there is an outline of the topics that most conscientious therapists inquire about when meeting with a prospective patient. This rather comprehensive inventory, however, is both under- and overinclusive. It lacks some items one would ask about if the client had certain symptoms, and at the same time, I doubt that I have ever interviewed anyone with whom I have probed every topic covered in that outline. The back-and-forth quality of an early session, in which the therapist not only asks questions but also defers to the patient's agenda for the meeting, militates against a slavish adherence to a format. I would not want to go to a practitioner who doggedly followed an outline rather than sitting back and listening to me describe my own understanding of my problems and their sources and ramifications.

When I read other therapists' writing, I am often exasperated that

they do not give the details of what they actually do and say with clients. With a few notable exceptions, they speak in generalities and in theoretical rather than descriptive language. To spare others that kind of exasperation, I have taken pains in what follows to be very concrete. Later in this book, I will comment on numerous theoretical matters that have practical clinical implications, but in this chapter, I try simply to represent the process of clinical interviewing, including the issues that influence how therapists tend to structure this process.

MY OWN STYLE OF INITIAL INTERVIEWING

I have been asked many times since *Psychoanalytic Diagnosis* was published just how I go about getting the information from individual patients that permits the kind of characterological inferences I explored in that book. I have been hesitant to present my own process as an exemplar of standard clinical practice, because it seems to me that every therapist develops a style of interviewing that is appropriate to his or her personality, temperament, convictions, training, and professional situation. My own way of working with people is idiosyncratic, reflecting all these things, and may be a poor model for a different kind of person in a different situation. But in sympathy with readers' curiosity about how therapists actually work, and in view of the relative dearth of self-disclosing accounts of what treaters explicitly say to patients, I offer the following as a description of my usual pattern of initial interviewing. Most of my patients who read it will probably protest that I did not do it just that way with them, and they will be right, but it is nonetheless the framework that is in my head and that orients me.

The reader should keep in mind that my clinical situation is a private practice arrangement in a home office. When my schedule does not permit my taking on a new client, I tell callers as much. Then I ask if they want to see me anyway for an hour, so that I can get a sense of them and their needs, with the aim of making an informed referral. When I do have openings, those who come for an initial interview assume that they will be able to work with me unless during our meeting they feel the chemistry between us is not good. Thus, unlike some clinics in which there is an intake process separate from a psychotherapy referral, in my practice, the intake session is usually the beginning of the ongoing relationship between the patient and me. Most of the people who come to me are voluntary and self-referred, and although this group contains a fair number of individuals with borderline and psychotic psychologies, few of the prospective clients who appear at my door are frighteningly disorganized or dangerous, or in need of immediate hospitalization.

My first contact is typically over the telephone: The interested party calls and usually states his or her reasons for considering therapy. I listen for a few minutes, make some comments intended to show that I have assimilated the information the person has given me, attempt to establish a warm connection, and then try to schedule a time when we can get together. I give directions to my office and take the person's phone number in case some unforseen event occurs, necessitating that I reschedule. If the caller has a question about my fee or my training or my orientation, I answer it, though sometimes I subsequently try to find out why that issue is on the person's mind. If the first contact comes via a message on my voice mail, when I call back, I identify myself as "Nancy McWilliams" rather than "Dr. McWilliams," because someone other than the prospective client may answer the phone, and for all I know, the person interested in my services is keeping from family members the information that he or she has sought treatment. I figure that in such cases, "Who's Nancy McWilliams?" is an easier question for the secretive client to field than "Who's this doctor who's calling you?"

At the time of the appointment, I shake hands, show the person in, and invite him or her to sit wherever would be comfortable, explaining that I will sit at my desk because it is easier for me to take notes there. I ask, "So how can I help you?" Then I listen. As long as the prospective client is talking in a communicative way, I say very little. If I find myself with a shy or inhibited person who has trouble talking, I ask a lot of questions and help to fill in what may otherwise be painful silences. I assume that the more I can reduce the person's anxiety, the better. It is frightening to tell one's troubles to a stranger, and whatever I can do to make it less so, I do. I generally take copious notes, for purposes of both recording important information and giving myself a task that distracts me from my own anxiety about a new situation.

After about forty-five minutes, I ask how the person feels talking with me, and whether he or she anticipates feeling comfortable working with me. During the last few minutes of the meeting, I want to accomplish several things: (1) to show the person I have been listening and have a feel for his or her suffering; (2) to assess the person's reactions to whatever notions I have about how to make sense of the problems described; (3) to convey hope; (4) to make a contract about regular appointment times, length of meetings, payment, cancellation policy, insurance arrangements, and the diagnosis to be submitted if a third party

is involved. Some practitioners have the main features of the contract written out on an information sheet that they give to each client.* I have not adopted this procedure yet, but for reasons of both clarity and liability, it is probably a good idea, especially if one's practice includes a number of borderline, psychotic, and otherwise disorganized people. Finally, I invite any concerns that the person wants to have addressed before plunging into the therapy proper, and except when such questions feel too intrusive, I answer them. Unless the patient has in the course of the hour gone into most of the background areas I would ordinarily investigate, I then tell him or her that during the next session I would like to take a complete history, so that I will have a context in which to understand his or her problems. My rationale for each of these practices follows.

Inviting the Client's Reaction to the Therapist

The question about how the prospective patient feels talking to me, in addition to its concrete objective of our deciding whether or not to work together, is intended to send the message that I will be interested in how he or she experiences our relationship. It opens the door to any underlying transference concerns that have not yet been obvious (e.g., "I'm feeling pretty comfortable, which is strange, because I thought it would be hard to talk to a female authority about this"). And it alerts the client to the collaborative nature of therapy; that is, it implicitly emphasizes that I am the person's employee, that I want to do a good job, that he or she has the right to evaluate me or fire me if things do not feel basically positive between us.

From my perspective, despite the transference needs of the patient and the narcissistic needs of the clinician, a therapy relationship—at least in a private practice setting where there is provider and patient autonomy—is essentially reciprocal. The patient takes care of me by paying my fee. I take care of the patient by trying to understand and help. Unlike friends, relatives, and others who may have tried to help the client so far, I expect no emotional support in return. Psychotherapeutic treatment is thus by no means a "paid friendship," despite what has been alleged by some critics of therapy (e.g., Schofield, 1986). In friendship, there is reciprocity in that both parties make personal disclosures, both take care of the other emotionally, and both get taken care of by

*See Appendix for an example of such a written contract.

the other. The reciprocity in psychotherapy is the exchange of financial support for emotional support and expertise, an arrangement with human equality but not structural equivalence.

Conveying Understanding

When people come to a therapist, they are usually afraid of being judged, misunderstood, or treated with a subtle professional contempt. They often regard their own symptoms with bewilderment and shame, seeing them as evidence of a vague craziness that makes no sense. One of the first things I try to convey is that their problems are not incomprehensible. The first session is no time for confident, elaborate interpretations, but it often helps the client greatly for the therapist to say something like, "I can see why, given what you say about your father, the situation with your boss was so difficult for you," or "I notice it's exactly ten years since your husband's death, so it's possible your depression is an anniversary reaction," or "These intrusive thoughts you've been having are a common aftereffect of trauma."

When I make statements such as these in an initial meeting, I do it tentatively, as if I am applying my expertise in an exploratory way and inviting the client to let me know if I am on the right track. The more disturbed a person is, the more critical is this aspect of the connection. Very often, significantly troubled people have been told nothing more than that they have a "chemical imbalance" or a "genetic defect," with no further information to the effect that whether or not this is true, there are reasons why they are suffering more at this particular time, and there is a potential for them to be significantly helped by talk therapy. They come to a psychotherapist feeling defective, and they are surprised to learn that there are ways of thinking about what they have been through that make their psychopathology comprehensible to another person. I recommend Harry Stack Sullivan's work (e.g., 1954) to anyone who needs to have a feel for the tone and orienting values of this kind of communication.

Assessing the Patient's Reactions to One's Tentative Formulations

How the person responds to my effort to communicate a preliminary understanding of the problems he or she has brought to me indicates a great deal about how the client will work in treatment. Some people are immediately compliant, others immediately oppositional; some feel crit-

icized, while others feel that the therapist has demonstrated a deep empathy. Some individuals cannot absorb any interpretation because it feels to them as if the treater is humiliating them with the demonstration that he or she has superior knowledge. Others feel that if all the therapist is going to do is to make empathic, facilitative reflections, they might as well be talking to a stuffed animal.

Every person is different with respect to how much he or she can accept from a therapist. When I was a patient in analysis, it was important to me to figure out everything I could by myself. Such an attitude reflected my rather counterdependent personality. I needed the analyst's presence and the data of my transference reactions, but especially in the early phases of my treatment, I preferred the sense of discovery to the situation of confirming or disconfirming someone else's interpretation. (Eventually, I made a lot of progress understanding and changing my counterdependency and became more interested in what my analyst had to say, but this took a couple of years.) The silence and discipline of a very classical kind of analysis was thus ideal for me. I was surprised when I began to practice as an analyst, however, that most people wanted more input from me than I had wanted from my therapist. In fact, they felt quite forsaken when I encouraged them to struggle alone to come to their own understandings. In an initial session, one wants to get some sense of how interpretations will be received, so that one can adjust one's style of clinical interaction to the particular needs of the patient.

Conveying Hope

Individuals who confidently expect a therapist to help them are probably in a small minority. Most people come to treatment having tried all kinds of approaches to address their psychological difficulties, from denial to willpower to self-help books and herbal remedies, and nothing has worked. Therapy is typically a last resort, to which they come with significant demoralization and cynicism. And however much we venerate our profession, it would be self-deluded for practitioners to believe that the general public has a high opinion of mental health professionals. Psychotherapists are widely seen—not without some justification—as individuals with serious psychological troubles, who feel better reminding themselves that other people are crazy too. Most incoming patients consequently are deeply skeptical about what we can offer them. Still, once they meet an actual therapist and find him or her to be a seemingly sane, competent human being, they may be able to access some optimism.

Sometimes it is a relieving surprise to a new client for the therapist to say, simply, "I think I can help you." I usually find myself saying this, and meaning it, toward the end of the first interview, once I have a preliminary understanding. Some variants of this statement are: "Your problem is very longstanding and entrenched. I think I can help you make some progress on it, but it's going to take a long time," or "I think I can help you, but only if you also address your addiction directly by going to AA or some other program with a success rate in getting people off drugs," or "I think I can help you to understand and deal with the long-term problems with other people that have been the consequence of your phobias, but if you want to get some immediate relief from these terrifying attacks, you might try going first or simultaneously to a colleague of mine who specializes in the short-term treatment of phobic reactions," or " I am confident that I can help you, but only on the condition that you also see a psychiatrist about medication for your mood disorder," or "I can tell that you really have no hope that change is possible and are coming to me despite your sense of futility. I guess for a while I'll have to carry the hope for both of us."

Addressing Practicalities of the Therapy Contract

Time and Length of Meetings

There is no reason to leave unclear anything about the practical aspects of the professional contract. A part of the initial meeting, once the two parties have decided to work together, is finding a time they can get together. It is important that this be regular, unless the patient's schedule is erratic (this is true for some professional musicians and other performers, for example) and the therapist can accommodate a shifting meeting time without resentment. It is also important that the therapist not offer an appointment that he or she will begrudge keeping, such as very early in the morning or very late in the evening. I am careful in an initial interview to say something like, "I do forty-five-minute sessions. Sometimes I find myself letting the time run over a couple of minutes, especially if you're talking about something deeply involving, but in general, I'll end the session promptly." Occasionally, I have had patients ask me whether I would give them notice when there were five minutes left, and I usually consent to do so, though later, I look to understand the meaning of the request. My office has a clock in full view of the client, and behind such an entreaty usually lie some warded-off dependency needs and/or some hostility about the therapist's practice of ending the session on time.

Payment

Most beginning therapists find it hard to deal directly about money. I remember realizing, when I started practicing, that it was emotionally unimaginable to me to get paid for doing something I found so fascinating. Also, many clinicians undervalue themselves and what they offer, or feel anxiously competitive if they charge an amount comparable to that of their own therapist. But after a while, it becomes clear to even a self-abnegating practitioner that this is the way one earns one's living, and that the work, although endlessly rewarding, is also demanding and exhausting. Given that money is a reality of a professional relationship, it is important to be straightforward, unapologetic, and reasonable about it.

Such an attitude conveys that the therapist is appropriately concerned with his or her own welfare—a particularly good example to set for masochistic clients. It is also helpful to those who are inclined to test limits. I once treated a psychiatrist who later told me that one of the most therapeutic things I had done for him had occurred in our first meeting. When he asked me my fee, I asked him what he charged for a forty-five-minute session. When he told me, I said, "That would be fine for me, too." In fact, his fee was higher than my usual one, but I had a sense that he would privately disdain someone who charged less than he did (see Chapter Nine). In accounting for how this interchange had been therapeutic, he explained that he had needed to trust that I would take care of myself and not be manipulable, like his mother.

This is not my usual way of setting a fee. Ordinarily I simply say, "My fee is ______. Do you have any problem coming up with that?" If the patient makes a reasonable argument that my regular fee is a hardship, I am willing to slide somewhat, especially with people who want to come, and would profit from coming, more than once a week. (Because I enjoy treating patients who cannot afford the going rates for therapy, I also work four hours per week at quite low cost, and when I have such a low-fee opening, I put a less affluent person there and explain that I do a certain amount of low-cost work.) I also ask if the patient would prefer to pay after each session or by the month, and I add that if the person pays by the month, I would like to get the check by the middle of the following month, because I do not organize my finances such that I can carry bigger debts. I ask if the client wants a bill, or needs one for insurance purposes. If the bill is to be submitted to a third party, I ask that I be paid up front and have the reimbursement come to the patient, explaining that with this arrangement, whatever mistakes and postponements the insurance company personnel make—and in my experience, such errors are legion—the patient will be the one fighting with them for payment, not me.

I do not work with managed care companies. When a patient's benefits are with a managed care organization, I explain to him or her why I believe it is virtually impossible to do ethical therapy under managed care. Until fairly recently (lately, the word has been getting out), most clients have been shocked to learn that their confidentiality is compromised in such arrangements. They are also appalled that despite the fact that the managed care company marketed itself to their employer as providing a full range of psychotherapy services, in reality, all that is covered is short-term crisis intervention. The sleight of hand by which managed care organizations have devalued good mental health treatment and made it unavailable to everyone but the wealthy was accomplished by their promising to provide all the care that is "medically necessary" and then redefining medical necessity to exclude virtually all psychotherapy. I hope that by the time this book sees print there will be a strong public movement to replace this inherently flawed and ineffective system of "cost containment," in which money that used to pay for health care now goes into corporate profits.

A specific, practical problem of working with companies who have strong financial incentives for denying treatment is that when one argues that a client should continue in therapy because he or she is responding well to treatment, the response of the managers of care tends to be, "So you've accomplished a significant treatment goal. Time to terminate the patient." If, on the other hand, one states that the person is not doing well and needs more intensive or long-term therapy, the predictable response is, "Obviously you're not the right person for this patient. We'll end the treatment with you and recommend medication or another provider." Thus, termination is the treatment of choice whether the patient is improving or not. Once a client learns what will happen under a managed care policy, he or she usually prefers to pay out of pocket. I then negotiate a fee that the person can pay without shortchanging his or her family—and that I can accept without unduly depriving mine.

Cancellation Policy

I am in a minority among therapists in not having a cancellation policy. Most of my colleagues have some arrangement by which patients pay all or part of the hourly fee when they cancel with insufficient notice. A

common rule is that if a client fails to let the treater know twenty-four hours ahead of their scheduled meeting, he or she will be charged for the session unless the two parties can agree on a time for a makeup session. At an extreme with respect to cancellation arrangements are the analysts who insist that their patients take vacations at the same time they do, and who otherwise charge them for time they take off from treatment, even for scheduled family vacations. These practices are sometimes quite central to the therapist's self-respect and therefore to his or her clinical functioning.

Cancellation policies follow the lead of Freud (1913), who argued that given the small number of individuals a full-time analyst treats, and the consequent importance to a therapist's income of each hour, it makes sense for the patient to "rent" a given appointment time and be responsible for it whether or not it is used. In other words, he suggested that undertaking therapy should be regarded as comparable to enrolling in an academic seminar: You can miss a class here or there, but you still have to pay for the whole course. From my perspective, the operative rule in choices about practice arrangements is that the therapist needs to protect against resenting the patient. It is very hard to have a sincere will to help a person by whom one feels demeaned or exploited.

Despite such considerations, I have been less influenced by Freud than by Frieda Fromm-Reichmann (1950) in these matters. Fromm-Reichmann argued that it is not customary in our society to charge for services not rendered and that in any case, a busy professional can make good use of the time freed up by cancellations. She felt that if a patient develops a pattern of canceling, there are ways to deal with it interpretively that will effectively address the behavior without imposing a sanction. An additional current consideration is that insurance companies typically do not pay for missed sessions (their executives seem to regard such policies as a scam, a rationalization for therapists' greed). As a result, for a patient using insurance, one has to keep track of the charges submitted for reimbursement alongside those that are not reimbursable. I find this kind of record keeping more onerous than just not charging. Also, my personal economy of scarcity involves time more than money; I am usually glad to have a free hour. Having said all this, I should note an exception to my general practice that applies to clients with significant psychopathy. With such patients, I lay down very strict rules from the outset about the client's financial responsibility for every session, whether the person comes or not.

One of my reasons for not charging for missed sessions is that I have a home office. When someone cancels, I am not stuck in a distant, rented suite with dead time on my hands and nowhere to go. I can always use the hour, if not to do something professional, then to do something domestic. I do charge for "no-shows," however, on the grounds that I am cooling my heels in my office, waiting. I do not describe my no-show policy during the first interview; I raise it if the situation comes up, and I implement it only after I have introduced the rule. Sophisticated patients often ask about a cancellation policy, and I am happy to give them my rationale if they express surprise at my lack of such a provision.

Diagnosis of Record

Some of my earliest training as a therapist was with rather authoritarian psychiatrists who promulgated the notion that no patient should ever be told his or her diagnosis. The stated justification for this position was that it might be upsetting and that it would contribute to the defense of intellectualization. I bridled at such ideas at the time, and I am even more negative about them now. The unstated agenda seems to me to be the preservation of the treater's superior power via private, inaccessible knowledge. Mystification has no place in psychotherapy (cf. Aron, 1996). Aside from the fact that anyone using insurance can find out his or her designated diagnosis by comparing the numbers on the bill with those in the DSM, it seems to me a matter of basic respect for the therapist to share the diagnosis, explain the basis for it, and discuss how the recommended treatment is appropriate to it. The practice of keeping a diagnosis from the patient also seems to me to reinforce the idea that emotional problems are somehow shameful, and that we should therefore convey information via euphemisms rather than in the language in which we really think about them.

Sometimes—and it is my impression that this is atypical, but it seems reasonable to me—I give the DSM to a client and show the person one or more diagnostic categories that pertain to the problems he or she came to work on, asking whether this label seems to describe accurately the person's complaints, or which of two possible diagnostic formulations is more nearly accurate. We thus make the official diagnosis together. Interesting information sometimes comes out of this process. I have had clients read a description of symptoms associated with the general category in which their psychopathology seems to fit, and then remark, "Oh, I forgot to tell you. I have that problem, too. I didn't think it was related." One woman whose mania I took months to diagnose correctly (because it manifested as rage, and it felt more like a bor-

derline diatribe than mania) looked at the DSM once I suggested that a bipolar process might be going on with her, and on reading the list of symptoms, exclaimed, "I do have racing thoughts! And I go on shopping binges!" She had always been too angry in her manic states to mention these correlates of her mood.

Another woman who was very paranoid, and who I thought would feel criticized and arbitrarily pigeonholed if I unilaterally provided a diagnosis on her insurance form, asked me if she could look through the DSM (then the DSM-II [American Psychiatric Association, 1968]) when I told her I needed to submit a formal diagnosis for insurance purposes. I said that given the fact that she was trying to change certain lifelong patterns in treatment, the Personality Disorders section was probably the best place to look. She scrutinized the possibilities, and then announced with great satisfaction: "There I am: Paranoid Personality! Look, it says hypersensitive, rigid, suspicious, jealous, and tending to blame others! Sounds right to me." The fact that she (correctly) diagnosed herself made the process of looking at her paranoia a whole different enterprise than if I had given her the same label in a way she had felt was authoritarian.

I feel strongly that the diagnostic process should be as consensual as the therapy process. A professional may have greater expertise and general knowledge of psychology than patients do, but patients' specific knowledge about themselves is the material on which diagnoses are based. A recent essay by Anthony Hite (1996) on the "diagnostic alliance" has spoken for this attitude with particular persuasiveness. Again, there is nothing in our nosology that is impossible for a client to understand if the clinician explains what it is in ordinary speech. The pretense that the patient would not understand, or would be too upset by hearing the technical words that apply to his or her suffering, seems to me mainly a rationalization in the service of an illusory superiority.

I also treat the diagnostic issue as a kind of necessary evil, explaining that no one is an exact fit with any of the available categories, and that they are only the roughest approximations of very complex conditions. As I have written at length (McWilliams, 1994), I find DSM-type, descriptive psychiatric diagnosis to be both reductionistic and not particularly useful clinically, but if one needs to supply a third party with an official label, the DSM is the best and most universal taxonomy we have. Like most practitioners, I stop thinking in terms of prefabricated categories once I have a reliable feel for the unique psychology of any individual patient. I want the people who come to me for treatment to know from the beginning that this is my orientation: I want to know

who they are, not what categories their symptoms match. Yet I do not withhold from them knowledge of the diagnosis of record.

Inviting Questions

At the end of an interview, I always ask if the client has any questions for me. More than half the people who come to me say at that point that they have nothing to ask; they feel good about the connection with me, and they look forward to our work together. Some people, out of either a sophistication about therapy or a good natural intuition, want to know nothing about me because they are interested in what they will project. Others have something very specific they want to address: What is my orientation? Where did I get my training? Have I had therapy myself? Do I have kids? Do I have any plans to move or retire? Am I in good health? What is my religious orientation? What do I think of deeply religious people? What are my politics? Do I think I can work without prejudice with someone of a minority sexual orientation? Am I specifically trained in trauma?

I respond to such concerns directly and economically. I feel it is a basic consumer right to get answers to questions that are a condition of hiring someone. While it is true that such queries always hint at deeper issues that might be fruitfully explored, an initial meeting does not seem to me the time to do it. The parties are still contracting for therapy; the employer (the patient) has not yet conferred upon the therapist the authority to begin interpreting. Anything significant to the client's psychology will reappear many times in the transference, whether or not it has been addressed realistically in an early meeting. Often, though, I handle such inquiries by saying something like, "I'll be glad to answer your question, but first, could you tell me why it's important to you to know that?" Because these early questions usually constitute tests (Weiss, 1993), it helps to know the client's thinking behind the request for information. Once the therapy is under way, I take a different attitude toward questions, examining them as they arise rather than just answering them.

Very rarely, someone will ask something in an initial meeting that feels too intrusive to me. For example, one or two prospective patients have asked me if I have ever had a lesbian relationship, and once I was asked if I had ever had an extramarital affair. In these instances, it seems to me important to be both honest and self-protective. What I tend to say is something like, "I can appreciate why that would be important for you to know, but I find myself feeling that my sexual life is

too private for me to be comfortable answering that question. Are you afraid that if I have not had that experience I can't possibly understand you?" Honesty and intimate disclosure are not the same thing, and although the curiosity of a client may be frustrated by a limit-setting reply, there is often a simultaneous relief that the person in authority can be trusted to maintain professional boundaries.

Preparing the New Client to Give a History

Unless the interviewee has given a very full personal history in the initial session (something that characterizes therapists in training but almost no one else), I say at the end of the intake meeting something like the following:

> "So. We'll meet next Tuesday at nine o'clock. What I'd like to do then is to take a very complete history—your parents, what they were like, your childhood, the major influences on you, your sexual history, your work history, your prior therapy, your dreams, and so forth. This will give me a context in which to understand what you've talked about today. Then in the subsequent session, the ball will be more or less in your court again. You should come in and talk about whatever is foremost on your mind, and it will be my job to listen and help you make sense of your thoughts and feelings. Does that sound okay?"

I do this not only to reduce the anxiety that most people have about diving into an undefined and rather intimidating procedure, but also to encourage the client to start reflecting on his or her personal history and its contribution to the current problem. A lot of what happens in therapy goes on *between* the actual sessions. Organizing things this way also reduces my own anxiety about diving in before I have enough data to feel I can understand the person's difficulties.

Sharing a Dynamic Formulation with the Client

A full dynamic formulation goes way beyond a diagnostic label, in that it includes at least the eight topics I will cover in the chapters to come, but the same principles I just noted about sharing a DSM diagnosis apply to offering some of one's dynamic hypotheses for the client's consideration. It is important to keep one's inferences tentative, to be aware of their limitations, to check them out with the patient, and to engage mutually in an ongoing process of revision and elaboration of the ways the two parties understand the person's psychology. Although the sharing of a dynamic formulation should be mediated by timing and tact, clients have the right to know the therapist's working assumptions about the nature of their difficulties. In fact, the therapist's communication of his or her provisional conclusions about the origins and functions of the patient's problems typically becomes the cornerstone of the working alliance.

The sharing of the dynamic formulation also should contain some ideas about how the therapy, given this tentative understanding, will attempt to address the patient's problems. The clinician's ideas should be conveyed with a sense of hope and the expectation of a gratifying collaboration. Thus, the therapist might say something like the following:

> "So far, what hits me between the eyes about your depression is how many losses you've had that you haven't mourned, and how much your family discouraged your feeling sad by their criticism of your 'feeling sorry for yourself.' You might find you have some anger about that and other things that you haven't felt comfortable admitting, and if we can access the grief and the anger, your depression may lift. Also, there's some evidence for a depressive streak that's congenital in your family, and it doesn't sound like you've had anybody address that and help you cope by learning what situations tend to depress you and why. How does this sound to you?"

Here is another possible dynamic formulation, as communicated to the client:

> "It sounds like you are shy and sensitive by temperament, but it seems that no one in your family knew how to help you get braver around people. With the best intentions, they made things worse by forcing you into social situations, where you clutched. Because you had one after another failure socially, you began to think there was something very strange about you, and eventually you related only to yourself and your thoughts. You were lonely, but the idea of being close to someone terrified you. Then when your boss criticized you, you retreated even further into yourself, to the point that you were hearing voices. We need to work on getting you more comfortable with others, including me, and part of that will involve

> looking at the things that you have believed make you so alien. Once we understand the meaning of some of your preoccupations, I think you'll find you're not so bizarre. In the meantime, if you're still hearing voices, you may want to consider seeing someone who will prescribe antipsychotic medications. Does that make sense to you?"

Educating the Patient about the Therapy Process

Just as a diagnosis and a dynamic formulation should not be withheld from a client, there is no reason for a therapist not to explain the rationale for any procedures he or she recommends (cf. Etchegoyen, 1991, on the democratic vs. authoritarian contract). Ordinary, nontechnical language is certainly adequate to express why one is interested in hearing the patient's dreams ("Very often I find that when nothing seems to be going on at the conscious level, a person's dreams will contain a lot of information about deeper preoccupations") or free associations ("The more freely you can talk, the better I can understand you; if you find yourself censoring anything, try to talk about it anyway, or at least tell me that you are finding it hard to talk about something") or memories ("The first step to resolving a problem is often understanding where it came from").

The same thing applies to clinical interest in the patient's reactions to the therapist. Most clients are somewhat taken aback by being asked what they are thinking and feeling about the practitioner; this was not what they expected to be talking about. They wonder if the therapist is asking out of insecurity or vanity or a need to feel reassured. Early in therapy, if I notice that a person seems uncomfortable with my asking how he or she is feeling toward me, I will say something like the following:

> "I know it's strange to be asked to be so direct, and it must feel awkward, especially when some of your responses to me are negative. But in a way, therapy is a microcosm, a chance to study a relationship at close range, and by investigating what happens between you and me, we have an opportunity to scrutinize some emotional things that may happen to you elsewhere, things no one talks about in social situations. You may find yourself feeling toward me the way you feel or have felt toward other people, and our comprehension of that should be very useful in your efforts to understand yourself and change."

This matter-of-fact, educative style applies also to more esoteric aspects of some therapies, including the famous analytic couch. There is nothing mysterious about the couch. I tell people that its utility was discovered accidentally by Freud, who had people lie down and look away from him because he got sick of being stared at all day. I go on to say that like a lot of serendipitous discoveries, analysts have learned that it has another, much more important effect. It not only allows the patient to relax, it also takes the therapist out of eye contact. Without being able to see the clinician's face, the client may notice that he or she has ideas about what the therapist is thinking or feeling that never came to mind before. I comment that, very often, people carry around a lot of unconscious apprehensions about what other people's reactions to them will be, and they learn to scan others' faces and disconfirm their fears before they even know they have them. The patient's use of the couch will bring such anxieties into awareness. I also say that I like to work using the couch because, like Freud, I find it tiring to be scanned, and I enjoy sitting back, not making eye contact, and thinking about how the client's words are stirring up my own associations.

These communications may all be considered part of the development of a working alliance. Greenson (1967, p. 196) gave a memorable example of this kind of education of a man who had gone through a long previous psychoanalysis without ever having been told the rationale for various analytic procedures. While obtaining a history, Greenson asked him his middle name. The patient, who had a pathologically compliant personality, thought he should free associate and answered, "Raskoniknov." This man was obeying what he regarded as the "rule" of free association, but he failed to get the whole point of the analytic enterprise. Greenson goes on to talk about how fruitless psychotherapy is in the absence of a working alliance in which both parties understand what is required of them, and why. In fact, a relationship without such a basis is a caricature of therapy.

CONCLUDING COMMENTS

There is an apocryphal story about D. W. Winnicott, the great British object relations theorist, that applies to the general tone of interviewing and treatment. I do not remember who told it to me, but here is the gist: Winnicott was once asked what his rules for interpreting were. He answered, "I interpret for two reasons. One, to let the patient know that I am awake, and two, to let the patient know I can be wrong." Aside

from being funny, there is great wisdom in this quip. If the therapist is doing his or her job properly, the client will be repeatedly correcting and revising the formulations that the therapist offers. The realization that the therapist is frequently wrong is one of the great therapeutic revelations. Patients will forgive almost anything except arrogance, and they are grateful for models of nondefensiveness. I recently asked a friend of mine how his analysis was going. "Great!" he replied. "He admits when he makes a mistake!"

On the topic of one's inevitable limitations and errors, I want to be sure the reader knows that my thinking about each of the issues I will address in the following chapters is not the kind of mental reflection I do in a typical clinical session. I am very good at organizing information once I have assimilated it, but the nature of a clinical interview—especially an intake interview—involves a kind of disorganized not knowing. As is evident in the previous examples, the formulations one floats to a client are neither so elegant nor so complex that they would require vast psychoanalytic knowledge to make. Even if I were capable of constructing a truly comprehensive formulation during the first interview, it would not be useful for the patient, who comes not to be wowed by the therapist's erudition but to see if there is a human being out there who wants to understand and has sufficient training to help.

I recently did an intake interview with a psychologist, a woman with an extensive background in the helping professions. I asked why she had chosen me as a therapist. Her reply was, "Because I hate you." I asked for some elaboration. "When I read your book," she said, "I got so angry that you knew all that stuff, and I'd been practicing for years and didn't know a lot of it. So I hated you. I want to get what you have." What I have is a capacity to take dense and sometimes preverbal material and make sense of it in the categories of psychoanalytic theories as I understand them. I am grateful for this capacity, and over the years I have come to appreciate it in myself and realize that it represents a personal synthesis of sorts that is not too common. But it operates only in retrospect, not in the immediacy of clinical contact, where I can be completely baffled and inarticulate. This patient who hates me will soon find that for many months, she will understand herself a lot better than I do, because whatever her blind spots turn out to be, she has already spent many years thinking about herself and her unique psychology. Similarly, I hope my readers understand that their skill or lack thereof at reeling off concepts post hoc has very little to do with whether they are good therapists in the heat of the clinical moment.

SUMMARY

I have tried here to give readers a feel for the process of clinical evaluation. With some caveats about its possible inapplicability to the situations of many therapists, I have given details of and rationales for my own practices during intake interviews, including my efforts to make a safe connection, to minimize anxiety, to elicit the client's reaction to me, to convey understanding, to assess reactions to my clinical hypotheses, to impart hope, and to address the practicalities of the therapy contract. These latter matters include issues of time, payment, cancellation, diagnosis of record, questions, and preparation for history taking. I have further discussed the importance of sharing the tentative dynamic formulation and doing some straightforward education of the client about any puzzling aspects of the recommended treatment. Finally, despite the fact that the following chapter topics represent central questions that analytic practitioners are trying to answer so that they can orient treatment properly, I have emphasized how during an intake interview one cannot reasonably expect to feel that everything has fallen into place and that one has a comprehensive understanding of the patient.