In this chapter we present an account of psychoanalytic case formulation as it is used clinically in conjunction with psychoanalytic treatment. Because it was developed in a clinical context, it is less formal and systematic than other approaches in this volume which are research based. For example, the psychoanalytic clinician does not typically record sessions, prepare verbatim transcripts, or have a panel of judges formally rate such material. At the same time, the psychoanalytic case formulation implicitly includes many of the concepts reviewed in other chapters, such as the Core Conflictual Relationship Theme (CCRT) (see Luborsky & Barrett, Chapter 4, this volume) and cyclical maladaptive behavior (see Levenson & Strupp, Chapter 6, this volume).

For present purposes we may define the psychoanalytic case formulation as a hierarchically organized set of clinical inferences about the nature of a patient's psychopathology, and, more generally, about his or her personality structure, dynamics, and development. These inferences which are generated in the course of the psychoanalytically informed interview include the presumed reasons for the patient's experience and behavior such as symptoms, dreams, fantasies, and maladaptive patterns of interpersonal relationships. For example, the clinician might observe that whenever the patient begins a new emotional involvement with a woman, he experiences an upsurge in claustrophobic symptoms. The patient might express anxiety
about being in a crowded elevator and its getting stuck between floors. The psychoanalytic explanation might be that these symptoms reveal an unconscious fear of being trapped in a relationship, which may lead to a loss of a sense of personal identity.

The inferences and the interpretations that follow in the course of therapy often include the therapist postulating a probable sequence of historical events and the meanings assigned to them by the patient, many of which have continued to be unavailable to the latter’s awareness. The nature of the evidence and clinical reasoning that lead to such clinical inferences and the means of attempting to validate interpretations based on them are addressed below.

**HISTORICAL BACKGROUND OF THE APPROACH**

The clinical case history method originated with Freud, and his early case studies continue to be taught as models of psychoanalytic thinking. Although other theorists such as Morton Prince (1905) also used the case study method, it was Freud’s extensive reliance on this method and the insights it yielded that leads us to emphasize his key role in the development of the case formulation approach. It is interesting to note Freud’s own, rare statement about the case history approach. In his discussion of Elisabeth von R., Freud (1900/1953) wrote:

> It still strikes me as strange that the case histories I write read like short stories and that, as one might say, they lack the serious stamp of science. I must console myself with the reflection that the nature of the subject is evidently responsible for this, rather than any preference of my own. . . . [A] detailed description of mental processes such as we are accustomed to find in the works of imaginative writers enables me, with the use of a few psychological formulas, to obtain at least some kind of insight into the course of that affliction [i.e., hysteria].

And, Freud continued, the case histories provide “an intimate connection between the story of the patient’s suffering and the symptoms of his illness” (p. 160).

The history of efforts at psychodynamic case formulation began with Freud’s search for treatment methods more effective than rest, hydrotherapy, and faradic stimulation (the application of low-voltage electrical stimulation to afflicted areas of the body). Freud began experimenting with hypnosis and eventually came to prefer the method of free association in which he directed the patient to say everything that came to mind. As we now know, this method became central to the evolution of psychoanalysis.
Freud was searching for the most efficacious way to facilitate the recall of so-called pathogenic memories. The theory he was developing was that the onset of symptoms coincided with a disagreeable experience that the patient forgot, that the quota of affect associated with this experience was “converted” to symptoms, and that the recovery of this experience and its associated affects was essential to the alleviation of the symptom (Breuer & Freud, 1893–1895/1955). The experience was both wished for and simultaneously dreaded in that it violated the person’s moral code. As is well-known by now, Freud came to the idea that hysterics suffer from reminiscences connected to unacceptable sexual wishes.

From the start Freud tried to present plausible accounts of why and how the patient’s symptoms developed and were ameliorated. Faced with a stream of seemingly disconnected, often bizarre sequences of verbal associations, Freud wanted to construct a meaningful explanation of the patient’s often irrational behavior. He was particularly struck by gaps in the patient’s memory, by the patient’s tendency to avoid certain material, and by the inexplicable nature of the patient’s symptoms. The assumptions of psychic determinism and unconscious motivation were central to his attempts at a rational explanation of the patient’s difficulties. The subsequent development of psychoanalytic theory showed an increasingly complex and subtle understanding of human experience, particularly from the perspective of unconscious, intrapsychic conflict, a core notion of Freudian theory. The major tenets of the theory can be found in Brenner (1973).

Rapaport and Gill (1959), two important later figures who contributed to the structure of psychoanalytic case formulation, argued that a comprehensive case formulation would have to include the following multiple perspectives: dynamic, structural, genetic, adaptive, topographic, and economic. That is, corresponding to the order of the preceding terms, the formulation would have to address the patient’s major conflicts (dynamic: e.g., wishes, and defenses against those wishes), those aspects of the patient’s personality involved in the conflicts (structural: e.g., id vs. superego), the historical and developmental etiology of the conflicts (genetic), the adaptive and maladaptive compromise formations involved in the patient’s defensive and coping strategies (adaptive), the conscious versus unconscious status of the conflicts (topographic), and the “economic” consequences of the preceding factors, not in the original sense of the distribution of “mobile” and “bound” cathexes but in the more descriptive sense of how constricted and brittle the patient’s adjustment is by virtue of the excessive “energy” invested in his or her defensive maneuvers. Although contemporary case formulations generally contain less metapsychological language than in the past, with the exception of the economic viewpoint, they do attempt to cover the perspectives just outlined.
CONCEPTUAL FRAMEWORK

There are three major conceptual models in contemporary, mainstream psychoanalysis in North America—traditional Freudian, object relations, and self psychology. Each model makes different assumptions about human beings and their core motivational dynamics. Some clinicians elect to adopt a multimodel approach in which they bring to bear each theoretical perspective with every patient (e.g., Silverman, 1986). Others use whichever model seems to fit a given case best, while some therapists stick to one of the models for most cases. Pine (1990) argues that each of the models refers to an important domain of human experience and each has a place in a comprehensive, multifaceted understanding of the patient. Unfortunately, we do not have a body of empirical evidence concerning the relative clinical utility of the different formulations offered by the several models. Nor do we know whether using any particular model or some combination of models is better than using no model at all beyond a commonsense, implicit personality theory. Clearly, these are issues for empirical study, as we note in the research section at the end of the chapter.

Following are the core propositions of the different models, focusing on what is formulated and why. (For a more detailed account of each model, see Greenberg & Mitchell, 1983.) According to the Freudian drive/structural model, human behavior is determined by sexual and aggressive drives, which have four attributes: a source, an aim, an impetus, and an object. The source of the drives is somatic processes that make a demand on the mind. The aim of the drive is gratification through discharge, and the object of the drive is the most variable aspect; gratification could be sought through an inanimate object, another person, or a part of one’s body. The system operates according to the pleasure principle (i.e., people’s goals are to reduce tension to an optimal level, maximize drive gratification, and minimize unpleasure). The person’s major motivational thrust is to seek satisfaction of the wishes which are the psychological derivatives of the instinctual drives. Wishes are attempts to reinstate “perceptual identity” with the memories of past gratifications (Freud, 1900/1953). Obstacles to the immediate or long-term gratification of wishes are inevitable, creating intrapsychic conflicts. That is, the person seeks to gratify the wish but simultaneously avoids seeking gratification when wishes threaten to give rise to anxiety, guilt, or fear of external punishment. In brief, Freudian theory conceptualizes human behavior from the perspective of intrapsychic conflict.

In the tripartite, structural model of id/ego/superego, the id is the repository of the drives, the superego represents the internalized standards and prohibitions of the parents and the culture, and the ego modulates drive discharge by automatically instituting defenses. Defenses are activated by “signal anxiety” based on the ego’s appraisal that the awareness or ex-
pression of certain wishes is apt to lead to traumatic anxiety. The principal anxieties, or danger situations of childhood, are loss of the object, loss of the object’s love, castration anxiety, and superego anxiety (Brenner, 1982). These anxieties correspond to the psychosexual stages of oral, anal, phallic, and genital development. These key Freudian concepts are part of the larger, complex structure of interlocking concepts that constitute the framework for organizing the clinical material. A formulation based on these concepts that takes account of the aforementioned metapsychological points of view will focus principally on the patient’s repetitive reenactments of core unconscious conflicts and fantasies; their defensive, adaptive, and developmental aspects; and their influence on character styles and object relationships (Perry, Cooper, & Michels, 1987).

A key feature of a Freudian formulation is an emphasis on unconscious fantasy, the conflicts expressed in such fantasy, and the influence of such conflicts and fantasies on the patient’s behavior both within and outside the consulting room. A corollary assumption is that the current, unconscious fantasies are based on core conflicts originating in childhood. Current maladaptive behavior is seen to be largely motivated by unconscious fantasies, even if patients experience their behavior as lacking a sense of personal agency or as attributable primarily to external circumstance. Indeed, a significant aspect of the interpretive work in the course of treatment is to help patients realize the nature and extent of their intentional, though not conscious, disavowal of motives and affects that clash with their conscious values and attitudes.

In general terms, Freudian analysts emphasize the importance of unresolved Oedipal conflicts whereas adherents of object relations theories and of self psychology stress the significance of pre-Oedipal issues. Stated briefly, pre-Oedipal issues refer to anxieties arising in the first 2–3 years of life in relation to concerns about loss of the “object” (i.e., the principal caretakers) and the loss of the object’s love, anxieties which correspond, respectively, to the oral and anal Freudian psychosexual stages of development. These anxieties are potentially present throughout life and the fear of their full-blown eruption is what triggers defensive reactions. The principal anxiety of the next psychosexual stage, the phallic stage, is castration anxiety which is said to arise in relation to the boy’s Oedipal complex (i.e., his wish to destroy the rival for his mother’s love and affection, namely, his father). For the models presented below it is issues of trust, safety, self-esteem, cohesion and preservation of self, and conflicted ties to parental figures who have also been significant sources of psychic pain that are seen as relatively more important than Oedipal conflicts in the development and maintenance of psychopathology.

From an object relations perspective (and for present purposes we combine the different theorists who represent this approach) the emphasis is on the internalized mental representations of self and other and their in-
teractions, particularly the affective coloring of these interactions. This approach emphasizes the tendency to split self and other representations into “good” versus “bad” and the difficulty of integrating these representations. Concepts of introjective and projective identification figure prominently in these formulations. Many clinicians find these concepts especially useful in describing the difficulties people diagnosed with borderline personality disorder have in internalizing a stable, soothing introject and in establishing a differentiated, integrated sense of self. In contrast to traditional Freudians, object relations theorists stress human relatedness rather than drive discharge as human beings’ central motivational aim. Correspondingly, their developmental formulations place relatively more weight on pre-Oedipal experience (e.g., the absence of “good enough” mothering and other environmental failures).

Case formulations based on this perspective will of course draw on concepts central to one or another version of object relations theories, principally those proposed by Klein (1948), Fairbairn (1952), Winnicott (1965), or Guntrip (1971), to mention only the more popular proponents of this point of view. Because this perspective stresses the patient’s difficulty integrating “good” and “bad” mental representations of self and other, case formulations can be expected to focus on the patient’s splitting off and disavowal of rage against parental figures in order not to threaten one’s tie to the object on whom one also depends. As part of this defensive effort the patient may present a facade of “good” behavior (e.g., appear to conform to the parents’ values and standards) along with a tendency to project onto others aspects of one’s “bad self.” The fully developed case formulation in this or any theoretical perspective emerges in the course of acquiring an in-depth knowledge of the patient in an intensive, exploratory psychotherapy.

There is general psychoanalytic consensus, particularly among object relations theorists that in their adult relationships patients reenact internalized object relations established in childhood. This is especially true for conflicted and unresolved relationships. Among the important clues to the nature of these internalized object relations are the patient’s recall of what have been referred to as “model scenes” (Lachmann & Lichtenberg, 1992) or “schemas” (Slap & Slap-Shelton, 1991). These kinds of memories are organizing experiences or prototypes of the person’s key issues and may be reenacted in the relationship with the interviewer or therapist. In monitoring ongoing interaction with patients, clinicians should be alert to the interpersonal implications of patients’ communications as much as their content. The relationship episodes that patients relate often are allusions to wishes and fears of what might occur in the course of therapy.

The self psychology model, developed originally by Kohut (1971, 1977, 1984), centers on the development and maintenance of a cohesive self and the factors that promote healthy versus pathological narcissism. Kohut’s self psychology focuses on the failure of parents to provide the
experiences necessary for the child to form a cohesive sense of self and to actualize joyfully its ambitions and ideals. A key notion for Kohut is the parents’ failure in empathic responsiveness, a failure that does not allow the child to use the parents as idealized selfobjects or as mirroring selfobjects. Observations of transference patterns are crucial to formulating the patient’s narcissistic problems and the manner in which the patient has attempted to compensate for his or her self-defects. Although Kohut’s theory is closer in some respects to Carl Rogers’s views than to Freud’s, his work has remained in the mainstream of American psychoanalysis.

The concept of selfobject refers to a generally unconscious, mental representation in which one person regards another as an extension of the self to be used to regulate aspects of his or her own sense of self (e.g., sense of cohesion or self-esteem). The two major classes of selfobjects are mirroring selfobjects and idealized selfobjects (Kohut, 1971, 1977). Both enhance the self by the self leaning on the perceived qualities contained in the mental representation of others, especially their perceived power, strength, and reliability. In the case of a mirroring selfobject, the person can have an experience such as “You admire me, and therefore I feel affirmed as a person of worth.” In the case of an idealized selfobject, the schematic equivalent would be, “I admire you, therefore my sense of self and self-worth are enhanced by my vicarious participation in your strength and power.” An everyday example of a mirroring selfobject experience is the young child’s observation of the attentive, joyful gleam in its mother’s eye, as might occur when the child masters a new skill. A common example of an experience of an idealized selfobject is the vicarious sense of power the young child feels when sitting on the shoulders of a parent.

For Kohut these kinds of experiences are reflections of parental empathy regarding the child’s needs and constitute crucial building blocks in the development of a firm, cohesive sense of self, or what he would call the development of healthy narcissism. It is only the excessive reliance on selfobject needs that is associated with pathology of the self. An essential emphasis in the Kohutian approach to treatment is to provide patients with the missing selfobject experiences on the assumption that this will help repair the self-defects which are said to originate from the parents’ failure to serve as phase-appropriate selfobjects. For therapists operating from this vantage point, the emergence of the mirror and idealizing transferences will provide vital data for an eventual case formulation specific to a particular patient.

Clinicians who prefer one or another of the aforementioned theories will make different psychodynamic formulations both at the outset of treatment and as the treatment progresses. For example, sexual difficulties are apt to be seen by the Kohutian in terms of disturbances in a cohesive sense of self, while in Freudian theory the notion of a fragmented self is more likely to be formulated as a derivative expression of castration anxiety.
What the Kohutian takes at face value is, for the Freudian, merely manifest content suggestive of a “deeper” meaning, and vice versa for the followers of Kohut.

Perry et al. (1987) state that a psychodynamic formulation, like a clinical diagnosis, has as its “primary function . . . to provide a succinct conceptualization of the case and thereby guide a treatment plan” (p. 543; but see McWilliams, 1998, for a contrast of DSM and psychoanalytic diagnoses). Such a formulation, based on whatever theoretical perspectives one prefers, “concisely and incisively clarifies the central issues and conflicts, differentiating what the therapist sees as essential from what is secondary” (p. 543). They urge that following any initial evaluation clinicians should write out at least a brief (i.e., 500–750 words) dynamic formulation as a working guide to understand and treat the case. The formulation, as they conceive of it, should focus on patients’ current problems in light of their individual histories and current situations; sketch the dynamic and other factors that seem to explain the clinical picture; offer surmises about patients’ individual backgrounds; and predict the likely impact of the foregoing factors on the process and outcome of therapy. We follow such a plan in the example given below.

THE NATURE OF PSYCHOANALYTIC INFERENCE

Before turning to a discussion of how the psychoanalytic clinician goes about formulating an actual case, it is useful to consider the process of clinical inference that undergirds case formulations. In line with the recognition that we can no longer speak of the theory of psychoanalysis, we have the increasingly accepted notion that, when formulating a case, the clinician creates a narrative structure. This structure is an attempt to provide a coherent, comprehensive, plausible, and we hope accurate account of the individual’s personality development and current functioning that is based on the life history of a particular patient as that history is told, lived, and retold by the patient in the course of the psychoanalytic encounter. However, there is no single, definitive, unchanging narrative to be told (Schafer, 1992). Implicit in this view is that there is no such thing as a psychoanalytic fact when we are talking about the reading of intentionality and meaning in patients’ behavior and experience. There are observations of overt behavior from which inferences are drawn concerning the multiple psychological meanings of what is observed. Furthermore, what is observed (i.e., what is attended to selectively), stored, and retrieved from memory to arrive at a case formulation at a given point in time is influenced by the nature of the patient–therapist interaction and the evolving narrative structure into which it is placed. In other words, observation as well as inference is theory-saturated (Messer, Sass, & Woolfolk, 1988). It is no wonder that
Freudian patients are found to have Freudian dreams, and Jungian patients Jungian dreams.

The higher the level of inference in case formulation, the stronger the influence of the particular narrative structures through which the material is being conceptualized. Theoretical concepts can be thought of as a series of lenses through which the data of observation are filtered. For example, if a patient’s first response to Card I of the Rorschach is “a mask,” clinicians would probably agree that the response connotes “concealment.” However, once we go beyond the inference of “concealment” to hypothesize what it is that is being concealed and why, we are increasingly guided by our preferred theory. As suggested earlier, traditional Freudian theory posits that adaptation to the environment requires that the id be socialized, renounce its unrealizable aims, and instead secure for the individual as much instinctual gratification with as little pain as possible. This developmental narrative of “the beast within that needs to be tamed” is consonant with the idea that the pleasure principle has to accommodate to the reality principle if the organism is to survive and adapt adequately. As Schafer (1992) points out, Freud’s other major narrative structure was that of the organism as machine in which behavior is strictly determined through shifts in the quantity of psychic energies.

Freudian analysts will formulate case material from these (and related) Freudian perspectives at various degrees of distance from the clinical data. That is, one can speak in experience-distant terms of transformations of psychic energies and/or on a more experience-near level in terms of wishes, fears, and conflicts. Thus, for the Freudian, the inference of “concealment” is likely to generate hypotheses about defense against sexual and/or aggressive wishes. For an object relations theorist influenced by Winnicott (1965), the same inference will likely lead to formulations in terms of the “true self” and the “false self.” As another example, whether we create a narrative in which idealization is seen primarily as a defense against hostility (i.e., a reaction formation), or whether it is regarded as stemming mainly from the search for an idealized selfobject to shore up one’s sense of personal cohesiveness and strength, would partly depend on whether we prefer Freud’s or Kohut’s theory. Those adopting a multimodel approach (e.g., Silverman, 1986) would more freely entertain both inferences.

The clinician brings to the analytic situation not only one or more psychoanalytic frameworks within which to order and organize the clinical data but other cognitive frameworks that interact with the psychoanalytic lenses through which the clinical material is viewed. It is useful, following Peterfreund (1976), to think of a series of “working models” that are brought to bear on the material. First, we have our commonsense working model of psychological functioning, or what might be called our implicit theories of personality. Included here are such everyday notions as the following: if mother favors one sibling over another, the less favored sibling is
apt to feel hurt, unlovable, and angry; reality is often more disappointing than the wishful fantasy would suggest; and past experiences have a psychological impact on future behavior.

Second, we have a working model of ourselves based on both the commonsense model noted earlier and on one or more psychoanalytic models through which we have come to understand ourselves. The commonsense and psychoanalytic models influence the model of ourselves, and these three models interact to influence our beginning understanding of the patient. A fourth model that influences our understanding of a particular patient is based on the aggregate of one's experiences with previous patients. Thus, the multiple, overlapping working models we employ include a commonsense mode, a preferred theoretical model, a model of ourselves based on these, and a model based on experience with previous patients.

In general, one could say that the telling and retelling of narratives is a means of situating the protagonist in relation to his or her mental life. In terms of Schafer's (1976, 1992) action language conception, this would mean attempting to develop a coherent, plausible narrative in which the patient comes to an “appropriate” appreciation of his or her role as the author of and actor in the script which is being enacted. From this perspective, behaviors that are initially understood as merely “happenings” are re-told as intentional actions. Alternate theoretical models with their different etiological emphases would yield different story lines, even though they all share a recognition of the adverse impact of childhood trauma. For example, in the Freudian story line, one would tend to emphasize the operation of defense as a kind of disclaimed action and, in general, see the patient as responsible for his or her emotional dilemmas. By contrast, Kohutian story lines probably tend to cast the patient in the role of victim. At the extremes, Freudians could be seen as “blaming” the victim while Kohutians could be seen as “blaming” the parents. In turn, these perspectives could result in subtle differences in one's sense of personal responsibility for who one has become and for one's future.

Aside from what we may call the preferred story line, analysts share certain assumptions about how the mind works. These assumptions guide clinical listening and the evolving psychodynamic formulation. To explicate them all would require at least a chapter-length treatment. Therefore, we confine ourselves to the major assumptions, which include psychic determinism, unconscious motivation, the ideas of displacement, and symbolic equivalence.

Psychic determinism refers to the assumption of lawful regularity in mental life. That is, significant psychological events do not occur on a chance basis. Thus, if the patient switches the topic in the course of the session, a working hypothesis that guides the psychodynamic formulation is that the shift is not random but is likely to be dynamically linked to the earlier topics. This assumption operates at the clinical level in terms of the
principle of contiguity. For example, suppose the patient says, in the first session, that she is afraid that if she starts to speak freely she will not be able to contain herself and will lose emotional control. She pauses momentarily, then asks where the women's bathroom is located. The clinician assumes that these two seemingly disparate topics are dynamically linked, as expressed in the following hypothesis: "The patient makes an unconscious equation between the control of thoughts and feelings and the control of bowel and bladder functions."

The working hypothesis one might hold regarding unconscious motives at play in this example could include a desire to expose herself in conflict with a wish to avoid humiliation based on the fear that her body is defective and her self, inferior. It is further assumed that these hypothesized possibilities are outside the patient's awareness at the beginning of treatment. The clinician would store these inferences in his or her memory and scan them periodically for their "fit" with other aspects of the evolving working model of the patient. If evidence emerged that these inferences were relevant to an understanding of the patient's core issues, the therapist could offer interpretations based on them. For example, "I notice that when you started getting teary just now you quickly tried to hold back your feelings. Recently you recalled how as a young girl you were afraid you might wet your pants if you were upset, and that if you did so, you would feel mortified. I wonder whether you're afraid that crying here would make you feel the same way." The nature of the patient's associations to such an interpretation, including what other childhood memories might be recalled, would be among the criteria a psychoanalytic clinician would use to evaluate the accuracy of the interpretation and its clinical utility.

It needs to be emphasized that this is merely an example of how a psychoanalyst might arrive at a particular clinical inference, which could become part of a dynamic formulation. We do not mean to suggest that this clinical hypothesis is necessarily a valid explanation for the contiguity of these two particular ideas in the patient's associations. Only further supportive, clinical material, uncontaminated by any suggestive interpretation of the kind offered previously, could increase one's confidence in the original hypothesis. It also should be noted that we are not implying that analysts are necessarily aware of the implicit "rules of clinical evidence" they are using but only that there is an underlying "clinical logic" to what might otherwise be seen as pure intuition or based on an arcane or mystical process.

In formulating a case, psychodynamically oriented clinicians use most or all of the working models described by Peterfreund (1976), usually on an implicit level. In so doing, they vary in terms of the quantity and quality of evidence they regard as necessary to support a case formulation. They also differ in how carefully they distinguish between observation and inference and the extent to which their formulations are theory-driven.
INCLUSION/EXCLUSION CRITERIA
AND MULTICULTURAL CONSIDERATIONS

General Considerations

There are no exclusion criteria for a psychoanalytic case formulation. The approach described here can be used with all patients, although the richness, detail, and comprehensiveness of the formulation will depend on how self-disclosing the patient is willing and able to be. The patient’s free associations as elicited in psychoanalytic sessions are the main source of information. The formulation, however, can also be based on interviews with someone who knows the patient, or on psychological test data.

The psychodynamically based case formulations also take into account other information about the patient. For example, in patients with organic or biological factors that contribute significantly to the patient’s pathology, unconscious conflict will play a more modest role in the overall case formulation. Nonetheless, the psychoanalytic clinician will look carefully at the premorbid factors in such patients’ psychological makeup that place a unique stamp on how their psychopathology is expressed. Thus, one will not rush to infer that the growing disorientation with regard to time, place, and sense of personal identity in a patient with Alzheimer’s disease has dynamic meaning. At the same time, selective confusions and distortions often are understandable as reflecting long-standing conflicts and personality styles. At a similar stage of dementia, not all patients will express guilt over burdening their children or deny that they were ever married to their spouse of many years. Similarly, even if there is a genetic basis for schizophrenia or depression, it still leaves us with the necessity of explaining the particular content of the schizophrenic’s delusional system or the psychotic depressed patient’s view of his or her “sins.” This way of looking at pathology has characterized psychodynamic approaches since Freud’s observations of individual differences in reaction to traumatic events.

Multicultural Considerations

We now turn to multicultural considerations in psychoanalytic case formulation. To understand the multitude of factors that shape peoples’ personality and contribute to the onset and maintenance of psychopathology, we need to situate our understanding of clients’ current and past circumstances and stressors in the context of their cultural, ethnic, and religious background. For example, feelings of guilt over sexual impulses in someone who has had an extremely stern and religious upbringing may have a quite different meaning than similar feelings in a person who has been raised in a secular, liberal home. In understanding the meaning of an eating disorder, it is most helpful to know the cultural contributions to the problem, such as the societal attitude to thinness or ideal body type.
The study of attachment in different cultures provides a good illustration of the importance of the clinician being sensitive to cultural differences. Rothbaum, Weisz, Pott, Miyake, and Morelli (2000) compared American and Japanese children in attachment situations. They reported findings in Japan that differed from those found in the American samples, which pointed to the conclusion that the Western emphasis on autonomy and individuation did not apply in the same way in the Japanese children. This called into question the universality of some basic assumptions of attachment theory and the predictions one would make about later competence and social functioning. For example, relative to the United States the Japanese culture values group harmony and cooperation over individual accomplishments. Inhibition of hostile feelings is encouraged; assertive, autonomous strivings are seen as immature. Japanese mothers are more apt to react to the infant’s need for social engagement than for individuation and to anticipate their infants’ needs rather than waiting for signals of distress.

Findings such as these have important implications for attachment theory, which bears a close affinity to object relations theories. Cultural differences in attachment styles clearly have implications for case formulation and for the conduct of psychotherapy. As one instance, in Japan the avoidance of self-enhancement and an inclination to self-effacement is culturally normative as is the inhibition of hostility. Inferences about the patient’s narcissistic issues, defensive styles, and core conflicts need to take into account these cultural differences. In the course of treatment, the therapist has to realize that strong filial piety is the culturally approved norm so that negative comments about one’s parents likely would be made with greater difficulty and more guilt. Finally, Japanese therapists seem not to worry about gratifying the patient’s dependency needs whereas American therapists are more concerned that such gratification would derail the patient’s autonomous strivings. American therapists might need to soften this attitude when treating Japanese patients, particularly newly arrived immigrants.

Speaking more broadly, although we may regard separation, loss, and death as universal issues with which all human beings must cope, it is essential to appreciate the variety of ways in which different cultures are organized to cope with them. Assessing a person from a culture in which communication with the dead is a common belief should not automatically lead to the unwarranted conclusion that this is a manifestation of psychosis. Culture-bound psychiatric syndromes in general need to be assessed within the framework of the culture in question. An example of a culture-bound syndrome is “ataque de nervose,” commonly found among Latinos in the Caribbean and in some Latin American countries. This culturally recognized idiom of distress, usually precipitated by a stressful event, includes a wide range of somatic symptoms, commonly accompanied by verbal and, sometimes, physical, aggression. The symptom picture overlaps with the
symptoms of a panic attack and resembles some DSM-IV-TR categories but might or might not be indicative of the person having an actual mental disorder (Sue, 2004). The clinician who is aware of a Latino client’s cultural background will be in a better position to evaluate the unconscious meanings of this syndrome. From a psychoanalytic perspective one would try to discern the unconscious wishes being expressed in the symptoms, the patient’s ego strength, and the possible reasons for the current failure of the person’s defenses (Lam & Sue, 2001; Okazaki, Kallivayalil, & Sue, 2002; Sue & Lam, 2002).

When evaluating a patient, the context of the evaluation is itself influential in determining the nature of the data that will be elicited. To illustrate: A 20-year-old African American, male college student was seen in a major urban city. His presenting complaint was that he often felt treated rudely and disrespectfully in this city compared with the polite treatment he had received in his small home town. In developing his case formulation the white clinician had to consider to what extent the prospective patient viewed his mistreatment by others as racially motivated and whether he might be probing to see whether he could expect to be treated respectfully by the therapist.

Our take-away point is that starting with the clinician–patient relationship, there are multiple, additional contexts including, but not limited to, the cultural one that the clinician needs to take into consideration in order to form an accurate understanding of the patient’s inner world and current stressors. Because the traditional psychodynamic approach to case formulation is attuned to the implicit meanings of interpersonal communication and to issues of trust and the therapeutic alliance, it is a method that can be used with patients of different cultural and ethnic backgrounds. The clinician needs to be aware of what is normative for an individual from a particular cultural and ethnic heritage and how the individual experiences that heritage with respect to variables such as self-esteem, social values, and attitudes. This is particularly important when the patient is trying to adapt to a community or culture that does not share his or her cultural or socio-economic background. Although it is undoubtedly wise for the psychoanalytic clinician to be sensitive to the issues outlined previously, what is stressed most in psychoanalytic practice are universal themes and issues with which we all must deal regardless of our particular cultural, racial, ethnic or religious background.

**STEPS IN CASE FORMULATION**

It should be apparent that there is no one, universally accepted method to construct a case study or formulation. Rarely is there any formal training in writing clinical narratives during graduate school, psychiatric residencies,
or psychoanalytic training. Probably the closest approximation to such training occurs in psychodiagnostic testing courses taught from a psychodynamic perspective. In such courses, students generally are taught to organize test reports into major sections, such as “behavioral observations,” “cognitive functioning,” and “personality functioning” and to link observations in each section to an overall formulation of the person. This would include adaptive strengths, pathological features, diagnostic and prognostic considerations, and suitability for treatment. To this would be added, when writing psychotherapy summaries, a discussion of transference–countertransference issues. Thus, there are guidelines but no precise format or specific sequence to be followed in writing up a case. We urge students to avoid jargon and generalities such as “his defenses are strained under stressful conditions,” and to construct a portrait of the individual that makes the person “come alive.” We discourage excessive speculation and recommend that inferences be stated with a degree of conviction proportional to the strength of the clinical evidence.

Despite these caveats, there is enough commonality among psychoanalytically oriented psychotherapists to allow us to set out a framework of concepts typically drawn upon in case writeups, as well as to suggest how an interview should be conducted to elicit the information on which the formulation relies. This is followed by a case example illustrating how the theoretical concepts and the framework are applied in practice. Based on the previously described psychoanalytic concepts, we now outline how they are covered in a case formulation. In doing so, we have drawn on Friedman and Lister’s (1987) useful format.

What Is Formulated

**Structural Features of Personality**

Structure refers to those aspects of psychological functioning that are fairly stable and enduring. There are four areas covered under this heading.

- **Autonomous Ego Functions.** These include disruptions in basic biological, perceptual, motor, or cognitive functions, including language. Of special import here is the adequacy of the patient’s reality testing.

- **Affects, Drives, and Defenses.** This refers to the person’s characteristic ways of experiencing impulses and feelings and containing them. Questions regarding drives and affects to be considered in the formulation include the following: Is the person able to tolerate a range of feelings without overly suppressing some or feeling overwhelmed by others? Is there one predominant affect that colors wide areas of the person’s functioning? Are closely related affects—such as anger, hate, irritation, and jealousy—sufficiently
differentiated or are they all subsumed under rage? How flexibly does the person respond on an emotional level to diverse circumstances?

Defenses are the intrapsychic mechanisms that allow us to manage difficult external events and internal turmoil. What are the characteristic defenses that the person employs? Are these successful in allowing the person sufficient emotional response without experiencing strong anxiety or depression? How mature or primitive are the defenses (e.g., intellectualization vs. denial or splitting)? Are the defenses interfering with or restricting the person’s enjoyment of life?

**Object-Related Functions.** These refer to the person’s basic modes of relating to others, including their internal representations of self and other and the links between self and other. Is the person able to be trusting, intimate, and, at the same time, autonomous? Can he or she sustain disappointment, disillusionment, and loss without becoming incapacitated? In relationships is the person overly controlling? too submissive? self-defeating? demanding?

**Self-Related Functions.** These refer to the person’s ability to maintain the coherence, stability, and positive evaluation of the self. They also include issues of the individual’s identifications, identity, ideals, and goals. Are the person’s values stable? Do ambitions match desires and talents? Is the person overly susceptible to shame and humiliation, inflation of self or deflation of self? That is, how susceptible is the individual to precipitous drops in self-esteem?

**Dynamic Features of Personality**

“Just as the structural viewpoint examines the form of psychological functioning, the dynamic viewpoint examines its content. . . . The focus is consistently on meaning and motive” (Friedman & Lister, 1987; pp. 135–136). The psychoanalytic case formulation responds to the following questions in this sphere: What is the meaning of the symptom understood psychoanalytically? What motivates the person to act in particular ways? What are the person’s major areas of conflict, be they intrapsychic or interpersonal? Within psychoanalytic theory, conflict and ambivalence are considered to be ubiquitous in human affairs.

What is the nature of the conflict among various motives such as wishes, fears, impulses, and needs? Does the patient effect some compromise among them which actually obscures the nature of the conflict? These wishes, fears, and conflicts are often of a sexual, dependent, or aggressive nature. For example, a woman may wish to enjoy sex more freely but feel morally remiss and guilty were she to do so. A man may wish to have an intimate relationship with a woman but, at the same time, fear being con-
trolled or engulfed by her, or overly dependent on her. A woman may wish to speak up and express herself in a group but fear being shamed or humiliated. Any of these conflicts can lead to the formation of symptoms, anxiety, or inhibitions.

Sometimes the wishes are particularly disturbing, taking the form of homicidal fantasies, ego-alien sexual fantasies (e.g., of incest), or primitive urges to merge with the object. For example, a person may feel angry and want to express it but then fear losing control and having the anger emerge as murderous rage. Typically, there are layers of motive, meaning, and conflict, only some of which will be apparent in the initial interviews. In this part of the formulation, the object is to describe the various areas of motive and conflict, both intrapsychic and interpersonal, that may operate on conscious or unconscious levels.

Developmental Antecedents

Preceding and underlying the structural and dynamic facets of a patient’s personality and psychopathology are earlier events that take on particular meaning depending on the developmental (or, in psychoanalytic parlance, “genetic”) phase in which they occurred. These may include traumatic events such as physical or emotional abandonment, sexual or physical abuse, surgery, parental psychosis, or drug abuse or more moderate stresses such as the birth of a sibling, parental discord, school failure, and so forth. The meaning and impact of these events will be influenced by their timing, namely, the psychosexual and psychosocial stage of development that the person was going through when they occurred. In this way, the formulation takes into account the stages of infancy, childhood, and adolescence as these have affected patients’ current psychological functioning.

Adaptive Features: Assets and Strengths

Because there tends to be an (understandable) emphasis in the case formulation on patients’ deficiencies and maladaptive ways of interacting, it is important not to neglect noting their strengths. What are their accomplishments? Do they have intellectual strengths? mechanical aptitudes? artistic talents? Are they able to get along with others? Can they assert themselves appropriately? and so forth.

In recent years, there has been increasing recognition of biological determinants of behavior as well as the psychological sequelae of physical illnesses and limitations (McWilliams, 1999; Morrison, 1997; Summers, 2003). Among such factors are temperament (e.g., impulsivity), genetic endowment (e.g., intelligence), medical illness (e.g., multiple sclerosis and HIV/AIDS), perinatal conditions (e.g., fetal alcohol syndrome), the effects of substance abuse or head injury (e.g., cognitive impairment or confusion),
and childhood psychiatric/neuorological conditions (e.g., Tourette syndrome). It is fitting to mention them here because, from a psychotherapy standpoint, the clinician’s task is to help patients marshal their ego resources to adapt to a reality that often leaves little or no room for change in the basic condition. Nevertheless, recognizing such situations and enabling patients to talk about their fears, shame, or esteem issues surrounding the difficulties in an accepting atmosphere can be invaluable in increasing their ability to cope.

The Psychoanalytic Interview

The most usual source of information on which the case formulation is based comes from a skillfully conducted, psychoanalytically informed interview. In some settings, initial demographic information, or even more extensive descriptions of the person’s complaints and background, are obtained by having the patient fill out a data sheet or life-history questionnaire. Objective tests such as the Minnesota Multiphasic Personality Inventory (MMPI) or the Millon scales, which are completed by the informant, may be used. In special circumstances, where the interview leaves considerable uncertainty regarding diagnosis and treatment recommendations, a full battery of tests is employed which includes projective techniques. The latter can be especially useful in addressing the structural and dynamic areas of the case formulation.

The interview can be thought of as having content and process features (MacKinnon & Michels, 1971), the first referring to the information to be gathered through the patient’s words and cognitive style and the second, to the manner in which interviewer and patient relate to each other.

Content of the Psychoanalytic Interview

Identifying Information. This includes the patient’s age, sex, ethnicity, socioeconomic status, education, marital status, occupation, means of referral, and living situation.

Chief Complaints/Symptoms. This is what the patient usually wants to talk about and it is important to get a clear picture of each symptom or complaint. What stresses or events precipitated the present episode? Were there previous occurrences, and, if so, under what circumstances did they occur and how were they resolved?

Personal and Family History. As time permits, one wants to get a history of each period of the person’s life—infancy, childhood, adolescence, and adulthood. The object is to discern the personality patterns the person has developed in the process of responding to the environmental forces that
have been formative. One may ask for the patient’s earliest memories as these can often shed light on dynamic issues. One particularly notes difficulties that have arisen and instances of psychopathology that were apparent at any phase of development.

Family history includes a description of the parents and siblings in the patient’s family of origin and the way he or she felt about and interacted with them in childhood and currently. Included are the names, ages, occupations, economic and social status, marital relationship, and history of physical and emotional illnesses of the most significant family members. One pays special attention to the occurrence of psychological problems such as depression, psychiatric hospitalization, suicide, alcoholism or other drug addiction, and mental retardation.

Optimally, one would conduct several interviews to be able to gather this much information and to observe the patient over a period of time. Typically, in the press of clinical practice, only one or two hours are available, and one must curtail the gathering of a full personal or family history, which are then combined in one section of the narrative. If the patient continues on to psychotherapy, one can then fill in the gaps as therapy proceeds.

Process of the Psychoanalytic Interview

Observing the Patient. In addition to gathering information from the patient, the interviewer notes the patient’s behavior in the course of the interview. The traditional psychiatric way of referring to these observations is the mental status exam. This is a description of the patient’s current emotions, behavior, thought processes, thought content, and perceptions. It includes appearance, general attitude (cooperative, withdrawn, seductive?), mood and affect (depressed, anxious, flat?), speech (coherent, relevant?), thought (grandiose, delusional, suicidal?), perceptions (hallucinations, de-realization?), cognitive functions (memory, intelligence, judgment, and insight), and sensorium (orientation as to time, place, and person). This kind of information will also help establish a formal DSM-IV diagnosis.

It is important to observe in connection with what dynamic themes and what events the patient shows affect as these will tend to be the most significant. One also strives to follow patients’ associations (i.e., to note the sequence in which themes are presented). This is in keeping with the psychoanalytic dictum that the order of a person’s verbal production is partly determined by inferred underlying psychic forces, as described earlier.

One takes note of the development of transference, countertransference, and resistance. Patients may reveal, even in initial interviews, the way in which they regard the interviewer, based on their relationship to parental figures. There may be an exaggerated need for gratification of dependency
needs, for example. The interviewer may experience a countertransference pull to gratify such needs, which alerts him or her to the nature of the transference. Regarding resistance, one notes how and when the patient expresses defense in sidestepping the recognition of certain feelings or thoughts, including those pertaining to the interviewer.

We turn now to a consideration of the general approach of the interviewer in obtaining the information on which the formulation is constructed.

**Optimal Stance of the Interviewer.** In the most general terms, the patient should be viewed as a partner in the interview, invited to struggle with contradictions, ambiguities, and puzzling aspects of his or her behavior. Although the clinical interviewer is an expert on human behavior, the patient is the more versed in the specifics of his or her functioning and, therefore, should be “engaged as thinker, synthesizer and co-creator of hypotheses” (Peebles-Kleiger, 2002, p. 55).

The interviewer should show an appreciation of the patient as a whole person, and not merely as an object of clinical focus. This includes attending to patients’ assets as well as deficiencies. One is interested not solely in patients’ diagnosis, symptoms, or complaints but in their total life functioning (work and love relations) in the context of their life history.

Even if one does not approve of what the patient does, it is important to try to accept the patient unreservedly. One attempts to maintain a certain degree of professional detachment, but this should not be construed as indifference. Nor should interviewers allow their own emotions to interfere with their judgment. Knowing their own emotional makeup and vulnerabilities will help them to predict those areas in which they are most likely to lose objectivity.

The clinical information should not be collected in a lockstep manner, but along the way where it seems to fit the flow of the individual’s presentation. One line of thought often leads the patient to another and if one has the aforementioned format in mind, much information can be obtained without the interview becoming a question-and-answer session. In fact, one of the advantages of an interview over a paper-and-pencil questionnaire is that it allows the interviewer to observe the flow of information, affect, and behavior and to follow up on areas of special import. This contrasts with more structured interview formats such as the cognitive-behavioral one. We believe that psychoanalytic interviewing requires a more fluid listening process (an evenly hovering attention) to discern unconscious themes and issues that may take some time to learn and even more to master. These will go hand-in-hand with increasing knowledge of psychoanalytic theory and conducting, or being in, psychotherapy.

The most general guideline we can offer about the psychoanalytic in-
terview is that one should try to listen without interrupting too frequently. Following are the circumstances in which the interviewer would want to intervene:

1. **One wants to know more about something than the patient is offering spontaneously.** One can simply lean forward expectantly, say “Uh-huh,” “I see,” or something similar. If this isn’t sufficient, one can say “I’d like to hear more about that.”

2. **The patient’s anxiety level is too high or too low.** One can say, in the former case, “Go ahead, You’re doing fine,” or “Something makes it hard for you to talk to me about this matter. Can you tell me what it is?” In the case of low anxiety, one may need to be more probing and challenging to stir up some feeling.

3. **To encourage emotional expression.** Pressing patients for details of an emotion-laden event often gets them to relive it partially and can yield a clearer picture of the dynamics.

4. **To control irrelevance and chit-chat.** Because time is limited, one has to keep control of the interview and deflect patients from irrelevancies. One should also try to understand the defensive function served by excessive or trivial verbiage.

5. **To channel the interview.** One can ask questions that tactfully steer the patient back toward significant areas already touched on, or to matters that have not been brought forward. One should not confuse tact with timidity; that is, if one asks questions firmly, not hesitantly, one is more likely to get a useful answer.

The foregoing is a very condensed set of guidelines for the psychoanalytic interview. For a fuller exposition of content and process of the interview see Bocknek (1991), McWilliams (1999), Peebles-Kleiger (2002), and Sullivan (1954). For a broader psychoanalytic understanding of personality structure as it derives from the clinical process, we recommend McWilliams (1994).

**CASE EXAMPLE**

The case example below follows a template for organizing and presenting information gathered in the interview and for formulating that information within a psychoanalytic framework. The sequence of elements of the formulation may vary from case to case, although we prefer the logic of starting with the building blocks or structural elements of personality and psychopathology and then proceeding to the dynamic and adaptive features. We regard elements such as drive, ego, object, and self as complementary, each providing a different window on the patient. However, for
some practitioners, more or most of a psychoanalytic formulation will fall into one or more of these domains.

Presentation of the Patient

Identifying Information

Jim is a 24-year-old, white, married, Catholic man in his first year of college, majoring in computer science. He is currently on leave from the U.S. Army which is financing his college education, upon completion of which he will owe 4 years of service as a computer programmer. He and his wife, Audra, to whom he has been married for 5 years, have recently returned from an army base overseas. Jim was self-referred to the college counseling center and this is his first contact with psychological services.

Presenting Problem: Chief Complaint and Symptoms

In taking an exam in a computer hardware course, Jim said he “blanked” out. Although the professor had a reputation for being tough, Jim had felt confident going into the exam. However, when he looked at the first question, he could not think clearly, got confused, and said to himself, “I can never do this. I don’t know this.” After he left the exam and sought the help of a tutor, it became clear that he did know the material and could have done well had he taken the exam.

Jim reported a similar sequence of events occurring twice before when he was taking college courses in the Army. In both cases, he knew the work well enough to have gotten a high grade had he followed through with the exam. He did not experience this specific problem taking exams in high school although he described himself as being perfectionistic about his work. For example, as a youngster he did excellent written and artistic work that the teachers admired but which he would crumple up and throw away as not being good enough. Although he could have had a career as a graphic artist, he prefers fields that are “sensible, logical, and orderly.”

Personal and Family History

Jim’s family consists of his father and mother and three younger siblings—Scott (22) who is 1 year younger, Michelle (21), 3½ years younger, and Warren (16), who is 8 years younger. They are living together in Arizona. Jim’s father is an auto mechanic and his mother is an office administrator.

Jim described his father as a man who had a very difficult childhood due to his own father dying when he was 6 and having been left with his mother whom he described as “a bitch.” In Jim’s mind his father was “a madman” who could not tolerate his children’s mistakes and would swear,
scream, or smack them if their behavior did not meet his expectations. He broke furniture and dishes when he was in a rage. If Jim was visibly upset, his father would call him a baby or a girl. He forced his children to address him as “Sir” and stated, “I’m God and this house is my castle. You follow my laws.”

When Jim was 7, he witnessed his father “lay out” a man who had tried to cheat him. The man cracked his head on the cement, and Jim had to clean up the blood. Jim decided at that moment that he would never fight his father and would always walk away from arguments. This resolution was reinforced on several other occasions when his father beat up other men. Jim handled his father’s demands by saying “OK, Dad, whatever you say.” He added that he hated his father and wanted to tell him to shut up, but held in his feelings, felt “totally tense,” and kicked and punched walls instead (but not in his father’s presence). He and Scott also rebelled silently by purposely not trying harder to improve their performance after father’s scoldings and admonishments. When Jim was little he had looked up to his father who was affectionate to him, but after the age of 6, he never agreed with his father. His father was frequently unemployed and the family in debt, with father passing bad checks. He also stole money from the children that came from their newspaper routes, birthdays, and gifts from relatives.

Jim described his mother as warm, affectionate, and encouraging, and he believed himself to be her favorite child. As a young child, he would often get into bed with his parents, on his mother’s side of the bed, and she would put her arm around him. His father brought an end to this when Jim was 6. Jim said there were times when his mother would sit with his father at the kitchen table and send Jim and Scott outside “like dogs.” He always felt his father vied with him for his mother’s attention “like another child,” and it bothered him when she would attend to his father and shut him out. He had a recurrent dream from the age of 4 in which the family was away, leaving him alone with his mother who was dressed up as she would be to go out with his father. There were also times when his mother would say, “I wish I hadn’t had you kids.”

The relationship between his parents was stormy and the children asked their mother to divorce their father. When she would threaten to do so, Jim’s father was contrite and cried, and “the whole matter blew over.” She would say that she feared that if she left, his father would blow his brains out, which Jim believes would have been the case. His mother worked from the time Jim was 11, leaving him to care for his siblings. During this time, there was often no phone, electricity, or food in the house. Jim found respite in music, art, and books.

As a teenager, Jim hated all authorities such as principals, teachers, and policemen. He wrote sexual, angry, and violent poetry at this time. He said his sex education consisted of his father’s saying, “If you want to fuck
somebody, go jerk off.” He was exposed to pornographic movies and magazines that his father left around the house, which Jim viewed while masturbating.

Jim’s “breaking point” came at age 16 after his father broke Scott’s nose when Scott had resisted being locked in the cellar for some minor misdemeanor. Jim began screaming and swearing at his father, telling him not to lay a hand on Scott. He said he was too angry to be scared and his father did not hit him. He told his father that he was leaving home and would never return. He then began spending his daytime hours at his girlfriend Audra’s house, feeling close to her parents. He and Audra got engaged but broke the engagement briefly over fights about her being extremely possessive. They married 3 years later when she was 17 and he was 19. The last two times Jim saw his parents were at the wedding and a year later before he left for the service.

Jim described his wife in very positive terms, adding that although they fought while overseas, they argue very little now. While abroad, he came to feel that he had never been free to have responsibility for himself alone and considered leaving Audra. He felt pressure to be her ideal and discussed this with a close army friend, Bill, who told him to be who he wanted to be. When Jim and Bill were put on separate shifts, Jim encouraged Bill to use their house when he wasn’t there. Bill then had an affair with Audra and, when Jim found out, they tried for several weeks to have an “open” marriage. Bill was told by a supervisor to stay away from Audra and she and Jim straightened things out. Jim felt betrayed by Bill and was afraid he would beat up Bill and kill him.

Currently, Jim feels good about his marriage, but he and Audra do have a conflict over his being turned on by pornography. They enjoy sex, but at times he is stimulated by sexual advertising, buys Playboy or Penthouse magazine and masturbates, or goes to porno houses and views movies.

So far Jim has been able to avoid any direct conflict with officers of higher rank, but he fears that he may one day react to an abuse of authority by, for example, laughing in the general’s face during inspection. He hates what the army stands for, and hates the President who, he feels, does not “wish to take care of us, but only wants to go down in history.” Jim would like to leave this country and live abroad or in the hills away from people.

Mental Status

Jim is an average looking man who came to one interview dressed neatly and to another looking wrinkled and unshaven. His affect was usually appropriate and wide ranging but he sometimes smiled while recounting upsetting events. In this connection, when asked to examine what he is experiencing, he backs off from his affect by minimizing, rationalizing, or
focusing on others’ feelings or motives. He does not appear depressed, nor is he suicidal, but there is a heaviness and seriousness to his mood. He is afraid of the intensity of his anger and will not fight for fear of hurting someone as his father did. He showed no evidence of thought disorder, severe acting out, or other serious psychopathology. He is very intelligent and has good judgment.

Case Formulation

In this case formulation, we draw only on the initial interviews because clinical cases are typically formulated at this juncture. Nevertheless, it is important to realize that a formulation may change as we learn more about the patient during the process of psychotherapy. In formulating a case, it is helpful to cover each of the inferential categories shown, although overlap among them is inevitable.

Structural Features of Personality

Autonomous Ego Functions. When taking exams, Jim’s cognitive functioning is severely hampered. He gets confused, blanks out, and is convinced that he is unable to proceed. That is, Jim’s ego is overwhelmed by anxiety in this circumstance, leading to a highly dysfunctional response. Otherwise, his ego functioning, including reality testing, is largely unimpaired.

Expression of Drive and Affect and Defenses against Them. Jim has trouble containing and modulating the fierce anger he harbors against all authorities. He has managed to do so but at considerable cost in terms of psychic energy expended. That is, he needs to be constantly vigilant against the possibility that he will flout authority in some inappropriate way, such as laughing at the army general, or lashing out and even killing someone (as he felt he might do with Bill). One way he defends against the anxiety generated by this danger is by acting in an overly compliant manner with his perceived (and actual) attackers.

Jim not only has to struggle to contain his rage against authority but also to cover over and displace his sadness at not having received the nurturance and care he wished for. He does so by minimizing and rationalizing his own needs and projecting his despair of having his dependency needs met onto others (e.g., the President “who does not care for the people”). Another way in which he contains troubling feelings and impulses is by focusing on study and work areas that are “sensible, logical and orderly”—hence, his interest in computers where the messiness of feelings can be readily avoided. His effort is to keep in control at all costs. His drive/defense configurations are characteristic of an obsessive-compulsive per-
sonality, although they are not severe or pervasive enough to constitute a personality disorder.

**Object–Related Functions.** In relating to others, Jim tries to act as if everything is fine and compliantly to meet their expectations. He wants to look good and keep the peace, and this picture of a cooperative, helpful person constitutes his internal representation of self. His view of others is that they make demands to fulfill their own needs but not his or others and take advantage of him (professors who expect too much of their students; Bill and Audra who had an affair at his expense; his parents who mistreated him; the President who “doesn’t care about us,” etc.). Thus, the internalized relationship between self and other can be characterized as that of giver to taker or victim to victimizer.

**Self-Related Function.** Jim’s sense of self is coherent and fairly stable, but also quite negative and, in some ways, false. It is negative insofar as he is subject to strong feelings of shame about his work or his actions and to lowered self-regard. It is false in that he tries to be the perfect son, husband, army man, and student but, in so doing, suppresses his own identity. Jim wants to be himself, speak up for himself, and take care of his own needs, but instead he feels that he lives at the whims of his wife, the army, and his professors. As such he is not a fully individuated person.

**Dynamic Features of Personality**

A central conflict for Jim, which is largely unconscious, is whether to obey authority slavishly or flout it defiantly. Currently, Jim either complies with others’ standards, which he assumes to be as unreasonable as his father’s, or he rebels in a passive way by doing what he wants to on the sly. For example, he turns to pornography, defying his wife’s wishes, and satisfying his own sexual needs. He shows up at the college exam but rebels against the “tough” professor by blanking out and refusing to comply with the professor’s implied demands that he perform, and perform well. The symptom of cognitive confusion is a compromise between a wish to go his own way by not even showing up at the exam and the contrary wish to be the good, obedient student who performs flawlessly. So he comes to take the exam but does not perform.

Jim evidences splits between good and bad internalized images of both parents. He says he hates his father but has internalized many of his father’s standards and acknowledges still feeling some caring for him. He idealizes his mother, failing to recognize her rejection of him and his siblings as a burden and her failure to intercede on his behalf with his brutalizing father.

Several dynamic perspectives might be considered in understanding Jim’s primary symptom of blocking during exams. Oedipal elements may
be interfering unconsciously with Jim’s exam taking. His self-report and recurrent dream reveal a strong childhood wish to have mother to himself and father out of the picture. That this is a sexualized wish may be hypothesized from the fact that, in the dream, his mother is dressed up as she would be to go out with father, and that, until the age of 6, Jim cuddled with mother in bed until extruded by father. He later acknowledged that she kissed him in a way that made him uncomfortable. Was this experienced as a sexual, arousing incestuous wish followed by disgust? One response to this Oedipal wish may be displacement of Jim’s rageful and competitive feelings toward father onto other authorities, such as the professor, whom Jim unconsciously wants to defeat even if it means bringing the house down, Samson-like, on himself—that is, failing the exam. Another motive for Jim’s blocking in exam-taking may be Oedipal guilt which requires that he arrange to fail in order not to surpass his father. The wish to have his mother to himself may represent both Oedipal elements and early dependent longings and efforts to get the kind of nurturance he needed to blossom. The concept of survivor guilt (e.g., Weiss, 1993) may also be at play in his feeling that fate dealt harshly with his parents and that he ought not do better in life than they, nor should he do better than he “deserves.” Not all these dynamic perspectives will prove to be accurate or resonant in understanding Jim’s symptoms and complaints, but more than one may well apply in accordance with the psychoanalytic concept of the multidetermination of symptoms. If Jim were to enter therapy, one would seek further evidence to support or refute these hypotheses.

**Developmental Antecedents**

Jim was emotionally abused as a child by a domineering, controlling father and a seductive, immature mother who did not protect him from his father’s inappropriate demands. He hates them, yet longs for what he missed out on as a child. Because of Jim’s abrupt withdrawal from his family during adolescence, he was never able to sort out his ambivalent feelings toward his parents. The sudden loss has left him with a barely acknowledged feeling of sadness, and there exists a lack of internal separation from them.

**Adaptive Features: Assets and Strengths**

Jim has considerable assets. He is bright, artistic, skilled with computers, and recognized by others as such. He has found some contentment by escaping into art, music, and books. Even removing himself from a noxious environment in adolescence speaks to his self-preservative abilities. He has compassion for others, including his wife with whom he now has a reasonably good relationship. His defenses are flexible enough such that he can
access feelings without becoming overwhelmed. He also seems trusting of
the interviewer and able to form a therapeutic relationship.

APPLICATION TO PSYCHOTHERAPY TECHNIQUE

Within a psychoanalytic framework, one use of a formulation is to deter-
mine suitability for an expressive, exploratory psychoanalytic therapy. The
following criteria are important to consider: (1) the willingness to share
personal thoughts and feelings with the interviewer; (2) access to, and an
ability to experience and tolerate, dysphoric feelings such as anxiety, guilt,
and sadness; (3) motivation for change; (4) psychological-mindedness, or
the capacity for introspection; (5) flexibility of defenses; (6) the degree and
intensity of fixation at the Oedipal versus pre-Oedipal stages; (7) a positive
response to interpretation such as demonstrable affect, new associations,
increased reflection, fresh memories; and so on. The formulation can help
determine suitability for a range of approaches including brief psycho-
dynamic therapy (when a clear focus is discernible), supportive therapy
(when defense strengthening is necessary), group therapy (to help alleviate
interpersonal problems), behavior therapy (e.g., for stress reduction), and
so forth.

Another major use of the formulation is to set out goals and outcomes
for therapy depending on the time and intensity of work possible. Here is a
set of goals for Jim were he to enter an open-ended psychoanalytically ori-
ented therapy:

1. **Autonomous ego functions: the symptom.** He will explore and un-
derstand the dynamics underlying his blanking out on tests, and gain symp-
tomatic relief.

2. **Dynamic and self-related issues.** He will acquire a clearer sense of
his wishes and needs and express more of who he is and what he wants. He
will be less conflicted about complying versus rebelling, and will have a
greater sense of freedom in choosing to act in either direction. His self-
esteeem will increase and will be less subject to buffeting by others.

3. **Affects, drives, and defenses.** Jim will be more able to face and ac-
cept his mixed feelings including anger, longing, deprivation, sadness, and
guilt. He will have less need to escape, minimize, rationalize, or project feel-
ings. He will be less inclined to act out violent feelings, and will be some-
what more relaxed and at peace with himself. He will work at expressing
anger in a modulated way.

4. **Object relations: general.** In his relationships with others, he will
come to feel less compelled to acquiesce automatically to fulfill others’
needs and will ask appropriately to have his needs met. That is, he will not
allow himself to be victimized or need to view the world according to the
sharp dichotomy of victimizer/victimized. In general, he will tend to be more open and comfortable with people.

5. **Object relations: parental introjects.** Jim will start to sort out his feelings about his parents and see them more realistically, with both their good and bad features. He will engage in a process of separating from them internally while feeling freer to visit them if he wishes.

6. **Object relations: marital interaction.** Jim will resolve his compulsion to view pornography by enjoying it without guilt or feeling less need for it, or both. The role it plays in his marital interaction will become clarified and at least partially resolved.

Broader aspects of a satisfactory therapeutic outcome are that the patient internalizes and comes to use the analyzing function initially supplied by the therapist and is able to arrive at a more integrated, self-accepting state. Although the formulation is not conveyed immediately or directly to the patient, its major elements would become clear as the therapy proceeds. The therapist’s role is to act as a catalyst for the patient’s self-exploration, using the case formulation as a road map for the journey. Thus, in addition to its role in prescribing the nature of the therapy and setting goals for it, the formulation serves like a ship’s rudder, helping first the therapist and then the patient to steer a course which is most likely to result in reaching the desired shore.

In the case of Jim, the formulation served as a guide for the treatment, including goal setting. The case was formulated primarily in accordance with concepts highlighted in contemporary Freudian and object relations theory. Jim’s major conflict was seen in impulse/defense terms as one between his wish to defy authority and to submit to it. One might expect this conflict to express itself in the way that Jim interacts with the therapist, namely, in a defiant and/or overly compliant manner. Interpretations in the therapy would address these themes, and the patient’s responses would help to elaborate the case formulation. It was also noted that Jim longs for what he missed out on as a child, that he does not feel sufficiently separate from his parents, and that there are splits between the good and bad internalized images of both parents. These aspects of the formulation lend themselves more readily to interpretations that stem from object relations theory so that in this case concepts from different yet related analytic theories influence the therapist’s interventions. For example, the formulation would lead us to expect that Jim will experience the therapist as someone whose nurturance he craves but from whom he expects to receive very little or by whom he expects to be mistreated. These enactments can turn out to be an obstacle to treatment or corrective emotional and interpersonal experiences.

Therapists vary in how much and at what level they share their developing working model of the patient. Most therapists offer a tentative, gen-
eral, jargon-free formulation which points to the repetitive, ego-alien issues already somewhat familiar to the patient. In most instances the formulation presented by the clinician is more descriptive than explanatory and does not include interpretation of unconscious content. In fact, most psychoanalytic clinicians strive to create a therapeutic atmosphere in which the therapist and patient are coinvestigators and coauthors of a series of formulations that will emerge in the moment-to-moment interactions of the two participants. Thus, therapist and patient decide on the goals of psychotherapy collaboratively in the context of a frank discussion of the conditions of treatment. (See Wolitzky, 2003, for a more detailed exposition of the theory and practice of psychoanalytic therapy.)

TRAINING

To write a psychodynamic formulation, students need to have knowledge of developmental and adult psychopathology and various psychoanalytic theories. They also need to learn dynamic interviewing and psychotherapeutic skills to collect information necessary to construct the formulation. Thus, supervised exposure to intake interview material, therapy transcripts, psychodiagnostic test data, and their own therapy cases provide the clinical experience to complement students’ theoretical knowledge. Psychoanalytic training programs often consider the student’s own psychoanalytic therapy to be a vital source of knowledge in developing the clinical acumen necessary to create a complex dynamic formulation of the patient.

Our view is that training should illuminate the choice points for intervention as a function of the theory of pathology and change that one embraces. Thus, if one formulates that the patient suffers primarily from a disorder of the self stemming from failures in parental empathy, and that the amelioration of self-defects requires the opportunity to form idealizing and mirror transferences to compensate for the failure of the parents to function as idealizing and mirroring selfobjects, then one will want to act in ways most likely to facilitate these kinds of transferences. The specifics, however, will derive from the formulation.

A Kohutian supervisor would encourage the student to allow these kinds of transferences to blossom and to be careful lest the patient experience a retraumatization at the hands of the therapist. A Freudian supervisor, on the other hand, would be more inclined to point to the defensive functions of these kinds of transferences and to advise the student to begin to offer interpretations of the wishes and conflicts that presumably underlie the manifest clinical material, as presented in the case formulation. In fact, it has been shown that analysts of different theoretical persuasions can be distinguished on the basis of the interpretations that they are prepared to offer the patient (Fine & Fine, 1990). The relationship between theory and
RESEARCH SUPPORT FOR THE APPROACH

There is the danger that once made, a case formulation will become fixed in the clinician’s mind, leaving him or her less open to other possibilities. For example, in a research project in which one of the authors participated several years ago (Dahl, 1983), clinicians weighted evidence in line with their own initial hypotheses more strongly than did other clinicians.

Involvement in the process of drawing inferences and making interpretations based on clinical material leads inevitably to a concern with the issues of reliability and validity. This topic is of vital importance with respect to the soundness of theory and the efficacy of treatment. Grünbaum (1984) has argued that data from the consulting room are “epistemologically contaminated.” That is, the factor of suggestion carried in the therapist’s interpretations, however inadvertent, prevents us from being in a position to validate core theoretical propositions within the context of the treatment situation. Grünbaum also argues that treatment outcome cannot be used to verify or disconfirm the accuracy of clinical interpretations. Others (e.g., Edelson, 1992), however, have taken issue with Grünbaum’s conclusions.

To give one example of how the issue of reliability and validity can be framed and studied, Caston (1993, p. 493) has pointed out that psychoanalysis is as much endangered by overinflated agreement on stereotypical dynamic formulas as by lack of agreement. That is, even when there is good agreement among judges (and often there is not; see Seitz, 1966), it can be spurious if judges are using stereotypical inferences that are not particular to a given case. In a study designed to test this hypothesis, Caston and Martin (1993) used verbatim transcripts from the first five sessions of an audiorecorded psychotherapy. Their novel methodology included having some analysts make ratings without benefit of reading the transcripts. The authors demonstrated that in most domains of behavior, analysts agreed well among themselves and to a greater degree than would be expected if they were basing their judgments on theoretical stereotypes. In other words, they were responsive to the particulars of a given case.

On the other hand, using a different method of study, Collins and Messer (1991) have shown to what extent case formulations can be dependent on one’s theoretical viewpoint. They found that two different research groups, guided either by Weissian cognitive–dynamic theory or by object relations theory, reliably endorsed different formulations of the same cases. This raised the question of whether adherence by the therapist to one or the other formulation had a differential effect on patient progress. To
study this, Tishby and Messer (1995) compared the relationship between therapist interventions which were compatible with either a cognitive–dynamic or an object relations formulation and patient progress. They found that therapist interventions compatible with the object relations formulation were the better predictor of in-session patient progress in the middle phases of brief psychodynamic therapy for the two patients studied, as well as in the early phase for one of them. More such studies are needed in which the same cases are formulated from different perspectives and the relationship of such formulations to patient progress and outcome studied. It is these and other formal methods described in the chapters of this book that will be an important testing ground for the value of psychoanalytic case formulation.

As we noted earlier, there have been several efforts (e.g., McWilliams, 1999; Summers, 2003) to articulate the nature of traditional psychodynamic case formulation as it is practiced in a clinical, as opposed to a research, setting and to offer suggestions for how such formulations can be improved. However, a literature search from 1997 (when the first edition of this book appeared) through the first half of 2005 failed to uncover more than two or three research studies focused on the kind of psychodynamic case formulation that we have described. In contrast, there have been several recent research studies based on formal, quantitative methods of psychodynamic formulation (e.g., Luborsky’s [Luborsky & Barrett, Chapter 4, this volume] and Perry’s [1997] approaches).

It is unfortunate that there is such a dearth of empirical work on the nonquantitative, narrative style of case formulation used in routine clinical practice, as this is the context in which 99% of case formulations take place. The more formal methods, although useful for psychotherapy research, do not directly inform us about the validity or utility of case formulation as it is conducted in the typical clinical situation. It is our impression that the vast majority of psychodynamic clinicians continue to embrace the narrative tradition. They are not especially interested in applying more formal, systematic methods of case formulation on the grounds that these quantitative approaches fail to capture the richness, subtlety, and complexity of the clinical process.

As is common in all areas of research on psychodynamic approaches, there is an inevitable trade-off between richness of narrative or “thick description” and quantitative, systematic approaches. To their credit, investigators such as Luborsky (Luborsky & Barrett, Chapter 4, this volume) and Perry (1997) have made some inroads on minimizing the negative effects of this trade-off. Both make room for unconscious wishes in their scoring systems but avoid high levels of inference and, thus, unreliability. There is a downside, however. For example, masochism is a quality that Luborsky (1997) says should not be inferred because it cannot be scored reliably. He describes three levels of inference of which only the two lower levels are
Luborsky gives a concrete example in which the patient says, “So I don’t even have unemployment coming in”; the wish that is inferred is “wants to get money” (p. 62). In formulating cases, psychodynamic clinicians do not want to be restricted to this level of inference and will gladly sacrifice reliability for complexity and subtlety.

Although Perry (1997) acknowledges that formulations of “dynamic patterns require clinical inference [his] rater-observers are required to support each assertion by listing the available evidence” (p. 142). While it is true that Perry’s system also allows for inferences of unconscious wishes, one gets the impression that the requirement to cite evidence probably results mainly in the positing of conscious wishes. In fact, neither Luborsky nor Perry reports the percentage of inferred wishes that are assumed to be unconscious. For example, Perry, who works within an Eriksonian framework, lists wishes such as “Be comforted, soothed,” “Be perfect, avoid shame,” and “Attention from opposite sex.” One assumes that most often the attribution of such wishes is based primarily on manifest content.

Our remarks are intended less as criticism of Luborsky’s and Perry’s work than at explaining why most psychodynamic clinicians do not make greater use of it. However, because Luborsky and his colleagues have been able to show that interpretation of the CCRT is correlated with therapy outcome (Crits-Christoph, Cooper, & Luborsky, 1988), the onus is on psychodynamic clinicians to show that interpretations of unconscious or deeper material are at least as effective in promoting positive therapeutic change.

It appears that aside from the formal methods of case formulation described in the chapters in this volume, virtually all the other recent empirical work on case formulation has been conducted by Eells (e.g., 1997) as described in Chapter 1 (this volume). Most relevant for our purposes is his unsettling finding that novice and experienced clinicians did not differ in the quality of their case formulations (Eells, Lombart, Kendjelic, Turner, & Lucas, 2005), although experts performed better than either novice or experienced clinicians. The experts, however, were a small, select group who were particularly interested in the issue of case formulation. They were either nationally recognized for their work on case formulation, had developed a method for case formulation, or had published or conducted workshops on the topic—hardly a typical group of clinicians.

These results are consistent with the fact that there rarely is any rigorous, sustained training in the construction of case formulations. In an earlier study, Eells, Kendjelic, and Lucas (1998) reported that when relatively inexperienced clinicians (psychiatric residents, social workers, and a psychiatric nurse) were asked to make case formulations based on brief vignettes, fewer than half included inferences about the causes of the patient’s problems and, in general, used only very low level inferences.

Eells (1997) advises that a case formulation “should serve as a blue-
print guiding treatment, as a marker for change” (p. 2). However, if inexperienced clinicians construct case formulations that are primarily descriptive (Eells et al., 1998) and if experienced clinicians are no better than novices at case formulation (Eells et al., 2005), one wonders how reliable and valid such formulations are as a “blueprint guiding treatment” when constructed by individual clinicians in the context of their routine clinical practice. One limitation of these studies, however, was that the clinical material was brief and perhaps lacked the richness to allow complex inferences. One reason that psychodynamic clinicians prefer open-ended, unstructured initial interviews is to create a more detailed database for case formulation. Despite having sounded these cautionary notes, we nevertheless favor further attempts to study case formulation empirically and to relate it to the process and outcome of psychotherapy.

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NOTES

1. It could be argued that the reference to three major models neglects Sullivan’s interpersonal approach, the neo-Freudian schools such as Jung, Horney, and Adler, and the disciples of Klein (e.g., Schafer, 1994). Nor does this categorization give adequate consideration to theorists who have attempted to integrate two models such as Kernberg’s (1980) effort to combine traditional Freudian and ego-psychological theory with object relations concepts. Nevertheless, the present classification is sufficient for our present goal of explicating the nature of, and the issues involved in, psychodynamic case formulation. Also note that, for present purposes, we use the terms “psychoanalytic” and “psychodynamic” interchangeably.

2. The postmodern sensibility in contemporary culture not only is seen in literary criticism and in the humanities but has influenced psychoanalysis as well. As Leary (1994) notes, a key feature of postmodernism is that there is no “truly objective” knowledge of the “real order” of things. As applied to psychoanalytic discourse, this view suggests that meanings are generated or created in a dyadic context; they are a coauthored narrative based on the interaction of two subjectivities. That is, whereas in Freud’s day there were meanings to be discovered, in the postmodern view there are no “essential meanings” to be unearthed. In keeping with Freud’s archaeological metaphor, one could dig into deeper and deeper layers of the unconscious and find important pieces of the individual’s past history that were living on in the present. Even if the idea that recall of a traumatic event would cause the symptom to disappear had to be abandoned, one could fall back on the notion that interpretations that “tally with what is
real” would alleviate symptoms. When it became evident that one could not reliably demonstrate any kind of cause-and-effect relationship between interpretations with specific content and symptom remission, the door was open to the theoretical pluralism that characterizes contemporary psychoanalytic thought.

REFERENCES


