1

Why Diagnose?

For many people, including some therapists, "diagnosis" is a dirty word. We have all seen the misuse of psychodiagnostic formulations: The complex person gets flippantly oversimplified by the interviewer who is anxious about uncertainty; the anguished person gets linguistically distanced by the clinician who cannot bear to feel the pain; the troublesome person gets punished with a pathologizing label. Racism, sexism, heterosexism, classism, and numerous other prejudices can be (and have often been) handily fortified by nosology. Currently in the United States, where insurance companies allot specific numbers of sessions for specific diagnostic categories, often in defiance of a therapist's judgment, the assessment process is especially subject to corruption.

One objection to diagnosing is the view that diagnostic terms are inevitably pejorative. Paul Wachtel (personal communication, March 14, 2009) recently referred to diagnoses, for example, as "insults with a fancy pedigree." Jane Hall writes that "labels are for clothes, not people" (1998, p. 46). Seasoned therapists often make such comments, but I suspect that in their own training it was helpful for them to have language that generalized about individual differences and their implications for treatment. Once one has learned to see clinical patterns that have been observed for decades, one can throw away the book and savor individual uniqueness. Diagnostic terms can be used objectifyingly and insultingly, but if I succeed in conveying individual differences respectfully, readers will not recruit diagnostic terms in the service of feeling superior to others. Instead, they will have a rudimentary language for mentalizing

different subjective possibilities, a critical aspect of both personal and professional growth.

The abuse of diagnostic language is easily demonstrated. That something can be abused, however, is not a legitimate argument for discarding it. All kinds of evil can be wreaked in the name of worthy ideals—love, patriotism, Christianity, whatever—through no fault of the original vision but because of its perversion. The important question is, Does the careful, nonabusive application of psychodiagnostic concepts increase a client's chances of being helped?

There are at least five interrelated advantages of the diagnostic enterprise when pursued sensitively and with adequate training: (1) its usefulness for treatment planning, (2) its implications for prognosis, (3) its contribution to protecting consumers of mental health services, (4) its value in enabling the therapist to convey empathy, and (5) its role in reducing the probability that certain easily frightened people will flee from treatment. In addition, there are fringe benefits to the diagnostic process that indirectly facilitate therapy.

By the diagnostic process, I mean that except in crises, the initial sessions with a client should be spent gathering extensive objective and subjective information. My own habit (see McWilliams, 1999) is to devote the first meeting with a patient to the details of the presenting problem and its background. At the end of that session I check on the person's comfort with the prospect of our working together. Then I explain that I can understand more fully if I can see the problem in a broader context, and I get agreement to take a complete history during our next meeting. In that session I reiterate that I will be asking lots of questions, request permission to take confidential notes, and say that the client is free not to answer any question that feels uncomfortable (this rarely happens, but people seem to appreciate the comment).

I am unconvinced by the argument that simply allowing a relationship to develop will create a climate of trust in which all pertinent material will eventually surface. Once the patient feels close to the therapist, it may become harder, not easier, for him or her to bring up certain aspects of personal history or behavior. Alcoholics Anonymous (AA) meetings are full of people who spent years in therapy, or consulted a bevy of professionals, without ever having been asked about substance use. For those who associate a diagnostic session with images of authoritarianism and holier-than-thou detachment, let me stress that there is no reason an in-depth interview cannot be conducted in an atmosphere of sincere respect and egalitarianism (cf. Hite, 1996). Patients are usually grateful for professional thoroughness. One woman I interviewed who had seen several previous therapists remarked "No one has ever been this interested in me!"

PSYCHOANALYTIC DIAGNOSIS VERSUS DESCRIPTIVE PSYCHIATRIC DIAGNOSIS

Even more than when I wrote the first edition of this book, psychiatric descriptive diagnosis, the basis of the DSM and ICD systems, has become normative—so much so that the DSM is regularly dubbed the ("bible" of mental health, and students are trained in it as if it possesses some self-evident epistemic status. Although inferential/contextual/dimensional/subjectively attuned diagnosis can coexist with descriptive psychiatric diagnosis (Gabbard, 2005; PDM Task Force, 2006), the kind of assessment described in this book has become more the exception than the rule. I view this state of affairs with alarm. Let me mention briefly, with reference to the DSM, my reservations about descriptive and categorical diagnosis. Some of these may be quieted when DSM-5 appears, but I expect that the overall consequences of our having deferred to a categorical, trait-based taxonomy since 1980 will persist for some time.

First, the DSM lacks an implicit definition of mental health or emotional wellness. Psychoanalytic clinical experience, in contrast, assumes that beyond helping patients to change problematic behaviors and mental states, therapists try to help them to accept themselves with their limitations and to improve their overall resiliency, sense of agency, tolerance of a wide range of thoughts and affects, self-continuity, realistic self-esteem, capacity for intimacy, moral sensibilities, and awareness of others as having separate subjectivities. Because people who lack these capacities cannot yet imagine them, such patients rarely complain about their absence; they just want to feel better. They may come for treatment complaining of a specific Axis I disorder, but their problems may go far beyond those symptoms.

Second, despite the fact that a sincere effort to increase validity and reliability inspired those editions, the validity and reliability of the post-1980 DSMs have been disappointing (see Herzig & Licht, 2006). The attempt to redefine psychopathology in ways that facilitate some kinds of research has inadvertently produced descriptions of clinical syndromes that are artificially discrete and fail to capture patients' complex experiences. While the effort to expunge the psychoanalytic bias that pervaded DSM-II is understandable now that other powerful ways to conceptualize psychopatholgy exist, the deemphasis on the client's subjective experience of symptoms has produced a flat, experience-distant version of mental suffering that represents clinical phenomena about as well as the description of the key, tempo, and length of a musical composition represents the music itself. This critique applies especially to the personality disorders section of the DSM, but it also applies to its treatment of experiences such as anxiety and depression, the diagnosis

of which involves externally observable phenomena such as racing heartbeat or changes in eating and sleeping patterns rather than whether the anxiety is about separation or annihilation, or the depression is anaclitic or introjective (Blatt, 2004)—aspects that are critical to clinical understanding and help.

Third, although the DSM system is often called a "medical model" of psychopathology, no physician would equate the remission of symptoms with the cure of disease. The reification of "disorder" categories, in defiance of much clinical experience, has had significant unintended negative consequences. The assumption that psychological problems are best viewed as discrete symptom syndromes has encouraged insurance firms and governments to specify the lowest common denominator of change and insist that this is all they will cover, even when it is clear that the presenting complaints are the tip of an emotional iceberg that will cause trouble in the future if ignored. The categorical approach has also benefited pharmaceutical companies, who have an interest in an ever-increasing list of discrete "disorders" for which they can market specific drugs.

Fourth, many of the decisions about what to include in post-1980 DSMs, and where to include it, seem in retrospect to have been arbitrary, inconsistent, and influenced by contributors' ties to pharmaceutical companies. For example, all phenomena involving mood were put in the Mood Disorders section, and the time-honored diagnosis of depressive personality disappeared. The result has been the misperception of many personality problems as discrete episodes of a mood disorder. Another example: If one reads carefully the DSM descriptions of some Axis I disorders that are seen as chronic and pervasive (e.g., generalized anxiety disorder, somataform disorder), it is not clear why these are not considered personality disorders.

Even when the rationale for including or excluding a condition is clear and defensible, the result can seem arbitrary from a clinician's perspective. From DSM-III on, a criterion for inclusion has been that there has to be research data on a given disorder. This sounds reasonable, but it has led to some strange results. While there was enough empirical research on dissociative personalities by 1980 to warrant the DSM category of multiple personality disorder, later renamed dissociative identity disorder, there was very little research on childhood dissociation. And so, despite the fact that there is wide agreement among clinicians who treat dissociative adults that one does not develop a dissociative identity without having had a dissociative disorder in childhood, there is (as I write this in 2010) no DSM diagnosis for dissociative children. In science, naturalistic observation typically precedes testable hypotheses. New psychopathologies (e.g., Internet addiction, especially to pornogra-

phy, a version of compulsivity unknown before technology permitted it) are observed by clinicians before they can be researched. The dismissal of clinical experience from significant influence on post-1980 editions of the DSM has created these kinds of dilemmas.

Finally, I want to comment on a subtle social effect of categorical diagnosis: It may contribute to a form of self-estrangement, a reification of self-states for which one implicitly disowns responsibility. "I have social phobia" is a more alienated, less self-inhabited way of saying "I am a painfully shy person." When its patent on Prozac expired, Eli Lilly put the same recipe into a pink pill, named it Serafem, and created a new "illness": premenstrual dysphoric disorder (PMDD) (Cosgrove, 2010). Many women become irritable when premenstrual, but it is one thing to say "I'm sorry I'm kind of cranky today; my period is due" and another to announce "I *have* PMDD." It seems to me that the former owns one's behavior, increases the likelihood of warm connection with others, and acknowledges that life is sometimes difficult, while the latter implies that one has a treatable ailment, distances others from one's experience, and supports an infantile belief that everything can be fixed. Maybe this is just my idiosyncratic perspective, but I find this inconspicuous shift in communal assumptions troubling.

TREATMENT PLANNING

Treatment planning is the traditional rationale for diagnosis. It assumes a parallel between psychotherapy and medical treatment, and in medicine the relationship between diagnosis and therapy is (ideally) straightforward. This parallel sometimes obtains in psychotherapy and sometimes does not. It is easy to see the value of a good diagnosis for conditions for which a specific, consensually endorsed treatment approach exists. Examples include the diagnosis of substance abuse (implication: make psychotherapy contingent on chemical detoxification and rehabilitation) and bipolar illness (implication: provide both individual therapy and medication).

Although a number of focused interventions for characterological problems have been developed over the past 15 years, the most common prescription for personality disorders is still long-term psychoanalytic therapy. But analytic treatments, including psychoanalysis, are not uniform procedures applied inflexibly regardless of the patient's personality. Even the most classical analyst will be more careful of boundaries with a hysterical patient, more pursuant of affect with an obsessive person, more tolerant of silence with a schizoid client. Efforts by a therapist to be empathic do not guarantee that what a particular client will experience

is empathy—one has to infer something about the person's individual psychology to know what can help him or her feel known and accepted. Advances in the understanding of people with psychotic disorders (e.g., Read, Mosher, & Bentall, 2004) and borderline conditions (e.g., Bateman & Fonagy, 2004; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Steiner, 1993) have led to treatment approaches that are not "classical analysis" but are rooted in psychodynamic ideas. To use them, one must first recognize one's client as recurrently struggling with psychotic or borderline states, respectively.

It is common for research purposes to define therapies, analytic and otherwise, as specific technical procedures. Therapists themselves, in contrast, may define what they do as offering opportunities for intimate new emotional learning in which "technique" is secondary to the healing potential of the relationship itself. Analytic therapies are not monolithic activities foisted in a procrustean way on everyone. A good diagnostic formulation will inform the therapist's choices in the crucial areas of style of relatedness, tone of interventions, and topics of initial focus. With the increased practice of cognitive-behavioral therapies (CBT), we are starting to see approaches to working with serious disturbances of personality that have been developed by practitioners of that orientation (e.g., Linehan, 1993; Young, Klosko, & Weishaar, 2003). In response to their own clinical experiences with individuality and complexity, CBT clinicians are now writing about case formulation (e.g., Persons, 2008) for largely the same reasons I did. I hope this book will be useful to them, as well as to my psychoanalytic colleagues.

PROGNOSTIC IMPLICATIONS

The practitioner who expects from a patient with an obsessive character the same rate of progress achievable with a person who suddenly developed an intrusive obsession is risking a painful fall. An appreciation of differences in depth and extensivity of personality problems benefits the clinician as well as the patient. DSM categories sometimes contain implications about the gravity and eventual prognosis of a particular condition—the organization of information along axes was a move in this direction—but sometimes they simply allow for consensually accepted classification with no implicit information about what one can expect from the therapy process.

A main theme in this book is the futility of making a diagnosis based on the manifest problem alone. A phobia in someone with a depressive or narcissistic personality is a different phenomenon from a phobia in a characterologically phobic person. One reason psychodiagnosis has a

bad name in some quarters is that it has been done badly; people have simply attached a label to the patient's presenting complaint. It is also impossible to do good research on different diagnostic entities if they are being defined strictly by their manifest appearance. As with any computer analysis, if garbage goes in, garbage comes out.

A strength of the psychoanalytic tradition is its appreciation of the differences between a stress-related symptom and a problem inhering in personality. (This was not always true. Freud originally made few distinctions between characterologically hysterical individuals and people with other psychologies who had a hysterical reaction, or between what would now be considered an obsessive person at a borderline level of functioning and a person with an obsessional neurosis.) A bulimic woman who develops her eating disorder as a first-year college student and who recognizes her behavior as driven and self-destructive is a very different patient from a woman who has had binge–purge cycles since elementary school and who considers her behavior reasonable. Both would meet the DSM criteria for bulimia, but one could reasonably expect the first client to change her behavior within a few weeks, while a realistic goal for the second would be that after a year or so she would clearly see the costs of her eating disorder and the need for change.

CONSUMER PROTECTION

Conscientious diagnostic practices encourage ethical communication between practitioners and their potential clients, a kind of "truth in advertising." On the basis of a careful assessment, one can tell the patient something about what to expect and thereby avoid promising too much or giving glib misdirection. I have found that few people are upset upon being told, for example, that given their history and current challenges, psychotherapy can be expected to take a long time before yielding dependable, internally experienced change. Mostly seem encouraged that the therapist appreciates the depth of their problem and is willing to make a commitment to travel the distance. Margaret Little (1990) felt relief when an analyst to whom she had gone for a consultation commented to her, "But you're very ill!"

A recent patient of mine, a psychologically sophisticated man who had seen several people before me for what he considered severe obsessive tendencies, confronted me: "So you're the diagnosis maven; how do you have me categorized?" I took a deep breath and responded, "I guess what most hits me between the eyes is the degree of paranoia that you struggle with." "Thank God somebody finally got that," he responded. For those few clients who demand a miracle cure and lack the desire or

ability to make the commitment it would take to make genuine change, honest feedback about diagnosis allows them to withdraw gracefully and not waste their own time and the practitioner's looking for magic.

Therapists working under conditions in which only short-term therapy is possible can be tempted to believe, and to convey to their patients, that brief therapy is the treatment of choice. Short-term therapy is, in fact, sometimes preferable for genuinely therapeutic reasons, but therapists should resist the human tendency to make a virtue out of a necessity. A good assessment will give the interviewer information about how likely it is that a short-term approach will significantly help a particular person. It is honest, though painful to both parties, to admit to limitation. The alternative, to make oneself and/or the client believe that one can do effective treatment with anyone despite obvious external constraints, contributes to self-blame in both participants ("What's the matter with me that we haven't made the progress we're supposed to have made in six sessions?"). Converse clinical situations used to be common: In the era some call the golden age of psychoanalysis, many people stayed in therapy for years when they may have been better off at a drug treatment center or in a support group or with therapy and medication. A careful diagnostic evaluation reduces the likelihood that someone will spend inordinate time in a professional relationship from which he or she is deriving little benefit.

THE COMMUNICATION OF EMPATHY

The term "empathy" has been somewhat diluted by overuse. Still, there is no other word that connotes the "feeling with" rather than "feeling for" that constituted the original reason for distinguishing between empathy and sympathy (or "compassion," "pity," "concern," and similar terms that imply a degree of defensive distancing from the suffering person). "Empathy" is often misused to mean warm, accepting, sympathetic reactions to the client no matter what he or she is conveying emotionally. I use the term throughout this book in its literal sense of the capacity to feel emotionally something like what the other person is feeling.

My patients who are therapists themselves often express brutal self-criticism about their "lack of empathy" when they are having a hostile or frightened reaction to a client. They wish they did not feel such disturbing affects; it is unpleasant to acknowledge that therapeutic work can include primitive levels of hatred and misery that no one warned us about when we decided to go into the business of helping people. Clinicians in this condition may be actually suffering from high rather than low levels of empathy, for if they are really feeling *with* a patient, they

are feeling his or her hostility, terror, misery, and other wretched states of mind. Affects of people in therapy can be intensely negative, and they induce in others anything but a warm response. That one should try not to act on the basis of such emotional reactions is obvious even to a completely untrained person. What is less obvious is that such reactions are of great value. They may be critical to making a diagnosis that allows one to find a way to address a client's unhappiness that will be received as genuinely tuned in rather than as rote compassion, professionally dispensed regardless of the unique identity of the person in the other chair.

Someone who strikes an interviewer as manipulative, for example, may have, among other possibilities, an essentially hysterical character or a psychopathic personality. A therapeutic response would depend on the clinician's hypothesis. With a hysterically organized person, one might help by commenting on the client's feelings of fear and powerlessness. With the psychopathic person, one might instead convey a wry appreciation for the client's skills as a con artist. If the therapist has not gone beyond the "manipulative" label to a deeper inference, it is unlikely that he or she will be able to offer the client any deep hope of being understood. If one overgeneralizes—seeing all manipulative clients as hysterics, or, alternatively, as psychopaths—one will make therapeutic contact only part of the time. A person with hysterical dynamics may feel devastated to be misunderstood as executing a cynical power play when feeling desperately in need of comfort for the frightened child within; a psychopathic person will have nothing but contempt for the therapist who misses the centrality of a penchant for "getting over" on others.

Another instance of the value of diagnosis in enabling the therapist to convey empathy involves the common situation of a patient with a borderline personality organization contacting an emergency service with a threat of suicide. Emergency mental health workers are ordinarily trained in a generic crisis-intervention model (ask about the plan, the means, and their lethality), and that model usually serves them well. Yet people with borderline psychologies tend to talk suicide not when they want to die but when they are feeling what Masterson (1976) aptly called "abandonment depression." They need to counteract their panic and despair with the sense that someone cares about how bad they feel. Often, they learned growing up that no one pays attention to your feelings unless you are threatening mayhem. Assessment of suicidal intent only exasperates them, since the interviewer is, in terms of the patients' not-very-conscious subjective experience, distracted by the *content* of their threat when they feel desperate to talk about its *context*.

A clinician's effort to follow standard crisis-intervention procedures without a diagnostic sensibility can be countertherapeutic, even danger-

ous, since it can frustrate borderline patients to the point of feeling that to be heard, they must demonstrate rather than discuss suicidal feelings. It also leaves the therapist hating the client, since the person seems to be asking for help and then rejecting the helper's earnest efforts to give it (Frank et al., 1952). Emergency workers trained in identifying borderline clients become adept at responding to the painful affects behind the suicidal threat rather than doing an immediate suicide inventory; paradoxically, they probably prevent more self-destructive acts than colleagues who automatically evaluate suicidality. They may also have fewer demoralizing experiences of hating clients for "not cooperating" or "not being truthful."

FORESTALLING FLIGHTS FROM TREATMENT

A related issue involves keeping the skittish patient in treatment. Many people seek out professional help and then become frightened that attachment to the therapist represents a grave danger. Those with hypomanic personalities, for example, because early experiences of depending on others came out disastrously, tend to bolt from relationships as soon as the therapist's warmth stimulates their dependent longings. Counterdependent people, whose self-esteem requires denial of their need for care, may also rationalize running from treatment when an attachment forms, because they feel humiliated when implicitly acknowledging the emotional importance of another person. Experienced interviewers may know by the end of an initial meeting whether they are dealing with someone whose character presses for flight. It can be reassuring to hypomanic or counterdependent patients for the therapist to note how hard it may be for them to find the courage to stay in therapy. The statement rings true, and it also increases the probability that they can resist temptations to flee.

FRINGE BENEFITS

People are more comfortable when they sense that their interviewer is at ease. A therapeutic relationship is likely to get off to a good start if the client feels the clinician's curiosity, relative lack of anxiety, and conviction that the appropriate treatment can begin once the patient is better understood. A therapist who feels pressure to begin *doing therapy* before having come to a good provisional understanding of the patient's personal psychology is, like a driver with some sense of direction but no road map, going to suffer needless anxiety. (Of course, one *is* doing therapy

during a diagnostic evaluation; the process itself contributes to a working alliance without which treatment is an empty ritual. But the formal agreement about how the parties will proceed, and what the boundaries and respective responsibilities of the participants will be, should derive from a diagnostic formulation.) The patient will feel the anxiety and will wonder about the practitioner's competence. This self-replicating cycle can lead to all sorts of basically iatrogenic problems.

The diagnostic process also gives both participants something to do before the client feels safe enough to open up spontaneously without the comforting structure of being questioned. Therapists may underestimate the importance of this settling-in process, during which they may learn things that will become hard for the patient to expose later in treatment. Most adults can answer questions about their sexual practices or eating patterns or substance use with relative frankness when talking to someone who is still a stranger, but once the therapist has started to feel familiar and intimate (perhaps like one's mother) the words flow anything but easily. When a parental transference has heated up, the client may be encouraged to push on by remembering that in an early meeting with this person whose condemnation is now feared, all kinds of intimate matters were shared without incurring shock or disapproval. The patient's contrasting experiences of the therapist during the diagnostic phase and later phases of treatment calls attention to the fact that the transference *is* a transference (i.e., not a fully accurate or complete reading of the therapist's personality), an insight that may eventually be crucial to the person's understanding of what he or she typically projects into relationships.

One source of some therapists' discomfort with diagnosis may be fear of misdiagnosis. Fortunately, an initial formulation does not have to be "right" to provide many of the benefits mentioned here. A diagnostic hypothesis has a way of grounding the interviewer in a focused, low-anxiety activity whether or not it turns out to be supported by later clinical evidence. Given human complexity and professional fallibility, formulation is always tentative and should be acknowledged as such. Patients are often grateful for the clinician's avoidance of pretension and demonstration of care in considering different possibilities.

Finally, a positive side effect of diagnosis is its role in maintaining the therapist's self-esteem. Among the occupational hazards of a therapeutic career are feelings of fraudulence, worries about treatment failures, and burnout. These processes are greatly accelerated by unrealistic expectations. Practitioner demoralization and emotional withdrawal have far-reaching implications both for affected clinicians and for those who have come to depend on them. If one knows that one's depressed patient has a borderline rather than a neurotic-level personality struc-

ture, one will not be surprised if during the second year of treatment he or she makes a suicide gesture. Once borderline clients start to have real hope of change, they often panic and flirt with suicide in an effort to protect themselves from the devastation they would feel if they let themselves hope and then were traumatically disappointed. Issues surrounding this kind of crisis can be discussed and mastered (e.g., in terms of the felt dangers of hope and disappointment just mentioned, guilt toward original love objects over the transfer of emotional investment from them to the therapist, and related magical fantasies that one can expiate such guilt by a ritual attempt to die), providing emotional relief to both client and therapist.

I have seen many gifted, devoted therapists lose confidence and find rationalizations for getting rid of an ostensibly suicidal patient at precisely the moment when the person is expressing, in an identifiably provocative borderline way, how important and effective the treatment is becoming. Typically, in the session preceding the suicide gesture the patient expressed trust or hope for the first time, and the therapist became excited after so much arduous work with a difficult, oppositional client. Then with the parasuicidal behavior the therapist's own hopes crumble. The former excitement is reframed as illusory and self-serving, and the patient's self-destructive act is taken as evidence that the therapeutic prospects are nil after all. Recriminations abound: "Maybe my Psych 101 teacher was right that psychoanalytic therapy is a waste of time." "Maybe I should transfer this person to a therapist of the other gender." "Maybe I should ask a biologically oriented psychiatrist to take over the case." "Maybe I should transfer the patient to the Chronic Group." Therapists, whose personalities are often rather depressive (Hyde, 2009), are quick to turn any apparent setback into self-censure. Sufficient diagnostic facility can make a dent in this propensity, allowing realistic hope to prevail and keeping one in the clinical trenches.

LIMITS TO THE UTILITY OF DIAGNOSIS

As a person who does predominantly long-term, open-ended therapy, I find that careful assessment is most important at two points: (1) at the beginning of treatment, for the reasons given above; and (2) at times of crisis or stalemate, when a rethinking of the kind of dynamics I face may hold the key to effective changes in focus. Once I have a good feel for a person, and the work is going well, I stop thinking diagnostically and simply immerse myself in the unique relationship that unfolds between me and the client. If I find myself preoccupied with issues of diagnosis in an ongoing way, I suspect myself of defending against being fully present

with the patient's pain. Diagnosis can, like anything else, be used as a defense against anxiety about the unknown.

Finally, I should mention that people exist for whom the existing developmental and typological categories of personality are at best a poor fit. When any label obscures more than it illuminates, the practitioner is better off discarding it and relying on common sense and human decency, like the lost sailor who throws away a useless navigational chart and reverts to orienting by a few familiar stars. And even when a diagnostic formulation is a good match to a particular patient, there are such wide disparities among people on dimensions other than their level of organization and defensive style that empathy and healing may be best pursued via attunement to some of these. A deeply religious person of any personality type will need first for the therapist to demonstrate respect for his or her depth of conviction (see Lovinger, 1984); diagnosis-influenced interventions may be of value, but only secondarily. Similarly, it is sometimes more important, at least in the early phases of therapeutic engagement, to consider the emotional implications of someone's age, race, ethnicity, class background, physical disability, political attitudes, or sexual orientation than it is to appreciate that client's personality type.

Diagnosis should not be applied beyond its usefulness. Ongoing willingness to reassess one's initial diagnosis in the light of new information is part of being optimally therapeutic. As treatment proceeds with any individual human being, the oversimplification inherent in our diagnostic concepts becomes startlingly clear. People are much more complex than even our most thoughtful categories admit. Hence, even the most sophisticated personality assessment can become an obstacle to the therapist's perceiving critical nuances of the patient's unique material.

SUGGESTIONS FOR FURTHER READING

My favorite book on interviewing, mostly because of its tone, remains Harry Stack Sullivan's *The Psychiatric Interview* (1954). Another classic work that is full of useful background and wise technical recommendations is *The Initial Interview in Psychiatric Practice* by Gill, Newman, and Redlich (1954). I was greatly influenced by the work of MacKinnon and Michels (1971), whose basic premises are similar to the ones informing this text. They finally issued, with Buckley, a revised edition of their classic tome in 2006 (now available in paperback). In *Psychodynamic Psychiatry in Clinical Practice*, Glen Gabbard (2005) has masterfully integrated dynamic and structural diagnosis with the DSM. For a well-written synthesis of empirical work on personality, applied to the area

of clinical practice, I recommend Jefferson Singer's *Personality and Psychotherapy* (2005).

Kernberg's *Severe Personality Disorders* (1984) contains a short but comprehensive section on the structural interview. Most beginning therapists find Kernberg hard to read, but his writing here is pellucid. My own book on case formulation (McWilliams, 1999) complements this volume by systematically considering aspects of clinical assessment other than level and type of personality organization, and my later book on psychotherapy (McWilliams, 2004) reviews the sensibilities that underlie psychoanalytic approaches to helping people. Mary Beth Peebles-Kleiger's *Beginnings* (2002), similarly based on long clinical experience, is excellent. So is Tracy Eells's (2007) more research-based text on formulation. For an empirical measure of inner capacities of the whole person that therapists need to evaluate, consider the Shedler–Westen Assessment Procedure (SWAP) (Shedler & Westen, 2010; Westen & Shedler, 1999a, 1999b). Finally, the *Psychodynamic Diagnostic Manual* (PDM Task Force, 2006) fills in many gaps left by this book.

Guilford Publications
72 Spring Street
New York, NY 10012
212-431-9800
800-365-7006
www.guilford.com