sive drive. Freud’s successors in the object relations movement have added a critical third “instinct” (if anything so complicated can still be termed as such), namely, dependency (attachment).

Freud tended to talk about people as if they were self-contained, individual systems. But beginning theoretically with Fairbairn’s (1952) challenge to classical Freudian theory, in which he argued that infants seek not drive satisfaction but relationship, and empirically with Bowlby’s (1969, 1973) studies of attachment and separation in infants, analysts have become increasingly impressed with the ubiquity of human connection, of our embeddedness in an interpersonal system where our sexual and aggressive nature is only part of the story. A huge literature on attachment has appeared during the last generation, as researchers and clinicians are repeatedly confronted with the evidence of people’s lifelong needs for objects and arenas for their various passions. A related emphasis among self psychologists concerns the permanence of people’s need for “selfobjects,” those who mirror and validate us.

All this relates to one other outcome of effective psychodynamic therapy, namely, the transformation of infantile dependency into mature adult dependency. Western myths about human independence notwithstanding, we all need each other in both emotional and practical ways throughout the lifespan. Psychotherapy does not take dependent people and make them independent; rather, it makes them capable of handling their natural dependency in their best interests. It confronts counterdependent people with their legitimate needs for others. The main differences between attachment in infancy and attachment in adulthood are that unlike adults, children cannot choose those on whom they depend, cannot ordinarily leave inadequate caretakers, and have insufficient power to influence their objects to change their behavior. Many adults come to therapy feeling like children trapped in destructive relationships and concluding that there is something dangerous about their need for others. Ideally, they figure out during treatment that it is not their basic needs that have been problematic but their handling of them.

**Pleasure and Serenity**

The final goals for a psychodynamic therapy that I want to discuss briefly are perhaps the most elusive to articulate. Despite the fact that most of us think we know what is meant by the term “happiness,” we are often rather self-defeating in pursuing it. Part of the blame for this can be laid on myths that permeate a commercial, market-oriented culture like ours, in which we hear unrelenting messages about how better bodies and more lavish possessions will save us from despair. In an individualistic, competitive culture, the promise is ubiquitously made that we each will be happy if we only have what we want. In many non-Western cultures, by contrast, the prevailing wisdom concerns how to learn to want what one has.

Psychoanalytic thinking is a curious blend of these sensibilities: It is thoroughly Western, positivistic, individualistic, and (originally, at least) concerned with drive satisfaction and frustration. Yet from the very beginning, there has been an emphasis on deference to the “reality principle,” to delay of gratification, to becoming “civilized” so that one hangs one’s self-esteem on one’s contribution to the larger community and can renounce immediate satisfactions in favor of more deeply nourishing, lasting kinds of pleasure. As Messer and Winokur (1980) concluded, the psychoanalytic worldview is tragic rather than comic (in the technical, not the popular sense of these terms). Analysts emphasize how deeply conflicted we are, how we have to give up our infantile wishes, how we have to compromise. With the general move toward more relational models of human psychology and psychoanalytic treatment, where attachment and separation are even more important concepts than drive and conflict, a focus on mourning has replaced an emphasis on striving.

A good dynamic formulation will illuminate the ways in which a person thinks happiness can be pursued and will consequently contain implications for intervention. People’s pathogenic beliefs and individual ways of supporting their self-esteem are often radically at odds with their prospects for genuine pleasure and contentment. Grieving over what is not possible sets the stage for enjoying what is. Very often, in the later phases of psychotherapy, a client will comment that while he or she had known previously what it was like to feel “high” or “in a good mood,” the overall peace of mind that evolved quietly during treatment was something he or she could not even have imagined. Just as orgasm is inconceivable to those without sexual experience, or the thrill of having a baby cannot be imagined until one becomes a parent, genuine serenity is probably inconceivable emotionally to the person who has settled for temporary bursts of elation.

**CASE FORMULATION FOR THERAPEUTIC RATHER THAN RESEARCH PURPOSES**

With the preceding objectives in mind, it becomes clear that what a therapist is doing when he or she makes a dynamic formulation is a
very different process from the symptom-matching exercise that comprises diagnosis in accordance with the DSM. As I have argued elsewhere (McWilliams, 1998), therapists and researchers bring very different sensibilities to the diagnostic process. For example, therapists become impressed in their work with how many communications occur through facial expression, body language, tone of voice, pregnant silences, seemingly innocent questions, lateness, patterns of payment, enactments, and other nonverbal nuances that require a disciplined subjectivity to decode. They learn to trust the clinical hunch. The efforts of the creators of the DSMs ever since DSM-III (1980) to rid diagnosis of subjectivity so that researchers can share objective measures of psychopathology have increased the reliability of diagnosis but have not contributed to its validity (Blatt & Levy, 1998; Vaillant & McCullough, 1998). Subjectivity is critical for discerning the meaning of a particular behavior.

The Personality Disorders section of the DSM-IV is acknowledged even by enthusiasts of that document to be problematic. A repeated complaint is that when a person meets the criteria for one of the official categories, he or she usually meets those for one or more of the others (Nathan, 1998). In other words, the delineation of behaviorally defined pathologies of character in the DSM has not succeeded in discriminating types of character pathology very well, much less in capturing the uniqueness of anyone's particular "disordered" personality. Nor should we expect a nosology like the DSM to be capable of doing so (see Clark, Watson, & Reynolds, 1995). The art of developing a dynamic formulation is, like other arts, not formulaic.

Researchers in the empirical, positivistic tradition use parsimony as a criterion of explanation, while practitioners are repeatedly impressed with multiple and overlapping causation, or what Waelder (1960) called "overdetermination" (see Wilson, 1995). In other words, in a research project, one tries to isolate variables so that a particular cause-and-effect process can be exposed, uncontaminated by other possible explanations. In understanding the meaning of a problematic behavior, in contrast, one typically finds many contributants, none of which alone would have created the symptom. Anything important enough to have become a major problem to a person is usually overdetermined, not caused by a discrete variable. For example, an obese patient of mine had to become aware of all of the following contributants to her weight problem before she could successfully diet and keep the pounds off: a probable constitutional inclination toward overweight and some hypoglycemic tendencies; a mother who was overconcerned with her eating habits (beginning with feeding her baby on a rigid schedule and later acting hurt if she failed to eat everything on her plate); a family pattern of using food to distract from anxiety and shame (the mother would bring out a cheesecake whenever someone was upset); an identification with a beloved obese grandmother; a childhood molestation in which she had been victimized but for which she had been blamed (leading her to want to demonstrate graphically in her appearance her lack of seductiveness); a pattern of sadness and loneliness that were assuaged by the ritual of coming home after school and comforting herself with snacks; the development of a defiant self-image as a person whose self-esteem inherited in intelligence rather than in physical vanity; and a witnessing of her father's wasting death from cancer, an experience that had created in her the unconscious conviction that losing weight was a precursor to and cause of death.

In analytic therapy, it is the unraveling of many different strands of causation that eventually permits patients to get mastery over patterns they seek to change. Therefore, when trying to come to an understanding of a complex human being and his or her complex difficulties, a therapist is silently pondering several related questions while drawing out and listening to the client. I have organized the rest of this book around those questions that I think are the most pertinent to a good dynamic formulation. They are not exclusive, but if the clinician knows something about each of them, he or she will know a great deal of importance for helping the client transform suffering into mastery. They include the following areas of the person's psychology: (1) temperament and fixed attributes, (2) maturational themes, (3) defensive patterns, (4) central affects, (5) identifications, (6) relational schemas, (7) self-esteem regulation, and (8) pathogenic beliefs.

In understanding the obese patient I have just described, it was thus important to discover with her (1) that she needed to develop particular strategies for counteracting her constitutional inclinations toward overeating and to change her meal pattern to accommodate to her hypoglycemia; (2) that she had learned in the earliest phase of development that she had better eat everything now, because food would be unavailable for the next four hours, and in later phases that not finishing her meals would injure her mother; (3) that she must replace eating with other means of handling anxiety; (4) that she could soothe herself when she was unhappy and lonely by taking a hot bath, calling a friend, or going shopping, and that, ultimately, by grieving over the many unfortunate aspects of her life, she could emerge from her chronic sadness; (5) that she believed she would magically have her grandmother's posi-
tive qualities if she had her obesity (and conversely, that she would avoid her mother's negative ones if she avoided being thin like her); (6) that she was still living in a posttraumatic mental state in which she saw others as potential molesters and blamers; (7) that the value system by which she had supported a fragile self-esteem as a teenager was now operating to deter her from enjoying and profiting from a normal degree of vanity; and (8) that whenever she lost a few pounds, she became unconsciously panicky that she would die like her father.

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

SUMMARY

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