DISTILLING THE ESSENCE OF TREATMENT:
A Beginner's Guide to the Retelling of an Analysis[1]

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Learning how to conduct an analysis and think psychoanalytically about treatment does not prepare an analyst-in-training for the task of writing the sort of case history that's required by certain institutes to graduate from psychoanalytic training or by certification bodies charged with the responsibility of assessing the quality of an analyst's work. Translating a lived, complex, intersubjective process—which takes place both verbally and nonverbally involving both primary- as well as secondary-process thinking—into a linear, coherent construct can prove quite challenging. So too can the task of learning how to shift back and forth between an examination of clinical material on a micro-process level as it manifests at a specific moment in time (a "vignette") or during a series of moments occurring over the course of time—as occurs in supervision—to a macro-process consideration of a few, selected themes that are longitudinally woven through the course of an analysis. Finally, finding a way to effectively condense all that has happened over the course of a lengthy analysis into a succinct 20-page report requires one have a keen sense of what to leave in and what to leave out. For those writing case reports to graduate from their institutes or become certified in psychoanalysis, there are additional issues and concerns related to the task of figuring out how to cut muster—how to write a case report

[1] I wish to thank Drs. Sharen Westin and Louis Weisberg, who provided case report examples from early in their careers before they'd graduated from psychoanalytic training.

that will be deemed worthy to graduate or become certified all the while struggling with the anxieties, resentments, fantasies, and resistances stirred up by this task. Particularly prominent are concerns about whether evaluators' judgements will prove arbitrary and the narcissistic vulnerability of putting one's sense of professional worth on the line by submitting to the judgment of others.

In this paper, I offer thoughts about problems inherent in the task of translating a lived experience into a written document. I also describe and discuss the sorts of feelings that get stimulated when one tries to write a case report that becomes the basis for one's professional advancement. The data upon which I base my observations and conclusions comes from my experience conducting a tutorial program for candidates writing up their cases for graduation and graduate analysts preparing their case reports for certification. During this tutorial work, I formed conclusions about the task of writing for professional advancement that grew out of discussions I had with these analyst-writers about their experiences.

A PRIMER ON WRITING FOR PROFESSIONAL ADVANCEMENT

Learning how to conduct an analysis and think psychoanalytically about the treatment does not prepare an analyst-in-training for the related task of writing the sort of case history that is required by some institutes to graduate from psychoanalytic training, that leads to certification in psychoanalysis, or is central to getting one's work into print. Translating a lived, complex, intersubjective, interactive process that takes place both verbally and nonverbally involving both primary- as well as secondary-process thinking into a linear, coherent construct can prove quite challenging. So too is the task of learning how to shift back and forth between a micro-process

examination of material that emerges during a specific moment in analysis (a "vignette") or a series of like moments occurring over the course of consecutive sessions—as occurs in supervision—to a macro-process consideration of a few, selected themes that emerge and become longitudinally woven through the course of the analysis.

We begin with an admission: Asking trainees to distill hundreds if not thousands of clinical hours into a condensed, twenty-page report of the sort required to become certified in psychoanalysis is a herculean task. After all, Freud's famous cases tend to run over 100 pages in length though they describe analyses that by and large were months long, not years long. This makes the task of saying something meaningful about a lengthy analysis a near impossibility. Acknowledging as much, Stephan Bernstein (Westin et al, 2008) would advise trainees to not try to convey the multitude of themes and issues addressed in the course of the analysis, and—instead—to pick, say, six sequences that are illustrative of one's work and to write about those instances in ways that "show us how you understand the analysis and integrate things for us" (p. 419).

Retelling an analysis in a succinct 20-page report requires one have a keen sense of what to leave in and what to leave out. It is essential that one make sure not to inundate the reader with too much information, particularly if that information will end up proving to be extraneous to the central issues one's selected to address. As they say, don't introduce the butler in the second act if he doesn't figure into the plot's resolution by the fourth act. Having said as much, I do not wish to create the impression that it is best that a case history be written in so airtight a way as to allow for no other possible interpretation of the material. Loose ends can never be completely

eliminated, nor should they be. All I am suggesting is that extraneous material can prove distracting, particularly if it ends up contributing nothing whatsoever to the ultimate understanding of the case. As a corollary: if a dream is mentioned to make a point, it is better to present the fragment of the dream that illustrates that point, rather than adhering to a sensed obligation to present the dream in its entirety. Furthermore, inexperienced analyst-writers may find it hard to resist the urge to include material they deem too interesting to leave out even though it has no bearing on the points selected for illustration.

Another matter that trainees must consider is the fact that the raw data of a psychoanalytic session often needs to be processed to make the case report crisper and easier to understand and follow. Discrepancies between how a clinical moment felt when it had happened and how it "reads" in its reporting can prove disturbing for those new to the field because it strikes them that the report they'd penned seems fictitious. Paikin (1995) wrote about how

> *A supervisee who had given an excellent report about a session added, with all signs of guilt, that the report was a "fake," because it was continuous and meaningful, which she didn't think was the case in the session" (p. 184).*

This, I submit, constitutes a core problem facing many who undertake translating clinical process into report form.

Another prominent issue that effects the writing of case histories involves the writers concern that he fashions a case report that will cut muster with the reader-examiner who is positioned to determine the trainee's professional advancement. The wish that one's work will be found acceptable stirs up fantasies, anxieties, resentments, as well as resistances as one sets oneself to

the task of completing a case history. Under such circumstances, Robert Michels (2000) notes, there is an intensification of "the struggle between the desire to tell a story accurately and the desire to be well regarded," which oftentimes results in a case report that "shows more about the applicant's fantasy concerning the certification process than about the case" (p. 361). Michels further notes that members who served on The Board of Professional Standards[2] *Committee on Certification*, now superseded by an external organization known as The American Board of Psychoanalysis, had been well aware of this problem, and he quotes Stephen Bernstein (1995)—who headed that Committee—as having cautioned applicants that "the committee does not…expect you to shape what you believe and what you did in order to conform to what you think we want" (pp. 7, 11). Many seeking certification historically expressed concern that their case reports conform to the tenants of ego psychology, with an emphasis on oedipal dynamics. Bernstein insisted this was not the case. He insisted that one is not required to announce one's theoretical orientation, though he noted it would undoubtedly become evident as one goes about reflecting on the observed data. After all, these is no such thing as data seen without the help of an organizing principle that directs ones attention to stimuli deemed salient in the process of culling observations that will go on to become the basis of one's theoretical inferences. However, despite reassurances to the contrary, it seems unrealistic to expect such reassurances to result in a trainee's being able to set aside the natural tendency anticipate and live up to the assessor's imagined expectations. Hence, it is hard for writers to remain exclusively focused on the task of demonstrating psychoanalytic competence *without regard for what "demonstrated competency" means to the assessor*.

[2] A now defunct Board of the American Psychoanalytic Association

A circumstance that compounds a trainee's difficulties knowing how to go about writing for professional advancement issues from the fact that training involves the reading of clinical reports appearing in the literature that were written with a different aim for a different audience. The primary task of writing a case report for publication is to provide evidence supporting the writer's proposed thesis and not to chiefly demonstrate *his ability to conduct an analysis* or even to showcase his ability to think analytically—though this later ability must be evident if the writer hopes to convince his reader of his reasoning. By contrast, case reports written chiefly for professional advancement are of another sort, which can prove confusing for those writing for graduation or certification. Bernstein (1992) outlines how case writing submitted for professional advancement should clearly demonstrate "process":

> A description of the process is a narrative of what happened in the analysis, how you helped this happen, and how you understand how this occurred. . . . The psychoanalytic process with an appropriate patient takes place in the context of a treatment situation which you have fostered; employs specific techniques and a certain attitude or perspective toward the patient; and describes various changes occurring over time. In order to demonstrate that the treatment was psychoanalytic in nature, the description should convey how you understood the inferred structure of the patient's mind. This will often be seen in relation to unconscious elements and resistances, the urges and the defenses and their representation in the transference (p. 470-471).

Beside the fact that published clinical work has a different purpose and is written for a different audience is the undeniable fact that a certain percentage of published clinical work represents an idealized version of what had taken place in the consulting room. This undeniable observation is

one many trainees have yet to realize. Reading published accounts of how an analyst had expertly and adroitly interpreted clinical material can create an unrealistic model of exemplary work thought by the trainee to epitomize what he is expected to emulate and approximate, against which his work will be judged. Local lore provides an anecdote telling of how Ralph Greenson (1967) pointing to his classic book, *The Technique and Practice of Psychoanalysis*, saying, "This is the *ideal* Greenson," then, pointing to himself, saying, "This is the *real* Greenson!" Here, Greenson alludes to the fact his retellings significantly improved upon his actual in-session performance interpreting. I suspect what he and many other writers present as their work sometimes reflects what they themselves *wished to have said at the time,* rewriting their interpretations to make them sound more elegant, succinct, and to-the-point compared with the originally delivered interpretation, which might have proven embarrassingly awkward in its original phrasing. One may consider such an admission shameful to the extent it suggests falsification that flies in the face of scientific honesty. One may further worry that such an admission casts serious doubt on the veracity of psychoanalytic treatment. There is, however, something worth considering before one reaches such conclusions. Verbatim reports of clinical interactions don't necessarily do justice to what analyst and analysand took away from a given interaction, which may require the addition of extra words—or other words—to faithfully convey to the reader the gist of what had been said and meant by each, resulting in a rewritten interpretation that might actually better represent what the patient gleaned from the otherwise clumsy interpretation that the analyst only half-remembers having made. Tuckett (1993) notes "in his attempt to communicate, the analyst *says* more than he consciously knows. This is strength, not a weakness" (p. 1184). If the analyst retrospectively recognizes this "more" to which Tuckett refers, and, as a result, includes it in his written report of the delivered

interpretation, he may paradoxically enhance the accuracy of the reported interpretation relative to how it may have seemed to have played out at the time.

In addition to determining an analyst-writer's capacity to conduct an analysis and think analytically, those charged with the task of assessing psychoanalytic competence also want to see evidence that the analyst-writer had influenced the patient (and, for that matter, been reciprocally affected by the patient) and can recognize and articulate that effect. Merely noting that a patient had essentially agreed with the analyst's interpretation does not necessarily constitute evidence since such declarations by the patient that the analyst "got it right" can just as easily constitute attempts to satisfy the analyst's narcissistic wish to feel competent and effective. Furthermore, the psychoanalytic model of therapeutic action that pictures change beginning with the analyst's interpretation, followed by a "light" going off in the patient's mind (the "Ah Ha!" moment), which then leads to the recovery of a repressed memory that serves to confirm the analyst's interpretation, is a rarely achieved ideal. Oftentimes, the actual interpretative process fails to conform to this idealized model, which led Modell (1991) to conclude, "the most effective interpretations are those made when we do not know whose construction it is, ours or the patients" (p. 234), echoed in Paikin's (1995) noting: "A supervisee looked up from his notes and said: 'I really don't know whether it was I or the patient who said this'" (p. 184). Expecting trainees, and trainees who expect themselves to demonstrate their influence by conforming to the idealized model of therapeutic action described above, potentially contributes to the fictionalization of a reported analysis insofar as it views the process from a strictly one-person psychological perspective.

Bernstein's Perspective

For several years running, Stephan Bernstein—who has been intimately involved in the process of psychoanalytic certification—conducted writing workshops at meetings of the American Psychoanalytic Association and published numerous papers on the subject (Bernstein 1992, 1995, 2000, 2008a, 2008b). Bernstein recommends that trainee-writers adhere to a three-structure format when constructing case reports to help them avoid the pitfall of *confusing observation with inference, data from theory*—which many see as a major stumbling block to those attempting to put their clinical experiences on paper (Klumpner & Galatzer-Levy, 1992; Tuckett, 1995; Boesky, 2005). What Bernstein believes to be essential is to not conflate the patient's lived experience with the analyst's reflections or formulations about that experience (Bernstein 2000). To this end, he advises that case reports first describe raw observations (experience-near, using actual quotes) sans interpretation, which includes the analyst's own, affective responses (including reveries)—just so long as those experiences aren't secondarily elaborated into theories about the experiences meaning. The experiencing section is then followed by "*the reflecting section*," which outlines what the analyst "made" of what he'd observed/experienced—his reflections on the raw data. These inferences are then employed in fashioning the analyst's interventions—in accordance with his prevailing theory of clinical action. How one arrives at these inferences is to be discussed (e.g., in terms of a repetition of past experiences, the utilization of defense mechanisms, and so on and so forth). Linking these paired sections of observation and reflection is a third section—*the transitional narrative section*—which serves to bridge sections that take place at intervals throughout the course of the completed analysis and (ideally) demonstrate changes taking place both inside and outside the consulting room. Bernstein notes that as the case presentation unfolds it is necessary to create a

timeframe for the reader (e.g., “by the sixth month of analysis,” “two months after the patient began using the couch,” etc.) so the reader has a clear sense of how far along the patient is in the course of his or her treatment. Using specific dates (“In July 1998, Mr. A. began twice weekly psychotherapy with me”) is less than optimal for locating oneself within the process because it requires that the reader do the math to know how far along in the treatment the patient is each time a date gets mentioned. Bernstein (2000) provides an example of such a segue:

> Over the next several months Mr. A continued to feel comfortable in the deepening process, exhibiting a comfort and ease that I too experienced. I saw this in his associations to greater ease in his professional work and a markedly greater closeness to his three sons. He had not seemed to appreciate their achievements before, but now there seemed to be a dawning realization of their successes and greater expression of care and closeness toward them. In addition, he spoke of having more discussions with his wife (p. 388).

Sometimes writers fail to keep their reader abreast with events taking place in the patient’s outside life because they are single-mindedly focused on describing the process taking place in the room. Mentioning changes taking place in the patient’s outside life helps document internal structural change that has taken place within the patient, presumably as a result of the analytic work. Whether a patient is dating more appropriate women, has developed the capacity to experience a deeper relationship with a significant other, or has matured in the way in which he handles anxiety, are the types of segues that help move the reader from one reported period to the next. Furthermore, if the reader is not kept up-to-date about what is happening in the patient’s outside life he will be taken by surprise when he learns that some monumental change has

occurred, though he hasn't any sense what led to that development. For example, one analyst I worked with wrote about Mr. A., who we suddenly learned had fallen in love and married, even though the writer had mentioned nothing about the courtship or about the nature of the relationship, other than the analyst's assessment that it seemed like a "very appropriate choice" for the patient.

COMMONLY ENCOUNTERED PROBLEMS

In this section, I will present what I consider problematic passages from case write-ups that I was asked by the authors to help revise. Italicized words or phrases indicate what I consider to be a flaw in the write-up's original sentence, and I present alternate ways of conveying the same information in italics that I believe improve the quality of the writing.

Failure to have Empathy for the Reader

It's essential that writers strive to have empathy for their readers. If one fails to pay close attention to what the reading experience might be like for the average reader one will pay dearly for the oversight. At best, the reader will put the paper down and it will go unread, though there is always the possibility that one will cause the reader to feel so irritated that he will develop a negative attitude about the paper and the writer as well. When the reader is one who is charged with the task of assessing whether the writer had earned the right to graduate for his institute or be granted certification, a lack of empathy for the reader can prove deadly. Bernstein (2000) expresses concern that writers work to ensure their case reports not overly burden the readers, writing

> The reader of a confusing, poorly presented case report may feel annoyed and thwarted in attempting to follow the clinical work. The affect mobilized and the effort needed to

> "find the analysis" in the writing can interfere with the reader's understanding of the process (p. 383)

How does one remember to keep the reader in mind? What types of writing styles are likely to prove off putting? What style of argument is likely to raise doubt in those reading the write up? It is worth reiterating a point mentioned earlier in the paper: if one presents one's work in a way that relies heavily on the analyst's authority ("I was present on the scene, you can take it from me") or one attempts to convince by employing a rhetorically persuasive style, one is likely to irritate the evaluator who is experienced enough to recognize such maneuvers and, accordingly, less likely to fall for such techniques. Abrams (1994) does an outstanding job outlining a number of problematic writing styles noted in papers submitted for publication.

> Some papers have an imperious quality. Authors who offer such contributions convey the impression that their authority alone is enough to justify an eager reception. The subliminal message is: 'You *must* find as I do'. . . . Other papers are less imperious but have a climate of affective intensity. Writers of such papers are absolutely convinced of the accuracy of their findings. They appear to believe that the climate of their own conviction is more valuable than what they report of the evidence. Indeed, some readers may be swept along such a current, but many others are left wondering how many of the 'facts' genuinely stand on their own merit . . . . Papers that eagerly propose hasty generalisations also promote discomfort, causing readers to rear back. . . . A variant of such a stylistic misadventure is the 'call-to-arms' paper. This paper uses a clinical illustration to urge a revolt in one sector or another of theory or technique. Adherents of a writer's cause need no such call, while adversaries will only become more reluctant to

focus upon the wisdom in the vignette. When such papers border on arrogance, even adherents draw back.

The Omission of Countertransference

Of the varied tasks that trainees face in the process of constructing a case report none is more personally challenging than conveying one's countertransference reactions. Though we now teach trainees that such reactions constitute legitimate data oftentimes necessary to fully understand a case, this doesn't universally translate into trainees feeling easier about divulging how they'd felt in the room with the patient. Many continue to fear that their reactions may not be those that others would necessarily have given the circumstances but—rather—might turn out to be indicative of their own neurosis. Fearing that divulging one's countertransference reactions will raise the assessor's eyebrow can result in the trainee's omission of such reactions that—if mentioned—might help the reader better appreciate what the experience had been like to live—which, in turn, might contribute to the reader's experiencing the case report as eminently believable.

Taking part in a group discussion about case report writing (which went on to be published), Sharen Westin (Westin, et al, 2008) presented a case report to a group of seasoned analysts experienced in evaluating such reports. Westin writes about how she thought she'd adequately portrayed a picture of her patient as an anxious, panicky toddler only to realize, after receiving feedback from the group, that by leaving herself out of the description by failing to describe how his behavior *had made her feel,* she had omitted critical data that would have helped the reader better appreciate what it felt like to be in the room with such a patient. "It came to me as a

revelation," remarks Westin, "that the treatment report is supposed to be about the process *and about me.* That was not my agenda. I was trying to convey a feeling about my patient without me as part of the story" (p. 411, italics added). Bernstein (2008a) describes this omission as that of "the hidden analyst," which—along with the equally limiting omission of "the hidden process" (what elementary school math teachers refer to as "showing your work" rather than merely coming up with the final mathematical answer)—often contributes to submitted case reports failing the certification process.

Susan Furman (2006) reports having had a similar epiphany after receiving feedback about a case report that she had penned—an epiphany that played a central role in consolidating her sense of self as an analyst:

> What I had previously understood to be analytic process was in reality a vigilant tracking of the verbatim interactions between my patient and me. Missing from the report was any demonstration of my thoughts and reactions as an analyst. I did not provide the reader with any insight into how I conceptualized change and worked as an analyst. I did not explain what led to my interventions: why I spoke or did not speak, how I chose my interventions, or how I evaluated their effectiveness towards deepening the analytic process. The careful reporting and repetition of details inundated the reader with material but did not explain the process that had taken place in the analytic dyad. I presented a clear picture of the patient but left the reader with a distant observation of the process and my thinking. Without an explanation of my understanding of the process of change, the reader was required to do the work of integrating the material and attempting to decipher

> the evolution of the analytic process. Integration and synthesis are the elements that differentiate process notes from analytic process (p. 684).

Stymied by the daunting task

As had proven to be the case in Westin's participation in the group discussion of her presented case report, it often turns out that the most salient data about the case doesn't end up in the written case history but, rather, emerges as if parenthetically, as one is talking candidly—"off the record"—to a fellow colleague about the case unencumbered by pressure of feeling the evaluators' eyes looking over her shoulder, which permits the writer to speak freely without giving the matter a second thought. I myself encountered this phenomenon repeatedly when I'd mentored trainees who were in the process of preparing their case reports. When these writers would talk to me about the case, revelations would emerge that were both well-stated and clarifying. Each time this would happen I would react emphatically with an insistent: "See! See! THAT is what you ought to have written! What you've just conveyed to me in this moment, when you weren't burdened by the need to say it right, hits the nail on the head!" I went on to liken this to the experience of sitting at a bus stop casually talking with a colleague about a particular case, expending little effort in the process of sharing what the treatment experience had been like. In comparable fashion, Bernstein (2008b) writes

> One useful way for the analyst to begin to find the basic themes of an analysis involves an exercise that I call the *three-minute chess game*. It is similar to the way that experienced chess players practice by forcing themselves to play an entire match in a very brief time. This may cause more automatic or preconscious processes to become

> apparent. In a similar manner, the writer may find out what he feels are the central themes and issues of an analysis by forcing himself to summarize the analysis to a colleague or supervisor in perhaps one to three minutes. If this exercise is repeated several times, and written down, the resulting choices, order, and priorities can act as an initial outline for the essential issues, which then can serve as a guide to reviewing the analytic notes (p. 447).

OTHER SUNDRY ISSUES

There are many other identifiable issues that may also negatively impact the quality of a trainee's efforts to demonstrate his ability to observe the process, think about the process, and intervene based on inferences he made about the process. Sometimes trainees fail to spell out their conclusions, hoping that obliquely alluding to the matter may help them escape the risks associated with explicitly stating the conclusions they'd reached. This may result in their presenting their "findings" in an overly tentative manner, which may prove to be a wise way of couching an interpretation offered to a patient since it helps them seem less adamant, but such tendencies toward circumspection, if they go too far, can weaken the case report. On the other extreme, trainees may end up making claims that are unsupported by the raw data, either because the raw data upon which they'd based such inferences go unmentioned or—if mentioned—don't amount to sufficient evidence to support what the reader comes to see as a leap in the trainees reasoning. In this category I would put dream interpretations that seem to either make no use of the patient's associations or, otherwise, fail to reference previous work done by analyst and analysand upon which the dream interpretation was based. Sweeping interpretations that attempt too much are also discussed in this section.

Pat Answers vs. Failures to Conclude

While it's important that trainees streamline their case presentations to produce a well-woven, easy-to-follow, coherent presentation, if they remove too many of the case's warts, either for the sake of aesthetics or to heighten the reader's sense of conviction about the veracity of the tale as told, new problems will arise. A case report that seems to answer all the questions—a report that is too pat or facile—is likely to arouse suspicion and irritation rather than conviction in the reader, which is something all who write for graduation and certification must keep in mind. Tuckett (1993) speaks to the appeal and dangers of a "convincingly written" case report:

> There is the possibility that a good, well-told and coherent story creates the risk of seduction, which in the context of communication to others can be summed up thus: the more a narrative is intellectually, emotionally and aesthetically satisfying, the better it incorporates clinical events into rich and sophisticated patterns, the less space is left to the audience to notice alternative patterns and to elaborate alternative narratives. (p. 1183)

On the opposite end of the spectrum are trainees who either fail to explicitly state their conclusions in no uncertain terms or feel obliged to include too many loose ends or present too much extraneous material—presented in an effort to portray themselves as endlessly open minded, dedicated to the task of leaving no stone unturned, free of any tendency to lapse into the problematic practice of seizing up an "overvalued idea" (Britton & Steiner, 1994), which threatens to bring continued investigation to a screeching halt. A writer may justify including *all* such material in the name of scientific honesty, but the unfortunate result of including material

that cannot be explained by the writer's conclusions is that the reader is left feeling unsatisfied, wondering to him- or herself about matters that were left dangling: "But what about 'x'? What about 'y'?" We tend to be unforgiving of a novelist or screenwriter who introduces information that is inconsistent with, or goes unexplained at the story's ending. So too, readers of analytic papers want the satisfaction of feeling that, by and large, the conclusions reached substantially explain the clinical phenomenon presented, with loose ends *more or less* tied up neatly, if not perfectly. This is not to suggest that write-ups are to be airtight since those written in this fashion also raise suspicions, it is only to describe the twin dangers that exists at the extreme ends of the spectrum.

Going too far: Inference run amok

The question of what constitutes psychoanalytic evidence or "data" ("facts") is a complex issue and space does not permit a lengthy discussion of the worthy topic. Writing about the subject, Tuckett (1995) offers the following:

> I argue that if free association and free-floating attention are being used by a trained analyst then other analysts can agree these are the facts: irreducible subjective facts as they have been called. But this selectivity and subjectivity about the occurrences leaves open the question of *what we take them to mean*. The great advantage of defining *clinical facts* in this way is that it is then possible to examine the inferences required to assess their significance…The concept of clinical fact in this view is a device to allow us to consider the complex array of meanings we can place on an occurrence and the processes

> of inference that have taken place: it allows us to see how the case is being made. (p. 657, italics added)

Sometimes case reports contain assertions (inferences) without the supporting data needed to back the claim. A good example is when a trainee lists various defense mechanisms he or she believes the patient is employing without providing illustrations of these defenses in action. Likewise, reports of dream interpretations made without referencing either the analysand's associations or background data upon which the analyst might reasonably draw his conclusion, places the reader in the uncomfortable position of having to accept the interpretation on faith. An example of this is provided in an analyst's write-up of Jennifer B., a depressed, rejection-sensitive woman who felt she'd been an unwanted child and now, at the age of twenty-nine, felt stuck in a marriage she'd agreed to more out of compliance than "real love." The patient had learned to be "a good child" who "followed all the rules." During her analysis, she rarely asked questions and tended to agree with most everything the analyst said, fearing he would find her an "unacceptable" patient. Early in the course of treatment, Jennifer reported the following dream:

> My husband and I were on a cruise ship that got stuck in the muck, and the passengers were required in some way to get the ship unstuck. Instead, I jumped off the ship into the water next to a large hangar-like structure that was shooting off a large stream of white colored liquid toward the shore. I was caught in that stream and flung toward the shore in an area of shallow, mucky water near dozens of sharp wooden spikes.

There is another section to the dream that further clarifies the dream's meaning, but for our purposes I wish to address the analyst's interpretation of this first part of the dream. We hear some of the patient's associations: that she equates sharp wooden spikes with the imagined dangers of psychoanalysis; that white colored liquid means "semen;" that the hangar might be a penis. She also notes that, like the ship, her marriage was "stuck." What the analyst offered in the way of an interpretation was: "I think that in your dream, you leave the cruise ship, your marriage, and go to me, the hangar, the ideal breast/penis that rescues you by flinging you toward shore on a stream of milk or semen." The point I wish to address is the analyst's statement that "her fantasy of me as the hangar, the idealized breast/penis…" The writer provides no patient associations that might help substantiate his claim, nor does he refer to previously established understandings the two had arrived at earlier that might substantiate his interpretation. If there were such evidence, the reader would want to hear it. Otherwise, the analyst's musing seems unwarranted, even though they may be entirely correct.

All-encompassing interpretations

To demonstrate their understanding of the complexities of the case, a trainee who is writing to graduate or an analyst writing to become certified may present an interpretation he or she made during a session that seems to cover all the bases—leaving nothing unnoticed or unaddressed. I believe such all-encompassing interpretations—if actually offered in session rather than representing the analyst's thinking to himself—run the distinct risk of overwhelming the patient, and I am prejudiced toward interpretations that are crisp, to the point, and cover just enough of the patient's unconscious for him or her to consider. All-encompassing interpretations that show up in case reports may not even be accurate depictions of the interpretation offered to the patient.

Some reported interpretations may even be consciously or unconsciously reworked and fashioned to "wow" the reader with the interpretation's breadth. For instance, during the middle phase of Mr. A.'s analysis, the patient reports a dream after the analyst returns from a week's vacation. In response to the reported dream, the analyst offered the following interpretation:

> I think you must have felt abandoned by my leaving on vacation, that I was a mother maybe getting married which you worried would mean that somehow I wouldn't take care of you anymore. So, to protect yourself from feeling abandoned by me, you imagined that I would see you as special and invite you [to the wedding] and then even that it was actually you that I married. But that made you worried about the father, maybe the man I married, who would be jealous—so you imagined that he would have another woman to talk to and so wouldn't be jealous.

There is, in fact, more than enough data to support the analyst's interpretation of the dream. But that is not my point. Rather, I am concerned with the inclusion of so lengthy and all-encompassing an interpretation in her case report because I do not feel it reflects "good technique." Some may disagree, but I would advise the analyst against including this particular interpretation *as an interpretation* in his case report. Instead, I would suggest paraphrasing the process of interpretation, still indicating how much of the material of the dream got covered as she and the patient worked on it together. Alternately, the trainee may choose to share his innermost thoughts about the dream's meaning, contrasting the breadth of his understanding with the more limited interpretation he ended up offering to the patient.

SPECIFIC DIFFICULTIES ASSOCIATED WITH WRITING DYMAMICS

There are a host of problems that involve what could loosely be called "writing mechanics." In this section, I identify seven guidelines for avoiding these commonly encountered problems.

1) Quotations, Verbatim Reports, and Paraphrasing

Sometimes trainees aren't sure about when to quote and when to paraphrase. Direct quotations are important insofar as they enliven the report, though they tend to work best if used to illustrate material that is of greater clinical importance or represents a telling example of how the patient characteristically expressed him- or herself. "I-said-she-said" exchanges should also be reserved to either showcase clinical exchanges that illustrate how psychic change had come about as a result of the analyst's contribution or to illustrate the analyst's style of interacting with or interpreting to the patient. As a rule, if the reader is invited into the inner sanctum of the consulting room by way of a verbatim account, the material had better warrant the use of direct quotations, otherwise the reader may end up feeling teased.

2) Verbs vs. Nouns; Present vs. Past Tense; Writing from the Patient's Perspective

Using verbs, which represent action (Schafer, 1978), is generally preferable to using nouns, which represent things. Consider these instances drawn from actual case reports: I would submit that the phrase "Her fantasy that analysis would *repeat* her experience of being abandoned…" is better than "her fantasy of analysis as a *repetition* of being abandoned…"; "she feared I would treat her with contempt and *reject* her as had her mother," is better than "she feared I would treat her with contempt and *rejection* as her mother had." Furthermore, using the present tense tends

to be preferable to using the past tense because it enlivens the case report by placing the action in the here-and-now rather than looking back on an experience that once was.

Writing from the patient's perspective produces a more experience-near view of the material. For instance, one analyst wrote that Ms. K. "felt she was quite ignored by both parents during her teen years because *her brother's illness apparently preoccupied the parent's attention*." Rewriting the sentence from the patient's perspective yields: "During her teen years, [Ms. K.] felt ignored by both her parents *whose attention was monopolized by her brother's illness*." No patient would ever use the phrase "apparently preoccupied." That phrase is obviously spoken from an outsider's vantage point, and—furthermore—casts doubt on whether the patient's account is factually accurate.

3) Using Technical Terminology When Everyday Language Works Better

Trainees may figure that if they don't use enough of the "lingo," they won't sound like "real" psychoanalysts. The problem comes when the use of lingo is not restricted to the "reflecting" section of the case report (Bernstein, 2000, p. 385), and instead makes its way into the "experiencing" (lived) sections. Problems also arise when the analyst-writer's use of technical terms serves to hide the fact he has a tenuous grasp of the deeper meaning of the material being presented. If a writer is overly reliant on technical terms, an assessor may conclude that the writer is hoping that these seemingly meaning-laden terms will do the work of explaining the case and are being offered in place of clearly articulated explanations that require little if any translation to be understood. Abrams (1994) writes about how clinicians are better served

> By avoiding technical language and using descriptive words instead. If technical language is felt to be an imperative, the terms ought to be placed in a sufficiently unambiguous context to leave no doubt about the author's specific meaning. Transference, for example, has come to be defined as virtually anything that patients feel about their analysts or sometimes as whatever transpires between the participants in the treatment setting. It is far better to describe what a patient feels rather than blanket those feelings with the term 'transference.'

Technical terminology tends to be experience-distant and is best reserved for sections of the paper in which the conceptualizing the case is the task at hand. For instance, one analyst reported that "[Mr. A.] recalled being an over anxious child, and this was always *endorsed* to him by his extended family." Rather than "endorsed," I recommended the phrase: "He remembers having been an anxious child, and his family always *treated* him as such—as if he were terribly anxious and dependent on his mother" (note: this later construction comes from material present in other parts of the write-up). This amended version captures the same meaning in an easier to understand fashion. In the introduction of a case, one analyst wrote "[her] initial *complaints* to me were *feelings of* anxiety, depression, *insomnia*, *crying episodes* several times per week, and she had frequent *emotional fights* with her mother and her boyfriend of one year." A more experience-near way of saying the same thing reads: "Ms. K *complained* that she felt anxious and depressed, had *trouble sleeping*, *cried* several times per week and frequently *fought* with her mother and boyfriend of one year." We can see, again, how the use of verbs helps enliven the write-up.

The use of professional terminology can result in another untoward effect insofar as it stands a chance of subliminally prejudicing evaluators who internally wince whenever they encounter a term closely associated with a school of thought (e.g., "projective identification," "self-object," "lived experience," etc.) that they personally find dubious—a term that adherents use to describe a clinical situation or process, which the evaluator likewise considers dubious. While evaluators are steadfast in their insistence that such things just don't happen, common sense suggests otherwise. This is not to suggest such practices are wide-spread, it is only meant to identify a factor that might tilt an evaluation in the negative direction.

4) Reporting the Patient's Reporting

Some trainees are inclined to report on the patient's reportings rather than present what the patient said without prefacing it by saying, for instance: "Ms. K. *recalled* thinking that her father was…" or, "She *remembers* herself as being 'the good little girl.'" It seems both redundant and counterproductive to draw the reader's attention to *the act of reporting* since doing so distances the reader from the lived moment being presented. One analyst wrote "when Mr. A was 17 *he recalled* his father chiding him severely for Mr. A's lack of control of his anger" (written as a reminiscence). Doesn't it read better to write "when Mr. A was 17, his father chided him severely for lacking control of his anger" (written as an event)?[3] Another analyst wrote: "Jennifer recalled trying to hide under her bed to hide from her mother, only to be dragged out and beaten." A more powerful statement leaves the act of recalling out: "When she was 'x' years

[3] Naturally, it could be argued that these two statements aren't synonymous because the one I've provided might lead the reader to conclude that I know for a fact that this happened, when all I truly know is that the patient has a memory of such an event. But I think this is splitting hairs.

old (or, "between the ages of 'x' and 'y'"), Jennifer would hide under her bed to avoid her mother, who would track her down, drag her out and beat her."

5) Mechanical Types of Writing

Mechanical writing is distracting to the reader because it draws the reader's attention away from what's being reporting—the report's content—to the process of it's telling. Writers sometimes feel a need to inform the readers that an issue presently being introduced will be discussed in greater detail further along in the write-up. I suspect this practice constitutes a defensive attempt to pre-empt criticism that the writer has glossed over an issue that should have been addressed in much greater detail. For instance, after telling us that Jennifer B. had a "rather distant" relationship with her father, the analyst feels the need to add: "More will be said about this later"—which, I would argue, goes without saying. Further along in the report, after mentioning the patient's adolescent relationship with a fellow camper named Paul, the analyst-writer informs us that he and the patient will "revisit this relationship during her analysis." Again, such commentary seems unnecessary. Other forms of mechanical writing include telling the reader what the writer is about to do (e.g., "I will describe a session that occurred approximately one month after beginning use of the couch") and prefacing the description of an intervention with a statement that the analyst considered the intervention necessary ("I felt it was important to inquire about the nature of this behavior as she seemed to be avoiding conflict"). If the analyst has elected to ask the patient about this, it goes without saying that he considered it worthwhile to do so.

Another type of mechanical writing are musings that go nowhere. Sometimes it proves useful for the analyst to retrospectively muse about an aspect of the case he or she had not understood at the time that—now in retrospect, a time-honored psychoanalytic tradition—reveals more than the analyst had initially understood. Such writing conveys both humility and ease—to the extent the analyst seems comfortable admitting his original ignorance without taking himself to task for the oversight—and, furthermore, it demonstrates his capacity to learn. There are other times, however, when musings are dropped into a write-up for no apparent reason other than to demonstrate the analyst-writer's capacity to leave no stone unturned. For example, an analyst writes about her concern that Mr. A. had a pattern of dropping out of previous therapies, causing her to have reservations about taking him into analysis. So far, so good. But then she goes on to write: "I wondered how these disruptions in his therapies might be related to his emotional life, specifically to the cycles of panic and depression." Having said as much, this statement ends up going nowhere, and I suspect only gets mentioned to demonstrate to readers that the analyst has *not* failed to notice that there must be a way to link this pattern of behavior to the patient's presenting complaints. If one doesn't yet know what a piece of behavior means, it is unnecessary to declare: "I think this must mean something; but what? I don't know"

6) Vagueness

Statements that are vague leave the reader confused as to what the writer means and, accordingly, requires further clarification. For instance, in her assessment of Mr. A.'s analyzability, the analyst writes: "[the patient] described a great deal of emotional confusion and disturbance." This statement, I would submit, tells the reader very little about the patient and begs for greater specificity. Readers often react negatively to such instances of vagueness and

may even conclude that the vagueness is indicative of the writer's lack of understanding about the case.

7) Extraneous Material

Sometimes a writer will include information he believes is "too interesting" to leave unmentioned, even though it contributes nothing to the analyst's overall explanation of the case. This, again, is an illustration of the principle that one ought not to mention the butler in act two if he ends up being inconsequential when all is said and done. One analyst talked at great a length about the patient's older brother, who'd been hospitalized during his adolescence for a bipolar condition. The analyst tells us that: "the brother continued to do well, he was stable on psychiatric medications, and intended on graduating and teaching at the high school level. During Ms. K's analysis he began dating a woman exactly his mother's age." Granted, this is most interesting, but it ultimately ends up contributing nothing to our understanding of Ms. K herself.

Sometimes, information that seems extraneous proves relevant once the writer clarifies his or her intent for including such material. A trainee submitted a vignette that he'd written as an assignment for a writing course I was teaching. The case was that of a man he'd been treating who was considering cutting back treatment from four to three sessions per week. The trainee introduced a dream with the following sentence: "[The patient] began a recent session reporting having taken a nap one afternoon during which he had a dream that involved me [the analyst]." I asked the trainee why he felt it necessary for us to know that the dream had taken place during an afternoon nap. As it turns out, trainee had ample reason to be this specific seeing that the dream

had occurred on the day he and the analysand did not meet around the time of day the patient's sessions typically occur. So, by dreaming such a dream the patient is "with" the analyst on the day the two don't meet, at a time in the treatment when the patient is considering cutting back his sessions. This information contributes to our understanding of the dream, the analysis of which revealed that the patient felt hurt that he had to wait to talk to the analyst, felt like a helpless child when he was with the analyst, and felt embarrassed needing anything from the analyst. This demonstrates a larger principle: When challenged about a word or passage that seems extraneous, vague, or unclear, writers oftentimes *can* provide a cogent explanation or elaboration that helps deepen the write-up.

Discussion

As candidates and early-career analysts approach the task of constructing a case report, they must contend with an array of different feelings, particularly if their professional advancement is riding on the report's ability to demonstrate psychoanalytic competence. Unless infinitely confident in his writing ability, the beginning analyst will feel frightened at the prospect of not passing and will anticipate the shame he will feel if the case report is not deemed worthy. He may feel resentful at being expected and required to accomplish the feat of translating his work into written form, and he may doubt his own ability to produce a case report that will pass muster with the certification committee. He may feel intimated by the "perfected" and exemplary writings of such notable clinical writers as Ralph Greenson, against whose work he may unfavorably compare his own, leading to hopeless resignation: "Why bother? Why even try?" Alternatively, he may question the committee's ability to recognize the inherent and indisputable worth of his work. He may even come to regard the status of non-certification as a testament to

his individuality—his having resisted the pressure to accommodate to the expectations of The American Board of Psychoanalysis.

Some of those who do elect to write up their cases may feel guilty that the resulting report seems factitious in some way or another. A few may go so far as to regard the case report as a "lie"—seeing it as a gross misrepresentation of what had transpired given how much goes unmentioned and how much of what gets mentioned has undergone revision. If the writer comes to the task of writing already suffering from the sense of being an imposter, or if he has lived life accommodating to the expectations of others, then it may be hard *not* to feel as though the case report is a lie—no matter how faithful it is to the lived experience of the analysis.

Of all the emotional challenges inherent in the task of writing, none compares with the potential shame of self-exposure. Returning to the aforementioned incident when I substituted a microphone for my own ears in order to produce a more scientific paper for Division 39, we might wonder whether a self-protective motive was also at play. I can see now what I had not been able to see then—that I was also, maybe primarily, motivated to remove any vestige of my subjectivity in order to avoid exposing myself to the potentially devastating criticism of two highly regarded experts and a room full of analysts.[4] The movement toward considering more and more of one's own subjectivity as legitimate and necessary psychoanalytic data is undoubtedly scary for many analysts, particularly those willing to expose their work in the form of case reports. And, if it weren't already hard enough for candidates and early-career analysts to write their cases up for graduation or certification, imagine how much harder the task has

[4] I am indebted to Stephen Bernstein, MD, for having drawn my attention to this dynamic when I presented this material at the June 2004 meeting of the American Psychoanalytic Association.

become since the emergence of the current requirement that candidates expose their subjectivity in their case reports.

When one first applies for admission to a psychoanalytic institute, one is required to write a personal statement. Those who are accepted for training know how to strike a balance between disclosing just enough of one's psychology to appear non-defensive and self-aware without going so far as to frighten the admissions committee with one's psychopathology. Once candidates make it to the point of writing their cases up for graduation or certification, they will again be confronted with a similar task, all the while fearing that some assessors may reel when exposed to certain types of subjectivities no matter how open those readers claim to be.

Summary

In this paper, I have illustrated how psychoanalytic case writing comes close to creative writing and how the production of a narrative account of an analysis trumps the scientific agenda to include all data. I have discussed the evidence that Freud and Greenson modified their clinical material for the sake of presenting a coherent case history, and I have suggested that this practice is widespread—facilitated by the process of secondary revision, selective memory, and the inability to simultaneously make an interpretation and accurately document that interpretation at one and the same time. I have also suggested that analysts need not be alarmed that clinical material gets reworked in the process of becoming a written case report because these modifications are in the service of capturing the gist of what had actually transpired. Accordingly, the resulting case report is likely to more faithfully represent the work than a verbatim transcript ever could.

Addendum: Things One Might Consider Including in a Case History

A checklist of the sorts of questions worth answering and the types of items worth including:

Questions worth Answering

1. How was the patient referred to treatment, by whom, and what was the presenting complaint?
2. What was the patient looking for from therapy and/or analysis? How does he imagine therapy will help him get better?
3. Past therapies: When? With whom? For how long? What precipitated seeking treatment at that time? How did those treatments play out?
4. How did the patient respond to the analyst's initial interpretation/interventions?
5. Analyzability: Does the patient show signs that they will be able to tolerate, and make good use, of analytic therapy? What misgivings does the analyst have about taking this patient into treatment?
6. How did the patient respond to the recommendation of more intensive treatment/analysis?
7. How was the fee set? What was the patient's reaction to the fee-setting process? Was the patient given a reduced fee? If so, what complications have arisen because of that decision?
8. How did the patient react to the idea of lying on the couch, and did anything have to first be worked through for the patient to become more comfortable using the couch?

9. What is your initial conceptualization of the case regarding diagnosis, defenses employed, anticipated problems, etc.?

Issues Worth Including

1. Dreams: A dream or two, preferably the initial dream and one from the termination phase.
2. Plenty of transference and countertransference material (including, if possible, any enactments).
3. Enough genetic background to make the story hold together.
4. Enough outside events and activity to demonstrate changes in the patient's life—signs of progress.
5. Lots of process, not just content.
6. Evidence of insight that go beyond interpretations made.
7. How certain specific issues were dealt with—the setting of fees, getting to the couch, the analyst's comings and goings.
8. Signs of progress both in and outside the consultation room.
9. Patterns: Be sure to demonstrate the way in which patterns play out in the analysis.

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