In conversation with Dr Nancy McWilliams

George Halasz

Dr Nancy McWilliams teaches at Rutgers University's Graduate School of Applied and Professional Psychology and has a private practice in Flemington, New Jersey. I first met Nancy through her books, her highly praised *Psychoanalytic Diagnosis*,[1] *Psychoanalytic Case Formulation*,[2] and *Psychoanalytic Psychotherapy*.[3] In 2004, Nancy delivered the 6th David Ingamells Memorial Lecture in Melbourne, where we briefly spoke about Professor Stanley I. Greenspan's plans to publish a book, *Psychodynamic Diagnostic Manual* [PDM].[4] She became associate editor. After reading it, I was curious to find out the 'behind-the-scenes' PDM story, the vision for its publication, how it has impacted on the mental health professions and, of course, how it relates to the *Diagnostic and Statistical Manual* (DSM).[5] While stated to be complementary to the DSM approach to psychiatric nosology, I thought that its values and power derived from the ideographic approach, traditionally a challenge and counterpoint to the nomothetic stance, the philosophy informing the DSM.

Currently, as president of Division 39 (Psychoanalysis) of the American Psychological Association, associate editor of the *Psychoanalytic Review*, and member of the editorial board of *Psychoanalytic Psychology,* Nancy is well qualified to comment on the ongoing crisis in contemporary US mental health. So when we met in New York, January 2008, I was curious to hear her views on how the PDM has been received since its publication as a **'**complementary**'** manual to the DSM**,** notwithstanding the latter's status, embedded within and beyond the psychiatric culture (e.g. its widespread use in diagnosis for disability reimbursement in schools and the courts). In time**,** could the PDM provide a viable alternative approach to psychiatric classification? Our conversation covered a number of issues that included tribulations faced in psychiatric publishing, psychological revisionism as

George Halasz
Honorary Senior Lecturer, Monash University, Clayton, VIC, Australia.

Correspondence: Dr George Halasz, Department of Psychological Medicine, Monash Medical Centre, c/- Burke Road Medical Suites, 30 Burke Road, East Malvern, VIC 3145, Australia.
Email: geohalasz@aol.com

doi: 10.1080/10398560802033037
© 2008 The Royal Australian and New Zealand College of Psychiatrists

perversion of science and changing attitudes to psychoanalysis, and we also touched on the personal losses that a number of contributors endured during the publishing process.

G: *I'm interested to hear about your involvement with Psychodynamic Diagnostic Manual's (PDM) publication, launch in 2006 and reception. You mentioned you got on the train after it had departed.*

N: That's right.

G: *What actually happened? I see the PDM as an important publication in psychiatry, the first viable alternative to the Diagnostic and Statistical Manual (DSM), although referred to as 'complementary'.*

N: It's very interesting. The way it got done was that Stanley (Greenspan), several years ago, got so distressed by what was happening in mental health care, often rationalized in terms of the DSM concepts, that he felt it was time to put together not just the psychoanalytic community's but also the wider practitioner community's understanding of psychiatric diagnosis.

G: *That 'practitioner community' formed by the coalition of five diverse organizations became the editors. How did that work?*

N: Well, my late husband was a political scientist and he used to say that you can get any fractious group together if you have a common enemy.

G: *So there was a perception of a greater external threat than between the organizations.*

N: Exactly. It's not that the DSM is exactly an enemy, but we've all seen the destruction that has been wreaked by assuming that the best way to think about people is in these discrete disorder categories that are mostly medicatable by pharmacology. So then Stanley went to the major psychoanalytic organizations in the United States, plus the international, and all of them shared the view that this should change. And while they may have a lot of hostilities about things like how many times a week constitutes analysis, they don't have any differences about how we need to think thoughtfully and individually and complexly about people's suffering.

G: *When did Stanley make the first approaches about the idea for a manual?*

N: Probably in 2003, maybe it was in 2002, but he basically got the project done in 2 years – it's quite remarkable. In fact, he wanted it done 6 months sooner than it was done, and I was the one who held him up because I kept feeling that it was not written well enough, it was repetitive in parts. So I was working like mad on it. So was Bob Wallerstein, to try to make it a little bit more consistent, condensed, well written, not so contradictory in parts. It was a committee product, and in that sense it's not different from the DSM.

He (Stanley) went to the leaders of these organizations and said, "I'm going to appoint the following task forces and I want you to appoint people to them." He had a task force on children, one on personality, another on outcome research, and symptoms, and a couple of others. The way I got involved was that I was on the Board of the organization that I'm now President of (Division of Psychoanalysis of APA), and the then-President, Jane Darwin, said "You're a natural for the Personality Task Force".

So I got assigned to that, and I had this very diverse committee, from Otto Kernberg through Jonathan Shedler. Everyone was nervous that that committee would find it particularly difficult to come to an agreement about personality.

But actually it didn't. As I began to see that the section was going to get written, and that I was the one who was probably going to write it, people began deferring to me to help resolve any controversies on the committee. Everybody was much more concerned on the committee about getting this done than about whether their particular point of view about the psychodynamics of personality ended up ascendant.

G: *Do you think they deferred to you partly on the merit of the success of your book, Psychoanalytic Diagnosis, which seems to me to foreshadow the PDM?*

N: Well it certainly had something to do with the success of my book, but it also had to do with idiosyncratic factors. Kernberg's wife was very ill, and he was over-extended. Eve Caligor's parents were killed suddenly in a traffic accident, and Drew Westen was overwhelmed with other work.

My husband died in the spring of 2005, but the first drafts were in by that time. He died very suddenly; I wasn't expecting him to drop dead, and I had been working up until that moment. After he died, for me the copy-editing part was actually a fairly welcome way to keep working and keep busy and structure myself. But I don't think anybody else wanted to write it particularly.

G: *Under those circumstances of your grief, were you comfortable to take on such a major task in addition to Stanley directing other sections to you?*

N: Well, I just wanted it so much to be good. I feel quite passionate about it. Most of the really creative work, and the work that involved making compromises among people's different ways of framing things, was already done by the time I lost my husband. Copy-editing comes easily to me. It was very tedious, though, because there was so much of it.

Psychodynamic Diagnostic Manual [PDM]

The PDM as a diagnostic framework provides a nosological conceptualization based on psychodynamic constructs for the range of character disorders and mental illness in children, adolescents and adults. Its goal is 'to complement the DSM and ICD efforts of the past 30 years in cataloguing symptoms by explicating the broad range of mental functioning' (p1). The manual's 857 pages are divided into three parts: part 1 covers adult mental health disorders, part 2 deals with child and adolescent disorders, and part 3 provides the conceptual and research foundations for a psychodynamically based classification system for mental health disorders.

The central structure of the PDM's three axes offers modifications to the DSM's familiar axes, with a P axis for Personality Patterns and Disorders, M Axis for Mental Functioning, and S Axis for Symptom Patterns. The PDM is stated to be a companion to the DSM and written as a response to the claim that DSM's impoverished view of mental disorders and strategy of narrowing of the mental health field's focus on simple symptom clusters, was possibly 'misguided'. (p3). Further, '. . . scientific evidence includes and often begins with sound descriptions, such as case studies'. '(I)nsufficient attention to this foundation of scientific knowledge, under the pressure of a narrow definition of what constitutes evidence (in the service of rapid quantification and replication) would tend to repeat rather than ameliorate the problems of current systems.' (p3). Clearly, one hope for the PDM is to address these deficiencies in psychiatric nosology.

G: *There's eight hundred odd pages in the final product, and I'm assuming you pruned it down from something much bigger.*

N: Yes. Well, not *much* bigger, but not as well written anyway. Some parts of it were, but it was somewhat internally inconsistent.

G: *How did you and Stanley finally come to agreement on what was 'in'?*

N: I think he basically accepted what came out of the committees. He mostly rode hard on the committees to get things done. He's a really good thinker, but he wasn't controlling about content. I think when Bob Wallerstein and I said we felt it was in shape, in terms of both content and style, we ended up having a lot of power, because people often do who are willing to do the hard work.

G: *Now to turn to your diagnosis book, speaking of style, I read wonderful reviews calling it a "charming textbook," and I thought "How extraordinary, not said often about textbooks". In fact, some reviewers regarded it as a book for supervisors as well as beginners. A book for all seasons?*

N: Yes, it's amazed me. I wrote it for beginners, but seasoned people – they like it. My recognition is a funny thing. I'm not in the American Psychoanalytic Association, although a couple of years ago they made me an honorary member. I've always been a little bit marginal to mainstream American psychoanalysis. I'm well known by people who have gone through programs that use my books, but people my own age professionally have only recently heard of me in this country.

I think I've always liked to be a little bit on the outside. I've never been a cheerleader for any particular orientation within psychoanalysis. I'm much more of an integrator than a person who develops a controversial position and puts it out there.

So I wasn't that well known generally. The people on my committee knew who I was. I'm not sure the other people on the project necessarily knew my work.

G: *That surprises me.*

N: They were very senior people, and they wouldn't have had to read my books. Well, it's not even that, it's that I wrote them basically to try to bring psychoanalytic thinking outside the psychoanalytic community, to non-psychoanalytic audiences. Within the psychoanalytic community I haven't been very busy.

G: *I see.*

N: So it's a strange kind of status that I have. But that didn't bother me; I like to work hard, and I like to copy-edit, and I wanted it to be good. So what was strange to me was that doing that chapter on personality was a little bit like writing "*Psychoanalytic Diagnosis Lite*." And I thought, "This is like new horizons in masochism. I'm burning myself out to write this book that doesn't have as much depth, that's going to compete with my own, and I don't get any royalties from it!"

G: *So how do you resolve this 'conflict of interest' when you now speak on behalf of the PDM? Do people now know you more for the PDM or your own PD?*

N: It depends on the audience. Psychoanalytic audiences know me for my books. When I speak at medical schools though, for example, they don't know my books and they think of me as the apologist for the PDM.

G: *Let's now turn to how the PDM was received?*

N: Stanley made a decision from the beginning to keep the price as low as humanly possible so that students could afford it. He also had a pool of

organizers who had self-published some books before, so he decided on self-publishing it. That way, also, whatever minimal royalties there were could be put into a fund for psychoanalytic research rather than into a publishing company.

There was some competition among major publishers to publish the PDM, but then the price would have been easily double what it is. I felt that we should go with a publisher, although I did not argue that particularly, because Stanley had the whole thing organized by the time I was working hard on it.

Because a publisher has the marketing facilities, and a publisher also has copy-editing facilities, which would have spared me a lot of work. As I took on more and more the effort to make it a well and uniformly written document, I ended up inadvertently becoming a kind of co-copy-editor with Robert Wallerstein, who copy-edited the research and other scholarly sections. I copy-edited the adult, child and infant sections. But I think it may have been a mistake not to go with a publisher, for publicity reasons. There are very few of us who were involved in the project who can do the publicizing.

In fact, there were disasters that befell most of us on the Steering Committee. Robert Wallerstein lost his son, Kernberg lost his wife, Marvin Hurvich lost his wife, Stanley had some health problems, I lost my husband, so this small group – Drew Weston didn't lose anybody but he was in great demand for political writings that he was doing, and he just didn't have the time to put a lot of energy into the PDM. So the number of people who could go out on the stump and speak about it were very few. I'm the only person, I think, who's going out maybe once or twice a month to give talks about it. Everywhere I go I'm enthusiastically received, but I don't stretch all that far.

G: *This book seems to suffer from the dual lack of what a normal book could be expected to receive: publicity and authors speaking about it. Both are missing.*

N: Right. So I'm doing my best.

G: *Could you say something about the audiences that are interested to hear about the PDM.*

N: Medical schools that have any psychoanalytically oriented people still on their faculties are very interested. Psychoanalytic institutes, graduate programs that still have psychoanalytically oriented faculty. Social work schools – same thing.

G: *You qualified each one with 'psychoanalytically oriented', as if it's the tail end of an era.*

N: Well, I worry that *is* the tail end of an era. I think we may have made another mistake, too, by calling it the *Psychodynamic Diagnostic Manual*. Stanley had been calling it, sort of generally, a "new type of classification system" and I remember saying, "Why don't you call it something simple like the *Psychodynamic Diagnostic Manual*. We could abbreviate it to PDM," and the next thing I knew, that was what it was.

G: *There's power!*

N: I know. I have more than I sometimes know. I'm speaking in California in about a month and the man who brought me out wanted me to speak about the PDM. He's in the humanistic tradition in psychology and he said, "Why did you call it the *Psychodynamic* Diagnostic Manual? Why not the *Psychological* Diagnostic Manual, because that way, people who are cognitive-behavioural and humanistic and family-systems oriented would know that this would also speak to them? Because it does." I'm not sure, though, that calling it the "Psychological Diagnostic Manual" would be the best idea, because some people would think of that as differentiating by discipline.

G: *Yes.*

N: We thought that it was honest to call it psychodynamic because it came from five psychoanalytic organizations.

G: *And no one put forward for calling it the "Psychoanalytic Diagnostic Manual", following the title of your book?*

N: Oh that's interesting. When I did the book I was told, "Call it anything but 'Psychoanalytic Diagnosis'. That term is dead. Everybody thinks it means that you have to be in treatment four times a week on the couch. If you have to call it anything, call it 'Psycho*dynamic* Diagnosis'". That's one of the few things that I stood really firm on about the book. I said it's psychoanalytic, and that's my understanding of what psychoanalysis is. My publisher supported me on that. But he also tells me that it's the only book he knows of that has basically transcended its title.

G: *Yes.*

N: He didn't particularly like the title either, but we just couldn't think of anything sexier. So we called it what it was.

G: *It reminds me that someone once advised me never to include the word 'death' in a lecture title because no one would attend. It sounds like psychoanalysis has a similar taboo around it.*

N: In the United States we especially love the new, you know. We over-valued psychoanalysis originally because it was new. And now because psychoanalysis isn't new, we're inclined to think that there's nothing valuable there.

There was a very funny article in my organization's newsletter by a man named Jim Hansell, a psychologist in Michigan, who tried to write a

psychology textbook that was friendly to psychoanalytic ideas. Nobody would let him use the word 'psychoanalytic', even when he was talking about object relations theory. And so he had to use other terms. He managed to get all the information into the book, but they told him that describing it as psychoanalysis would be the kiss of death.

I'm stubborn and I keep using it proudly because I think it's so misunderstood.

G: *So you're actually suggesting that it's an American cultural phenomenon, this passion for novelty, that forced you to abandon the title 'psychoanalytic' in favour of 'psychodynamic'?*

N: Right. I don't think we even considered calling it 'psychoanalytic' because of the risk of its being misunderstood as narrow and ideological.

G: *So where does that lead to in the next 5 to 10 years? The kiss of death also for the word 'psychodynamic'?*

N: I don't know. In fact, I'm very worried about the PDM because we definitely view this as our first effort and want to be open to all of the criticism that we can get from colleagues to improve it.

For example – this is I think so funny – we heard very quickly from a man in California who said, "You purport to have this fine biopsychosocial developmental model going here, but what about the elderly? You have the infants and children and adolescents ...." And we all went 'whoops'. You know, we didn't think of that. We just thought – our average age among the people that put this together is probably about 70, and we didn't think about older patients!

G: *Would you like to reflect on that dynamic? Is that denial or splitting?*

N: I suspect it's denial! But definitely in the second edition we'll have a part on the elderly. He's absolutely right.

But I don't know who's going to do this, especially if Stanley bows out for any reason. He has various non-profit groups and organizations that he runs or works with, whereas I'm just a private practitioner, basically. I don't have his resources, and I also don't particularly want to devote the rest of my career to successive editions of the PDM. But I don't know who else is going to come along who wants to take that particular torch up.

G: *Is there a potential successor or a protégé Stanley has been mentoring?*

N: No, I think he's thought of me as partly in that position, but I'm 62 years old and I'm not ... I mean, I think we should have somebody in their 40s who's excited about this and is a good writer and broadly educated in the psychoanalytic tradition.

G: *Maybe in your capacity of public speaking to PDM you could invite interested people?*

N: I haven't done that; I probably should. I still feel as if it's Stanley's project, and I don't want to be too ... I have always checked everything with him. He spearheaded it; it was his conceptualization.

And I guess I've been reluctant to take too much autonomy in suggesting what the next thing should be. I certainly, when I speak about it, ask for people's feedback about it – where it's helpful, where it's not, what they think we should change. And I keep a file about that.

G: *When I read the PDM, I saw obvious strengths, but also some limitations. Are you considering the second edition?*

N: Yes. Again, if Stanley's up for it, it should come from him. He's the one who appointed all the taskforces. I had nothing to do with that. I was just put on a committee, and then I was made the chair of that committee, and then I was recognized as a person who could write and edit well and ended up going over it for clarity, consistency, non-redundancy, and style.

Unlike the DSM, which has all the resources of the American Psychiatric Association, it's a little bit of a problem that we were sponsored by five organizations, because no single organization has the job.

G: *In Melbourne at the World Psychiatric Conference, November 2007, a French psychiatrist speaking about plans for WHO's ICD 11 mentioned the PDM. Are people speaking about it at US conferences?*

N: No. There are pockets of places, but there are still many places that haven't even heard of it. I'm starting to put together a list of things to talk to Stanley about, and one of the things that I think we should do for a next edition is go with a publisher. Again, I don't know quite how the money worked for the PDM. He had some resources. He would reimburse me for travel down to Washington, the once or twice I went down there.

I think that, especially in retrospect, it looks like not as good a decision to self-publish. But again, I'm not sure whether it would have gotten done otherwise.

G: *As I read the PDM I wondered if the DSM might inadvertently have created a culture of psychiatric revisionism over the last half century, its 'atheoretical' non-contextual approach dehumanising our patients' symptoms.*

N: That's accurate, I think.

G: *And the DSM may have been a necessary antidote to the excesses of the psychoanalytic era, when interpretation*

was seen as the magic bullet, as if narrative and symbolism has priority over reality.

N: Yes.

G: *Which is why I think Allan Schore is so grounding, with his paradigm shift in this era of psychological revisionism. The revisionist construct which confuses 'science' with 'scientism', I think, may have reached its peak with the DSM-IV-R. I can see how Allan Schore's paradigm shift may be embodied in the PDM approach. Because as that era wanes, something else has got to ascend, the PDM may offer that new approach. That's the way I cast my review of it – it's a book of its time, a manual, like yours was, you know, 12 years before as a lone voice, which is psychoanalytic. Our conversation today has alerted me to the language of why 'psychodynamic'. But the sentiment in the PDM is still real as opposed to revisionist. And I'm wondering what is going to happen with the DSM-V. How close a copy it will be of the PDM.*

N: Well, it's hard to tell. I think that for many of the people working on the DSM-V, the PDM isn't even on their radar screen. I don't think so anyway, but it's hard for me to tell.

G: *The ICD committees are looking at all different sorts of nosologies as they progress to ICD 11. That's more European influenced as well, with the English input. But at the WPA (2007) meeting, they emphasized how they are searching for a nosology that accommodates the subtlety and the complexity of the human condition in health and dysfunction. DSM's critics claim that it has lost that mandate. Is the PDM a viable contender?*

N: That makes sense. You pervert science long enough ...

G: *That's what psychological revisionism is, a perversion.*

N: Wonderful idea, I'm really with you on that.

G: *Earlier you've mentioned managed care and drug companies. Where is the future of psychology as licensing to prescribe progresses?*

N: I am angry at my organization for throwing so much of their energy into that. I understand that there are areas in which it's valuable to have more prescribers, and I don't see in principle why psychologists couldn't learn as much as dentists learn about prescribing, but I just feel ... I know what's going to happen with that. More and more people will start learning how to prescribe, and that means they'll learn less and less about psychotherapy, because more and more time will be taken up with pharmacology. It was politically the worst thing we possibly could have done at a point when psychology and psychiatry needed to co-operate about certain things in the context of the culture.

G: *Are there market forces behind this transformation of psychology?*

N: I don't know. I'm sure market forces are happy to exploit it, but I suspect that the narcissism of psychologists has more to do with it. Psychologists are, well you know, we're newer in the psychotherapy business than psychiatrists, and the oldest of us still remember being not admitted into psychoanalytic institutes because we weren't doctors, and being talked down to by psychiatrists with much less training than we have. So there's enough resentment to fuel this identification and competition.

G: *So it's a turf war?*

N: I think that preceded any exploitation of the dynamic that the drug companies are happy to do.

Temperamentally, I'm an optimist – I have a sunny disposition; intellectually, however, I'm quite pessimistic. I think we are a fairly decadent culture now in the United States, that empires rise and decline, and we're in a decline. I'm seeing politicians struggle mightily to counter the effects of extraordinary amounts of money and greed, and I don't know that there's going to be the populist backlash that we would need to get a reasonable health care system.

The Republicans have successfully conflated capitalism with democracy, and even Americans whose best interests lie in having universal health care get terrified that this means that it's socialism, and that means it's not democratic, and it's just crazy. It's very crazy.

G: *I'd like to turn to Professor Allan Schore's forthcoming award from the APA. What contribution does it recognize?*

N: Well, I think psychoanalytic psychologists have felt painfully on the defensive in recent years. And he is one of a very few scientists who are saying we now have the neuroscience that shows that the concepts we've been talking about more metaphorically are actually nameable in the brain. We're so grateful for that.

You know, a lot of the reason he's been honoured is that we've lived with years of being marginalized by American psychology and being told that we do voodoo and poetry and we're not scientific. Some of the most – this isn't true of mainstream CBT people – but some of the most ideological cognitive-behavioural people, who were burned by psychoanalysts in the era when they were pretty arrogant, are very happy to tell us that they're scientific and we're not.

G: *Is Allan redressing the historical imbalance in a way?*

N: Yes, I think so. Mark Solms also. There are a lot of people now ... Dan Siegel, for example. And it's

certainly the hot area now, too. Most of the groups that get involved here are multi-disciplinary. I guess the reason that we honoured Allan was that he is a psychologist and my organization is an organization of psychoanalytic psychologists.

G: *I'm delighted that you actually named him as a 'scientist'.*

N: He is a scientist. And I think that we're all scientists in the sense that we do naturalistic observation and talk about it. You wouldn't have a Darwin or a Lister or a Pasteur if we defined science the way the American Psychological Association often does, but we hypothesis-generators are always on the defensive.

One of the things that's happened is that in American academic psychology it used to be true that people who taught it, who were interested in clinical psychology, had a practice. But it's become so hard to get tenure that if you're an academic now, you spend all your time getting grants, often drug-funded grants as the public sources of funding have dried up, and doing endless quick, easily publishable studies. So there's been an erosion of any capacity for empathy for what it's really like to be a therapist. Academics read about some therapist in Colorado who tried to do re-birthing therapy and they say, ''What are these people doing? They're all crazy, they need to be accountable, and we need to teach our students that everything has to be based on evidence, and that the evidence we were taught was the best, randomized controlled trials, is the only acceptable evidence''.

The chasm between the academic researcher and the clinician in psychology has become wider and wider. So students are increasingly taught by people who don't know a thing about psychoanalytic psychotherapy from personal experience. They devise manuals, as if psychotherapy should resemble research.

G: *You've just provided for me a profound link that has clarified the dynamics of revisionism, where ideology is progressively disconnected from human experience by the leaders of the professions of psychology and psychiatry.*

N: That's right. When the press wants to call, they call the universities, they don't call the experienced practitioner. So the people who are distant from the actual clinical trenches are defining what should be the trends.

G: *I think that cultural revisionism arises as the basic human contact, one-to-one, vanishes. You mentioned that you regard yourself as an optimist, can you think how this process can be countered?*

N: Well I'm very interested in the next American election because I think there, you are beginning to see some backlash against the domination of health care by the wealthy and the corporate sectors.

In that sense, I see a correction starting to happen, and that may influence things like government grants. If we get more government money to sponsor research, the government has to be somewhat responsive to its citizens, unlike corporations, which aren't. They have to be responsible to their stockholders who want short-term profit not long-term results.

G: *If the current government was a corporation, would you regard it as a poor corporate entity?*

N: Yes, they are. And I think they've gone to the absolute limit of how much you can spin things and distort things and try to make bad objects out of good ones.

G: *And just a final point, can we look to the future, problems and solutions?*

N: Well here's the problem with insurance companies. I can see a lot of hope if we have a different system of healthcare organization, if there's more government involvement. If we extend Medicare, for example, which means to socialize medicine.

But the problem with individual insurance companies, the set-up that we have now, is that your private insurance depends entirely on your employment. And it's a very mobile culture, and people change their jobs a lot, so insurance companies do not have a long-term view. They know you're not going to stick with them from the time you're little to the time you're old. Furthermore, they evaluate their benefit managers every year: How much did you save for us this year?

There's no incentive for the long-term. Now public health policy in our country should have incentives for the long-term, incentives for prevention that may not pay off for 15 years. But insurance companies don't. They have incentives for prevention that pay off in 2 or 3 years and that's about it. So it's hard to engage them. Somebody who was really creative and politically astute and able to speak their language, though, might be able to engage them.

G: *How can this be accelerated?*

N: Perhaps by the power of lawyers in this culture. We litigated for 50 years before we got the tobacco companies to stop doing things, and that is one way we make change here.

G: *So litigation's the hope?*

N: I think so. I'm not quite happy with the kind of culture where that has to be how it's done, but that is one way to get things done here. Public education helps, too. For example, despite the power of the formula companies, most mothers

breast-feed now. That wasn't true a couple of generations ago.

G: *I like that.*

N: Every once in a while a book will inspire a transformation. The culture was running on slavery, and then *Uncle Tom's Cabin* was published, and people just couldn't quite rationalize slavery anymore. So something happens.

G: *Could the PDM become psychiatry's Uncle Tom's?*

N: Well, I think what you would need is a really good novelist who could somehow make this story compelling!

REFERENCES

1. McWilliams N. *Psychoanalytic Diagnosis. Understanding personality structure in the clinical process.* New York: Guilford Press, 1994.
2. McWilliams N. *Psychoanalytic Case Formulation.* New York: Guilford Press, 1999.
3. McWilliams N. *Psychoanalytic Psychotherapy.* New York: Guilford Press, 2004.
4. PDM Task Force. *Psychodynamic Diagnostic Manual.* Silver Spring, MD: Alliance of Psychoanalytic Organizations, 2006.
5. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* (4th ed., text rev.) Washington, DC: Author. 2000.