

Characteristics of Optimal Clinical Case Formulations

The Linchpin Concept

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Clinical assessment would ideally culminate in the construction of an empirically grounded, comprehensive case formulation that would: (a) organize all of the key facts of a case around one causal/explanatory source; (b) frame this source in terms of factors amenable to direct intervention; and (c) lend itself to being shared with the client to his or her considerable benefit. This article elucidates these factors and their rationales, provides two case examples illustrating their use in clinical practice, and discusses relationships between the present approach and other contemporary approaches to case formulation.

“There is nothing so practical as a good theory.” *Field Theory in Social Science* (1951, p. 20)

—Kurt Lewin

Clinical assessment would ideally culminate in the construction of an empirically grounded, comprehensive case formulation that organizes all of the key facts of a case around a “linchpin.”^{1,2} That is to say, it would organize them around some factor that not only integrates all of the information obtained, but in doing so also identifies the core state of affairs from which all of the client’s difficulties issue. Further, it would do so in such a way that this formulation becomes highly usable by the clinician and the client in matters such as their selection of a therapeutic focus, identification of an optimum therapeutic goal, and generation of effective forms of intervention. Most importantly, the existence of such a formulation would allow the clinician to focus therapeutically on that one factor whose improvement would have the greatest positive impact on the client’s overall problem or problems.

Based upon a conceptual framework known as Descriptive Psychology,³⁻⁵ the purpose of the present article is to explicate the above contentions in a threefold manner. First, those factors that would be embodied in

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an optimal case formulation, as well as the rationales for these factors, will be discussed at length. Second, two case examples illustrating the use of such formulations in clinical practice will be presented. Third and finally, some relationships between the present approach and other prominent case formulation approaches, such as those from DSM-IV⁶ and from various therapeutic schools, will be discussed.

OPTIMAL CLINICAL CASE FORMULATIONS

In the optimal case, a clinical case formulation would embody the characteristics listed in this section. In relating these, I shall for simplicity's sake speak as if the client were always an individual, but everything that will be said applies equally to couples and families. Further, since the central concern here is with a desired *product* of assessment and not with its methods, I will not be concerned with the means (interviews, observations, tests, etc.) that might be used to gather information.

CHARACTERISTICS

1. Organizes Facts Around a "Linchpin."

In the typical clinical case, in addition to presenting a problem (or problems), the client virtually always provides an abundance of further information. This information might include items about his or her emotional state, current situation, personal history, world view, perceptions of self and others, goals, expectations, and more. In some cases, this information has been organized by the client into a personal theory or formulation of the problem, but this formulation has not as a rule been helpful in providing a successful solution.⁷⁻⁹ In other cases, the data have not been organized by the client into any sort of coherent cognitive package, and are experienced for the most part as a somewhat confusing jumble that has rendered focussed, effective remedial action difficult or even impossible.¹⁰ They have not, for example, been organized into causal sequences (e.g., "This fact A about me results in facts B and C about me"). They have not been sorted well into those factors that are important and relevant, as opposed to those that are neither. Not infrequently, relevant items of information (e.g., important core beliefs, or personal behavior that creates interpersonal difficulties) have been left out of the client's formulation, resulting in a situation where critical elements of the problem are not even considered in attempts to resolve it. In any event, whether the client's view be confused or defective in some other way, he or she stands badly in need of a new formulation of the problem that will enable him or her to resolve it.

CASE 1

Curt, a 37-year-old owner of a successful and highly reputable small business, possessed little beyond some fragmented mini-theories regarding what lay behind his host of highly distressing presenting concerns. I shall attempt to capture something of his confusion by simply relaying the basic items of information he provided at intake in the order that he related them.

Curt began by stating that he had been “desperately unhappy” for as long as he could remember, experienced considerable hopelessness about this, but was sustained by the meagre hope that his depression would lift. He had had fleeting thoughts of suicide at various times in his life, but had never come close to an actual attempt. He reported chronic anxiety, as well as chronic worries over numerous matters (e.g., losing his business or his health). He wondered aloud if he might somehow “want to be unhappy” or “be driven to be unhappy.” Curt stated that, objectively, he seemed to have a good life since he had a successful business, a devoted wife, and ample financial resources. He then went on to report that “I am a shit and I live in constant dread that I will be exposed as such. . . a fraud.” He related that he was haunted continually by the question, “Who am I?”, and that this left him “desperate for some image to crawl into.” He deemed himself a “bullshitter” who “snowed” his customers into purchasing work of mediocre quality, and felt guilty about this. He stated that he saw himself as “undisciplined,” “stupid,” “untalented,” and “pathetic.” Finally, he related that he craved the applause of his employees and that he could only feel good about himself, and enjoy a sense of identity, when he had put in a long hard day of productive work and received acclaim from them. However, even when this happened, these accomplishments seemed to count for nothing the following day. Despite considerable intelligence, Curt had never been able to understand how this crazy quilt of complaints fit together, much less how he might act effectively to ameliorate them.

The job of the assessing clinician is to organize the amalgam of data provided by the client into a usable cognitive unity.^{1,2,10} It is to sort the relevant from the irrelevant, to discern what is cause and what effect, to bring items of information into the equation that perhaps the client has not considered, and to do whatever else it takes to accomplish this objective. In the end, and here the present conception diverges from many others, it is to discern the crucial “linchpin”^{1,2} at the heart of this cognitive whole. That is to say, it is to discover and to highlight some factor that is such that it not only organizes all of the information obtained, but in doing so also identifies the core state of affairs from which all of the client’s difficulties issue. The determination of such an organizing source at the heart of the

client's difficulties will have the status of an *empirical hypothesis* or *theory*, its adequacy to be determined by how well it fits all of the important empirical facts of the case and how fruitful it proves as a generator of successful therapeutic interventions.

Positing the existence of linchpin factors may seem to violate the widely held position that human problems are as a rule multiply caused, and that they, therefore, do not lend themselves to being explained in terms of some single factor. However, it should be clarified, the concept of a "linchpin" is not that of a single cause or influence acting in isolation. Rather, it is a concept having to do with what is at the center of multiple states of affairs—a "common pathway" as it were between prior influences and current consequences. A linchpin, as the metaphor implies, is what holds these together; it is what, if it be removed, may cause them (most importantly, the destructive consequences) to fall apart.

In Curt's case, the linchpin that seemed best to organize and to explain all of the data had to do with his mode of self-management. The term employed to characterize this mode was that of "overseer," an image that has been used in the past to capture the central issues in obsessive-compulsive personality disorder.^{11,12} As an overseer to himself, Curt had instituted a regime of self-governance entailing certain modes of self-direction and self-criticism. In brief, the mode of self-direction was self-coercion, and the primary operative "commandments" were: (a) "Thou shalt be engaged in constructive, productive, utilitarian work activity at all times; any other activity whose value is entirely intrinsic or, if instrumental, accomplishes nothing important, is a frivolous and sterile waste of time;" and (b) "Thou shalt be the best, and be perfect, in everything you do." In the face of perceived transgressions of these commandments, Curt's mode of criticism was one marked by heavy resort to the use of highly degrading labels ("unlovable," "undisciplined," etc.) and an excessive harshness. Finally, the constant negation of any value in his own behavior or in himself arising from his ceaseless self-criticism left him unable to conceive any positive overall image of who he was, a state of affairs that he characterized as a "poor sense of identity." Thus, in sum, Curt's regime of self-governance created (a) continual perceptions of personal defect and failure, (b) constant anxiety both that he would be "found out" and that he was ill-equipped to meet life's challenges, (c) a poor sense of identity, and (d) vast amounts of depression and despair that he could ever be an acceptable human being.

The foremost advantage of identifying a linchpin is that it permits the therapist to target what might be termed the *biggest ripple factor* in the case.

This is the factor that, should it change for the better, would have the greatest positive impact on all of the client's reported difficulties and on his or her life in general.¹³ In the case of Curt, for example, should he be able to alter his characteristic mode of self-regulation in more effective and humane directions, then positive effects would be noticed in his depressive mood, self-esteem, hopelessness, anxiety, chronic worries, and sense of identity.

In contrast, when the facts of the case do permit such unification, but we fail to identify an organizing state of affairs at the center of the client's problems, the danger becomes that of needlessly pursuing change in a piecemeal fashion. For example, in Curt's case, not finding a common link, we might then regard him as a "multi-problem case" and adopt a strategy of taking his list of complaints, prioritizing them, and pursuing them one at a time.

Thus, determining and therapeutically addressing linchpin factors results in a tremendous efficiency in therapy, but one that is not achieved at the cost of superficiality. We do the client the inestimable service of getting to the heart of the matter.

2. Targets Factors Amenable to Intervention

Aside from fulfilling the basic requirement that an individual case formulation organize the facts of a case around a central state of affairs, the terms in which such a formulation is framed become very important. It is quite possible to posit the existence of a linchpin for a case in such a way that the formulation might in essence be true, but not sufficiently useful from a therapeutic standpoint. For example, such formulations might link all the facts of a case to some event in the client's past (e.g., being the child of an alcoholic), some global personality trait (e.g., obsessive-compulsiveness), some mental disorder (e.g., generalized anxiety disorder), or some state of affairs not amenable to direct intervention (e.g., a "symbiotic tie" or "weak ego boundaries"). The point here is not that such facts and descriptions are without value or importance; it is that they are not suitable as *ultimate* formulations because they are not framed in terms of factors (a) that are currently maintaining the client's dysfunctional state, and (b) that are directly amenable to therapeutic intervention.

Assessment is for the benefit of the acting clinician. Its *raison d'être* is to guide him or her toward selecting interventions that are the most likely to bring about a resolution of the client's problems.¹³ Thus, the ultimate product of assessment, the individual case formulation, would ideally be in terms that identify those factors that currently maintain the problem and

that permit ready translation into effective therapeutic action. For example, in Curt's case, the stated formulation hypothesized that at the core of all of his problems and concerns was his current mode of self-management. This mode of self-management comprised certain self-directorial and self-critical behaviors. Such behaviors can be changed. It further comprises certain self-created and self-imposed rules and standards. Such rules and standards can be reappraised and, if found wanting, changed or rescinded. Finally, it comprised certain undergirding beliefs (e.g., "I must treat myself this way to achieve excellence; anything less and I will lapse into complacent mediocrity"). Such beliefs can be evaluated as to their merits, and altered. Thus, the linchpin element in Curt's case, summarized in the expression "overseer regime," is explicitly formulated in terms of factors that are currently operative and highly amenable to therapeutic intervention.

3. Enables Beneficial Use by the Client

An optimal individual case formulation may be shared with the client to his or her considerable benefit. Such a formulation, first of all, serves to organize the client's thinking about his or her problems. Rather than being restricted by a defective personal formulation of the problem, or feeling enmeshed in a bewildering maze of emotions, perceptions, self-accusations, and other factors, the client can identify a central maintaining factor. Second, the client can discern in this central factor a focal point toward which ideally he or she should direct energies for change. Rather than struggling on multiple fronts or not knowing where to attack his or her problems, the client can pinpoint that place where change efforts can most usefully and beneficially be targeted. Third, the ideal formulation places the client in a position of power.⁷ Rather than locating the root of the problem as residing in some factor likely to be perceived as incomprehensible and/or beyond the client's control (e.g., his or her history, character, or possession of a mental disorder), it locates it in terms of something the client is doing and/or thinking, and so in principle could cease to do or to think. In so doing, finally, it diminishes the tremendous fear, helplessness, and hopelessness that attend clients' beliefs that they are "crazy" or otherwise helpless in the face of their problems.

For these reasons, it is recommended that the individual case formulation be shared with the client. Further, it is recommended that therapist and client, when negotiating a therapeutic contract, adopt the linchpin element as the focus of their collaborative efforts. In the case of Curt, for example, the overseer formulation was shared with him. It served to

diminish considerably his confusion and his helplessness about his multiple problems, to discern precisely where his personal efforts could best be targeted, and to identify the specific behaviors, rules, and beliefs that he needed to alter. Finally, as the basis of the therapeutic contract, it became the explicit focus of collaborative efforts in a 20-session course of therapy that was ultimately successful in getting him to dramatically revise his basic mode of self-management, and with this its many painful and debilitating consequences.

CASE 2

Fran, an 18-year-old freshman at a large state university, came to therapy with a presenting concern of compulsive behavior. The only child of two very caring, but overprotective ranchers in eastern Colorado, she had come to university to pursue a career as a consultant to ranchers on commodity price fluctuations. Her ambition, in her own words, was "to keep them from being wiped out." Soon after matriculating, Fran had begun to experience a strong compulsion to make sure that all of the electrical switches in her dorm room were turned off whenever she left. Attempts to overcome this problem by making herself leave such switches on resulted in intense anxiety. Probed about reasons for her behavior, Fran stated that she was afraid that, should she leave a switch on, the dorm's electrical circuits would overheat and cause an electrical fire. Queried about fuses and circuit breakers, she stated that she was fully aware of the nature of these protective devices, but that this knowledge made no difference. At the conclusion of the intake session, Fran expressed concern about the tendency of psychotherapists to place the blame for problems on their clients' parents. Noting that "this is my problem and not theirs," she admonished me: "keep my parents out of this."

After making little progress in the first three sessions, Fran was asked during the fourth to go back and to recount her fears of what would happen if she left an electrical switch on. She reiterated that she feared an electrical fire. I then asked her to take the matter further and to tell me what would happen as a consequence. "Well, the dormitory would burn down," she replied. "Okay, and what would happen then?" "Well, I don't know why I think this, but the university would not have full insurance coverage"... "And then?"... "My parents would have to make good the balance"... "And then?"... "They would lose their ranch and wind up financially ruined and disgraced because of my behavior." Thus, from this unusual exchange emerged a chain of obsessional thoughts having to do with her parents' ruination and

disgrace, as well as a clarification that the function of her behavior was, however magically, "to keep them from being wiped out."

Pursuing this matter further, I hypothesized that an individual who was having persistent fantasies about her parents' destruction was likely a person who harbored some anger toward them. In light of Fran's warning to keep her parents out of the therapy, I explored this hypothesis rather cautiously. It emerged over the next few sessions that Fran indeed harbored enormous anger toward her parents, and that, while she suppressed it, she was quite aware of this anger. She related that she felt stifled and smothered by their overprotective ways. Further, she believed that they exerted constant pressure on her to shine in the world so as to shed glory on them. Finally, it became evident that Fran had an extraordinary reluctance to broach even the slightest of issues with her parents for fear of hurting them, and so had accumulated a vast store of unresolved issues and grievances over the years.

Thus, the linchpin in this case was hypothesized to be Fran's suppressed anger toward her parents. Having its roots in a host of unresolved grievances coupled with a radical inability to address and resolve these, her mounting anger manifested itself in the form of obsessional fantasies of their financial destruction and disgrace. However, since Fran also loved her parents and wished to protect them, she recoiled from these frightening obsessive images and undertook strong measures to prevent their realization by turning off electrical switches. The hypothesis of anger as the linchpin factor, then, ties together a plethora of facts about the presence of unresolved grievances, Fran's radical inability to address these, the content of her obsessions, the content of her compulsion, and the overprotective, conflict-avoidant family environment in which the focal problem emerged.

Based upon this linchpin formulation, therapeutic efforts were targeted toward helping Fran: (a) to become aware of her anger as the central difficulty, (b) to identify the unresolved issues that generated this anger, and (c) to become able to broach and negotiate these issues with her parents in constructive ways. Despite some initial reluctance, Fran proved quite able to accomplish all of these things. Further, far from being devastated by her raising of issues, her parents were willing and able to discuss them, and a number of very constructive family dialogues took place. Upon returning after Christmas break, Fran reported tremendous progress with her family effort and a complete absence of all obsessive-compulsive difficulties. At six-month follow-up, she remained free of symptoms.

In this case, then, the identification of a current, central problem-maintaining element, and the modification of this element, resulted in a

strong ripple effect. Fran's obsessions and compulsions were eliminated. She became far more competent at the core life skill of identifying and constructively addressing issues in intimate relationships. And, beyond these individual benefits, Fran's family took a very important step away from their longstanding rule that potentially divisive issues must never be openly addressed.

RELATIONSHIPS TO OTHER APPROACHES TO ASSESSMENT

THE DSM-IV APPROACH

Perhaps the most widely practiced approach to clinical assessment today is that promulgated by the American Psychiatric Association in its *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV). In this approach, one assembles an overall clinical picture based on information pertinent to five different areas or "axes." These areas have to do with the presence or absence of (a) a mental disorder (e.g., paranoid schizophrenia or posttraumatic stress disorder); (b) a personality disorder or mental retardation; (c) a general medical condition; and (d) psychosocial or environmental problems (e.g., a recent divorce or job loss). Finally, it includes (e) a global assessment of the client's general level of functioning. In essence, the mental disorder typically constitutes the focal problem in this approach, and the remaining factors represent either causal factors (e.g., a medical condition or recent critical life event) bearing on the focal disorder, or contextual factors within which this disorder exists (e.g., the presence of a personality disorder or of a high general level of functioning).

As the case of Fran and her obsessive-compulsive disorder illustrate, there is no incompatibility between the use of DSM-IV *diagnostic categories* and the general approach advocated in this article. In the present approach, while these diagnostic entities do not fulfill the criteria for being regarded as linchpin factors, they may be regarded as an important subset of the set of all problems that clients present, and that might therefore constitute the appropriate focus of clinical assessment and intervention efforts.

However, there are important differences between the DSM approach to *assessment* and that recommended in this article. Essentially, DSM-IV's axis methodology does not call for any of the characteristics cited above as constitutive of an optimal case formulation. First of all, it does not call for any attempt on the part of the assessing clinician to identify a central, problem-maintaining factor whose modification would provide a broad positive ripple effect. Second, it does not advocate that a clinical case formulation be framed in terms amenable to intervention. Third and finally, it contains no recommendation that the formulation be sharable with, and

highly usable by, the client—that it be used to organize the client's thinking, to clarify for him or her where change efforts would best be targeted, or to place the client in a position of power by framing the problem in terms of things the client is doing or thinking, and so in principle could cease to do or to think.

In sum, what emerges here is a general picture in which there is no in-principle incompatibility between the use of DSM-IV mental disorder categories and the present approach. However, there is substantial incompatibility between its assessment methodologies and those advocated in this article.

OTHER RELATED APPROACHES TO CLINICAL CASE FORMULATION

A review of the assessment literature reveals a small number of authors who advocate an approach to case formulation with significant similarities to the present one. Schact, Binder, & Strupp,² employing a psychodynamically oriented interpersonal approach, stress the importance of determining in each case what they term the “dynamic focus.” This is a repeated pattern of interpersonal behavior on the part of the client that can be seen as central to the whole range of his or her problems. In the therapeutic approach advocated by these authors, the primary effort lies in helping the client to identify, understand, and ultimately modify this focal behavioral pattern. In a similar vein, Persons,¹ operating within a cognitive-behavioral framework, advocates a search for what she terms the “central underlying mechanism.” This mechanism is a core belief or schema that underlies all of the emotional, behavioral, and cognitive difficulties one observes at the overt level (cf. the work of Beck and his associates¹⁴ on core “underlying assumptions”), and the central therapeutic goal accordingly becomes the modification of this central belief. Finally, family systems theorists^{15,16} characteristically search for, and seek to modify, repetitive interactional patterns (“structures”) within the family that are both central and causal with respect to a wide range of problematic phenomena in that family.

The essential similarity between these approaches and the present one lies in their stress on the vital importance of determining central, organizing factors that are currently maintaining the problem and that are directly amenable to therapeutic intervention. The primary difference lies in the fact that each of these approaches needlessly restricts the range of what might constitute such a central cause to their own theoretically preferred variables. Such a restriction places an unnecessary, potentially problematic, and essentially *a priori* constraint on the enterprise of determining what is at the heart of our clients' problems. In contrast, the present approach

advocates an open-ended, empirically based search that, as the cases of Curt and Fran illustrate, might culminate in the determination that different kinds of factors are centrally operative in different cases.

FINAL CONSIDERATIONS

PROCEDURES FOR DEVELOPING AN OPTIMAL CASE FORMULATION

While the primary concern in this article has been with the product of assessment activities, a few words seem in order regarding some procedures that may be used to construct such products.

1. Determine the Facts of the Case

In erecting an optimal clinical case formulation, the first step in the present approach, as in most approaches, is that of carefully ascertaining the important facts of the case. Here, it is recommended that the clinician behave like a detective who first determines the precise nature of the crime to be solved, and then uses this as a guide to determine what sorts of evidence are and are not relevant. On this “detective model,” in contrast with assessment methods in which the information to be gathered is determined a priori, the clinician begins by getting a very clear picture of the presenting concern(s). He or she then uses this picture to decide what kinds of facts are relevant to creating an explanatory account of the problem, and focusses efforts on gathering these facts. Such an approach streamlines the assessment process by minimizing time spent gathering extraneous information.

In obtaining assessment information, the primary operative caution is not to admit anything into the clinical picture that is not grounded in the facts of the case.⁴ While this caution is self-evident, it is mentioned because, despite its self-evident quality, it is frequently violated in clinical practice. For example, some clinicians will almost routinely include descriptors, such as “low self-esteem,” “poor self-concept,” or “underlying anxiety,” in most of their case formulations without there being any observational foundation for such descriptors.¹³

2. Develop the Facts into an Explanatory Account

The second basic step in erecting a case formulation overlaps chronologically with the first. It is that of developing the facts obtained into a useful explanatory account of the client's difficulties. Here, two separate lines of development may be used singly or in combination.

The first of these lines of development is that of dropping the details, and looking for the patterns that emerge.⁴ As the facts of the case unfold, the clinician deemphasizes the details and seeks to detect the presence of

broader patterns. For example, in the case of Curt, the myriad details of his complaints were deemphasized, even as it was noted that they comprised a syndrome usually exhibited by persons who are pathogenically self-critical.¹⁷ Thus, primary attention was devoted to establishing the nature of the self-critical pattern that proved to be the linchpin for all of his difficulties. Or, to cite a second example, a young male client reported a series of romantic relationships whose dissolution both confused him and disturbed him greatly. Rather than focusing on the details of these romances, the clinician noted a “Pygmalion” pattern that ran through all of them. The young man would repeatedly choose naive, dependent women and successfully enlist them in a process of changing themselves under his guidance. However, in his behavior lay the seeds of his ultimate failure: when these women had changed, they would no longer find a guru-pupil arrangement congenial, and would abandon him. With experience, the clinician will hopefully acquire a large repertoire of clinically significant patterns, and will become increasingly adept at recognizing their presence in clinical cases.

The second method for developing the facts of a case into a useful explanatory account is that of assimilating these facts to known explanatory forms. For example, among the more well known of such forms are ones that are associated with prominent psychological theories. These include: “Behaviors will tend to be maintained when they are successful in securing desired states of affairs”¹⁸; “A person will take the world to be as he or she has found it to be”¹⁹ (cf. Freud²⁰ on “transference distortion”; Beck & Weishaar¹⁴ on schema acquisition); and “Helplessness elicits passivity elicits helplessness.”²¹ Other, less widely promoted, but nonetheless valuable, explanatory forms include: “Coercion elicits resistance,” “Provocation elicits hostility,” and “Status takes precedence over fact.”⁴ (NB: Within psychology, there has been a tendency to balkanize such explanatory forms into competing theories. See Bergner²² for a theoretical integration of them. For the present, it is instructive to recall that it is commonplace for the ordinary person to employ many of these forms in a highly competent yet coordinated way: “He got angry both because he took her remark as an insult [cognitive explanation] and because he could not let it pass without regarding himself as a wimp” [self-concept explanation].)

3. Check, Implement, and Revise if Indicated

Finally with regard to procedural matters, having arrived at an initial formulation, it is important for the clinician to entertain several questions. Is the formulation consistent with the observed facts of the case? Does it

account for all of them? Does it provide a good fit with the pattern or explanation alleged? Is it useful—i.e., does it heuristically suggest powerful interventions that have a good prospect for success? If the formulation proves deficient in any of these ways, it must be revised. If it does not appear to be deficient, the next step is implementation of the formulation through clinical interventions. Finally, results of such intervention should be used to maintain or to revise the initial formulation.

In the last analysis, generating powerful linchpin formulations, like generating scientific theories, is a matter, not of following some pre-established, step-by-step procedure that guarantees success, but of competence. Like any other competence, it can be developed by most clinicians who make its acquisition a personal goal and who work hard over time to search for integrating, linchpin factors in their clinical assessments.

LINCHPIN FORMULATIONS NOT ALWAYS POSSIBLE

It was noted at the outset, and indeed in the title of this article, that what is being described is an “optimal” case formulation. Obviously, what is optimal cannot always be obtained. In certain cases, for example, there may be two or more influential states of affairs at work which cannot be integrated, and which will require separate attention. In other cases, we will be limited by our own ability to discern integrating linchpin factors in the myriad facts of our cases.

NO UNIQUELY CORRECT LINCHPIN

It is a general feature of the world that, for any given portion of it, there is no privileged, uniquely correct description. Even something as simple as a rock may correctly be described as a “rock,” “a Newtonian object,” “a container of a geologic record,” “a potential weapon,” and more. In the same way, it is possible that the same case material in the hands of two different competent clinicians may yield differing, but nonetheless cogent and effective linchpin formulations.

SUMMARY

Being able to discern the presence of a central organizing linchpin in a given clinical case represents a highly advantageous state of affairs. One can, by virtue of this, proceed in a very efficient and economical, as opposed to piecemeal, fashion. Further, one can achieve this economy and efficiency without paying the price of superficiality, since one is getting to what might be termed “the heart of the matter” in the client’s case. Finally, one has in a linchpin formulation a central blueprint that provides (a) a clear, constant goal for therapist and client; (b) a clarification for clients of

both their power and of where and how they would best target their efforts; and (c) a vast heuristic suggestiveness as to how one might proceed therapeutically to bring about important change.

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