

Psychodynamic Formulation



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Contents

Acknowledgments	ix
Introduction	xi
PART ONE Introduction to the Psychodynamic Formulation	1
1 What is a Psychodynamic Formulation?	3
2 How do We Use Psychodynamic Formulations?	8
3 How do We Construct a Psychodynamic Formulation?	12
PART TWO DESCRIBE	17
4 Self	23
5 Relationships	32
6 Adapting	41
7 Cognition	52
8 Work and Play	61
Putting it Together – A Description of Problems and Patterns	69
PART THREE REVIEW	75
9 What We're Born with – Genetics and Prenatal Development	81
10 The Earliest Years	90
11 Middle Childhood	101
12 Later Childhood, Adolescence, and Adulthood	113
Putting it Together – A Developmental History	123

PART FOUR LINK	135
13 Trauma	143
14 Early Cognitive and Emotional Difficulties	152
15 Conflict and Defense	163
16 Relationships with Others	173
17 The Development of the Self	182
18 Attachment	191
Putting it Together—A Psychodynamic Formulation	201
PART FIVE Psychodynamic Formulations in Clinical Practice	213
19 Psychodynamic Formulations in Acute Care Settings	215
20 Psychodynamic Formulation in Pharmacologic Treatment	222
21 Psychodynamic Formulation in Long-Term Psychodynamic Psychotherapy: Revising Over Time	230
22 Sharing Formulations with Our Patients	238
Epilogue	247
Appendix – How to Use <i>Psychodynamic Formulation: A Guide for Educators</i>	249
Recommended Reading	253
Index	259

Acknowledgments

Constructing a psychodynamic formulation is one thing, but trying to teach someone else to construct one is something else entirely. It's like trying to teach someone to tie a shoe. You know how to do it, but what are the steps? How do you put things together? What do you have to know in order to do it? This is what my coauthors and I tried to figure out. The result is our DESCRIBE/REVIEW/LINK method and a curriculum that helps students learn why psychodynamic formulations are important and how to construct them from the bottom up. Along the way, Sabrina Cherry and I wrote formulations and discussed our thought process over countless phone calls; Carolyn Douglas helped to keep us balanced between nature and nurture; Ruth Graver helped to devise a wonderful, dimensional way to describe function; and Anna Schwartz reminded us of the centrality of trauma and the utility of formulations in multiple settings. Both *Psychodynamic Psychotherapy: A Clinical Manual* and *Psychodynamic Formulation* would not be what they are if not for this incredible team of women who are outstanding clinicians, educators, and writers. I am, as ever, grateful for their time, effort, creativity, and friendship.

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I'd also like to thank the many students and educators who are using and enjoying *Psychodynamic Psychotherapy: A Clinical Manual*. The overwhelmingly positive response we got to the *Manual* energized us write this companion volume. We are delighted that it has helped to make psychodynamic technique more understandable, and we hope that this book does the same for psychodynamic formulation.

Older and wiser than they were when we wrote the first book, my children William and Daniel are now resigned to the idea that their mom likes writing on nights and weekends. I know that they are proud of me and of the work I'm doing. They will be ready to edit the next book. And, once again, Thomas read every word – sometimes twice – and kept the faith even when I didn't. I couldn't do any of it without him.

Deborah L. Cabaniss
New York
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Introduction

When we look up at the Rocky Mountains, we see some of the most beautiful scenery on Earth. If asked to describe it, we could wax poetic about the snow capped peaks, alpine meadows, and craggy ravines. That's what they are now – that's what we see. But how did the Rockies get to be the Rockies? How did they form? To figure that out, geologists have used information gathered from the rocks themselves, as well as theories about plate tectonics, to hypothesize that the Rockies arose when two continental plates collided. No one on Earth saw this happen – in fact, no one has ever seen a tectonic plate. However, the evidence is good that forces moving beneath the Earth's surface millions of years ago led to the formation of one of the most beautiful places on the globe. These subterranean forces, in addition to millions of years of rain, snow, ice, and wind, made the Rockies what they are today. This hypothesis helps us understand the history of our planet and predict the way the Earth will continue to change in response to forces working below and above the surface.

When we meet adult patients, we see what they are like now. We hear their speech, observe their behaviors, and listen to their ideas. But how did they come to be the way they are? What forces shaped them? Like geologists, psychodynamic psychotherapists look beyond the surface for answers to these questions. They hypothesize that people are shaped by forces working both beneath and above the surface over time, and they believe that thinking about how that happened is important for understanding a person's past, present, and future. Their hypotheses are their **psychodynamic formulations**, and these formulations are essential to every aspect of the way they treat their patients.

Students and clinicians are often needlessly daunted by the prospect of creating psychodynamic formulations, wondering how they can learn about subterranean forces that even their patients cannot easily access. While it takes time and thought, every clinician can learn to construct psychodynamic formulations using three steps:

1. DESCRIBING the patient's problems and patterns
2. REVIEWING the patient's developmental history
3. LINKING the problems and patterns to the history using organizing ideas about development

This book will teach you each of these three steps using clear language and illustrative examples. **Part One** will introduce you to the psychodynamic formulation and the DESCRIBE/REVIEW/LINK method; **Part Two** will teach you to DESCRIBE problems and patterns; **Part Three** will teach you to REVIEW the developmental history; and **Part Four** will teach you the various ways of LINKING the problems and patterns to the history using different organizing ideas about development. **Part Five** will offer ways to use psychodynamic formulations in various clinical situations and settings. Finally, Parts Two–Four are followed by **Putting it Together** sections that offer full, clinical illustrations of the part of the formulation you’ve just learned about. Note that all of the clinical examples in the book feature fictional people.

A psychodynamic approach to case formulation is unique in that it considers the way the unconscious mind affects our thoughts, feelings, and behavior. However, as psychodynamic psychotherapists, we are interested in everything that has affected and will affect our patients. This includes both nature and nurture. For this reason, we have intentionally included a considerable amount of information about genetics, temperament, and trauma and the way in which they impact development. It is our firm belief that we should not construct psychodynamic formulations in silos – we cannot hypothesize about the development of our unconscious thoughts and feelings without considering the impact of our endowment and early cognitive and emotional problems on that development. Our hope is that this will encourage you to think broadly about the myriad factors that have affected the way your patients think, feel, and behave.

This book is appropriate for medical students, social work students, psychology students, psychiatry residents, and practicing clinicians. It can be used by individuals who are interested in learning about psychodynamic formulation on their own, as well as by students and teachers in educational settings. Our students learn to DESCRIBE in their earliest years of training, to REVIEW developmental histories slightly later, and to LINK once they have a substantial amount of clinical experience (see Appendix for more specifics). Whether you are an individual learner or an educator, we suggest that using *Psychodynamic Formulation* in this stepwise fashion will help you and/or your students to learn to construct psychodynamic formulations without feeling overwhelmed by the task.

Constructing formulations is not just an interesting exercise – it’s an essential part of how we treat our patients. Although this book will teach you to *write* a psychodynamic formulation, our true goal is for you to use what you learn here to constantly *think* about psychodynamic formulations for every patient you see. Without psychodynamic formulations, we can only see the surface – we cannot understand the extraordinary forces that work together to shape the way people think, feel, and behave. It is this understanding that helps us to know what our patients need to learn about themselves, and what they need to develop, in order to live more satisfying, freer lives. So, let’s move on to begin learning about *Psychodynamic Formulation*.

PART ONE:
Introduction
to the
Psychodynamic
Formulation

1 What is a Psychodynamic Formulation?

Key concepts

A formulation is an explanation or hypothesis.

A case formulation is an hypothesis that helps us to answer questions about the way a patient thinks, feels, and behaves.

A psychodynamic formulation is an hypothesis about the way a person thinks, feels, and behaves, which considers the impact and development of unconscious thoughts and feelings.

A person's development is affected by both hereditary and environmental influences, and thus, both should be included in a psychodynamic formulation.

Psychodynamic formulations do not offer definitive explanations; rather, they are hypotheses that we can change over time.

What is a formulation?

Very nice history. Now can you formulate the case?

All mental health trainees have heard this, but what does it mean? How does one formulate a case? Why is it important?

Formulating means explaining – or better still, hypothesizing. All health care professionals construct **formulations** all the time to understand their patients' problems. In mental health fields, the kinds of problems that we are trying to understand involve the way our patients think, feel, and behave. We often call this kind of formulation a **case formulation**. When we formulate cases, we are not only thinking about *what* people think, feel, and behave but also *why* they do. For example,

Why is she behaving this way?

Why does he think that about himself?

Why is she responding to me like this?

Why is that his way of dealing with stress?

Why is she having difficulty working and enjoying herself?

What is preventing him from living the life he wants to lead?

Different etiologies suggest different treatments; thus, having hypotheses about these questions is vital for recommending and conducting the treatment.

What makes a formulation psychodynamic?

There are many different kinds of case formulations [1–3]. There are cognitive behavioral therapy (CBT) formulations, psychopharmacologic formulations, and family systems formulations – just to name a few. Each type of formulation is based on a different idea about what causes the kinds of problems that bring people to mental health treatment.

One way of thinking about this postulates that these problems are often caused by thoughts and feelings that are out of awareness – that is, that are **unconscious**. This is called a **psychodynamic frame of reference**. Thus, a psychodynamic formulation is an hypothesis about the way a person’s unconscious thoughts and feelings may be causing the difficulties that have led him/her to treatment. This is important to understand, as helping people to become aware of their unconscious thoughts and feelings is an important psychodynamic technique.

A developmental process

It’s well known that psychodynamically oriented mental health professionals are interested in their patients’ childhoods. But why? Well, using psychodynamic technique is about more than just helping people to become aware of their unconscious thoughts and feelings – it’s also about understanding how and why those unconscious thoughts and feelings developed. We can use that understanding in many different ways when we treat our patients. Sometimes we share this understanding with our patients to help them see that they are behaving as if earlier conditions still persist:

Example

Mr A’s mother, while loving, was extremely undependable. For example, she frequently forgot to pick him up from school. As an adult, Mr A has difficulty believing that his friends and lovers will be consistent in their relationships with him. His therapist is able to help him see that this difficulty may have stemmed from his out-of-awareness fear that people in his adult life will behave as his mother did.

At other times, we use this understanding to help patients develop capacities that were not fully formed during their earlier years:

Example

Ms B, a brilliant student, is unable to think highly of her accomplishments. Raised in foster care, she never received praise for her talents. Understanding this, her therapist is able to help her to believe that her perception of herself is not consonant with her abilities. Over time, she is able to develop new ways of managing her self-esteem.

Finally, we can help support patients' functioning that is impaired by acute or chronic problems:

Example

Mr C presents for therapy because he is having difficulty handling his children during his long divorce. He describes feeling that his parents' divorce, which happened early in his life, had catastrophic effects on his development. His therapist helps him to acknowledge his fear that his divorce will permanently damage his children and to understand the way in which this fear is affecting his parenting. This helps him to relax with his children and to develop alternate strategies for engaging them.

Although their techniques are different, each of these therapists uses an understanding of the patient's development to guide the treatment. Thus, our psychodynamic formulations need to include

1. ideas about how unconscious thoughts and feelings might affect our patients' problems
2. ideas about how those unconscious thoughts and feelings might have developed

That's all well and good, but how can we understand a developmental process that has already occurred? Even with camcorders and scrapbooks, we can't go back in time with people to watch their development unfold. In this way, constructing a psychodynamic formulation is a lot like being a detective trying to solve a mystery – the deed is done and we have to look backward and retrace our steps in order to crack the case. Like the detective, we work retrospectively when we construct a psychodynamic formulation – that is, we first look at our patients' problems and patterns and then scroll back through their personal histories to try to understand their development.

Nature or nurture?

So how *do* our characteristic patterns of thinking, feeling, and behaving develop? John Locke said that each person is born as a blank slate – a *tabula rasa* [4]. E. O. Wilson argued that social behavior is shaped almost entirely by genetics [5]. Nature – nurture – we have to believe that it isn't one OR the other but BOTH. Freud called the nature part "constitutional factors" and the nurture part "accidental factors" [6]. However you think about it, people come into the world with a certain genetic loading and then continue to develop as they interact with their environment. The more we learn about the interrelationship between genes and environment, the

clearer it is that our genetics shape our experience and vice versa, so some complex interaction between the two results in our characteristic views of ourselves, the way we relate to other people, and our methods for adapting to stress. Thus, in thinking about how to understand and describe how our patients develop, we have to consider genetic, temperamental, and environmental factors.

More than reporting

A news story gives a report of *what* happened; a psychodynamic formulation offers an hypothesis of *why* things happened. Here are two examples to illustrate the difference:

Reporting

Mr D was born prematurely to a teenage mother who had a postpartum depression. He had severe separation anxiety as a child and spent long periods of time home "sick." As an adult, he is unable to be away from his wife for more than one night.

Formulating

Mr D was born prematurely to a teenage mother who had a postpartum depression. He had severe separation anxiety as a child and spent long periods of time home "sick." It is possible that his mother's depression affected Mr D's ability to develop a secure attachment and that this made it hard for him to think of himself as a separate person. This may have impeded his capacity to separate successfully from his mother. Now, it may be making it difficult for him to be apart from his wife for more than one night.

Although both vignettes tell a "story," only the second attempts to link the history and the problem to make an etiological hypothesis. A psychodynamic formulation is more than a story; it is a narrative that tries to explain how and why people think, feel, and behave the way they do based on their development. In the above example, the sentences "It is possible . . ." and "This may have impeded . . ." suggest causative links between Mr A's problem with separation and his history – links of which he is not aware of and are thus unconscious. *These causative links make this a formulation and not just a history.*

Different kinds of psychodynamic formulations

Psychodynamic formulations can explain one or many aspects of the way a person thinks, feels, or behaves. They can be based on a small amount of information (e.g., the history a clinician obtains during a single encounter in an emergency room) or an enormous amount of information (e.g., everything that a psychoanalyst learns about a patient during the course of an analysis). They can try to explain how someone behaves in a moment of therapy, during a discrete crisis, or over a lifetime. They can be used in any treatment setting, for brief or long-term treatments. If they are responses to questions about how people think, feel, and behave that consider the impact and development of unconscious thoughts and feelings, they are psychodynamic formulations.

Not a static process

It's important to remember that a psychodynamic formulation is just an hypothesis. As above, we can never really know what happened, but, in order to understand our patients better, we try to get an idea of what shaped the way they developed. Earlier in the history of psychoanalysis, the psychodynamic formulation was thought to be a definitive explanation of a person's development. Now we understand that it is better conceptualized as a tool to improve our treatment methods and understanding of our patients.

Hypotheses are generated to be tested and revised. The same is true of psychodynamic formulations. The process of creating a psychodynamic formulation does not end when the clinician generates an hypothesis; rather, it continues for as long as the clinician and patient work together. The formulation represents an ever-changing, ever-growing understanding of the patient and his/her development. We can call this a **working psychodynamic formulation**. Over time, both patient and therapist learn about new patterns and new history. With this, new ways of thinking about development may become useful, and these can help generate new hypotheses. The process of describing patterns, reviewing history, and linking the two using organizing ideas about development is repeated again and again during the course of the treatment, shaping and honing both the therapist's and patient's understanding.

Formulating psychodynamically is ultimately a way of thinking

We think that the best way to learn to formulate psychodynamically is to actually write a psychodynamic formulation. Taking the time to do this, as well as forcing yourself to commit your ideas to paper (or screens!), will help you to consolidate your ideas about a patient and to practice the skills that you will learn in this book. But not all formulations are written. In fact, most are not. We formulate psychodynamically all the time – when we listen to patients, when we think about patients, and when we decide what to say to patients. Ultimately, formulating psychodynamically is a way of thinking that happens constantly in a clinician's mind. Our hope is that you will use the skills that you learn in this book to formulate psychodynamically all the time with all your patients.

Now that we have introduced some basic concepts, let's move on to Chapter 2 to further explore the way we use psychodynamic formulations.

2 How do We Use Psychodynamic Formulations?

Key concepts

The psychodynamic formulation is our map – it guides every aspect of the treatment. Having a working psychodynamic formulation enables us to

- make treatment recommendations and set goals
- understand what patients need developmentally
- develop therapeutic strategies and predict the way patients will react in treatment (transference)
- construct meaningful interventions
- help our patients to create cohesive life narratives

Sometimes we share our psychodynamic formulations with our patients, and sometimes we use them privately to help shape our therapeutic strategies and interventions.

Formulation is our map

Having a working psychodynamic formulation means having a continuously evolving idea about the unconscious thoughts and feelings that affect our patients' ways of thinking, feeling, and behaving. But how do we learn about a part of the mind that is out of awareness? We **listen** carefully to what our patients say so that we can pick up clues that might guide us toward unconscious material, we **reflect** on what our patients say, and we **intervene** in ways that help them to learn more about their minds [7]. As we listen, we do not necessarily know where we're going – in psychodynamic psychotherapy, we follow the patient's lead. But the fact that we follow the patient's lead does not mean that we work without a map. That map is our psychodynamic formulation. When we have a sense of our patients' primary problems and patterns, their developmental histories, and how and why they developed as they did, we listen to them with this in mind.

Using a psychodynamic formulation in treatment

To further explore this, let's consider the example of Ms A. She is a 43-year-old woman who has come for treatment with Dr Z because she is worried that her husband will leave her. She explains that her husband is a "genius" and that she cannot understand why he wants to remain married to someone who just stays home and takes care of the children. She says,

I've become one of those boring housewives. The only thing I can talk about is the soccer schedule.

Making a treatment recommendation and setting goals

As Dr Z conducts the evaluation, she learns that Ms A is unable to say anything good about herself. Dr Z also recognizes that Ms A's self-effacement seems incongruous given her apparent abilities – she was a gifted painter who gave up her career when she married. Dr Z begins to wonder about why Ms A has this view of herself. As Dr Z takes the developmental history, she learns that Ms A's mother was a world-famous scientist who was critical of her daughter's complete lack of interest in science, preferring Ms A's brother who became a physicist. Dr Z constructs an early **psychodynamic formulation** (hypothesis) that Ms A has unconscious, maladaptive ways of perceiving herself and regulating her self-esteem and that these unconscious self-perceptions and conflicts might have developed as a result of Ms A's problematic relationship with her mother. Although Dr Z knows that she has much more to learn about Ms A, she uses her preliminary formulation to make a **treatment recommendation** and to work with Ms A to **set early goals**, saying:

It is clear to me that you are worried about your relationship with your husband. However, it also seems that you are overly tough on yourself and that you do not allow yourself to do things that interest you. These difficulties could be related to longstanding feelings you have about yourself that may date back to your early relationship with your mother. Exploring these feelings in a psychodynamic psychotherapy may help us to understand why you are so unhappy in your current situation and help you to improve both your relationship and your feelings about yourself.

Forming a therapeutic strategy

Ms A agrees and she and Dr Z begin a twice-a-week psychodynamic psychotherapy. Dr Z uses her hypothesis that Ms A was not able to develop an adequate sense of self to understand that Ms A has a **developmental need** to improve her self-perception and her capacity for self-esteem regulation. This forms the basis for Dr Z's **therapeutic strategy**; she will listen to everything that Ms A says, paying close attention to material that might relate to Ms A's difficulties with her sense of self.

Conducting the treatment

For example, one year into the treatment, Ms A says to Dr Z,

You must be tired of me just talking about my problems day after day. You probably have other patients who need your help more than I do.

Dr Z uses her formulation to help Ms A notice her problematic self-perception, saying,

I think that you presume that I, like your mother, will be disappointed in you and will be more interested in others.

Creating a life narrative

Over time, Ms A begins to believe that Dr Z is, in fact, truly interested in her. Through her conversations with Dr Z, she realizes that she had a distorted expectation that Dr Z, like her mother, would find her dull and lacking. Together, they use this formulation **to create a life narrative** for Ms A, which helps her to make sense of how she developed this maladaptive unconscious fantasy. In Ms A's words,

I never realized how hurt I was that my mother wasn't as interested in me as she was in my brother. I also never understood the toll that this took on the way I thought about myself. I'm now seeing that my husband isn't uninterested in me – I just presume that everyone is.

As the treatment unfolds, Dr Z deepens and alters her formulation, but she continues to use it to help her to set goals, develop her therapeutic strategy, listen to the patient, construct interventions, and foster Ms A's understanding of her life. It will remain key to every part of the treatment, from beginning to end.

Do we share our formulations with our patients?

Sometimes we share our psychodynamic formulations with our patients, and sometimes we use them privately to shape our therapeutic strategies and interventions. As we'll discuss further in Chapter 22, we make decisions about this based on what we think is most clinically helpful for the patient in that moment. When patients are self-reflective and able to think about the impact and development of their unconscious thoughts and feelings, it can be helpful to share our formulations:

Example

Ms B is a 30-year-old woman who comes to therapy with Mr Y because she is unsure about her upcoming wedding. She says that although she loves her fiancé, she is worried that she will

end up being as unhappy a wife as her mother was. In therapy, Ms B and her therapist evolve the hypothesis that Ms B has an unconscious conflict – although she loves her fiancé and wants to spend her life with him, she feels guilty about having the kind of marriage her mother never had. Understanding this allows her to go ahead with her wedding and to feel better about her relationship.

When patients are less self-reflective, it may be more useful to use our formulations privately:

Example

Ms C is a 58-year-old woman whose husband of 25 years died 6 months ago. She comes to the clinic for help with disorganization, explaining to Dr X that she is having trouble doing things like paying bills and balancing her checkbook. After determining that Ms C does not have symptoms of anxiety, depression, or cognitive impairment, Dr X asks Ms C whether her husband had taken care of the household finances. Ms C acknowledges that he had, but says that she doesn't think that her current problems have anything to do with her husband's death: "I've always been independent, so I'll be fine alone." Dr X hypothesizes that Ms C's inability to take over her husband's tasks is related to feelings about having lost her husband, but thinks that Ms C is not ready to talk about this and that she is highly invested in feeling independent. Therefore, Dr X uses her formulation privately to help Ms C develop strategies for doing one task at a time. This helps Ms C to feel more able to approach these tasks and to feel more independent, although she remains unable to discuss how much she misses her husband.

While both Mr Y and Dr X developed psychodynamic formulations about their patients, Mr Y shared his formulation with Ms B, while Dr X used her formulation without explicitly sharing it. But how did these therapists construct their formulations? We will begin to explore that in Chapter 3.

3 How do We Construct a Psychodynamic Formulation?

Key concepts

When we construct psychodynamic formulations, we

DESCRIBE the patient's primary problems and patterns

REVIEW his/her developmental history

LINK the problems and patterns to the history using organizing ideas about development

How do we develop hypotheses to explain things we observe? It could be anything – a cultural trend, the relationship between two people, or a natural phenomenon. For example, let's say that people have a sense that there was less snowfall than usual in their town, and they want to know whether this will be a trend. First, they need to define the phenomenon by using careful observation and measurement. Then, they have to research the history of snowfall in the area. Once they've done this, they can use meteorological theories – for example, theories about global warming – to help them link their observations and the history to form an hypothesis about what's happening and what might happen in the future. They can then explain their hypotheses to others in a cogent way.

The three basic steps to create a psychodynamic formulation

We follow the same steps when we construct psychodynamic formulations to help us understand how and why people develop their characteristic patterns of thinking, feeling, and behaving. This process involves three basic steps. We

DESCRIBE the primary problems and patterns

REVIEW the developmental history

LINK the problems and patterns to the history using organizing ideas about development

Taken together, these three steps comprise the formulation. Each step is crucial to the process and is discussed at length in Parts Two–Four; we briefly outline them here by way of introduction.

DESCRIBE the primary patterns and problems

Before we think about *why* people developed their primary problems and patterns, we have to be able to describe *what* they are. Here, we're not just talking about the chief complaint, but about the issues that underlie the person's predominant ways of thinking, feeling, and behaving. We can divide these into five basic areas of function:

- self
- relationships
- adapting
- cognition
- work and play

It is important to describe each of these areas in order to understand the way a person functions. To do this, we learn from what the patient *tells* us as well as from what the patient *shows* us. For example, a patient may say that he/she gets along well with others but then argue with the therapist throughout the evaluation. We have to use both sources of information when we describe his/her relationships with others. It's also essential to have more than just a surface description of each of these functions in order to really understand our patients. We will address all these areas and how to describe them in Part Two.

REVIEW the developmental history

When patients come to see us, we "take a history" to understand the events that led up to the presenting problem. But to construct a psychodynamic formulation, we need to do much more than that. Our goal is to learn everything we can about our patients in order to begin to make links between their histories and the development of their primary problems and patterns. To do this, we have to take a **developmental history**. This kind of history begins before birth, with the patient's family of origin, prenatal development, and genetic endowment; it includes every aspect of the first years of life, including attachment, early relationships with caregivers, and trauma, and it continues through later childhood, adolescence, and adulthood, until the present moment. Since we don't know why people develop their typical patterns, we have to consider everything – we're interested in heredity and environmental factors and the relationship between the two. We want to understand periods of development that went well, as well as periods that were problematic – we need all the information we can get to try to hypothesize causative links between the history and the development of the patient's primary characteristics. Reviewing the developmental history is the subject of Part Three.

LINK the problems and patterns to the history using organizing ideas about development

The final step in constructing a psychodynamic formulation is linking the problems and patterns to the developmental history to form a longitudinal narrative that offers hypotheses about how and why the patient developed his/her ways of thinking, feeling, and behaving. In doing this, we can be helped by **organizing ideas about development**. These organizing ideas offer us different ways of conceptualizing and understanding our patients' developmental experiences. They help us to take the information that we have learned from the history and think about how it could have led to the problems and patterns we see in our patients. Different ideas may be more helpful in understanding different problems and patterns. The organizing ideas that we discuss in Part Four address the impact of the following on development:

- trauma
- early cognitive and emotional difficulties
- conflict and defense
- relationships with others
- the development of the self
- attachment

So let's begin constructing psychodynamic formulations with Part Two – DESCRIBING function.