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SPECIAL ARTICLE

THE PSYCHODYNAMIC FORMULATION: YESTERDAY'S ECHOES, TODAY'S REALITY*

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When we look at Mount Kinabalu we see an astoundingly beautiful scenery with granite peaks veiled in wisps of clouds. How did this majestic mountain come to be what it is now? Geologists used information gathered from the rocks and plate tectonics theories in order to hypothesize that it was a granite intrusion formed 15 million years ago and thrust upward one million years ago by tectonic movements. No one on Earth saw this happen. However, the evidence showed that forces moving beneath the Earth's surface millions of years ago led to the formation of one of the most enchanting places on Earth. These subterranean forces, in addition to millions of years of rain, snow, ice, and wind, made what Mount Kinabalu is now. This hypothesis helps us understand the Earth's history and predict how it will continue to change in response to forces working below and above the surface.

The starting point of any clinical encounter is the patient's narrative of his/her life story. (1) When our patients share their life narratives, we hear their speech, observe their behaviors, and listen to their thoughts. We wonder how they came to be the way they are now and ponder on what forces may have shaped them. We hypothesize that our patients are shaped by forces working beneath and above the surface over time. (2) These forces derive from early parent-child interactions and color our patients' narratives. These narratives are highly predictive of future patterns of relationships. (1) Thus, our hypotheses allow us to understand our patients' past, present, and future. (2)

As clinicians it is our responsibility to be sensitive towards patients and understand their problematic behavior as emanating from unmanageable feelings and conflicts. Furthermore, we must be cognizant of the fact that our patients' inner lives are continuous with their mental health problems. The psychodynamic formulation plays an important role in helping us realize these tasks. (3)

What is a psychodynamic formulation? Let us begin to understand it by first defining the term formulation. A formulation is a hypothesis or a tentative explanation. Although a formulation and a clinical diagnosis primarily function to provide a concise case conceptualization that guides the treatment plan, they are not the same. (4, 5) A formulation is not a diagnosis and it does not rely on the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD). A DSM or ICD diagnosis reflects a snapshot of the patient's current functioning while a formulation is an ongoing and living document. (4) A hypothesis about how a patient thinks, feels, and behaves is called a case formulation. (2)

In developing case formulations, various theoretical models may be utilized. The cognitive behavioral model, psychopharmacologic model, family systems model, and psychodynamic model are some frameworks that may be used alone or in conjunction with each other. (2, 6) The cognitive psychoanalytic

theory posits that a patient's psychopathology emerges from unconscious frightening and constricting beliefs held during childhood. (7)

Another way by which a case formulation may be defined is by answering the question: "Why did this particular person, given his or her particular personality, current life circumstances, and personal and family history, develop this specific psychological problem at this particular point in time?" (5, 8) This question defines the information that is necessary to the formulation. It takes into consideration various theoretical orientations but it does not advocate a specific one. In addition, the explanatory or meaning making perspective of the psychodynamic formulation is underscored and differentiated from the phenomenological or categorical approach of psychiatric diagnosis. (8)

What makes a good case formulation? Ivey proposed ten criteria. It is (a) concise, (b) based on all or most of the known facts of the case, (c) focused on the details of the patient's symptoms, history, experience, and behavior, (d) an explanation of how the patient's history and psychological make-up contributed to the symptoms, (e) why the patient's problem emerged when it did, (f) why the problem persists in the present, (g) theoretically consistent and coherent, (h) expressed in simple, jargon-free, and experience-near language, (i) provides a sense of understanding the patient's difficulties in relation to her significant early relationships and life events, and (j) an anticipation of the patient's response to treatment. (8)

What makes a formulation psychodynamic? A psychodynamic formulation, once considered as the backbone of psychiatry, is a cohesive hypothesis about how patients' interpersonal and unconscious processes influence how they think, feel and behave. (2, 6, 9) It is constructed after the assessment interview and focuses on conflicts that pervade the patient's history and explains how and why the patient tries to resolve these conflicts in a maladaptive manner. Furthermore, it discusses how the maladaptive resolution of conflicts lead to symptoms, character pathology, and interpersonal problems. (3) Another way by which a psychodynamic formulation is appreciated is by considering it as an attempt to identify the area of maximum psychological pain and how the patient defends against it. (4)

The psychodynamic formulation highlights the following assumptions: (a) conscious & unconscious meanings, feelings, representations, & motives play a primary role in understanding psychopathology; (b) sexual & aggressive impulses, feelings, & fantasies & attachment needs are principal determinants of human motivation; (c) conflict between competing motives, feelings, & representations of self & others result in psychic distress; (d) unconscious defense mechanisms are protective against psychic distress; (e) symptoms & pathological personality traits are expressions of psychic conflicts or deficits & the patient's way of managing them; and (f) subjectively perceived emotional quality of early childhood interactions with primary caregivers & siblings shapes the patient's personality. (8) Although unconscious elements of the mind are given emphasis, a psychodynamic formulation does not preclude non-dynamic factors such as hereditary and environmental influences on the patient's inner world. (2, 6, 9) The psychodynamic formulation integrates knowledge from biological psychiatry, social psychiatry, and behavioral psychology. (3, 10) Thus, the psychodynamic formulation is nestled on the biopsychosocial approach. (5, 11)

Although the psychodynamic formulation is an essential element in psychodynamic psychotherapy, the clinician who thinks in a psychodynamic manner does not necessarily have to work in a psychodynamic therapeutic way with the patient. The psychodynamic formulation leads to a deeper understanding of the patient's problem or predicament and it may be used in various ways. The hypotheses we generate guide the treatment process and help us anticipate outcomes such as how the patient interacts with us or responds to being prescribed medication. The psychodynamic formulation also allows us to understand the developmental needs of the patient and help the patient create a cohesive life narrative. The hypotheses we make are tentative and speculative because they may be modified through time with additional data. We may or may not share our formulation with the patient. (2, 3, 4, 5, 6, 9, 10) Several sessions are needed to identify and confirm repeated patterns but it is possible that a single interview may provide data for the experienced therapist to construct a formulation. (4)

Several misconceptions about a psychodynamic formulation abound. (5) These include the

notions that (a) a psychodynamic formulation is necessary only for patients undergoing long-term, expressive psychotherapy, (b) constructing a psychodynamic formulation is primarily a training exercise, (c) constructing a psychodynamic formulation is an elaborate and time-consuming task, (d) a psychodynamic formulation need not be written, and (e) therapists will not be able to appreciate or accept material that does not fit their formulation.

These beliefs are erroneous because (a) a psychodynamic formulation is a fundamental component of all treatments, (b) even experienced therapists may benefit from a psychodynamic formulation in understanding complex or difficult cases, (c) the initial psychodynamic formulation is focused on leading unconscious needs and defenses and does not need to be an exhaustive discussion of each symptom or character trait, (d) documenting the psychodynamic formulation will help achieve a clearer understanding of the patient and enable the therapist to communicate that understanding in a consistent manner, and (e) a psychodynamic formulation helps therapists recognize and address their limitations as they realize the incompleteness of their formulation.

The psychodynamic formulation does not only describe what takes place within the patient. It also underlines what happens within the relationship of the patient with the therapist. This is an emotionally imbued relationship that is characterized by ebbs and flows, volatility, and fluidity that we take great care to understand because they reflect repeating patterns of affect, expression, and behavior. The Triangle of Insight and the Triangle of Persons are useful frameworks that detect such patterns. The former includes three elements namely, “out there”, “back then”, and “in here”. The latter, originally published by David Malan, describes others, parent, and therapist. Both triangles are similar except that the latter highlights the transferences of the patient. Comparing both triangles, “out there” is similar to others (referring to the patient’s relationships), “back then” is similar to parents or significant family members, and “in here” is similar to the therapist (referring to ongoing interactions with the therapist). These triangles enable the clinician to chart affects, expressions, and behavior against these three points and to identify and track relationship patterns. Furthermore, these frameworks allow the clinician to take note of transferential aspects of the patient-therapist relationship and to plot each point of the triangle against another. An example is unresolved experiences “back then” may occur “in here” in the therapy room and may also shape interactions with other people. Being alert to patterns that emerge within the patient-therapist relationship is a key element in the groundwork of psychodynamic formulation. The theoretical framework that we use to organize the formulation will influence the patterns that we pay attention to because different frameworks underscore different patterns. (4)

Formulating patients’ problems in a psychodynamic way is a key clinical skill for all psychiatrists and clinical psychologists. Various formats of writing a psychodynamic formulation have been proposed but there is no one particular approach that is agreed upon.

Curtis and colleagues developed what they called a plan formulation that is composed of four parts: (a) goals (behaviors, affects, attitudes, or capacities that the patient wishes to achieve; may be specific and concrete or general and abstract); (b) obstructions (irrational pathogenic beliefs that hinder the patient from accomplishing his/her goals); (c) tests (the patient’s actions that are taken to appraise the danger or safety of pursuing one’s goals); (d) insights (knowledge of the nature and origins of the patient’s pathogenic beliefs. (7)

Summers described four parts of a psychodynamic formulation: (a) summarizing statement, (b) description of nondynamic factors, (c) psychodynamic explanation of central conflicts, and (d) predicting responses to the therapeutic situation. In addition, he emphasized the integration of other elements in the traditional format of the psychodynamic formulation. These include temperament, genetics, childhood psychopathology, psychopharmacology, subsyndromal or syndromal psychiatric disorders, and trauma. (10)

Perry and colleagues recommended the same format but emphasized that the formulation

should be brief and composed of 500 to 750 words. (5) Böhmer proposed a similar format but he expanded it into five parts. These parts are described below. (3)

1. Illness narrative
    a. Brief identification of the patient
    b. Summary of the presenting problem
    c. Salient features of the patient's life history (e.g., childhood trauma, life stages where major changes occurred)
2. Pathogenic factors
    a. Predisposing factors (focus on the patient's developmental history; e.g., mother is not responsive to the needs of her child)
    b. Precipitating factors (focus on the patient's current life circumstances; e.g., sense of rejection brought about by relationship problems)
    c. Maintaining factors
        i. Internal (focus on the patient's personality organization; e.g., internalized tendency for self-loathing)
        ii. External (focus on triggers; e.g., stressful family environment)
3. Non-dynamic factors that contributed to the psychiatric disorder; e.g., genetic predisposition, physical illness, socio-economic factors, cultural factors
4. Psychodynamic explanation (why the patient is suffering from this problem at this stage of life; how the problem came about)
    a. Personality structure
        i. Control and regulation of instinctual drives
        ii. Defense mechanisms
        iii. Capacity for interaction, communication, or attachment
        iv. Ability to empathize with others
        v. Self-perception and self-image
    b. Central conflicts
        i. Dependency vs. autonomy
        ii. Submission vs. control
        iii. Desire for care vs. self-sufficiency
        iv. Valuing self vs. valuing object
        v. Guilt conflicts
        vi. Oedipal or sexual conflicts
        vii. Identity conflicts
    c. Characteristic patterns of interpersonal relationships (patient's past history and therapist's experience with the patient)
        a. Meaning and use of treatment to the patient
        b. Modes of resistance
        c. Transference (patterns of past primary relationships are repeated in present relationships)
        d. Countertransference
5. Prediction of the response to the therapeutic input

The following is an example of a psychodynamic formulation adapted from Böhmer. (3)

1. Illness narrative

"P", 26 years of age and studying Christian counseling, presents with a history of recurrent depression. He recalls that he first suffered from a depressive episode about 10 years ago. At that stage he had an "identity crisis" when he thought that he might be gay. He tried to suppress such feelings and lead a "normal" life, but later admitted to himself and others that he was gay. Initially he had felt relieved, but in the last year he had become more and more depressed and had been treated with several antidepressants. His depression became worse in the last couple of weeks and he started to withdraw more and more from people. His father, with whom he had a close relationship, died from a heart attack when Peter was in his first year at school. The mother, who is still alive, has a long-standing history of depression. He describes her as a withdrawn person; they never had a close relationship and he struggles with guilt feelings towards her, since he is still financially dependent on her. He has an older brother who is very successful in his career.

2. Pathogenic factors

The absent mother and early death of his father can be seen as predisposing factors. Early losses in childhood and problems in attachment lead to a vulnerability to depression in adulthood. A precipitating factor is the fear of soon having to start his career as a counselor in his church. His church does make allowance for homosexual counselors, but they have to live a life of celibacy. He states that such a life is a sacrifice God demands of him and claims that he has made peace with it. Maintaining factors are guilt feelings towards his mother. He attributes the guilt feelings to still being dependent on her; it may however be that because of her depression she was often experienced in his infancy as being absent and not responding to his needs which could have

led to an ambivalent identification with her and the development of aggressive feelings and therefore also guilt feelings towards her. This would contribute to the development of a harsh superego, which would exacerbate feelings of inferiority in relation to his very successful brother. The fact that he will soon have to start his career is also an ongoing stressor.

3. Non- dynamic factors
A family history of depression points towards the likely contribution of genetic factors in the etiology of his depression.

4. Psychodynamic explanation
a. Personality structure

“P” was a sensitive and introverted person in whom the early death of his father and the problematic relationship with an absent or uninvolved mother played an important role in the development of his depression. His depressed mother could not respond to his needs and was experienced as a “bad object” leading to feelings of aggression towards her and insecure attachment. Being however dependent on his mother, aggressive feelings were repressed and internalized and he developed a false, compliant self. An internal process of splitting led thus to the identification with a bad internal object and dependency on external “good objects”. The splitting was reinforced by the death of his father, which caused a regression and reawakening of oedipal conflicts, a conflict from which he, with the death of his father, emerged as the victor. His main defense mechanisms were rationalization, intellectua-lization, repression and passivity.

b. Central conflicts
The above-mentioned oedipal conflict, and the repressed anger towards the mother, led to severe unconscious guilt feelings and contributed to the development of a harsh superego. A healthy identification with a father figure who could withstand oedipal rivalry was not possible and this contributed to problems with his sexual identity. It can also be postulated that the internalization of a “bad object”, a sense of a bad self, as well as oedipal conflicts played a role in his passive acceptance of the demands of the church to lead a life of celibacy. Such an acceptance helped him to cope with his guilt feelings and the underlying fear that rivalry can be destructive. After the second interview he mentioned a recent dream about someone having burnt himself; he however made a Freudian slip and said that the person “was a burnt offering”; the person was thus being sacrificed. This can be seen as an expression of his conflicts around submission and control and intense feelings about his view of having to obey the church and God, and thus be acceptable, and his desire to be himself, to be allowed to live his life and not to be sacrificed.

c. Interpersonal relationships
His poor self-image also contributed to his depression. He was not assertive in his interactions with others and feared that he would be rejected, leading to further interpersonal problems and withdrawal from friendships.

5.Predicting responses to the therapeutic situation

“P” would most likely welcome the option of psychodynamic insight -oriented psycho-therapy, because of his introspective nature and psychological mindedness. It can be expected that the patient will initially be very compliant and friendly towards his psychiatrist. He will probably, as part of the transference, see the psychiatrist in a similar way as a primary caretaking figure, whom he has to please and handle carefully. His aggressive, resentful self will be repressed and it will take some time to build enough confidence and trust to allow hidden feelings such as anger, resentment and rivalry to surface. He will then most probably become a more demanding and difficult patient who will test the ability of the psychiatrist to tolerate and contain these intense feelings. It is possible that with the deepening of the transference, anxiety and resistance may necessitate more supportive phases during psychotherapy, which may for example include cognitive or behavioral techniques.

Other authors proposed methodologies in constructing a psychodynamic formulation. Faden and McFaden recommend an acronym called PRESS which stands for Psychologically minded, Relationships, Ego strengths, Stimulus, and Superego. (9)

Cabaniss and her colleagues advocated a three-step process (Describe, Review, and Link) that emphasizes the patient’s unconscious processes. In describing, the clinician points out the patient’s problem and patterns related to

self, relationships, adapting, cognition, as well as work and play. In reviewing, the clinician discusses genetics and prenatal development, earliest years (birth to age 3), middle childhood (age 3 to 6), later childhood (age 6 to 12), adolescence (age 13 to 18), young adulthood (age 18 to 23), and later adulthood (age 23 to present). Finally, in linking, the clinician connects the patient's history and problems or patterns to the patient's relationships with others by using an organizing framework that will help guide the treatment process. (2) These frameworks include the impact of trauma, the impact of early cognitive and emotional difficulties, unconscious conflicts and defense (ego psychology), unconscious repetition of early relationships with others (object relations theory), the development of the self (self-psychology), and early attachment styles (attachment theory). (1, 2) These frameworks underline the assumption that people possess inner lives that are essential in understanding their outer lives.

Furthermore, these models highlight that people's inner and outer lives are products of their individual life histories. Using ego psychology as a framework, the psychodynamic formulation describes how unconscious wishes, unconscious fears, and psychological defenses lead to patterns of inhibition, symptoms, and character problems. The self-psychology framework postulates that character problems arise from failure of the child's environment in providing empathic responses. A failure that leads to a distorted and inhibited self-development and hinders the capacity to maintain interpersonal relationships. This model further posits that the transference needs of the patient compensate for the failure of self-development. The object relations theory emphasizes the developmental failure in integrating the different representations of self and others that may be partial or contradictory. It also highlights displacement and defensive misattribution of aspects of self or others. (1) Attachment theory focuses on how the early dyadic relationship between the patient and the primary caregiver contributed to the patient's insecure attachment style. It further explains how insecure attachment can lead to problems with the sense of self, relationships with others, adapting to stress and anxiety, and self-regulation. (2)

The role of culture is essential in constructing the psychodynamic formulation. This is particularly important for patients belonging to collectivist societies that view the self as deeply embedded in some collective such as family, coworkers, tribe, or scientific society. In this context, the self is assessed by a specific reference group. Statements such as, "My family thinks I am introverted." or "My coworkers believe that I travel too much." exemplify this particular worldview. (12)

Self-construal in collectivist societies is predicated on the normative imperative of maintaining interdependence among individuals. Thus, for one to be considered "normal" one must see oneself as "part of an encompassing social relationship and recognize that one's behavior is determined, contingent on, and organized by what one perceives to be the thoughts, feelings, and actions of others in the relationship." The meaningfulness and completeness of the self is determined by the social relationship in which one casts itself upon and the drive to become less differentiated from others. Thus, "one is motivated to find a way to fit in with relevant others, to fulfill & create obligation, and to become part of various interpersonal relationships." The basis of self-esteem is founded on one's ability to maintain harmony within the social context by fitting in, occupying one's proper place, promoting others' goals, being indirect, and "reading others' minds". (13)

Bracero pointed out that the therapist's knowledge of the patient's culture is necessary in conceptualizing the problem and setting the treatment goals. He discussed how working with Asian patients whose cultural values emphasize filial piety demands sensitivity to the patient's sense of obligation to comply with familial and social authority even if it meant sacrificing one's desires and ambitions. Thus, encouraging an Asian patient to express anger directly to his father may be too distressful for the patient because it is in violation of his cultural norms and values that are integral to his self-image and self-esteem. (14)

The ability to formulate a patient's problem in a psychodynamic way is fundamental in psychiatry because it allows for better management of patients. It keeps the clinician constantly thinking about the patient and the therapeutic alliance, which is the most crucial determining factor in the success of psychotherapeutic work.

Given its tentative nature, the psychodynamic formulation is open to revision and correction as more data is unearthed. (3, 4, 5) Such alterations lead to corresponding modifications in the treatment plan. (5) The process of constructing the psychodynamic formulation may be complex and the clinician may feel lost in this complexity. In this situation, the words of Donald Winnicott may be comforting: “I think I interpret mainly to let the patient know the limits of my understanding. The principle is that it is the patient and only the patient who has the answers.”

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