Creating a Psychodynamic Formulation From a Clinical Evaluation

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Dr. Kassaw: Ms. A, a 29-year-old woman, came to the Baylor Psychiatry Clinic after a romantic relationship with a boyfriend had ended a few months earlier. She indicated that she was struggling with letting go of the relationship and moving on to new relationships. She felt that she spent an unusual amount of time ruminating over the circumstances of the breakup. The relationship had been about 4 months in duration and was with someone that she had known from her singles organization. She felt that the relationship had proceeded well until they became sexually involved, which she referred to as being "intimate." This had been a problem in previous relationships; a sense of insecurity developed after she became sexually involved with a boyfriend. Her efforts to compensate for feelings of insecurity had resulted in her becoming increasingly demanding of reassurance. When her demands had not been met, she sent an impulsive, angry e-mail message to the boyfriend. His response to the e-mail message had been to effectively break off the relationship by no longer communicating with her. She felt remorse about the precipitous message and sought, unsuccessfully, to reestablish the relationship. She indicated that she would like a brief course of therapy to help her with the repetitive nature of her behavior in relationships.

She had sought therapy on two previous occasions, both after the end of a romantic relationship. Neither of the previous therapeutic relationships had lasted more than a few sessions, and she did not feel that they were particularly helpful. She related that one of her therapists had spent more time talking about her own relationship problems than about Ms. A's.

Dr. Gabbard: I will interrupt Dr. Kassaw periodically to illustrate how bits and pieces of data can be used to develop psychodynamic hypotheses. Although little history has been revealed up to this point, Dr. Kassaw has nevertheless provided some key points that are useful in beginning to think about a psychodynamic formulation. Ms. A told Dr. Kassaw that the precipitating event for her seeking out treatment was the ending of an intimate relationship following sexual involvement. She also said that the outcome of the recent relationship reflected the course of previous relationships with men. She then proceeded to report that she had seen two therapists, but she had ended treatment with both of them after a few sessions because she did not feel that they were particularly helpful.

A basic premise of psychodynamic thinking is that internal object relations etched in neural networks from early childhood development tend to repeat themselves again and again in adult relationships. Here we see a pattern of difficulty in sustaining intimate relatedness both in romantic relationships and in therapeutic relationships. Whenever a patient informs you about experiences in other therapeutic relationships, you should be alert to the possibility that the pattern will repeat itself in the relationship with you. Keep in mind, however, that the therapist's contributions must always be taken into account. In other words, the behavior of the therapist may be largely responsible for the course of the therapy.

"Often one of the most difficult tasks in psychodynamic therapy is allowing the patient to be who he or she is rather than making assumptions about the patient's inner world on the basis of one's own experiences."

Dr. Kassaw: Ms. A had a master's degree in social work and worked with disadvantaged families in a state social service agency. She was born and raised in a rather affluent area of a large Texas city. Her father was an orthodontist, and her mother a housewife. She was the second of four daughters. She recounted a fairly uneventful childhood. She thought of herself as a "tomboy," meaning that she preferred more physical play as opposed to "girl" play with dolls, playing house, etc. The event that she considered most significant in her development occurred at the age of 5.

Her family was staying with relatives for a family wedding. She and her 3-year-old sister were in a bedroom in the home when an intoxicated uncle entered the room and touched the girls' genital areas. Ms. A crawled under the bed, leaving her sister behind. She recalled that she knew immediately that there was something wrong with the encounter, especially after the uncle told them not to tell their parents. Within a short period of time, she attempted to tell her mother about the incident. She felt that her mother's reaction was inadequate: "That wasn't so bad." She wished that her mother would have become tearful or angry. Her father said he was afraid that he would become violent toward the uncle if he confronted him. This response was also experienced as her father making up an excuse rather than comforting her; her father was refusing to protect her. She felt that the violation of her trust as a child and the perceived lack of response on the part of her parents had led to her current problems with intimacy in relationships.

Dr. Gabbard: The patient presented what Lichtenberg has called a "model scene." In this case it was a remembered event, with all the fallibilities of memory inherent in such a recollection, which depicted an organizing experience in the patient's life. She linked this event to her current difficulties with intimacy in relationships. One should always pay careful attention to a patient's theory of pathogenesis in describing his or her symptoms and difficulties. Often that theory is inextricably linked to a theory of the therapeutic action of psychotherapy that may be useful to explore when the therapy gets underway. In this memory, the patient experienced sexual abuse from an uncle and then crawled under the bed, leaving her younger sister in a vulnerable position. One can speculate that feelings of survivor guilt and a sense of being traumatically overwhelmed were both involved in this model scene. The impact of the trauma is perhaps worsened because of her mother's dismissive reaction and her father's refusal to confront the uncle, leaving the patient feeling unprotected. We know from Fonagy's work at the Anna Freud Center in London that trauma may be less pathogenic if it can be discussed and processed with a parent or parental figure to help the child contextualize and understand what happened. If the parents are unable to fulfill that function, and no one else is available to process the experience with the patient, the trauma is likely to leave more significant scars.

Dr. Kassaw: Let me now share some observations about Ms. A, even her manner in the waiting room. I called her name, and she jumped up and rather energetically said, "You pronounced my name right!" She was a youthful, attractive woman with long dark hair. She wore no makeup and dressed rather casually in loose-fitting clothing, as one might find in an outdoor store. She was pleasant and easy to converse with, relating her story in an organized and thoughtful way. During the first session and a number of others after, she would choose the chair farthest away from me. If that chair was not against the wall, she would move it so that it was. She indicated that her moods had been "sad," but her outward appearance was actually rather cheerful. She was never tearful during her initial visits. She showed no signs of perceptual abnormalities or cognitive difficulties.

I felt that this was a young woman suffering from intimacy problems, and her fear of closeness played out in the treatment room by her moving her chair back. I also sensed that she was likely to care for others and focus on the other person in the room rather than on herself. Her outward emotional appearance was of paramount importance and required her to control all negative affect continuously.

Dr. Gabbard: A psychodynamic clinician must pay careful attention to nonverbal behavior. While, traditionally, we think of slips of the tongue or dreams as ways of perceiving unconscious themes with the patient, we now know that nonverbal behaviors are at least one other "royal road" to the patient's unconscious. Early experiences with others are internalized as part of procedural memory and produce a how-to guide to relatedness. As Freud once noted, experiences that are not remembered or verbalized will be repeated in action, the original meaning of "acting out." Hence, when the patient scooted her chair back to avoid being too close to Dr. Kassaw, we could observe some form of anxiety about what might happen. Ms. A did not feel that there was sufficient interpersonal distance. Even though she was superficially cheerful and compliant, making a good impression, she was afraid of something. She might not even have known what she feared; perhaps the "nameless dread" that Bion wrote about. In any case, it was a nonverbal manifestation of her fundamental concerns about closeness that had brought her to treatment.

Dr. Kassaw: I diagnosed Ms. A with adjustment disorder, not otherwise specified. She did not meet criteria for any affective disorder, anxiety disorder, or other axis I disorder. There was no obvious axis II disorder either, although I thought that her primary defenses of avoidance, isolation of affect, and reaction formation would be most consistent with cluster C personality traits. The avoidance was manifested in the evaluation by her tendency to steer clear of conflictual issues unless I brought her back to them. The isolation of affect took the form of intellectualizing about her problems rather than allowing herself to experience the feelings associated with them. And the reaction formation was most clearly manifested by her pattern of being overly ingratiating to people at work with whom she was angry. She was actually a high-functioning professional woman, and, other than her subjective sense of distress, she had no measurable changes in her daily life.

After the first couple of visits, I noticed that Ms. A had indicated that she wanted "brief therapy for relationship problems" when she was screened for the clinic over the phone. We discussed her goals in therapy: to deal with the current situation in a short-term focused way or to examine her experiences more in depth. I was a little surprised when she chose the longer-term therapy, which she suggested might last a year. She was not at that time interested in psychopharmacologic management of symptoms, nor was there any indication for medication.

Dr. Gabbard: Experience with patients in the real world of training clinics makes the trainee aware that patients have often not read the DSM-IV and do not know that they are supposed to fit neatly into one category or another. Some patients appear to fall between the cracks, and adjustment disorder, not otherwise specified, may be the best tentative diagnosis we could identify. On the other hand, a basic premise of psychodynamic psychiatry is that we treat the person and not just the illness.

What Dr. Kassaw also began to understand was that there was a complex pattern of relatedness embedded in the patient's character that made it difficult for her to achieve satisfying love relationships. This same tendency might have made it difficult for her to receive help from a therapist. While this level of difficulty has traditionally been referred to as "character neurosis," this illness category does not mesh neatly with the axis II personality disorders, which tend to suggest much greater disturbance than is typical of this patient. When we strive to develop a psychodynamic formulation, we are really interested in a

diagnostic understanding of the person and his or her difficulties in addition to the descriptive diagnosis. Specifically, we attempt to gain an understanding of the person that will guide the psychotherapy. While all psychodynamic formulations should be based on biopsychosocial understanding, this patient presented little in the way of data that would clearly link her to substantial neurobiological disturbances. Hence, our major focus was on the psychosocial sphere, and neither Dr. Kassaw nor the patient saw medication as useful.

Dr. Kassaw: I had an initial feeling of closeness to Ms. A, even when she would move as far away as possible from me. I often mused to myself that, had she not been my patient, given our closeness in age, experience, and interests, we would have been friends. During the weeks around her initial evaluation, I had also had a great deal of turmoil in my life. Two weeks before meeting her, I had been in a rather serious car accident. Although not outwardly injured, I was feeling quite psychologically vulnerable and unsure of myself. The third year of residency had just started and was a large change from previous years in our program, since I dealt entirely with outpatients. Finally, I was navigating some of my own relationship problems, which were somewhat similar to hers. My own relationship struggles left me feeling very drawn to her but also made me wonder how I was supposed to help someone when the answers were not exactly forthcoming in my own life.

Dr. Gabbard: Dr. Kassaw has been courageous enough to share her own initial reactions to the patient, which were a source of valuable information for the formulation and planning of treatment. As psychodynamic clinicians, when we evaluate or treat a patient, we recognize that we are always working in a two-person field. We do not look at the patient as a specimen under a microscope. Nor do we regard ourselves as dispassionate, detached scientists. Rather, we recognize that we all have a complex set of conflicts, internal object relations, and struggles that influence the way we view the patient. We also make note of what the patient induces in us, knowing that any kind of countertransference is a joint creation involving some aspects of the patient's influence on us and some elements of our own past and our own conflicts.

Dr. Kassaw noted that the patient was the kind of person she would have liked to have had as a friend if she were not treating her. Keep in mind that a previous therapist had begun disclosing all of her own personal problems to Ms. A, much as a friend might have. Hence, we might develop an initial hypothesis that the patient is a person who is very accommodating to others in her attempts to please them, even to the point of sacrificing her own needs to take care of the other person's. Dr. Kassaw also saw striking similarities between her own life and the patient's, and she needed to be aware of the potential to overidentify with the patient and mistakenly assume that there was a one-to-one correlation between her own thoughts and feelings and those of the patient. Often one of the most difficult tasks in psychodynamic therapy is allowing the patient to be who he or she is rather than making assumptions about the patient's inner world on the basis of one's own experiences.

Dr. Kassaw: Ms. A felt that she was the favorite daughter in her father's eyes, receiving money, a credit card, and special gifts that her sisters did not. She felt closer to her father than to her mother, almost wanting to be a boy until she entered junior high. She remained close to her father and felt him to be generally supportive and understanding of her. She saw her mother as unnecessarily critical of her and recalled a time when her mother scolded her for accidentally spilling milk, as if she had spilt the milk with intent. She also saw her mother as functioning in a quid pro quo manner, creating unilateral contracts in which generosity was to be repaid with affection.

Ms. A had recently moved into a condo. Her mother had offered to place labels on the kitchen drawers to indicate their contents. Ms. A had become very upset with her, feeling that this seemingly generous offer came with expectations of affection in return. Ms. A also felt that her mother performed a supportive role to derive her own gratification. As an example, she had gone with Ms. A to the doctor and had made a point of telling the doctor all she does for her daughter. Ms. A felt that her mother had failed to respond empathetically to her, including not calling her when she was too ill to attend the most recent family Thanksgiving gathering.

Ms. A perceived her mother as sending a mixed message to her regarding romantic relationships. Her mother was highly critical of her interest in boys at the age of 11 and encouraged her to have a career before a spouse. However, she had also criticized Ms. A for the fact that she was single and had not given birth to grandchildren. (While Ms. A was growing up, her family took in pregnant teens, housing them until they gave birth.)

One of the most intense issues between Ms. A and her mother was related to separation. Ms. A's mother refused to financially help her with graduate school if she moved to another city. (Had Ms. A stayed near her parents, her mother had indicated that school and living expenses would have been covered.) The first dream Ms. A discussed in therapy occurred after a cousin's wedding:

> **We were on the roof of the church. The bride, the groom, me—we each had big lavender balloons, which were taking us to [a city]. My cousin and her new husband were already floating away. I was about to go as well, but my mother insisted on taking more pictures of me. Mother started to back up with the camera. I saw what was going to happen, but I couldn't do anything. Mother fell off the roof of the church. I ran down to the ground, but I already knew that she was dead.**

Dr. Gabbard: First dreams may be extremely useful in an assessment process because they may communicate in symbolic form something the patient cannot quite articulate as part of the life narrative emerging in her history. Ms. A had been given the message that it was not acceptable for her to grow up, leave home, and find her own life away from her mother. To be more precise, the patient had perceived her mother as giving this message. We always need to be careful in assuming there is a one-to-one correlation

between a parent's actual behavior and the way the parent's behavior is perceived by the patient. A wedding is a developmental watershed, a departure from the family of origin and the formation of a new family. The bride and groom floated away, but the patient was held back by a mother who insisted on taking pictures. Mother then backed off the roof of the church and plunged to her death.

We do not know the full range of meanings the dream may have because it was not analyzed. However, the dream and the other material taken together provide further insight into the patient's complaint about difficulty in forming intimate relationships. Separation from her mother was viewed as catastrophic. If she did not meet her mother's needs and live for her mother, her mother might die. At a more deeply unconscious level, Ms. A might have been struggling with aggressive wishes toward her mother—i.e., that she would have liked her mother to die so she could be free from her control. Dreams may present disguised and unacceptable wishes involving hostility toward one's parents. However, these wishes are probably so far from consciousness and so intensely defended against that it would not be productive to bring them up early in the assessment or therapy. Moreover, her postulated wish to destroy her mother was a hypothesis only at this time. Confirmation from clinical data was needed.

One implication of the patient's experience of her mother's message to her was that she must separate and individuate only insofar as she could meet her mother's needs. Her self-development was profoundly affected by this conflict about being destructive to her mother by becoming who she really was. Winnicott noted that children who are consistently unable to be valued by the parent will find another way to make contact by finding and developing an aspect of self that the parent recognizes and appreciates. Thus, children may develop a "false self" to accommodate the parents' image of who they should become. This compliant solution occurs at the cost of the development of the "true self," which is progressively buried and sequestered because it is viewed as unacceptable to the parent. In Ms. A's case, her mother's love seemed contingent on repaying her mother with affection and gratitude. It was too risky to express autonomous strivings because she was convinced it would be destructive to her mother. Ms. A then grew up feeling that neither her mother nor her father empathetically validated how she actually felt; instead, they wanted her to follow a script they had written for her.

It takes little imagination to speculate on how this formulation might guide the therapy. A likely development in the process would be that Ms. A would set out to be a "good patient," to give the therapist what she wanted, while secretly resenting that she was meeting the therapist's needs instead of her own. She would assume there was a quid pro quo involved in the process, in which the therapist was willing to help as long as the patient met the therapist's needs. Let us hear more from Dr. Kassaw about how the therapy began and whether it followed these predictions.

Dr. Kassaw: Our therapeutic relationship was characterized by Ms. A's effort to bring up discussion content for the sessions. However, she was very reluctant to display negative affects, such as sadness and anger, especially if these emotions were directed toward the therapist. She was quite inhibited when she first became tearful during a session and apologized for her behavior. Interpretations regarding transference were threatening, but she did not report that she was disappointed in, or in disagreement with, the therapist.

After several months of this denial, one day I received an electronic page that had to be answered as we were walking into the room for therapy. The conversation was brief and dealt with an administrative matter at one of the emergency rooms. As soon as I hung up the phone, Ms. A said, "I feel like crying." She became tearful, and I inquired as to what had happened. She said that she felt as if I was not paying attention to her and not caring for her.

Soon after that, Ms. A told me a story of a dinner with her sister. Her sister had not responded as she had wished to a painful statement Ms. A had made. Ms. A sat in silence until her sister stopped recounting an unrelated matter and inquired what had happened. I said, "I imagine that you were very angry while you sat there in silence." She briefly continued talking without any acknowledgment of my observation. Suddenly she stopped mid-sentence and said, "No, I was feeling defensive. I was not angry; I was hurt. I felt hurt." I acknowledged that my observation had been speculative and encouraged her to talk more about the experience of my error. Later in the session she said, "I'm feeling so panicked, my heart is racing, I'm sweating. I just want to get up and run out of this room." We were able to connect this feeling to the way in which she had felt when her mother had instructed her on the "right" feelings to have in certain situations.

Dr. Gabbard: We can speculate that Ms. A's efforts to be the perfect patient were in the service of a barely conscious formulation of the therapeutic action of psychotherapy. If she could have achieved a perfect empathic bond with Dr. Kassaw, her wounds would have been healed, and she would have finally received the pure love, the perfect attunement, and the special sense of recognition for which she longed. Fortunately for everyone concerned, Dr. Kassaw was imperfect, and some degree of disappointment occurred when Ms. A's therapist responded to an electronic pager at the beginning of the session. With a patient of this sort, the therapist has to fail the patient. Another way to put this basic axiom is that the patient must transform the therapist into a transference object. More precisely, the therapist is usually transformed into a series of transference objects. Psychotherapy often unfolds as a series of ruptures in the therapeutic alliance, followed by exploration of what caused the rupture and, ultimately, a reparation of the alliance. Dynamic psychotherapy is not like surgery, in which a strategy is mapped and followed as closely as possible. The therapist has a game plan, but detours and potholes regularly appear on the road to recov-

ery. Two people talk in a room about the patient's experiences, and something unexpected happens. Then the two parties engage in a process of figuring out what happened and why.

In this case, when Dr. Kassaw tried to repair the rupture, the patient related an incident involving her sister, and Dr. Kassaw suggested that she might have been angry. Ms. A felt misunderstood and clarified that she had been hurt, not angry. She again felt that Dr. Kassaw had failed in her attempts to attune herself to the patient. Patients with this type of psychopathology often have difficulty with transference interpretations, as Dr. Kassaw reported. The suggestion by the therapist that the patient actually feels something different from her conscious experience feels like a repetition of empathic failures from childhood.

I once said to a patient with an eating disorder, "I don't think you are really sad. I think you are angry." She replied, "You're just like my mother—when I said I was sad, she said, 'No, you're not sad; you're hungry.'" That patient taught me that patients are at times our best supervisors. The point, of course, is that transference interpretations must be used judiciously with patients of this type. While this patient's symptoms certainly did not fit into the category of narcissistic personality disorder, her feelings of hurt at the misattunement of her therapist were typical of the kind of narcissistic vulnerability in the patients described by Kohut in his early writings that developed into self psychology. We must also note the positive aspects of this situation—namely, that Ms. A now trusted her therapist enough to express her true self and disagree with what Dr. Kassaw suggested to her. On the other hand, she became terrified that her anger would be destructive and felt like she had to flee the room.

In developing a formulation for these clinical observations, we might hypothesize that similar concerns lead to the dissolution of Ms. A's intimate relationships. In other words, when relationships reached the point at which she began to feel misunderstood and angry, she had to flee to avoid the consequences of her destructiveness. Her model scene involving sexual abuse might help explain why the sexualization of her relationship with her boyfriend created difficulties for her. Sexuality mobilized anger in her because it had been linked to exploitation. Hence, she worried about how her aggression might destroy intimacy. The transferences that unfolded with the therapist might give us a real-life glimpse of what happens in other relationships. This is also true of certain countertransference reactions that may say as much about the patient as about the therapist.

Dr. Kassaw: One of the most challenging situations that came up during the course of therapy was with regard to Ms. A's current boyfriend. Their relationship was rather rocky, and I felt torn between voicing my disapproval of the man and his attitude toward her on one hand and retaining therapeutic neutrality on the other. If I had done the former, I would have felt as if I had been taking on the role of the overly protective mother who would not allow her daughter to separate from her and make her own independent decisions. As a way of dealing with my concerns, I tried to point out how Ms. A's relationship with her boyfriend was similar to how she felt she had been treated by her mother—namely, she felt like he was dismissive and unempathic toward her. However, I found myself biting my tongue at times to avoid saying, "Break off this relationship!"

Dr. Gabbard: Dr. Kassaw again demonstrates the value of countertransference as a therapeutic tool. This vignette is a beautiful example of projective identification. Through Ms. A's behavior (i.e., her way of relating to her less-than-optimal new boyfriend), Ms. A evoked a response in her therapist that was much like that of her mother. Dr. Kassaw started to feel protective and wanted to take over for Ms. A rather than let her make her own decisions. This countertransference was jointly created, of course, and involved an amalgam of Dr. Kassaw's past experiences and what the patient induced in her. Joseph Sandler called this type of reaction "role responsiveness." Therapeutic neutrality is undergoing radical redefinition these days. The therapist's subjectivity can never be completely eliminated, and Ms. A undoubtedly could detect Dr. Kassaw's concerns about her romantic pursuit.

There is a wonderful Ralph Greenson story in which his patient told him that he knew Greenson was a political liberal. Greenson was surprised, since he never espoused political views during a session. The patient explained, "Whenever I say something conservative, you interpret me. When I say something liberal, you say nothing." We are far less opaque than we think, and there are therapeutic advantages to our transparency. The fact that Ms. A could observe Dr. Kassaw's disapproval provided an opportunity to work through their conflict in a way that was different than what had happened with her mother.

By way of summary, let us review several key principles in forming a biopsychosocial formulation of this case with a psychodynamic emphasis:

1. Do not try to be all-inclusive. You cannot explain all of the patient's difficulties. Focus on one or two key themes that are at the core of the patient's problems.
2. Illustrate how certain developmental experiences may have contributed to the current complaints that the patient brings to treatment.
3. Identify stressors that may have triggered symptoms or unpleasant affective states that lead the patient to seek help.
4. Draw on here-and-now transference and countertransference data from your interaction with the patient that may link the patient's past to current life problems.
5. Predict how the patient's relationship patterns may emerge in the doctor-patient relationship and influence the course of psychotherapy.
6. Keep in mind that a formulation is only a hypothesis or a set of hypotheses. The formulation must be revised continuously as new data appear.

An initial formulation for Ms. A—one of many that might be useful—could be constructed as follows:

1. Ms. A sought help after a romantic relationship broke up when it became too intimate.
2. Ms. A's difficulties in sustaining intimate relationships appear to be related to her lifelong experience of her parents as lacking sufficient empathic attunement to her inner states.
3. To win her parents' approval, she developed a pleasing facade—a false self—that tried to adapt to the other person's needs.
4. However, this sacrifice of her authentic sense of who she was led to resentment and anger, which she feared would destroy relationships with those she loves and leave her feeling alone and unloved.
5. Hence, she was conflicted about whether or not she could risk authenticity when she becomes close to someone.

This pattern of relatedness may manifest itself in therapy as a need to give to the therapist what she thinks her therapist wants while secretly feeling misunderstood, resentful, and invalidated.

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