Psychodynamic Formulation

Notes and Models.

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The therapeutic triad.

- Patient internal dynamic structure.
- Reality.
- Clinician's theoretical model.

- A formulation must be driven by the patient dynamic and reality, informed by knowledge of models

- TL:DR One model does not fit all
The problem of reality.

“A theory of object relations, if is not to be phantasmagoric and mythological, must include constructs which provide for a relationship between the individual and external reality…

Reality is thus a necessary constituent of a psychoanalytic theory of object relations. It is, not however, a sufficient one. “

Greenberg and Mitchell, 1983
Patient dynamics.

- Defensive styles.
- Cognitive structures.
- Life events.
- Object relations.
Defensive styles.

- Mature.
  - Sublimation, humour, disavowal

- Distorted.
  - Denial, undoing, reaction formation.

- Destructive.
  - Acting out, splitting
  - Projection, projective identification.

- Disorganized
  - Psychosis.
  - Disorganization behaviour.
Denmark’s unsavoury experiment shows us why Kerala’s fat tax may be a healthy idea only in theory -

Consumers could always switch to cheaper but equally unhealthy food options.
Clinical approach.

- Mature and distorted
  - complex people, not stereotypes
  - Generally tolerate interpretations.
  - Can use structured dynamic therapies such as Malan's.

- Destructive and Disorganized.
  - Objects, not empathic people
  - Generally cannot tolerate interpretation
  - Can use behavioural and supportive approaches.
Mature

- Is dynamic formulation needed.
  - Cognitive formulation.
  - Consider short, time limited interaction.
  - Malan's triangles.
Triangle of Conflict

Defense

Anxiety

Hidden Feeling/Impulse
Triangle of Persons

Others

Parent

Therapist
The second triangle has THREE links

O/P  Feelings directed at the Other are derived from those directed towards the Parent

O/T  Some form of similar feelings are directed at both the Other and the Therapist

T/P  Transference feelings are derived from feelings about Parents.
Malan's ‘triangles’ - ‘anxiety’, ‘defence and hidden impulse’ and ‘other, therapist and parent’ - form a heuristic framework within which much psychodynamic work can be conceptualised. Finding a pattern that runs through the patient's relationships - past, present in the outside world and current with the therapist - is the cornerstone of the psychodynamic formulation, which, I am delighted to note, is now seen as a skill all candidates for the MRCPsych examinations are expected to be able to demonstrate. If they read Malan they should have no trouble with this task.

Jeremy Holmes, Br J Psychiatry, 2001
Role counter-transference.

- In formulation, counter-transference is the signal your feelings give you. It reflects
  - Reality of what is in the room.
  - Own unconscious process
  - Defense styles of patient.

- In Malan's work, the patient's feelings to the parental figure resonate with your own.
  - What you avoid may tell you as much as what concerns you.
  - Interpretation → socratic questions around the triangles.
Cognitive State.

- What is impeding insight?
  - Do not forget intellectual ability.
  - Reality distortion, splitting, acting out contraindications exploratory work.

- How much anxiety can this person tolerate?
  - Diverse and skilled coping skills?
  - Is work on coping needed first?

- Is dynamic working going to do too much harm?
CBT on distortions...1

- Filtering.
  - We take the negative details and magnify them while filtering out all positive aspects of a situation. For instance, a person may pick out a single, unpleasant detail and dwell on it exclusively so that their vision of reality becomes darkened or distorted.

- Polarized Thinking (or “Black and White” Thinking).
  - In polarized thinking, things are either “black-or-white.” We have to be perfect or we’re a failure — there is no middle ground. You place people or situations in “either/or” categories, with no shades of gray or allowing for the complexity of most people and situations. If your performance falls short of perfect, you see yourself as a total failure.

- Overgeneralization.
  - In this cognitive distortion, we come to a general conclusion based on a single incident or a single piece of evidence. If something bad happens only once, we expect it to happen over and over again. A person may see a single, unpleasant event as part of a never-ending pattern of defeat.
Jumping to Conclusions.
- Without individuals saying so, we know what they are feeling and why they act the way they do. In particular, we are able to determine how people are feeling toward us.

Catastrophizing.
- We expect disaster to strike, no matter what. This is also referred to as “magnifying or minimizing.” We hear about a problem and use what if questions (e.g., “What if tragedy strikes?” “What if it happens to me?”).
Control Fallacies.

- If we feel externally controlled, we see ourselves as helpless a victim of fate. For example, “I can’t help it if the quality of the work is poor, my boss demanded I work overtime on it.” The fallacy of internal control has us assuming responsibility for the pain and happiness of everyone around us. For example, “Why aren’t you happy? Is it because of something I did?”

Fallacy of Fairness.

- We feel resentful because we think we know what is fair, but other people won’t agree with us. As our parents tell us when we’re growing up and something doesn’t go our way, “Life isn’t always fair.” People who go through life applying a measuring ruler against every situation judging its “fairness” will often feel badly and negative because of it. Because life isn’t “fair” — things will not always work out in your favor, even when you think they should.
• Blaming.
  - We hold other people responsible for our pain, or take the other track and blame ourselves for every problem. For example, “Stop making me feel bad about myself!” Nobody can “make” us feel any particular way — only we have control over our own emotions and emotional reactions.

• Shoulds.

  We have a list of ironclad rules about how others and we should behave. People who break the rules make us angry, and we feel guilty when we violate these rules. A person may often believe they are trying to motivate themselves with shoulds and shouldn’ts, as if they have to be punished before they can do anything.
• Emotional Reasoning.
  - We believe that what we feel must be true automatically. If we feel stupid and boring, then we must be stupid and boring. You assume that your unhealthy emotions reflect the way things really are — “I feel it, therefore it must be true.”

• Fallacy of Change.
  - We expect that other people will change to suit us if we just pressure or cajole them enough. We need to change people because our hopes for happiness seem to depend entirely on them.
Global Labeling.
- We generalize one or two qualities into a negative global judgment. These are extreme forms of generalizing, and are also referred to as “labeling” and “mislabeled.” Instead of describing an error in context of a specific situation, a person will attach an unhealthy label to themselves.

- Always Being Right.
  - We are continually on trial to prove that our opinions and actions are correct. Being wrong is unthinkable and we will go to any length to demonstrate our rightness. For example, “I don’t care how badly arguing with me makes you feel, I’m going to win this argument no matter what because I’m right.” Being right often is more important than the feelings of others around a person who engages in this cognitive distortion, even loved ones.

- Heaven’s Reward Fallacy.
  - We expect our sacrifice and self-denial to pay off, as if someone is keeping score. We feel bitter when the reward doesn’t come.
Summary part one.

- If using mature defenses, CBT or Brief dynamic.
- Consider ability to tolerate exploration and past
  - Past psychiatric history gives clues.
  - A developmental history gives more.
- Formulate either using:
  - Malan for Brief Psychodynamic.
  - Beck for CBT.
- There is no need to use psychodynamic in every case: formulation is driven by clinical situation.
Part II

Why object relations is useful.
Distorted and Damaging.

- Generally no sense of a real or unchanging other.
- This fluidity is also seen in oneself.
- Drive theory less useful.
- Object relations more useful.
Drive theory.

Relationships meet needs
  In Freudian terms, libidinal needs.
  Not merely sexual, though Freud thought so.

The frustration of these needs leads to.
  Sublimation, humour deferral
  Disavowal, repression (suppression)
  Denial.
Object relations relate to:

Denial
Projection.
Acting out
Projective identification

Look for intense, unstable relationships: home, work, recreation.
Fairburn in five minutes.

Fairbairn thought of the libido as object seeking. That is, he thought that the libido is not primarily aimed at pleasure, but at making relationships with others.

The first connections a child makes are with his parents. When the bond is formed, the child becomes strongly attached to his parents.

The early libidinal objects become the prototypes for all later experience of connection with others.
Object.

- Not a whole person
- But an image of a person: a straw man.
- Idealized or Anathemized.
- Greater (superman) powers
- Hero or Villain
The **internal object relation** describes a relation which exists in the person's mind.

In the normal situation, healthy parenting results in a child with an outward orientation towards real people, who can give real contact and exchange.

When the needs of the child are not met by the parents (e.g. dependency needs and the need for affirmative interactions) a pathological **turning away from external reality** takes place.

Instead of actual exchange with others, fantasised, private presences are established, the so-called internal objects.

To these internal objects the child relates in fantasised connections, the internal object relations.
Fairbairn envisioned the child with largely unavailable parents as differentiating between the responsive aspects of the parents (the good object) and the unresponsive aspects (the unsatisfying object).

The child internalises the unresponsive aspects of the parents and fantasizes those features as being a part of him, because they are not available in reality.

This defence mechanism is known as "splitting of the ego", where the good and the bad parts of the parents are kept apart, and where there is no possibility to feel ambivalence.
Ego splitting.

“The child cannot do without parents, yet living in world in which parents, the constituents of one's entire interpersonal world, are unavailable or arbitrary is unbearably painful.

Therefore... the first in a series of internalizations, repressions and splits takes placed, based on the necessity of preserving the illusion of goodness of the parents as real figures in the outside world”
Good enough.

If you continually give a child all wishes → spoilt, petulant. If you do not give a child some wishes and needs then neglected, abused.

Most parents meet children's needs in a manner good enough to contain their anxiety.

“the mother’s eventual task is gradually to disillusion the infant, but she has no hope of success unless at first she has been able to give sufficient opportunity for illusion”
The child's frustration at not having needs met leads to rage. This splitting of the negative, bad object from the loved, good object resolves itself by the development of a memory track that includes both needs being met and unmet by the same parent (object) in real life.

This is associated with an acknowledgement of the bad object within the child, and the development of shame, guilt and lying.
Split.

As adult, consider others either all good or all bad. 
In parallel, consider self either competent or bad. 
  • No ambivalence 
  • Loss of memory / denial of other state. 

Acting this out: 
  • Team confusion. 
  • Self harm 
  • Idealization and destruction of relationships.
Projection.

Lack of acknowledgement responsibility.
  Or emotions.
  Pain or loss doing so unbearable.

The unwanted emotions attributed and blamed:
  The therapist
  Parents
  Past trauma
  The “system”.
Projection vs Projective ID.

Verbal or conscious vs nonverbal.

“You are so ANGRY!”

vs.

“Why are you becoming angry?”
Projective Identification.

This is nonverbal and unconscious.
Within the relationship, the other experiences and acts out the unwanted relationship.
Allows the patient to blame other, for they are acting in the manner the patient finds unbearable.
Borderline: Batman and the Joker.

Regression to infantile state with objects split into good and bad.

Use of Splitting, Projective ID Acting out.
Antisocial: Squad X.

The world and system is evil.
The system is a game.
I will do what it takes to win.
It is always the other's fault.

Use:
  Denial (guilt)
  Projection.
  Acting out.
Narcissist: Tony Stark.

All others are to serve me.
I am perfect.
If I am frustrated, I will rage.

Use:
- Denial
- Projection
Histrionic. [All Manga heroines]

Must be the centre of attention.

Depressed if not.

External over internal life.

Kawaii

Cute/athletic.

Fear of aging, loss style
Application.

Use defenses to drive formulation; NB projective identification can and will occur with all of these.

Four dysfunctional positions:
Split (Borderline)
Projected (Antisocial)
Dis-ambivelant (Narcissistic)
Demanding (Histrionnic)
Treatment planning.

Generally,

- avoid interpretation:
  - supportive not exploratory.
- Coping skills not CBT.

Constant treating team.

- “Therapeutic frame”

Minimize splits.

Team supervision.
Part III

Other models.
Introduction Mentalization

Introducing the mentalizing model
Mentalization as another approach.

**Phenomenology** is the indicator used by clinicians to distinguish mood disorders from BPD.

**Affective instability** in BPD is reactive, characterized by irritability and anxiety, and lasts for a few hours or at most a few days. Environmental triggers are often present.

Commonly, these are interpersonal events related to abandonment fears, which is not the case in bipolar I disorder.

Patients with BPD tend to move rapidly from a normal mood to anger, rarely show persistent elation, and are high in harm avoidance, whereas patients with bipolar disorder are not.

What is mentalization?

Mentalizing, the ability to infer mental states of oneself and others,

is a key component of affect regulation and self-identity,

a central aspect of interpersonal relationships and social function

a focus on mentalizing may affect a range of disordered mental processes, whatever the source of pathology.
“We have made the case that a core feature of BPD is vulnerability to loss of mentalizing and this is especially so in interpersonal situations and when fear triggers the attachment system.

With the loss of mentalizing, failure, rejection, shame, and abandonment, for example, are experienced in psychic equivalence mode.

In psychic equivalence, thoughts are experienced as facts; feelings are not modulated by higher level mental process. Both are equated with reality—feeling bad means to the person that they are bad.

There is no attenuation through “as if” experience and so thoughts and feelings are experienced with unshakeable force and intensity. Greater self-harm and destructiveness may result because the patient seeks to get rid of these extreme experiences.

• Bateman and Fonagy, J Clin Psychol, 2015
Depression in Borderline.

Depression creates a state of hypomentalizing, characterized by

- poverty of thought,
- lack of interest,
- anhedonia,
- withdrawal from others.

Patients literally cannot think and feel.
Formulation is shared.

Borrowed from cognitive and interpersonal therapy, the formulation is presented to the patient formally.

However, this is taken a step further in mentalization therapy. The formulation is shared, it is collaborative.
Mentalization formulation 1

• The primary aim of the formulation is to **organize the thinking about the problems for therapist and patient**

• Mentalizing is modelled in a formal way. The clinician gives clear examples from the patient's history:
  • to illustrate the loss of mentalizing and its effects on functioning,
  • examples of good mentalizing and its resultant effects.

• In his or her attitude during the assessment, the clinician is required to model humility about the nature of truth.
In addition, the formulation identifies

- components of risk in intentional terms;
- beliefs about the self;
- central current concerns in relational terms and identification of attachment patterns
- a mentalizing profile, including positive features and vulnerability factors.
• The formulation also anticipates the unfolding of treatment in terms of the underlying problems—
  • what will interfere
  • what are the likely patterns of interaction with the service and the clinician.
• The initial goals, often related to reducing risk or problems that will interfere with effective delivery of treatment, and longer term goals, commonly linked to social and interpersonal function, are itemized
### Mentalizing framework

<table>
<thead>
<tr>
<th>Question</th>
<th>Consider</th>
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<tbody>
<tr>
<td><strong>What areas of mentalization strength does the pt. demonstrate?</strong></td>
<td><strong>Genuine interest in mental states of self and others, curiosity, acknowledgement of opacity, perspective taking, tentativeness, give-and-take etc</strong></td>
</tr>
<tr>
<td><strong>What areas of mentalization difficult does the pt. demonstrate?</strong></td>
<td><strong>Unjustified certainty about internal states of self/other; rigid adherence to single perspective; excessively sparse or over-detailed Mz; focus on <em>behavioural</em> descriptors, lack of interest in mental states etc.</strong></td>
</tr>
<tr>
<td><strong>In what context does the pt. struggle with mentalization?</strong></td>
<td><strong>What? Where? When? Who?</strong></td>
</tr>
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Fonagy: example of formulation

Describing a Mentalization Formulation
Treatment planning.

Structured.
Clear goals.
Time limited.
Explicit discussion of
  Supervision.
  Other team members.
  Co sessions.
In the session

• The aim of identifying the **interpersonal affect focus** is to enable the patient and clinician to consider
  • what happens in their relationship,
  • decide if this is a significant indicator of what happens outside in other relationships,
  • develop the patient's early warning systems so he or she has a chance to manage it before it happens.

• The patient focusing directly on the relationship holds the danger of **reducing mentalizing rather than increasing it**, and so the clinician starts the affect focus by stating *her*, not the patient's, component of the problem.
Explicit stating these things.

Introducing The Model
Mindfulness non-formulation.

Support your clients with depression and anxiety disorders by using the core competencies of Mindfulness Based Cognitive Therapy.

Our cutting-edge online courseware will change your approach to treating depression and other clinical problems.
Mindfulness.

- Based on meditation.
  - Underlying theories of acceptance or compassion.
- Skills based.
- Often added to Cognitive Therapy.
- The theoretical explanations are quite biological
  - Activation Prefrontal cortex $\rightarrow$ influence Amygdala.
  - Not dynamic or interpersonal.
...and you can get CME for online training.

http://www.mindfulnoggin.com/
Problems mindfulness.

- Universal application.
  - Compared with other talking therapies, which are more specific.

- Lack of theory?
  - Does the person get lost in the convergence to one solution?

The “problem of soap” – is this a religious or neurochemical way of describing what happens in any talking therapy?
Final advice.

• You will only get good at this by practising.
• Use the model of disorder that fits with the treatment clinically.
• Share formulations when appropriate
• Look at structures of support.
  • Formulation is a core discussion point in supervision.