The Psychodynamic Formulation Updated

RICHARD F. SUMMERS, M.D.*

The goal of this article is to update the conceptualization and format of the traditional psychodynamic formulation to include new areas of knowledge and thereby increase its usefulness. Following a historical review of the concept of psychodynamic formulation, new elements are proposed as essential to update this clinical and educational tool. The traditional formulation format is described along with the modifications necessary to incorporate the new elements. A case example of an updated formulation is offered, including the traditional and new elements, and the potential value and limitations of this new approach are discussed.

The psychodynamic formulation, whose function is to “provide a succinct conceptualization of the case and thereby guide a treatment plan” (1), requires a shift in emphasis to keep pace with the changes in the knowledge base and practice of psychiatry and psychoanalysis. The purpose of this article is to suggest several ways in which this cornerstone of the clinician’s thought process can be amended and updated.

Most clinicians are in favor of the biopsychosocial model, yet this “big tent” of psychiatric conceptualization all too often results in a bland picture lacking in depth. On the one hand, the typical biopsychosocial formulation includes a descriptive diagnosis that refers to psychological and social issues, but is lacking in inference about psychological motivation to the extent that it does not provide an adequate guide for treatment. On the other hand, the classical psychodynamic formulation provides a refined and focused picture, but is seen as antiquated and not in keeping with the remarkable developments in neuroscience. Between these two alternatives, a psychodynamically informed, biopsychosocial formulation, or an expanded and more inclusive psychodynamic formulation, may serve the needs of the thoughtful contemporary clinician.

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HISTORICAL REVIEW OF PSYCHODYNAMIC FORMULATION

McKinnon and Michels' (2) excellent guide to interviewing focused on the psychodynamics of a wide range of psychopathologic entities. Their clear delineation of each dynamic constellation led the way to concise formulation of individual cases. McKinnon and Yudofsky's (3) subsequent work, focused on psychiatric evaluation, set out specific guidelines for psychodynamic formulation, and gave excellent examples.

A close look at the concept and use of psychodynamic formulation began with Perry et al.'s (1) elegant and concise review. They presented a clear format for a brief formulation. The four essential parts were: (i) a general summary of the case, (ii) a review of "non-dynamic factors," (iii) a description of core psychodynamics using the ego psychology, object relations, or self psychology model, and (iv) a prognostic assessment that identifies potential areas of resistance. The Perry, et al. format is summarized in the first and second columns of Table I.

Although Perry et al. make explicit reference to the importance of including neurobiologic factors in the formulation, and also comment on the relevance of a psychodynamic formulation to nondynamically focused treatments, they do not provide a systematic format for including these elements.

Friedman and Lister (4) clarified that formulations are used to organize clinical data, increase clinicians' empathy, select appropriate treatments, and further research. They suggested that psychodynamic formulation emerged in the psychoanalytic tradition as a tool for teaching. They noted that psychodynamic formulation has had continued use within psychoanalytic circles, but has also received attention in the literature on short-term psychodynamic psychotherapy, and other less mainstream psychodynamic approaches. Finally, they observed that the biopsychosocial approach integrates the psychodynamic with neurobiologic and social factors, but there are no guidelines about what psychodynamic aspects should be included.

Melchide (5) provided a simplified model of formulation emphasizing predisposing factors and precipitating events.

Shapiro (6) agreed with Perry, et al.'s work, and extended the framework to children. He referred to his and Esman's (7) cogent summary of the four core notions of the psychodynamic perspective: (i) unconscious mental life, (ii) symptoms driven by internal conflicts, (iii) the meaning and significance of symptoms to the individual and their effect on his/her adaptation, and (iv) the potential for change through understanding the
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displacements of past conflict into the treatment setting. He implied that these factors must be expressed in the formulation. His exposition is followed by numerous excellent examples of succinct formulations of children.

Perry (8) provided an overview of attempts to develop more scientific and reliable methods of formulation, asking whether "the therapy is destroying the science of psychoanalysis," that is, whether the clinical emphasis on, and the heuristic value of, psychodynamic formulation has slowed the development of more objective and reliable tools. He reviewed five formulation methods described in the same publication, and concluded that much more data must be gathered before it is possible to determine the potential contribution of these methods. He noted that the earlier years of a new science provide fertile ground for clinical exploration and hypothesis generation, but the time has come to begin to test those hypotheses.

The 1990's have seen a tremendous growth in the development of new psychotherapies, e.g., cognitive therapy, interpersonal therapies, and specialized psychotherapies for the treatment of refractory depression. With the exception of McWilliams' recent volume on psychoanalytic case formulation, there has been little further work on, and discussion about, psychodynamic formulation (9). McWilliams' thorough treatment of the subject incorporates new domains of data into the traditional formulation, including temperamental and organic factors, and includes other paradigms, such as cognitive and relational models. But, she is not specific about the format for written formulations, and unfortunately includes few complete examples.

NEW ELEMENTS TO BE INCORPORATED IN THE PSYCHODYNAMIC FORMULATION

To keep the concept of psychodynamic formulation current, it must be articulated within the context of a more complete explanation for a patient's presentation and history, that is, an up-to-date "succinct conceptualization." Thus, new areas of nondynamic knowledge must be integrated with the traditional dynamic formulation. In this section, we summarize new domains of data that are relevant to understanding an individual, and which are discrete new elements in the updated psychodynamic formulation.

1. The role of temperament is an important determinant of behavior and experience, and surely affects the child's emerging experience of self and others, and determines important aspects of relationships (10, 11).
Psychodynamic formulation should attempt to clarify aspects of mental life that may be derivative of intrapsychic conflict and/or developmental difficulties, and those aspects determined by temperament.

2. Twin studies and other genetic studies have identified hereditable components to many personality features heretofore thought to be entirely a consequence of environmental experience (12). The systematic study of the genetics of personality has begun, including an investigation of gene-environment interaction. Traditional psychodynamic formulations may have overestimated the importance of environmental factors and/or neglected the importance of this interaction in explaining personality or character. An awareness of the genetic factors in personality may help to focus a formulation on the areas of conflict where its guidance may be most useful.

3. Better classification and identification of childhood psychopathology has helped to elucidate the potential impact of childhood psychopathology on development and adult psychopathology (13). This would include identification of learning difficulties and other neurodevelopmental vulnerabilities, and their impact on the individual and on personality dynamics (14).

4. The impact of subsyndromal illness on emotional development has not been well studied (15), e.g., mild mood syndromes that later become a full-fledged illness, or anxiety problems that do not meet the severity threshold. The possible subsyndromal symptoms that even young children experience may have a profound impact on the development of self-esteem, and may be crucial factors in emotional development (16). This may be evident retrospectively only when reconstructing an adult patient's development.

5. The extent of childhood and adult trauma, and its effect on mental life, has been subject to a rich and complex debate in the last quarter of the 20th century. Its rightful place as an external factor in the development of psychopathology is clear, as is its often-profound effect on personality development and intrapsychic life (17). An updated psychodynamic formulation will need to carefully conceptualize the effects of single traumatic experiences, recurrent trauma, and recurrent micro-trauma on experiences of self and other, self-esteem regulation, and on subsequent psychopathology.

6. Other models arising out of the psychoanalytic tradition provide alternative explanatory frameworks. Perry et al. note that the ego psychology, object relations, and self psychology models represent the dominant psychodynamic paradigms (1). But, others, such as the schema model,
described by Slap (18), which also has an analog in the cognitive therapy literature, provides another psychodynamic descriptive framework which has clinical heuristic value. Slap's model identifies a schema arising in childhood and representing a condensed pathologic scenario that dominates perception, fantasy, thinking, and behavior. Incorporating elements of the ego psychology and object relations perspective, this model has the virtue of relative simplicity and a clear operational focus in treatment.

7. With the advent of increasingly effective and powerful psychopharmacologic treatments, there are many individuals who have had effective medication treatment over an extended period of time, and at earlier critical developmental periods. Surely, these interventions, and their effect on patients' experiences, have also shaped their experience of self. These effects must now be considered to be important environmental experiences in their own right that affect subsequent development.

FORMAT FOR UPDATED PSYCHODYNAMIC FORMULATION

The proposed updated psychodynamic formulation includes the above seven elements by elaborating on Perry, et al.'s traditional format. The updated formulation encompasses the traditional formulation and the new elements, which are printed in italics. Table 1 illustrates both the traditional and updated formulation elements.

Part 1 of the formulation summarizes the patient's identifying information, events precipitating the illness, extent and quality of interpersonal relationships, and salient predisposing factors. Because Part 1 sets the scene for the formulation, summarizing critical information and foreshadowing the formulation, we add a summary of important neurobiologic factors, e.g., temperament, childhood psychiatric illness, subsyndromal illness, adult syndromal illness, and relevant family psychiatric history, to the list of predisposing factors identified. Behavior to be explained by the formulation is also included.

Perry, et al.'s Part 2 details the nondynamic factors relevant to the formulation. We call for a thorough review of the neurobiologic vulnerability in the style of a "review of systems": temperament, genetically determined aspects of personality functioning, childhood psychopathology from the syndromal perspective, history of subsyndromal or prodromal illness, adult syndromal psychiatric illness, identifiable traumatic experiences, and psychopharmacology responsiveness. In this section, these factors are described with important supporting evidence. Of course, there will be variation in the degree of certainty about these factors, ranging from clearly supported
diagnoses with good data, to inference and hypothesis. Because the formulation is always a work in progress, hopefully to be modified and refined, inference is not only permissible, but also necessary to work toward a comprehensive picture of the patient.

The psychodynamic synthesis is presented in Part 3. Following Perry, et al., the focus is on the central conflicts, the tracing of these conflicts through the patient's history, and the patient's attempted resolution of these conflicts. Perry et al. call for the formulation of the central conflicts, and characterization of wishes, defenses, and developmental difficulties, using one of the three psychodynamic models. Their thorough and clear presentation was accepted in the subsequent literature.

The need to integrate the traditional psychodynamic factors with the profile of neurobiologic vulnerability was the impetus for this paper. Although the field is in an early stage of understanding these issues, there is a developing clinical knowledge base in this area. First, the updated formulation addresses the impact, during the developing years, of the patient's neurobiology on the form and content of the psychodynamic conflicts. Just as the experiences of self and other are shaped by events, so are they shaped by the individual's neurobiology. For example, the temperamentally active and aggressive child will address the developmental challenges of separation-individuation and of the oedipal period differently from the more placid child. The child with a bipolar vulnerability, who develops syndromal illness in the late teenage years, and whose subclinical symptoms were retrospectively present in the preteen years, likely had subtle deficits in affect regulation which affected drive regulation and identity development. The child with symptoms of ADHD who experienced profound narcissistic injury associated with difficulties in rule-bound behavior may have particular challenges in developing a sense of mastery. Childhood OCD may intensify separation difficulties because of a profound need for reassurance and alternatively a sense of premature autonomy and aloneness.

Second, the updated formulation incorporates hypotheses about how the psychodynamic issues have contributed to the development, recurrence, maintenance or resolution of syndromal illness. Typical examples here would include the triggering of panic attacks and panic disorder by the activation of conflict over aggression in a work setting, or the recurrence of depression associated with increased marital tension when there is a history of earlier separation and loss. Although Perry et al. indicate the relevance of psychodynamic conflict to syndromal illness, they do not
regard such discussion to be an essential aspect of psychodynamic formulation.

Third, the formulation explains the longitudinal course of symptoms and illness resulting from the interaction between the neurobiologic and psychological vulnerability. Just as the traditional psychodynamic formulation requires a longitudinal (or developmental and psychogenetic) approach, the updated formulation requires using the longitudinal perspective model to explain the confluence of events and vulnerabilities over the life cycle.

Part 4 focuses on predicting the patient’s response to the therapeutic situation, drawing on the synthesis of Part 3, including prognosis, the patient’s experience of treatment, and probable transference manifestations. The updated formulation includes a specific reference to anticipated reactions to psychopharmacology, as this should almost always be considered in treatment planning. The defensive style and transference paradigm will inevitably affect a patient’s attitude toward medication, along with other specific experiences and beliefs.

The prognosis should be informed by the synthesis of psychodynamic and neurobiologic factors identified in Part 3, and the discussion of prognosis includes ideas about the anticipated phases of treatment and expected reactions and responses during those phases. For example, the prognosis for a patient with moderate-to-severe major depression that has been refractory to previous psychopharmacology and psychotherapy could be expected to begin with a prolonged phase of psychopharmacology trials, and identification of, and attention to, psychological factors which have contributed to treatment-refractoriness. During this initial phase, depressive symptoms will likely remit periodically, associated with a particular enacted transference reaction. The next phase for this patient will focus on more intensive and productive psychotherapeutic work involving a more clearly delineated transference reaction that the patient is able to work with more effectively, and the symptom response might become more robust and stable. The psychological reaction to psychopharmacology will likely involve the dynamics associated with the depression, and the responsiveness of the patient to psychopharmacology might be greater following the elucidation and working through of some of these issues.

The following case example illustrates the format and content of the updated formulation. The traditional elements as described by Perry, et al. are in standard font and the new elements are printed in italics.
CASE EXAMPLE

PART 1: SUMMARIZING STATEMENT
Dr. A. is a 33-year-old physician with a history of depression, social anxiety, repeated disappointments in love, and a pattern of high achievement with dramatic lapses. He presented initially for treatment during his first year of medical school because of feelings of extreme loneliness, anxiety, and constant suicidal preoccupation. He has been in treatment for the past six years with a combination of insight-oriented psychotherapy and psychopharmacology. He experiences a great longing for intimacy, both in a romantic relationship with a woman, and in friendships with men, and feels constantly disappointed. The most intense periods of depression, anxiety, and suicidality follow social disappointments. He had marked childhood shyness, depressive symptoms beginning in the preteen years when he began to feel more socially isolated and different from others, and atypical depressive symptoms during his teenage years. He has a genetic vulnerability to depression, and probably to schizotypal thinking. He is a successful professional, but given to unreliability in scheduling and meeting deadlines.

PART 2: DESCRIPTION OF NONDYNAMIC FACTORS
Dr. A's paternal uncle had paranoid schizophrenia, and his father, a successful attorney, is described as emotionally aloof, overly rational, and highly inhibited. His mother, an emotional and needy woman, suffers from chronic low-grade depression. Dr. A. has fair skin and has always blushed easily; he was an anxious and chronically shy child with behavioral inhibition. His high school and early college social experiences were dominated by intense social anxiety and a markedly fluctuating mood with persistently low self-esteem. Prior traumatic experiences included frequent teasing and humiliation by other boys during the teenage years, and rejection and public humiliation by the first girl he kissed. He responded well to treatment with combined SRI antidepressants and low-dose atypical antipsychotic medication; the psychopharmacologic treatment was associated with reduced interpersonal sensitivity and less catastrophic responses to disappointment.

PART 3: PSYCHODYNAMIC EXPLANATION OF CENTRAL CONFLICTS
Dr. A. experiences an intense longing for intimacy, wishing to be loved and cared for by a woman. He often experiences intense rejection, feeling that everyone but he is paired off with a member of the opposite sex. He also yearns for closeness with men, wanting to be guided and protected. He is perfectionistic, expecting to make only the most appropriate comments in
a social situation, and to produce only the most excellent work. He responds to his need for others, and his anxiety about it, with self-defeating behavior, such as turning in work late, keeping others waiting, and confessing excessively about his history of depression.

He is ambivalent about his overly close relationship with his mother, who, he feels, tells him too much about her thoughts and feelings. He thinks she treats him as if he were her husband, and though he relishes this role, he feels controlled and fears regression to excessive dependency. He feels overwhelmed by her needs, and experiences this in other women as well. His identification with his father is limited by his anger, competitiveness, and lack of closeness. His father is seen as distant and detached, with a kindly manner but a lack of empathy. The combination of fears of excessive closeness with women and difficulty identifying with men, has led to a shaky sense of masculinity that causes him to repetitively seek out relationships with women that end in his being either rejected by them or causing the rejection himself. He fears the rejection, yet brings it on because of his greater fear of being overwhelmed by loss of autonomy and regressive revival of passive dependency needs.

These issues were also reflected in his pattern of difficulty committing to completing academic commitments, and extracurricular activities. These behaviors express his anger at impending rejection, yet bring it about at the same time. Experiences of disappointment often lead to morbid fantasies and fragmentation fears with escalating acting-out behavior that has included parasuicidal behavior at times. Sometimes he counterphobically responds to his neediness through aggressive and even argumentative behavior, such as his individual political protests in high school when he felt so socially isolated, or his neglecting to ask permission to deadline extensions while in college, or his surprisingly defiant attitude toward his superiors in the clinical setting where he works.

Dr. A's neurobiologic vulnerability to social anxiety and shyness, as well as his predisposition to depression, probably contributed to proneness to rejection as a child, and intensified his experiences of disappointment and anger. This likely made him even more dependent on his mother, and more sensitive to the disappointments in his relationship with his father. The schizotypal vulnerability, also exhibited by the uncle and the father to some degree, may cause his reaction to these losses and frustrations to be more chaotic and disorganized, leading to occasional self-mutilative behavior, cognitive distortions about the motivations and reactions of others, morbid preoccupation, and an intense inner experience of emptiness and aloneness. His fear of rejection, and the self-defeating behavior which has become
associated with it, tend to perpetuate the pattern of recurrent depression and social anxiety. Though more recently Dr. A. has made significant and continuing strides in developing social contacts and activities, his need to undermine the possibility of feeling better because of the fear of more rejection has led to prolonged plateau periods of depression and futility.

The longitudinal course of illness began with social anxiety and intense rejection sensitivity that exacerbate the preoedipal and oedipal conflicts described above. This led to increasing depression in adolescence, and a crisis of dependency and loss precipitated by entering professional school. The symptomatic depression and social anxiety worsened the potential for positive relationships and other life experiences, which further exacerbated long-standing deficits in self-esteem, self and object representations, and resulted in escalating parasuicidal behavior. Dr. A's painful experiences of anxiety, hopelessness, anger, and fragmentation provoked an increasing sense of demoralization and failure which in turn intensified the depressive and social anxiety symptoms.

PART 4: PREDICTING RESPONSES TO THE THERAPEUTIC SITUATION

The patient has many positive prognostic features, including a high level of academic function, consistent and stable, if neurotic, relationships with parents, and a history of consistent prior participation in therapy. However, it was anticipated that following the development of an initial positive transference attitude toward the therapist, the aggressive and competitive feelings associated with the father, and the dependent feelings with their associated struggle for autonomy related to the mother, would begin to develop. These were hypothesized to lead to a prolonged period of self-defeating behavior in treatment, with experiences of failure and rejection, self-destructive acting out, and counterphobic reactions. The likely attitudes toward psychopharmacology were hypothesized to follow the same pattern, with superficial acceptance and covert rejection. It was anticipated that a more lengthy psychotherapeutic treatment would be required to work through the combined preoedipal and oedipal issues in the context of significant underlying neurobiologic vulnerability.

DISCUSSION

The goal of this article is to update the conceptualization and format of the traditional psychodynamic formulation to include new areas of knowledge and increase its usefulness. As illustrated in the case example, the updated formulation has several advantages.

First, it will stimulate clinicians to consider more deeply the specific
interactions of dynamic and nondynamic factors in understanding the development, maintenance, and resolution of patients' difficulties. It encourages the development of a full database about temperamental and genetically based factors and the impact of syndromal and subsyndromal conditions. It then challenges us to specifically hypothesize about the interaction of these factors with the patient's conflicts, identity, relationships, and experiences. Thus, the updated formulation may serve as an impetus for more accurate understanding of individual patients, and will certainly raise interesting questions that can be explored in research settings.

Second, the value of the psychodynamic formulation for guiding and "staying the course" during treatment, and for education and training has been previously discussed (1). A more thorough and inclusive formulation will be more valuable for these purposes. The importance of concise communication between clinicians has never been more important with the increased popularity of split treatment. This treatment model, with psychotherapy provided by one mental health professional and medication provided by a psychopharmacologist, makes effective communication about the nature of the patient's problem essential.

Third, the traditional psychodynamic formulation inherently takes a longitudinal view of the patient's conflicts, beginning with their genesis, and tracing them through subsequent life stages. The updated formulation also takes the longitudinal view, including this psychogenetic perspective, but makes it more comprehensive by interweaving psychological experience and neurobiologic vulnerability. This wider scope may be necessary to more fully account for the patient's experiences and symptoms.

Fourth, the content of the traditional psychodynamic formulation has been seen as the first edition of the concisely summarized insight a patient might hope to gain about him or herself through treatment. Later in the treatment, the formulation has likely undergone many revisions, and the clinician's and the patient's understanding will have converged significantly. The updated formulation will increase the modern patient's awareness of the role of both psychological and neurobiologic factors in his or her life and experience, and would be a first pass at glimpsing the complex understanding that might be gained in a successful treatment.

It is important to note two potential limitations to the updated formulation. First, the literature review noted the problems with any clinically derived individual case formulation. While there have been a number of efforts to develop more scientifically reliable techniques for making psychodynamic formulations (8), each was based on a particular theoretical model and none passed through the stage of study to the point where there
was demonstrated clinical utility. Although the approach described here does not allow for scientific verifiability, it is proposed as a valuable clinical heuristic. It is systematic in that it includes the defined framework suggested by Perry, et al. (1), and has defined domains of data which must be gathered and included.

Second, should this approach be referred to as “case formulation,” as opposed to psychodynamic formulation? Because of the particular value of psychodynamic conceptualizations, and the need to preserve these ideas and integrate them with new explanatory models, the decision was made to refer to the formulation discussed here as an updated psychodynamic formulation. This is an attempt to distinguish it from the more general biopsychosocial formulations that are usually limited in their focus on psychological conflict.

REFERENCES


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