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CHAPTER IV

CASE FORMULATION: FINDING A FOCUS

Case Formulation in TLDP

The major concept that distinguishes brief dynamic psychotherapy approaches from long-term psychotherapy is the limited focus of the treatment. Brief therapists need a central theme, topic, or problem to serve as a guide so they will be able to stay on target--a necessity when time is of the essence. Brief therapists cannot pay attention to all clinical data; even fascinating clinical material must sometimes be ignored. Practitioners working with short term models must learn to use selective attention (Malan, 1963) and benign neglect (Pumpian-Mindlin, 1953), or run the risk of being overwhelmed by the patient's rich intrapsychic and interpersonal life.

But how does one discern a "focus" for the therapeutic work? Are we talking about the patient's presenting complaint? For example, "I don't want to be unhappy any more." Or are we referring to a specific behavior? "I have trouble speaking up in a room full of people." Or is it a circumscribed problem? "I am too intimidated by authority figures."

In TLDP the focus for the therapeutic work is the recurrent interpersonal patterns that create and maintain dysfunctional relationships in the patient's life; these in turn are thought to lead to symptoms and problems in living. In other words, the TLDP focus is the maladaptive, interactive style of the patient. Given such a large and inclusive focus, how does one go about identifying this "style?"

In the past psychodynamic brief therapists used their intuition, insight, and clinical savvy to devise formulations of cases. While these methods may work wonderfully for the gifted or experienced clinician, they are impossible to teach explicitly (and untenable to test empirically). One remedy for this situation was the development of a procedure for deriving a dynamic, interpersonal focus--or Cyclical Maladaptive Pattern (CMP) (Schact, Binder & Strupp, 1984).

Briefly, the CMP outlines the "vicious cycle" a particular patient gets into in relating to others. These cycles or patterns involve inflexible, self-perpetuating behaviors, self-defeating expectations, and negative self-appraisals, that lead to dysfunctional and maladaptive interactions with others (Butler & Binder, 1987; Butler, Strupp & Binder, 1993). The CMP is comprised of four categories which are used to organize the interpersonal information about the patient:

(1) Acts of the Self. These include the thoughts, feelings, wishes, and behaviors of the patient of an interpersonal nature. For example, "When I meet strangers, I can't help thinking they wouldn't want to have anything to do with me" (thought). "I am afraid to take the promotion" (feeling). "I wish I were the life of the party" (wish). "I yell and scream at my kids when they get in my way" (behavior). Sometimes these acts are conscious as those above, and sometimes they are outside awareness, as in the case of the woman who does not realize how jealous she is of her sister's accomplishments.

(2) Expectations of Others' Reactions. This category pertains to all the statements having to do with how the patient imagines others will react to him or her in response to

some interpersonal behavior (Act of the Self). "My boss will fire me if I make a mistake." "If I go to the dance, no one will ask me to dance."

(3) Acts of Others Toward the Self. This third grouping consists of the actual behaviors of other people, as observed (or assumed) and interpreted by the patient. "When I made a mistake at work, my boss shunned me for the rest of the day." "When I went to the dance, guys asked me to dance, but only because they felt sorry for me."

(4) Acts of the Self toward the Self (Introject). In this section belong all of the patient's behaviors or attitudes toward oneself--when the self is the object of the interpersonal dynamic. How does the patient treat him or herself? "When I made the mistake, I berated myself so much I had difficulty sleeping that night." "When no one asked me to dance, I told myself it's because I'm fat, ugly and unlovable."

Figure 4.1 below contains a schematic form for categorizing patients' CMPs. Actually writing down the CMP following the initial session(s) can be very helpful way for trainees to keep focused and to track changes in their formulations. Some institutions (e.g., Winer, personal communication) have even required this form to be a part of their psychiatric inpatient charts, so that whoever is working with the patient on a particular shift can be appraised as to what the current CMP is for a specific patient.

ID:	
1. Acts of the Self	
2. Expectations of Others' Behaviors	
3. Actual Behaviors of Others	
4. Acts of Self Towards Self	

5. Countertransference Reactions	

GOALS:
New Experience
New Understanding
Patient Name: **Date:**

Figure 4.1 Form for the Cyclical Maladaptive Pattern (CMP)

By putting the data from these four categories together, the therapist can usually grasp a particular patient's idiosyncratic interpersonal story or scenario. While people might have many interactive stories (depending upon their mood, setting, other people, etc.), the CMP centers around the person's major, overriding, preemptive interpersonal pattern. This pattern describes the predominant, dysfunctional style which gets the patient into difficulties and/or leaves him or her feeling anxious, depressed, or unfulfilled.

The therapist frames the CMP information in a narrative fashion: Patients are described as feeling, thinking, wishing, and acting in such-and-such ways; imagining other people will react to them in such-and-such ways; observing that other people do react to them in such-and-such ways; all of which relates to how they treat themselves. For example, "I distrust other people (Acts of the Self) and stay away from them (Acts of the Self), because I have come to expect that other people are cold and thoughtless (Expectations of Others); others ignore me (Acts of Others), which leaves me having to protect and isolate myself (Acts of Self Toward the Self) since I can rely on no one (Expectations of Others)."

The therapist can start with any of the four categories and build a similar scenario, since they all interact to form one dynamic interlocking framework. For example, one could begin describing the patients' introject or how they treat themselves, and relate this to how they act toward others and how others react back, which is reflected in what they feel they can expect from their interpersonal world. "I have to protect myself; since I cannot get my needs met by others, I isolate myself; other people respond by ignoring me; and, therefore, I have come to expect the world to be a cold and thoughtless place."

These categories serve two purposes: (1) to provide an organizational framework--to make comprehensible a large mass of data; and (2) to provide a heuristic system which can lead to fruitful hypotheses and other useful models. A CMP should not be seen as an encapsulated version of Truth, but rather as a plausible narrative which incorporates major components of a person's interactive world. As such, it is possible for there to be a number of equally feasible dynamic formulations (Messer & Warren, 1995).

In addition to the four categories of the CMP, I add a fifth one--the therapist's countertransference. How are you feeling being in the room with this patient? What are you pulled to do or not do? The therapist's countertransferential reactions are a very important source of information for understanding the patient's life-long dysfunctional interactive pattern. One's reaction to the patient should make sense given the patient's dynamic focus. How others react to the patient and the patient's expectation of others' behaviors should have parallels with how the therapist is feeling and acting toward the patient, because the therapist is now a part of that individual's interpersonal world.

As previously discussed (see Chapter III), TLDP uses countertransference in a very specific way. The assumption is that the therapist cannot help but become entangled in the patient's dysfunctional interactions--not as a helpless fly caught in a spider's web--but rather as an active, responsive and responding force which contributes to the dysfunctional dynamic. The image is more like the batter who hits a pop fly because of the angle of the ball thrown by the pitcher.

If your countertransferential responses to the patient seem inconsistent with the interpersonal narrative, one possibility is that you are experiencing the patient in response to your own unique history (more in line with the classical definition of countertransference). Does the patient remind you of your brother with whom you've been competitive since you were five years old? Such an idiosyncratic reaction would have less to do with the patient's CMP than with your own (the therapist's) personal issues.

Another reason for countertransferential reactions which do not fit with the CMP is that there may be more information to be learned; that is, the CMP needs revision. The patient might be too vague for you to get a good handle on the situation or may be purposefully obfuscating (e.g., "malingering"). When your reaction to the patient is not understandable given the patient's acts, expectations, actual behavior of others, and introject, then something is amiss.

In the assessment phase of the treatment (which begins with the first contact with the patient--even by phone), the therapist listens for information which can be funneled through the four organizational categories of the CMP. In addition, the therapist attends to his or her own affective, cognitive, and behavioral reactions to the patient's presentation.

A Clinical Application

In order to make the concept and usefulness of the CMP come alive, I will present to the trainees in the Brief Psychotherapy Training Program the opening session with a patient--Lydia Ludlow. I will then work with the trainees to generate a dynamic focus for Ms. Ludlow.

Ms. Ludlow presented for therapy with multiple problems which she discussed in a tangential, unfocused manner. I like discussing her case early in the training, because if the trainees can learn how to derive a focus for her, then they should have less difficulty with patients who present more cogently and concisely.

Ms. Ludlow was a 45 year old married woman who was recently separated from her husband. Her numerous problems included compulsive eating, marital difficulties, financial problems, an alcoholic mother, and "I don't know what love is." Her previous therapist recently increased her fee to an amount which the patient felt she could not afford. She, therefore, came to the Outpatient Clinic.

I purposely do not give more information about Ms. Ludlow's background, because I am interested in preparing the trainees to attend to what they are seeing, hearing, and feeling in the session as a way of obtaining sufficient information to derive a dynamic focus. It is obvious from the way the CMP is obtained that the emphasis is not on DSM-IV diagnoses nor on the specific content of the problem, but rather on the patient's interpersonal processes.

[In the Classroom with the Trainees:]

[Setting: A seminar room located in the psychiatric outpatient clinic of a large teaching medical center. There is a circle of eight chairs around the periphery of the room with a videotape playback machine and a blackboard at one end. I sit near the VCR; the other chairs are occupied by the various trainees--three psychology predoctoral interns, two psychiatric residents, one social work intern, and one clinic staff member.]

(L)evenson: Now that I have told you a little bit about the patient, Ms. Ludlow, let me tell you some things bit about the therapist, Margaret Ellison. Dr. Ellison, at the time of this therapy, was a third year psychiatry resident. She had just rotated off the inpatient unit. Not only was Ms. Ludlow her first brief psychotherapy patient, she was also her very first outpatient case. Dr. Ellison came into training, much as you have, with a brief introduction to TLDP.

I advise the trainees to let the patients tell their own stories in the beginning session(s) rather than relying on the traditional psychiatric interview or clinic intake form, which structures the patients' responses into categories of information (e.g., developmental history, schooling, medical history). With the patients'

interactions less confined, therapists can learn not only from the content of the patients' stories, but also from the manner in which they convey this information (for example, emphasizing minute details; externalizing all responsibility for events; seeking guidance and reassurance from the therapist). In this way the trainees will learn first hand what is the content and process of any dysfunctional patterns.

I ask the trainees to videotape their first session and to inform patients that this is an evaluation session to see if TLDP is appropriate for them. Patients are further told that the therapists in the Brief Program work as a team, showing portions of the videotape and consulting with colleagues and a supervisor during a group supervision session. Therapists let patients know at the second session (which is scheduled for the following week) the decision of the team regarding the suitability of TLDP for them. If the team decides that the brief, interpersonally-focused treatment is not appropriate (e.g., the problem is not an interpersonal one, the patient is psychotic, the patient is not willing to maintain regular appointments), alternatives are discussed with the patient. (A fuller discussion on selection criteria is contained in Chapter V.)

[Classroom:]

L: I will play for you the first five minutes of Dr. Ellison's first evaluation session with Ms. Ludlow. I have written the four categories of the dynamic focus on the blackboard. As we listen to Ms. Ludlow on tape, I will write down some of what she has to say under one of the four groupings. I will place enough of what she has to say under each of the four categories so that you can get an idea of how I listen and organize material in order to derive an early formulation of a case.

When we have seen these initial five minutes of the first session on videotape, I will then ask you for your own countertransferential reactions to this patient. We will then practice using information about Ms. Ludlow's thoughts, feelings, and behaviors, her expectations of others' behavior, the behavior of others toward her, and her attitude and behavior toward herself, along with your reactions to Ms. Ludlow to derive an interpersonal narrative of her interactive style. This will enable us to formulate Ms. Ludlow's life-long, cyclical, maladaptive pattern.

[Videotape begins]:

Therapist: Well, maybe you can tell me a little bit about what's going on for you in getting into this program.

Patient: Um. (pause) I've never been in with any kind of psychology until I was married. I used religion to try to get better. I didn't hate psychologists, but I just didn't turn to them. I've gone to Health, my HMO, and most recently to the Care Center. The lady's leaving the Care Center and their fees were going up. She said she'd keep me on, but she's caught in the middle.

Therapist: Where is this Care Center?

Patient: Downtown Funston.

Therapist: How long have you been working with her?

Patient: Not that long. There was a long waiting list. I did an intake at Mt. Rushmore Clinic and the Care Center and they both said that's fine, but there was a long waiting list. And I've had to wait and wait. And I lost my HMO coverage, so I've been making do. But I've done a lot of reading. Alice Miller's book on child abuse and Scott Peck's <u>People of the Lie</u>. That's my parents. I can't get all the answers. Positive affirmations aren't enough. I need more.

Therapist: Can you say what's troubling you now and what brought you into therapy?

Patient: When I see what my parents did and what they taught me --I don't know what love is. I'd like to get back with my husband. It isn't manipulation. I'm a compulsive eater. If I'm on a strict diet, honest to God, my metabolism changes. It really does. I'm eating measured protein. I'm on the edge of answers. I watch Bradshaw on TV and they talk about compulsive behavior and manipulation. And I t hink I've almost got it.

Therapist: You said you don't know what love is. Can you say more about that?

Patient: I don't know what being together and I don't know what being OK is. My parents are like this. [Interlocks her fingers and pushes and pulls hands together in front of her.] *My mother's drinking; dad's pouring. I don't feel loved; I don't feel OK.*

[A few minutes later in the same session.]

Patient: I realized my parents weren't there for me. They're self-centered and holier than thou. They've concentrated on my problems all my life. My dad is a doctor; he specializes in weight control. My mother is a health fanatic and a size 4. They concentrated on my physical defects. I was beautiful. But then it was one damn thing after another. My lip curled so they made me massage it, and then they got me braces. And I was grateful for that. But it's one thing after another. They've been trying to fix me all my life.

Therapist: What was that like for you, when you were younger?

Patient: They were perfect. I didn't see them as human beings until a few years ago.

[Shutting off videotape and talking to trainees:]
L: Let me get your countertransferential reactions first. Imagine you are the therapist--you are Dr. Ellison. How are you feeling and thinking about Ms. Ludlow? How are you being pushed and pulled to react to her?