Chapter 8
A Psychodynamic Perspective on Assessment and Formulation

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Abstract This chapter explores the scope, depth, and application of contemporary psychodynamic theory to clinical social work. It opens by refuting several commonly held misconceptions about the psychodynamic approach: that it is synonymous with Freudian psychoanalytic treatment, attends only to internal conflicts rather than to person–environment transactions, and has little empirical support. In fact, the guiding assumptions of psychodynamic theory—the importance of attachment and early development on later functioning; the impact of trauma; the need for sustaining relationships, ego integrity, and a sense of agency; the way the external world is taken in and becomes part of us—are critical to clinical practice. In this chapter, the components of a psychodynamic assessment and case formulation are explored, each with specific examples and assessment suggestions: defenses, affect and affect regulation, attachment style and relational patterns, identifications, conflicts, pathogenic beliefs, self-esteem and identity, trauma, strengths, and the interaction between self and aspects of the environment (e.g., how internalized stigma and oppression affect beliefs, motivation, self-efficacy, and expectations about life). Also important in the psychodynamic perspective is the clinician's use of self as an important source of knowledge.

Keywords Psychodynamic · Relational theory · Affect · Attachment · Conflict · Cognitive distortions · Defenses · Ego strengths and weaknesses · Unconscious · Pathogenic beliefs · Psychodynamic Diagnostic Manual (PDM) · Psychodynamic formulation

Introduction: Why This Matters

Psychodynamic theory has exerted a significant influence on clinical social work assessment, formulation, and treatment. However, this theory is often shrouded in misconceptions, confusion, and controversy, intimidating many newcomers who

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erroneously assume that it is suitable only for the "worried well," not for the oppressed and vulnerable populations that social work largely serves. Nonetheless, when beginning clinical social workers are exposed to this way of thinking about human development, psychological symptoms, and suffering, they appreciate the depth and complexity the theory provides for understanding both internal and external dynamics impacting the client. The value of a psychodynamic assessment becomes all the more valuable as a clinician begins to work with a client, whether supportively or in change-oriented therapies.

This chapter begins by defining key terms and exploring the scope and meaning of contemporary psychodynamic theory in social work. A review of the empirical support for psychodynamic theory and psychodynamically oriented practice serves to refute the misconception that the approach has little empirical basis. Next, a dynamic perspective is offered on the interaction between individual and environment that informs psychodynamic thinking, challenging the tendency to bifurcate these domains so that etiology and pathology are situated in one *or* the other domain. The chapter's essential point is that the dynamic and reciprocal interaction between individual and environment must be held central in assessment and case formulation. Consistent with a bio-psycho-social framework, psychodynamic thinking offers theoretical speculation about the hyphenations that separate these ontologically distinct domains, as well as their role in both well-being and suffering.

The scope of psychodynamic assessment is broad and includes, among other factors, attachment/relational style, defenses, ego strengths, early development, conflicts, identifications, self-esteem, pathogenic beliefs, the nature and quality of the facilitating environment, class, gender, race, and various forms of oppression. The subjective experience of the practitioner is also utilized as an important source of clinical information.

Guiding Questions

1. What is contemporary psychodynamic theory and what role does it play in assessment and case formulation?
2. What empirical support exists for psychodynamic concepts and practice?
3. What specific aspects of a person's personality, functioning, and life experience are assessed from a psychodynamic perspective?
4. What is the dynamic interaction between the individual and the environment?

What Is Psychodynamic Theory?

New practitioners are understandably puzzled by what, exactly, constitutes psychodynamic theory (Brandell 2004). Very often, psychodynamic theory is mistakenly equated with the classical Freudian theory of a century ago. Critics who fail to keep up

with contemporary advances in psychodynamic theory propagate this myth in stereotypic ways, most egregiously in introductory psychology texts. In fact, contemporary psychodynamic theory contains many elements and guiding assumptions from empirically validated theories in various interdisciplinary fields, including social work, although they are rarely appropriately attributed. These guiding assumptions include the importance of early development for later functioning, the impact of psychological trauma, the need for empathic and sustaining environments, the way the external world is taken in and becomes part of us, and the fact that much of our experience in the world has unconscious dimensions. Support for these ideas comes from empirically validated theories such as attachment theory (Shilkret and Shilkret 2011), regulation theory (Schore and Schore 2014), object relations theory (Goldstein 2001), and neuroscience (Cozolino 2014; Miehls and Applegate 2014). The specific contribution of psychodynamic theory is in its hypotheses about the forces and interactions implied by the *hyphenations* in the bio-psycho-social perspective.

Central to psychodynamic theory, therefore, is the idea of a *dynamic interaction*, in contrast to a static or descriptive account of distinctly psychological and social phenomena. A dynamic perspective accounts for human motivational forces (desires, wishes, impulses) that interact with the external world (structures, rules, demands), producing a variety of possible outcomes. It also accounts for our sense of agency (our relative capacity to act freely in and on the world) and the facilitating or limiting aspects of social structures (external patterns of social organization). In addition, a dynamic perspective accounts for the impacts of oppression beyond a linear and unidirectional force.

In effect, it addresses the forces, motivations, and structures that operate both internally and externally, sometimes consciously, at other times beyond conscious awareness. Conceived in this way, psychodynamic theory is far broader than speculating about psychological conflicts in the mind as if they were independent of the external world. For example, psychodynamic theory allows us to talk meaningfully about a concept like internalized racism. Rather than limiting our understanding of this phenomenon to concrete or descriptive terms, a psychodynamic exploration incorporates ideas related to unconscious processes, psychological defenses, and structural forces. In this way, psychodynamic thinking allows us to understand the complex relationships between various processes and their effects.

It is important to distinguish psychodynamic theory from psychoanalytic theory, although as Berzoff et al. (2011) point out this is not easily accomplished, as the terms are often used interchangeably. Psychodynamic theory is considered much broader in its scope than psychoanalytic theory, although the former clearly draws heavily on the latter. Psychoanalytic theory is derived from, and historically linked to, the practice of psychoanalysis, and is comprised of many streams or schools of thought that owe their origin to Freud's earliest theorizing (Palombo et al. 2009). All subsequent psychoanalytic thinking can, in fact, be thought of as an extension, modification, or rejection of these early contributions. The historical development of psychoanalytic thought led to the emergence of drive theory, ego psychology,

object relations, and self-psychology (Berzoff et al. 2011). Contemporary developments include attachment theory, relational theory, and intersubjective theory.

While there are important differences among these schools of thought, each offers unique contributions and answers to enduring clinical questions, including the following: What is the role of the unconscious? What is the impact of early development? What are our prime motivators? How is the mind structured? How does the external world become part of us? How do we connect to others? How do we develop a sense of self? How do we protect ourselves from emotional pain? And how do we regulate our internal world?

Empirical Support for Psychodynamic Practice

> Many aspects of Freudian theory are indeed out of date, and they should be: Freud died in 1939, and he has been slow to undertake further revisions (Westen 1998, p. 333).

Tongue in cheek though it may be, Westen's quip suggests a widely held perception that psychoanalytic theory is still equated with Freud's writing from the early twentieth century and perhaps better left as a relic of that generation. Those not versed in contemporary psychoanalytic writing might ask: What value can psychodynamic theory have for contemporary social work assessment and practice? Well, lots actually. For an extensive empirical review of major psychodynamic concepts, readers are referred to Westen's (1998) wide-ranging analysis of the evidence for major theoretical propositions informing psychodynamic practice. These concepts, for which Westen argues there is considerable evidence, include the ideas that much of mental life, including motivation, is unconscious; our mental and emotional life is often bound up in conflict, particularly around important relationships; stable personal patterns are developed in childhood and endure into adulthood; our mental representations of self and others influence behavior; and finally, personality development moves from less mature and dependent states to greater independence and mature self-regulation. Such empirical evidence is important, as psychodynamic practice relies on a foundation of informed interdisciplinary research. The translation of these ideas into psychodynamic therapies then becomes the focus of research aimed at seeking empirical support for these approaches, both in themselves and in comparison with other treatments.

Mishna et al. (2013), in their review of evidence for psychodynamic practice, suggest that it is "social work's best kept secret" (p. 289). They conclude that a "growing body of evidence signifies the need to incorporate psychodynamic understanding into social work education and practice" (p. 299). Shedler (2010) also concludes that "considerable evidence supports the efficacy of psychodynamic psychotherapy" (p. 98). Both articles provide a compelling review of the literature in support of psychodynamic practice. While a full review of such evidence is beyond the scope of this chapter, readers are encouraged to consult Drisko and Grady (2012) and Fonagy et al. (2005) for additional scholarly review.

The Psychodynamic Assessment Process

Perhaps it is easier to start with what a psychodynamic assessment is *not*. It is not a formulaic process. There is no checklist of items to ask each and every client, no lists of five or seven or twelve criteria to meet (as i DSM diagnostic categories). There are no hard and fast timelines, no rigid rules. Moreover, the assessment process is not separate from or independent of the nature and quality of the developing therapeutic relationship. The assessment process from a psychodynamic perspective is just that—*a process*. There is, of course, content to explore and formulations to develop, perhaps theories to apply, but first, it is important to consider the assessment process itself and the clinician's own stance.

The assessment process begins with attention to the therapeutic relationship and establishment of a connection with the client. Clients make decisions early on as to whether the clinician is a person that they can open up to, tell secrets, and trust. And indeed, as Control Mastery Theory suggests (see Silberschatz 2005), clients continue to unconsciously test the clinician for these conditions of safety. Consequently, attending to the client's subjective sense of safety and trust pays huge dividends in the quality of the information gathered. We will return later to the importance of the therapeutic relationship in the assessment process with a discussion of the value of considering transference and countertransference.

Rather than extracting information from the client, like a laboratory attendant drawing blood, the assessment interview is collaborative in nature. The client is an active participant in the process and is encouraged to speculate on the meaning of events and stories told. The clinician might ask: What effect do you think such and such event had on you? Do you see any connections between this and that? How do you make sense of that? Because insight, self-reflection, and self-understanding are valued in a psychodynamic approach, posing such questions helps the clinician understand how the client has generated meaning and encourages a curious attitude toward life experience. Of course, holding curiosity is a highly valued trait in a clinician as well, and an important force in the process.

The reins of a psychodynamic clinician's curiosity are in the hands of theory and intuition. Held gently, the reins steer here and there, responsive to what is taking place, rather than the tight-fisted grasp of a dogmatic practitioner who is certain which paths to go down. Theory helps us know where to explore, what doors should and can be opened, and what aspects of *this* person's history might be examined. For example, the etiological basis of depression is complex and diverse, requiring us to explore questions of trauma, loss, attachment, abandonment, abuse, neglect, genetic vulnerability, oppression, and so on. Holding the possibility of a complex and diverse formulation of a client's situation necessitates a complex and diverse scope of assessment. The purpose of any assessment is to gather information that will lead to a reasonable and therapeutically viable understanding and formulation of a client's presenting problems. In essence, assessment from a psychodynamic perspective is as much process as product.

What Is Assessed?

The suggestion that assessment from a psychodynamic perspective is a process, a collaborative venture, an exercise driven by both theory and curiosity, has not yet answered the question of what exactly is assessed. In this section, we explore what a psychodynamic assessor attends to.

Consistent with a long-held social work practice principle, a psychodynamic perspective "starts where the client is." Opening questions are directed at what has brought the client here today. What kind of help is he/she looking for? Open-ended questions allow the client to further expand on these problem areas. The importance of open-ended questions cannot be over estimated. These are questions (or more accurately, directives) such as: "Can you say more about that?" "Tell me more about what that was like." "It would be helpful if you could share more about your current situation." Open-ended questions provide space for clients to tell their stories as unimpeded as possible. They also allow the clinician time and space to listen. Much has been written about listening from a psychodynamic perspective beyond what space allows for here, but suffice to say that beyond gathering basic information, the primary activity of the clinician is listening deeply to the client. Such listening also attends to the *way* the client tells the story. The clinician listens for overarching themes, dominant metaphors, and recurring patterns. In addition to this broadly focused attention, the clinician listens for specific data that answer important theoretically informed questions that are highly relevant for formulating a treatment plan. Much of what follows owes considerable credit to McWilliams (1999, 2004); although not a social worker, her writing has made an enormous contribution to the application of psychodynamic theory to assessment, formulation, and treatment.

Assessing Defenses An important part of psychodynamic assessment is evaluating the client's defensive structure. Accordingly, we consider what defenses the client uses most frequently and for what purposes. However, assessing defenses is not straightforward and has to be inferred from a range of client information and behavior. That is, the clinician cannot simply ask: "So, can you tell me what kind of defenses you characteristically employ to ward off anxiety and conflict?" Defenses by their very nature operate unconsciously. Thus, skill in assessing defenses comes with time, experience, knowledge, and helpful supervision.

Nonetheless, each person tends to use a cluster of defenses that are often consistent with individual personality style. Still, we must ask whether these defenses are reflective of the client's current situation or indicative of the client's overall personality style, or both. Are the defenses considered lower or higher level defenses? Lower level defenses tend to distort reality more than higher level ones and, when used consistently over time, reflect the nature of one's personality development (Goldstein 1995). For instance, people diagnosed with borderline personality disorder may be prone to use splitting (seeing others or themselves as all good or all bad), denial (of major aspects of reality), projection (consistently

blaming others for one's own downfalls), and projective identification (seeing and fixing the problem in others), particularly when under emotional distress. Individuals who have been severely traumatized may make extensive use of dissociation (separating off internal aspects of themselves). People who function at a higher level may be more inclined to use intellectualization (use of ideas disconnected from feelings), rationalization (giving "reasonable" rationales for behavior), undoing (reversing an unacceptable thought, feeling, or behavior), and sublimation (turning an impulse into socially acceptable behavior) to protect themselves from anxiety and emotional distress. Everyone uses a range of defenses, including the so-called higher and lower level defenses, so it is important not to jump to conclusions early on. The important question is whether these defenses are adequate to manage the anxiety and distress, knowing that what is being defended against is a mixture of conscious and unconscious elements. Assessing a client's defenses is an important aspect of assessing overall ego strength and weakness, which will be discussed below, but it cannot be stressed enough how important defenses are to an individual's overall functioning.

Assessing Affect Hand in hand with evaluating a client's use of defenses is assessing affect and affect regulation. Clinical social workers often work with clients who struggle with affect regulation. Some are impulsive or easily trigger to anger and aggressive outbursts. In contrast, others might be highly constricted in their emotional world and unable to name a feeling. Some may struggle to contain overwhelming feelings of sadness and loss. Still others may be overwrought with anxiety to the point of debilitating panic. The question can be considered for each client: What are the dominant affects the client is struggling with? Sadness? Anger? Rage? Envy? Jealousy? Shame? etc. What is fueling these affects? And further, what is the client's capacity to fully feel, regulate, and verbalize these feelings? Answers to these questions are central to developing a treatment plan that might range from supportive interventions to expressive and ego modifying forms of treatment (Goldstein 1995). Data to answer these questions may come from the observation of the client's behavior in the treatment interview or from self-report. But when we link the issue of affect with the idea of defenses, the assessment from a psychodynamic perspective becomes more complex. For instance, because of psychological defenses, it is not uncommon for a client who presents as sad and weepy in early sessions to actually be experiencing and containing a great deal of anger or rage. The opposite can also be true—a client who presents full of anger and rage may be defending against a good deal of sadness and depression underneath.

Consequently, the clinician who is undertaking an assessment from a psychodynamic perspective will be wondering: Can this client withstand the full impact of affect that is not consciously being processed? What is the client's capacity for affect regulation? Answers to these questions are important with respect to a proposed treatment approach.

Assessing Attachment Style and Relational Patterns Contemporary clinical social work practice has a strong relational foundation—putting the therapeutic relationship at the heart of our work (Goldstein et al. 2009). Consequently, central to a psychodynamic assessment is consideration of the client's attachment style and relational patterns (Brandell and Ringel 2007), as there is considerable evidence that attachment difficulties underscore a host of mental and emotional problems (Fonagy 2001). Although not used in a purely diagnostic sense, it is important to assess whether a client is securely or insecurely attached. If insecurely attached, what descriptive terms aptly fit the client's subjective experience and behavior? Is the client preoccupied with other people? Or, on the contrary, dismissive of attachments, preferring to retreat inside when experiencing need? Are the client's relationship patterns "all over the map," suggestive of a disorganized style of attachment? Is this person able to maintain boundaries when connecting with others? How are separations handled? And in the "here and now," how does the client relate to the clinician? Does the client present as passive and dependent, waiting for the clinician to solve the problems, or does the client keep the clinician at a distance, unable to trust the help that is offered?

Again, answering these questions may take time, and one has to be cautious about reaching conclusions too quickly since there are many reasons a client may be reacting to a clinician—reasons that may have to do with differences in class, gender, sexual orientation, and race within the therapeutic dyad, rather than with an attachment problem. Caution is also advised not to arrive at conclusions based on little information or data that are primarily reflective of seeing a client at an especially distressed period.

Assessing Identifications The link between adult attachment patterns and early development has been well established; so too, there is a strong connection between early development and one's later identifications—that is, the people we have *internalized*. Given that we take in the external world, consciously and unconsciously, the good and the bad, it is important to know something about the significant figures in a person's early life (McWilliams 1999).

The clinician might ask: "Who were you closest to growing up? Who was there for you when you needed help or support? Was there anyone you admired or wanted to emulate?" Sadly, it is sometimes very difficult to find even that one person—when the answer to the question was "nobody was there for me"—but it is important to keep searching, even if the answer is perhaps a coach for one season or a baby sitter at another moment. It is also important to assess whether there were significant figures in the client's life with whom they *dis*-identified, perhaps consciously rejecting them. For instance, a young male client might state, "I knew early on that I did not want to grow up to be like my father who was abusive to my mother and us kids." In assessing these identifications and their internalization, the clinician can simply reply: "Tell me about your mother/father—what was she/he like as a person?" The answer to this open-ended question provides a glimpse of how that person was internalized by the narrator. What the clinician is listening for

is not some objective truth about this person (as even siblings may have very different perspectives) but, rather, how the person is held in the mind of the client. Frequently, the client captures the internalized experience in a metaphor or a prototypical story.

As is often the case, significant figures in one's life were/are neither all good nor all bad. Consequently, the internalization of these important people may contribute to conflicted internal states in relation to these people. One way of defensively dealing with this conflict is to split off "all the good parts" or split off "all the bad parts." In the latter case, it is not unusual for a client to initially present a parent in idealized terms, only later to share "the other side." Another client might initially portray a parent as all bad, negating the positive qualities and good aspects of this caretaker. The realization that caretakers can be both good and bad leads to what Melanie Klein referred to as the depressive position (Hinshelwood 1989).

Assessing Psychological Conflict Freud believed that living in a modern civilized world contributed to psychological conflict, an idea that seems to have proven true. As Freud also knew, people are conflicted for many reasons: relationships, work, parenting, major life decisions, transitions, and so on. Consistent with psychoanalytic thinking, aspects of these conflicts are usually unconscious.

Moore and Fine (1990) write that "psychic or intrapsychic conflict refers to struggle among incompatible forces within the mind [while] external conflict is that between the individual and aspects of the outside world. (They often go together, however)" (p. 44). Some conflicts may emanate from opposing desires such as independence and dependence, or autonomy and wish to please others. Other conflicts might emerge as a consequence of clashes between sexual and aggressive impulses and one's internalized prohibitions about such behavior. Wrought with conflict about these opposing desires and wishes, the ego is thought to institute compromise formations that may take the form of symptoms (Schamess 2011). For example, a young person might be conflicted about a choice to attend college away from home or to study nearby. Operating outside of awareness is the idea that leaving home will injure one or both parents. The conflict about pursuing independence might result in depressive symptoms that, by default, cause the young person to remain in the home.

Similar to assessing defenses, it is not simply a matter of directly asking the client: "So what are you conflicted about?" Rather, the process requires careful listening to the tension in the narratives, the "push and pull." In many cases, the clinician will hear a tension that can be summarized as a conflict between *wishes and fears*. In the above example, the client's conflict is between the wish for independence and a fear of harming a loved one. The impact is often symptomatically expressed with anxiety or perhaps depressive symptoms. To what degree there is a basis for this particular fear may require further therapeutic exploration.

Assessing Pathogenic Beliefs In addition to grappling with a client's conflicts, it is important to assess pathogenic beliefs, that is, cognitive distortions that may have conscious and/or unconscious dimensions. These pathogenic beliefs may take the

forms such as: "I'm just a bad apple"; "Everybody is just there to use and exploit me"; "I can't do anything right"; "If I let someone get close to me they will leave"; "Nobody can be trusted"; or as in the example cited above, "If I pursue my own independence it will harm others."

There are enumerable pathogenic beliefs that can be identified during assessment using cognitive models of practice (Northcut and Heller 1998). What differs in a psychodynamic perspective is the idea that the origin of some of these pathogenic beliefs may remain unconscious (McWilliams 1999). A clinician might curiously explore these beliefs further with questions such as: "When did you first start thinking that you were a bad apple?" Or, "Where do you think that idea came from?" Consequently, exploring the origin and interpersonal history of these beliefs that are outside of the client's awareness becomes part of the work toward changing these cognitions.

Assessing Self-esteem Self-esteem and its regulation are frequently presented as a problem in clinical practice. Chronic low self-esteem can be associated with numerous disorders, particularly mood disorders. Therefore, assessing for healthy self-regard and its maintenance is important. Does the individual have a strong self-regard that is not prone to wild, sporadic fluctuations? For instance, some individuals who are sensitive to criticism can find themselves plunging to depths of despair and self-loathing following a minor insult or psychological injury. Others may have an unrealistic overevaluation of themselves, giving off an air of arrogance and self-centeredness, consistent with a narcissistic personality style. For others, their presentation might secretly conceal a veiled form of narcissism (Kealy and Rasmussen 2012). Like other aspects of a psychodynamic assessment, the clinician must determine whether the presentation of the client is situational and contextually driven, or reflective of longer patterns of self-experience.

Assessing for Trauma Trauma, abuse, and neglect are frequent experiences in the lives of many social work clients (Ringel and Brandell 2012). Psychodynamic theory has made many important contributions to understanding the effects of traumatic experience and their relationship to mental disorder. Indeed, early psychoanalytic theory frequently concerned itself with the effects of psychic trauma, particularly in response to world wars and sexual abuse. Contemporary concerns for the effects of trauma have broadened our conceptualizations to include relational or developmental trauma (e.g., sustained childhood abuse and neglect), in addition to shock trauma (e.g., being robbed at gunpoint). Severe and lasting childhood trauma will affect neurodevelopment and impact, among many things, an individual's capacity for affect regulation (Schore 2012a).

Awareness of trauma and its relationship to mental health alerts the clinician to assess for such experiences. For example, van der Kolk (2005) argues that the origins of borderline personality disorder are related to early childhood traumatic experience. Accordingly, at one mental health clinic where I worked, it was a standard part of the assessment interview to ask "Have you ever had unwanted sexual experiences?" The reasoning was that if you *don't* ask directly, it may be a

long time before the client is able to share these potentially traumatic experiences, particularly experiences that generate shame.

Other questions might address specific aspects of the client's potential experience. For people from non-dominant groups: "Have you ever been bullied?" For people of color: "Have you experienced racial hate?" For first responders (police, fire fighters, paramedics, etc.): "Have you ever had your life threatened?" For people living in impoverished neighborhoods: "Have you ever been the victim of violent crime?" In each case, the line of questioning has to be done with tact and timing, always for the purpose of understanding the client's presenting concerns and life story. At the same time, it is important to remember that not everyone who is exposed to a potentially traumatic experience will develop symptoms.

Assessing Strengths Having explored the need to assess for defenses, affects, attachment style and relational patterns, identifications, conflicts, pathogenic beliefs, self-esteem, and trauma, it is equally essential to assess for strengths, assets, and positive aspects of the person's life. The importance of identifying a client's strengths for a balanced assessment and treatment planning ought to be patently obvious; nonetheless, it often remains neglected. In doing so, there is no need to shift paradigms; that is, one can still hold a dynamic perspective. Using the concepts from above with the same line of questioning and listening, a clinician can similarly identify an individual's strengths. For instance, a client could be described as having a secure attachment style, trust for others, strong ego defenses, and healthy self-esteem. From an ego psychology perspective (see Schamess and Shilkret 2011; Goldstein 1995), an individual might be assessed as having good reality testing, clear judgment, and considerable mastery of some of life's essential tasks. The same person might, of course, also show significant impairment in object relations, poor regulation of affects and impulses, and rigid use of defenses. A balanced assessment of a client's relative strengths and weaknesses provides the clinician with greater clarity and specificity moving forward into treatment. Additionally, the clinician assesses strengths in the client's social environment and the impact of these resources for the client's well-being.

Clinician's Use of Self

As objective as we would like to be in conducting a clinical social work assessment, we can never make claims for complete objectivity—nor would we want to. Our subjectivity, or put in psychodynamic terms, our countertransference, provides an additional *way of knowing*. From an interpersonal neurobiological perspective (Schore 2012b), we connect with clients right-brain- to-right-brain, registering nonverbal, non-conscious affect. Our job, from this perspective, is to reflect upon and attempt to sort out what we are feeling and experiencing. This reflective knowledge may suggest important information beyond the client's conscious verbal reports.

For instance, a client may tell a story of loss in a matter-of-fact way that evokes considerable sadness in the clinician. Does this affective experience in the clinician reflect split off or dissociated affect in the client? Possibly. But whatever the answer may be, a clinician must hold a reflective stance about his or her own psychological and emotional experience of being with this person at this time. Further, this view on the clinician's use of self-necessitates that the clinician have a deep awareness of his or her *own* identities, personality, life history, and social location. Given that the assessment interview is a profoundly relational event, understanding our side of the equation becomes essential in the interpretation and formulation of the assessment data.

A Dynamic Perspective on the Role of the Environment

The role of the environment has been a theoretically contentious issue in clinical social work practice. The historic splits in theorizing, what some refer to as the battles between the internal and external (Berzoff et al. 2011) or the micro-and-macro divide (Kondrat 2002; Payne 2005), have plagued social work for more than a hundred years (Haynes 1998). Much of this debate is beyond the scope of this chapter to review. Suffice it to say that psychoanalytic theory has long been criticized for privileging the internal world of the client over external realities. However, contemporary psychodynamic perspectives have witnessed a major shift in recent years, a shift toward the *dynamic interaction* between the individual and the environment. This integrated approach requires that we theoretically incorporate both psychodynamic theories and critical social theories in our assessment and treatment interventions. Again, space here does not allow a full exposition of these ideas but readers are encouraged to explore the work of Berzoff et al. (2011), Rasmussen and Salhani (2008, 2010a, b), Alford (1989), Craib (1989), Elliot (2004), Clarke (2003), Borden (2009), Layton et al. (2006), Oliver (2004), Rustin (1991), Wachtel (2002), and Altman (2010). All are fine examples of work to integrate the social and psyche dimensions in a dynamic fashion.

In assessing the environment, psychodynamic practitioners are interested to know about many aspects of life that are common concerns from a general social work perspective—work, income security, family, access and barriers to resources, housing, supports, spiritual elements, education, and so on. Most particularly, however, a psychodynamic assessment is interested in understanding forms of oppression such as race, class, gender, ability, age, and sexual orientation from both a *descriptive* account of these categories and also as the *dynamic* interaction between these oppressive social forces and their relationship to the presenting problems or symptoms.

For instance, oppressive social forces of homophobia and heterosexism exert a negative force on individuals who do not conform to heteronormative models and thus need to be accounted for. Such understanding must be mindful of conscious and unconscious dimensions of these dynamics, accounting for internalized oppression along with the very real external barriers that prevent one from

actualizing a full life, including the effects of external and internalized stigma. This same thinking considers how the practitioner may have also internalized oppressive dynamics at an unconscious level.

The Use of the DSM and Psychodynamic Diagnostic Manual (PDM)

Psychodynamic practitioners, like many other social work clinicians, have an uneasy relationship with the *Diagnostic and Statistic Manual* (DSM). Critiques of the DSM come from many quarters, and certainly this volume captures many of these concerns. Perhaps a central critique of the DSM from a psychodynamic perspective is the fact that it is descriptive and atheoretical. Although describing disorders by clusters of symptoms holds some value and arguably remains an important starting ground for treatment decisions, the diagnosis tells us little about individuals' uniqueness, personal stories, subjectivity, and the experience and meaning of the "symptoms" that have been catalogued. The DSM describes much yet explains little for a particular individual.

Consequently, some psychodynamic practitioners have turned to the Psychodynamic Diagnostic Manual (PDM). This manual was collaboratively developed by several psychoanalytically oriented professional associations representing psychiatry, psychology, and from social work, the National Membership Committee on Psychoanalysis in Clinical Social Work (PDM Task Force 2006). Diagnostically, the framework set forth in the PDM systematically describes "healthy and disordered personality functioning; individual profiles of mental functioning, including patterns of relating, comprehending and expressing feelings, coping with stress and anxiety, observing one's own emotions and behaviors, and forming moral judgments; and symptoms patterns, including differences in each individual's personal subjective experience of symptoms" (PDM Task Force 2006, p. 2).

In this regard, the PDM is argued to better represent the whole person, rather than a cluster of symptoms. Complexity is embraced through a multidimensional approach to capture overall functioning and subjective experience. The PDM is organized along three dimensions or axis; Dimension I includes personality patterns and disorders, Dimension II captures mental functioning, and Dimension III focuses on manifest symptoms and concerns. Integrated into an overall understanding of the individual, the PDM contributes to a more comprehensive diagnostic formulation that captures cognitive, emotional, and behavioral functioning.

The Psychodynamic Formulation

A psychodynamic formulation is thus a theoretically driven exercise in analyzing and synthesizing complex data about a person and his or her life experience. While it is a formulation, it is far from formulaic. It is essentially a tentative hypothesis about psychosocial functioning that attempts to understand symptoms and presenting problems within an indivdiual's life context. It is more than simply recounting or summarizing the client's history. Although a psychodynamic formulation may incorporate a DSM diagnosis, where appropriate, it recognizes that, for example, depression in one person can look considerably different from depression in another. A depressed gay African American adolescent may present with the same symptoms (low mood, poor appetite, poor sleep, suicidal ideation, etc.) as a fifty-year-old white male executive, also diagnosed with depression, but the social and psychodynamics of each case may be significantly different and lead to different formulations. The symptoms are important, but so too are the unique events, life situations, and subjective experiences.

A psychodynamic formulation may be focused around a core issue, particularly if that issue is thought to underscore the client's most pressing concerns. Summers and Barber (2010) organize their thinking around the following core psychodynamic problems: depression, obsessionality, fear of abandonment, low self-esteem, panic anxiety, and trauma. For Luborsky and Crits-Christoph (1998), developers of the Core Conflictual Relationship Theme (CCRT) method, the focus is on three interacting components. The first component has to do with what the client wishes for, the second component with the way other people respond to this wish, and the third with how the client reacts to these reactions. For example, a child may wish to be comforted by a parent when emotionally distressed but is rebuffed, which the child internalizes as "my feelings don't matter." When this experience is repeated many times, the child may develop an internal style of disavowing his or her own feelings, with a concordant interpersonal style of not expecting emotional attunement from others.

From a clinical social work perspective, one that gives credence to the bio-psycho-social perspective, a psychodynamic formulation must also consider a broad range of social forces. In particular, a dynamic formulation must include an understanding of various forms of oppression. This work is speculative and requires thoughtful consideration on the clinician's part, especially in the task of attributing proportional weight to various oppressive factors. To exclude these forces is to deny important aspects of a client's lived experience.

Conclusions

Assessment from a psychodynamic perspective is a complex, unfolding process. Recognition is given to conscious and unconscious forces, present and past, and internal and external dynamics. Held central is the dynamic and reciprocal

interaction between the individual and the social world; often, identification of a core issue attempts to explain as much of the person's suffering as possible. As we will see in the case of Ray, the ensuing analysis results in a rich and intricate formulation that attempts to do justice to his lived experience. While trauma and loss will be suggested as core issues for Ray, this is not meant to negate other possible assessments and treatment issues. It is entirely possible that two psychodynamically oriented clinicians might arrive at somewhat different conclusions, given the same data. In the end, however, most would agree that attending to unconscious forces, early development, defenses, attachments, identifications, relational qualities, pathogenic beliefs, personality, oppression, trauma, and one's dynamic interaction with the environment form the basis of assessment for the purpose of providing clinical social work treatment. Nonetheless, any assessment is only the starting point—merely an abstract impression of a real life.

Application to the Case of Ray

The case of Ray is complex. Respecting that complexity, yet succinctly capturing core issues in a way that leads to treatment goals, is the task of a psychodynamic assessment and formulation.

Briefly summarized, Ray's presenting problems involve relational dynamics with his current girlfriend including, most importantly, acts of physical aggression toward her. Aggression is further noted in other settings toward males with little provocation. He presents to therapy reluctantly at first, apparently motivated to save his relationship. Ray is currently faced with the possibility of losing his police job, deemed not stable enough for full duty. He has overdosed twice in the past few months and was diagnosed with a major depression. Following the second overdose, he was diagnosed with bipolar disorder, type II. Ray's history is presented in somewhat idealized ways, although there is a significant history of victimization (bullying and child sexual abuse) and trauma (failure to rescue children, and the events of 9/11). He was adopted shortly after birth, presenting his early environment in positive terms.

To begin, Ray presents with a number of important strengths. He is hard working, determined, loyal, and a committed parent. He completed high school and police academy, suggesting intelligence, ego strength, and the ability to complete goals. In treatment, he appears motivated to change and has deepen a relationship with the clinician.

From a psychodynamic perspective, *core* problem areas appear to arise from the effects of trauma and loss. Trauma has both a significant historical dimension in the form of sexual abuse and a more recent impact through work-related experiences. The repeated sexual abuse occurred at the hands of a highly valued authority figure, at a key developmental period (age 13) for building *relational* intimacy and trust. It is hypothesized that shame and disgust are likely dominant *affects* that Ray must defend against. These affects are, for the most part, *unconscious*. He appears to keep

these affects outside of awareness through the *defenses* of denial, dissociation, minimization, and turning against the self. Further, the unresolved effects of trauma include, most prominently, rage. This affect may be displaced and acted out in current life situations, disconnected from its original source. Consequently, affect and its regulation are central therapeutic concerns.

Cognitive distortions in the form of self-blame ("he felt it was his fault") are characteristic for victims of sexual abuse, and function to diminish *self-esteem.* His self-esteem is further negatively impacted by the potential loss of a valued occupation and relationship problems. Indeed, it seems that his whole worldview (loyalty, duty, trust) has been severely challenged by these traumatic life events.

Diagnostically, Ray is thought to suffer from a major depression and bipolar disorder. The evidence for depression seems non-controversial; however, data supporting the diagnosis of bipolar disorder are not evident in the case description and would need further exploration. The Psychodynamic Diagnostic Manual (PDM) describes two different depressive personality disorders as follows: "the introjective (previously called melancholic), characterized by guilt, self-criticism, and perfectionism, and the anaclitic, characterized by shame, high reactivity to loss and rejection, and vague feelings of inadequacy and emptiness" (p. 44). There is some evidence for both forms of this subjective experience of depression for Ray; consequently, further probing in treatment is recommended. Either way, longer-term treatment is recommended by the PDM. The PDM states "…data suggests that interpretation and insight are pivotal to therapeutic progress with introjective patients, while the experience of a reliable relationship seems more central to the improvement of anaclitic ones" (p. 46).

Curiously, the *diagnosis of PTSD* is not mentioned despite considerable evidence for the label (nightmares, helplessness, emotional distress, guilt, intrusive images, etc.) and direct exposure to overwhelming traumatic situations. This traumatic distress was exacerbated with subsequent police duty of watching screens of people being victimized, while immobilized to help. Although trauma does not explain all of Ray's life difficulties, it would seem to be a huge mistake to not fully assess its impact on his functioning. The PDM notes that PTSD impacts affective states, cognitive patterns, somatic states, and relationship patterns. With respect to the latter, the PDM indicates that "relationship patterns may include changes in relating to others, based on decreased trust and increased insecurity, and states of numbness, withdrawal, chronic rage, and guilt" (p. 103–104).

Ray presented for help "distressed over his relationship with his live-in girlfriend Cecilia." What can be said about his *relationship style and attachment patterns*? While further assessment information is required, particularly with respect to details related to the adoption, there is some suggestion of an anxious, preoccupied attachment style. He appears jealous and controlling in his intimate relationships. His current relational difficulties are in contrast to his reports of more idealized early childhood experience, although interestingly, there is no mention in the report of his mother and their relationship—including information about her death and his experience of this loss. However, the case study report does suggest a deepening

therapeutic relationship characterized by increase sense of safety and trust, which bodes well for a successful therapeutic outcome.

There are numerous social forces that shape and influence this case study. Being *Caucasian* ordinarily concurs considerable privilege, and likely does for Ray, yet he was bullied as a youth for his different appearance of being "blonde and slight of build." *Gender* dynamics influence the way the Ray experiences his own masculine identity and relationship expectations, giving shape to the way he presents his problems. Ray's violence in his intimate relationship suggests the internalization of patriarchal views of male dominance in such unions. He highly values loyalty ("above all else") and experiences rejection as a complete affront to his sense of self ("once something is broken, it's broken"). His views with respect to intimate relationships require additional exploration and challenge. Further, Ray's middle-*class* upbringing intersects with gender in his expressed values and aspirations. He appears to seek satisfaction and stability in family life and work. His choice of occupation is consistent with traditional gendered identity and middle-class values. Unfortunately, while success in these goals was temporarily attained, it has recently been lost. His income, one important marker of class and status, is at serious risk. A rapid downward shift in his class status has been experienced as a "devastating" loss for Ray and must be incorporated into an understanding of his suicidal depression as well as his relationship losses.

Practical Exercises

1. Select a client from your field placement, or consider a character from a book or film, and try to understand the person in terms of some of the core concepts of psychodynamic assessment. What conflicts, identifications, and defenses can you identify? What do you observe about this person's affect regulation, relational patterns, and self-esteem? What kind of assessment tell you that a psychiatric assessment does not?
2. Now consider this person within his or her environment. First, write a straightforward *description* (economic and cultural factors, oppression, etc.). Then rewrite this description from a *dynamic* perspective, exploring the interaction between social forces and their relationship to the presenting problems or symptoms. What has been internalized? What unconscious processes may be occurring?
3. A psychodynamic formulation revolves around a core issue. Based on your analysis in the first two exercises, what do you believe is the person's core issue? What evidence supports your conclusion? What evidence might be used to argue against this conclusion? What do you need to find out in order to decide whether your conclusion is correct?

References

Alford, F. (1989). *Melanie Klein and critical social theory*. New Haven: Yale University Press.

Altman, N. (2010). *The analyst in the inner city: Race, class, and culture through a psychoanalytic lens* (2nd ed.). Hillsdale: The Analytic Press.

Berzoff, J., Melano Flanagan, L., & Hertz, P. (Eds.). (2011). *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts* (3rd ed.). Lanham: Jason Aronson.

Borden, W. (2009). *Contemporary psychodynamic theory and practice*. Chicago: Lyceum Books.

Brandell, J. (2004). *Psychodynamic social work*. New York: Columbia University Press.

Brandell, J., & Ringel, S. (2007). *Attachment & dynamic practice: An integrative guide for social workers & other clinicians*. New York: Columbia University Press.

Clarke, S. (2003). *Social theory, psychoanalysis and racism*. New York: Palgrave Macmillan.

Cozolino, L. (2014). *The neuroscience of human relationships* (2nd ed.). New York: W.W. Norton & Company.

Craib, I. (1989). *Psychoanalysis and social theory*. Amherst: University of Massachusetts Press.

Drisko, J., & Grady, M. (2012). *Evidence-based practice in clinical social work*. New York: Springer.

Elliot, A. (2004). *Social theory since freud: Traversing social imaginaries*. London: Routledge.

Fonagy, P. (2001). *Attachment theory and psychoanalysis*. New York: Other Press.

Fonagy, P., Roth, A., & Higgitt, A. (2005). Psychodynamic psychotherapies: Evidence-based practice and clinical wisdom. *Bulletin of the Menniger Clinic, 69*(1), 1–58.

Goldstein, E. (1995). *Ego psychology and social work practice*. New York: Free Press.

Goldstein, E. (2001). *Object relations theory and self psychology in social work practice*. New York: The Free Press.

Goldstein, E., Miehls, D., & Ringel, S. (2009). *Advanced clinical social work practice: Relational principles and techniques*. New York: Columbia University Press.

Haynes, K. (1998). The one-hundred year debate: Social reform versus individual treatment. *Social Work, 43*(6), 501–509.

Hinshelwood, R. D. (1989). *A dictionary of Kleinian thought*. London: Free Association Books.

Kealy, D., & Rasmussen, B. (2012). Veiled and vulnerable: The other side of grandiose narcissism. *Clinical Social Work Journal, 40*(1), 356–365.

Kondrat, M. E. (2002). Actor-centered social work: Re-visioning person-in-environment through a critical theory lens. *Social Work, 47*(4), 435–448.

Layton, L., Hollander, N. C., & Gutwill, S. (Eds.). (2006). *Psychoanalysis, class and politics: Encounters in the clinical setting*. London: Routledge.

Luborsky, L. & Crits-Christoph. (1998). *Understanding transference: The core-conflictual relationship theme method* (2nd ed.). Washington, DC: American Psychological Association.

McWilliams, N. (1999). *Psychoanalytic case formulation*. New York: Guilford Press.

McWilliams, N. (2004). *Psychoanalytic psychotherapy: A practitioner's guide*. New York: Guilford Press.

Miehls, D., & Applegate, J. (2014). Introduction to neurobiology and clinical social work. *Smith College Studies in Social Work, 84*(2–3), 140–143.

Mishna, F., Van Wert, M., & Asakura, K. (2013). The best kept secret in social work: Empirical support for contemporary psychodynamic social work practice. *Journal of Social Work Practice, 27*(3), 289–303.

Moore, B., & Fine, B. (1990). *Psychoanalytic terms and concepts*. New Haven: The American Psychoanalytic Association and Yale University Press.

Northcut, T., & Heller, N. (1998). Assessment of cognitive schemes and attribution in psychodynamic treatment. *Smith College Studies in Social Work, 68*, 185–202.

Oliver, K. (2004). *The colonization of psychic space: A psychoanalytic social theory of oppression*. Minneapolis: University of Minnesota Press.

Palombo, J., Bendicsen, H., & Koch, B. (2009). *Guide to psychoanalytic developmental theories*. New York: Springer.

Payne, M. (2005). *Modern social work theory* (3rd ed.). Chicago: Lyceum Books.

PDM Task Force. (2006). *Psychodynamic diagnostic manual*. Silver Spring, MD: Alliance of Psychoanalytic Organizations.

Rasmussen, B., & Salhani, D. (2008). Resurrecting fromm. *Smith College Studies in Social Work, 78*(2/3), 225–301.

Rasmussen, B., & Salhani, D. (2010a). Some social implications of psychoanalytic theory: A social work perspective. *Journal of Social Work Practice, 24*(2), 209–225.

Rasmussen, B., & Salhani, D. (2010b). A contemporary Kleinian contribution to understanding racism. *Social Service Review, 84*(3), 333–350.

Ringel, S. & Brandell, J. (Eds.). (2012). *Trauma: Contemporary directions in theory, practice, and research*. Los Angeles: Sage.

Rustin, M. (1991). *The good society and the inner world: Psychoanalysis*. Verso, London: Politics and Culture.

Schamess, G. (2011). Structural theory. In J. Berzoff, L. Melano Flanagan, & P. Hertz (Eds.), *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts* (3rd ed.). Lanham: Jason Aronson.

Schamess, G., & Shilkret, R. (2011). Ego Psychology. In J. Berzoff, L. Melano Flanagan, & P. Hertz (Eds.), *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts* (3rd ed.). Lanham: Jason Aronson.

Schore, J. (2012a). *The science of the art of psychotherapy*. New York: W.W. Norton & Company.

Schore, J. (2012b). Using concepts from interpersonal neurobiology in revisiting psychodynamic theory. *Smith College Studies in Social Work, 82*, 90–111.

Schore, J., & Schore, A. (2014). Regulation theory and affect regulation psychotherapy: A primer. *Smith College Studies in Social Work, 84*(2–3), 178–195.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist, 65*(2), 98–109.

Shilkret, R., & Shilkret, C. (2011). Attachment theory. In J. Berzoff, L. Melano Flanagan, & P. Hertz (Eds.), *Inside out and outside in Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts* (3rd ed.). Lanham: Jason Aronson.

Silberschatz, G. (2005). An overview of research on control-mastery theory. In G. Silberschatz (Ed.), *Transformative relationships: Control-mastery theory of psychotherapy* (pp. 189–218). New York: Routledge.

Summers, R. F., & Barber, J. P. (2010). *Psychodynamic psychotherapy: A guide to evidence base practice*. New York: Guildford.

Van der Kolk, B. A. (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals, 35*(5), 401–408.

Wachtel, P. (2002). Psychoanalysis and the disenfranchised: From therapy to justice. *Psychoanalytic Psychology, 19*(1), 199–215.

Westen, D. (1998). The scientific legacy of Sigmund Freud. *Psychological Bulletin, 125*(3), 333–371.