

## FORMULATION GUIDELINES FOR TRAINEES

Observed Clinical Activity (OCA)

### 1. The Requirement to Formulate the Case

The Committee for Training believes that the ability to formulate a case is one of the more important skills of a consultant psychiatrist. Formulation is a formal requirement in the presentation of the Observed Clinical Activity (OCA). Preparing the formulation is one of the tasks undertaken by the trainee during the period between the patient interview and the presentation to the Supervisor. The formulation is a set of explanatory hypotheses or speculations that link the findings on history and mental state examination with the putative diagnosis, and as such should precede the diagnostic statement.

### 2. What is a Formulation?

In the psychiatric literature, the term 'formulation' is utilised by different authors in quite diverse ways. In the United States, it often implicitly means psychodynamic formulation. Other authorities<sup>1</sup> use it to mean a comprehensive overview of the case encompassing phenomenology, aetiology, management and prognosis. Formulation is an explanatory hypothesis to provide a structure to further management.

In the context of the RANZCP OCA, formulation is a set of explanatory hypotheses (or speculations), which address the question:

'Why does this patient suffer from this (these) problem(s) at this point in time?'

The formulation is an integrated synthesis of the data. It should demonstrate an understanding of this unique individual, with his/her vulnerabilities and resources and how he/she comes to be in the current predicament.

The essential task in formulation is to highlight possible linkages or connections between different aspects of the case. The focus upon these inter-relationships adds something new to what has already been presented. In this sense, the formulation is more than a summary.

### 3. Models or Frameworks for Formulation

The Committee for Training wishes to emphasise there is no expectation the formulation will necessarily be a *psychodynamic* one. The use of more than one framework is often appropriate.

Most formulations will utilise **several** frameworks. The trainee is not required to describe the models he/she is using, nor to explicitly state which models are being used.

Models which *could be* utilised in preparing a formulation *include*:

- Biological (e.g.: genetic predisposition, physical illness, etc.)
- *Psychological/Developmental (for example psychodynamic, attachment, CBT, Behavioural)*
- Social (e.g.: family systems theory, role theory, etc.)
- Spiritual (e.g.: Cultural, religious belief(s), etc.)

The Committee accepts that many models and frameworks can contribute to our understanding of the development of psychiatric disorders. For example, Erikson's Life Stages or the notion of 'Coping Mechanisms' may be appropriately incorporated in a formulation.

#### **4. Formulation Guidelines**

The Committee for Training has no hard and fast rules about which material should be included in the formulation versus other components of the presentation. For example, some trainees may choose to highlight stressors and level of functioning in the formulation, in which case it is not necessary to repeat the material in the diagnostic statement. Most formulations will comprise three sections.

##### **Section I**

This will usually be a brief introductory statement that places the patient and their problems in context. The notion of the patient's 'predicament' may sometimes be helpful in presenting this section. Example: 'Ms Jones, currently a patient on an acute medical ward, has a ten-year unremitting history of anorexia nervosa. Her condition has become life-threatening in the context of a breakdown in the treatment alliance with her usual psychiatric treating team'.

##### **Section II**

This section highlights the important biological, psychological and socio-cultural aspects of the history which have potential explanatory power. In contrast to the preceding section, this section provides a more 'longitudinal' perspective.

The concept of 'vulnerability' (or predisposing factors) can often be usefully invoked in this section. It is crucial in this section (and also in the preceding section) to exercise judgment as to which aspects of the history are selected and to convey an appropriate sense of emphasis and priority. This choice will be dictated to some extent by Section III.

##### **Section III**

The task in this section is to make linkages between the material of Section I and Section II using hypotheses derived from an acceptable model or framework. Thus, the patient's vulnerabilities are juxtaposed with current stressors (and/or environment) to provide a plausible explanatory statement. Again, given the short time available, the trainee will need to be selective and give priority to the most plausible linkages between the material of Section I and Section II. In many cases, only a small number of linkages may be appropriate.

Given the trainee's limited knowledge of the patient (and our limited knowledge of cause/effect in psychiatry), the formulation will invariably be hypothetical. In other words, it would usually involve a set of 'educated guesses'. It is the plausibility of these speculations which makes the difference between a good and a poor formulation.

#### **5. Variation between Cases**

Although many cases lend themselves to formulation according to the above structure, this should not be interpreted as providing a 'formula' which will fit every case. Example 1 in the appendix is a formulation which does fit this structure. The four other examples in the appendix (cases of Dementia, Personality Disorder and Chronic Schizophrenia) less readily fit this framework. In such cases, formulation may take the form of describing factors such as:

- the possible impact of the illness upon the patient and his/her lifestyle (in both its early phases and currently);
- the possible relevance of the premorbid personality to the present picture (e.g.: possible interactions between axis I and axis II diagnoses);
- the possible impact upon the family;
- possible ways in which the patient's current environment may be impinging upon the symptoms.

Occasionally, patients are seen in whom one would anticipate finding linkages of various kinds, but these appear to be perplexingly absent. In such cases, the trainee should describe the kind of linkages he/she has sought, remark upon their incongruous absence and speculate about what factors might underlie this.

## 6. Additional Information

The Committee for Training considers it most appropriate to incorporate a statement about the patient's strengths (or protective factors) in the formulation.

Formulation, as conceptualised here, does not include a management or prognostic statement.

Most medical students seem able to complete the nine cell matrix comprising:

- biological/psychological/social X predisposing/precipitating/perpetuating

This is indeed a framework for organising the components of a formulation. However, the Committee would anticipate that trainees would proceed in a less stilted fashion and be better able to **prioritise** linkages and interconnections in a more sophisticated way (e.g.: by highlighting the recurring themes in the history).

## References

<sup>1</sup> Sperry, L, Gudeman, JE, Blackwell, B, Faulkner, LR (1992): *Psychiatric Case Formulations*. American Psychiatric Press, Washington.

The Committee for Training would like to acknowledge and thank the RANZCP Committee for Examinations for the development and permission for use of this document and the case studies within.

## **EXAMPLE 1: A CASE OF DEPRESSION**

Mr Jones is a 45-year-old mechanic living with his wife and two adolescent children. His family environment is experienced by him as stressful. In particular he describes his wife as detached and uncaring. His depressive symptoms (of three weeks' duration) appear to date from his being made redundant at work.

Of relevance in the patient's background is a strong family history of both depression and alcoholism, suggesting a possible genetic contribution. An important theme which emerges from the early history is the patient's constant unsuccessful striving to win affection and respect from his parents who, he feels, favoured his siblings. As a child, it seems that only when he was ill was this kind of attention (from his mother) forthcoming.

In addition to loss of income, unemployment has impacted negatively upon Mr Jones' self-esteem. His role as 'provider' is also threatened and I would speculate that his wife and children may well behave even more negatively towards him. There are parallels between his family of origin and his current family environment. In particular, his wife's detachment parallels that which he experienced from his mother and his efforts to win her affection have likewise floundered. I wonder whether his depressive illness may result in some secondary gain in terms of his family paying more attention to him, now that he is ill. His mother seems to have reacted in this way during his childhood.

## **EXAMPLE 2: A CASE OF DEMENTIA**

Mr Robinson is a 72 year old retired accountant who was unable to tell me the reasons for his admission to hospital or its duration. While he could answer direct questions, he lacked spontaneity and his answers were vague, lacking depth and detail. On direct questioning, he admitted to memory difficulties for some time which were confirmed on cognitive testing with deficits as outlined previously. These factors mean that the history I have obtained is sparse and of doubtful accuracy.

Mr Robinson gives a history of somebody who had a happy childhood and as an adult has been a competent member of the workforce, an active member of his local church and community and a responsible husband and father. He has been happily married for 45 years, but described himself as 'lost' since his wife's recent admission to hospital following a fall. This seems to precede his own admission. He denies any significant medical or psychiatric history and does not drink alcohol. On brief physical examination he seemed healthy.

The patient was aware of his cognitive difficulties and had some insight into his disorder. Clearly, this entails multiple losses for him and the sad affect and tearfulness he displayed (when describing these) seemed to me to represent more a process of grief and bereavement, rather than organic emotional lability or major depression (although the latter requires exclusion). Similarly, his anxiety seemed clearly related to fears concerning his future.

I would hypothesise that Mr Robinson may have been suffering from dementia for some time, with his wife possibly 'protecting' him in a practical way. There seems to be minimal other supports. Her admission to hospital would have both removed that practical support and acted as a major psychosocial stressor, precipitating his own deterioration in functioning and highlighting his inability to live independently.

### **EXAMPLE 3: ORGANIC PERSONALITY DISORDER/FRONTAL LOBE SYNDROME**

Mr Gary Smith is a young unemployed man aged 21 years, who lives with his parents in an urban apartment. He was hospitalized after a severe aggressive episode, which occurs on a background of poor impulse control and alcohol misuse.

Prior to a severe closed head injury sustained last year, Mr Smith was a high functioning individual who had reached the second year of medical studies. While he now looks physically well, he has been unable to return to his studies. On mental state examination, he displayed evidence of frontal lobe impairment (as I have already described) and on neurological examination, primitive reflexes were found.

It seems that the patient and his parents have suffered a devastating and acute series of losses. His high premorbid intelligence, academic and sporting achievement, a promising career, even his personality, all appear to be in jeopardy. The parents must also be alarmed by the episodic violence and the possibility that their son is going to be dependent on them in the future.

Gary and his family face a considerable period of grieving to come to terms with their losses. Moreover, uncertainty and fear about the future are creating considerable anxiety for all concerned. Although alcohol relieves his tension, because of his brain damage, the patient's tolerance for alcohol may be reduced. After a few drinks, his frustration tends to explode into aggression. Neither he nor his parents can control this situation - presumably there is substantial anger in all family members - and they are all clearly signalling the need for outside help.

The family has emotional, intellectual and financial resources. The patient's premorbid personality includes many strengths. He seems well aware that his judgement and self-control are often poor since the accident and that alcohol, although providing some relief, is hazardous for him.

### **EXAMPLE 4: CHRONIC SCHIZOPHRENIA**

Peter is a 29-year-old single man on an invalid pension with a 10-year history of chronic schizophrenia. He lives intermittently with his family or in local boarding houses. Over the last 10 years, there has been a progressive decline in his overall level of functioning, with relapses of acute symptoms occurring with stressful events in the family or non-compliance with medication. His family has responded to his illness with what appears to have been either over-protection or alternatively with denial and rejection. He currently presents following eviction from a boarding house due to increasingly disturbed behaviour, in response to abusive auditory hallucinations and paranoid delusions involving the staff.

Peter was a shy child, the only son in the family, and he was often aware of an expectation from his father for him to achieve. The history that a maternal aunt suffered from a psychotic illness may indicate a genetic predisposition to schizophrenia, but also appears to have caused guilt and self-blame in his mother. Peter's increasing withdrawal in adolescence may have been a reflection of family pressures, dealing with the tasks of adolescence or the first signs of illness. Peter formed few friendships and had been failing in his studies at the time of his first psychiatric admission at 19 years of age. With the continuation of his illness, Peter has failed to develop the skills for relationships and independent living and continues to rely heavily on his family.

He continues to plan unrealistically for a future in which he will study and develop a successful career. He is very reluctant to attend a rehabilitation program. This reflects his difficulty in accepting the limitations of his illness and perhaps also the unresolved need to meet his father's expectations. It appears that parental guilt and grief over Peter's illness leads them to reject him at times. This is often compounded by Peter developing persecutory delusions about the family. When he attempts to live independently, he frequently abuses alcohol, relapses and the family demands he return home. Peter experiences these demands as over-controlling and feels criticised. Thus, both of the family's responses to his illness (either rejection or over-protection) appear to contribute to a high EE environment, predisposing to relapse.

## EXAMPLE 5: A CASE OF A PATIENT WITH PERSONALITY DISORDER

Mr A is a 22-year-old single man on unemployment benefits, who presents with a benzodiazepine overdose. The patient's stated reason for his current distress is that it is the fifth anniversary of a close friend's suicide. However, I suspect that Mr A is not being completely open about what is really happening in his life. He has bruising to his face and arms, which he has passed over with a joke each time the cause for these injuries has been raised. He admits to having lost control of his use of alcohol and benzodiazepines over the past couple of months. Mr A seems aware of his own amusing theatricality.

Mr A is the only child of older adoptive parents and nothing is known about his biological parents. He says he always has been afraid of his father. At school he was teased for being effeminate. Although Mr A gives a history of sexual relationships with men since age 17, he protests that he is not 'gay'. He says he has always been 'dramatic' and has frequently caused himself embarrassment when fantastic stories about himself and other people cannot be substantiated. Mr A's only employment has been at his mother's catering business. This ended because of his repeated non-attendance at important functions. He has not obtained his driver's licence. There is a forensic history of creating a public nuisance, when he caused the local hospital to be evacuated with a bomb hoax in angry retaliation for not being admitted to the psychiatric ward.

There are many apparent gaps in our knowledge of important issues necessary to understand Mr A and the reasons for his current social and occupational impairment. How his biological parentage may have contributed to his current difficulties may never be known. I would like to further explore what difficulties occurred in the early developmental years arising from Mr A's temperament, his adoptive parents' style of parenting and advanced age, and the fit between Mr A and each of his parents. Also, what effect the teasing and his conflicted emerging sexuality have had on his sense of self and how his coping mechanism of narcissistic self-aggrandisement has impacted on his ability to achieve intimate friendship and gainful employment. I would also further investigate how dangerous he is when enraged and how frequently this occurs. I would like to elicit the exact details of his current predicament, which he seems to be concealing, and the reasons for this. Drug dependence, triangulated or even sadomasochistic relationships and prostitution need to be borne in mind as more data is sought from available corroborative sources. While there is no apparent axis 1 diagnosis, the possibility of a mood disorder needs further clarification.

## Disclaimer

This information is intended to provide general guide to practitioners, and should not be relied on as a substitute for proper assessment with respect to the merits of each case and the needs of the patient. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.

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