Formulation I

The College and formulation.

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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 use it to mean a *comprehensive overview* of the case encompassing phenomenology, aetiology, management and prognosis.

In the context of the RANZCP Clinical Examination, 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?’

*RANZCP guidelines*
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.
Formulation Guidelines

The Committee for Examinations has no hard and fast rules about which material should be included in the formulation versus other components of the presentation. For example, some candidates may choose to highlight stressors and level of functioning (DSM axes IV and V) 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 judgement 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 candidate 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 candidate’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.

RANZCP guidelines.
Structuring the task.

- Summary.
- Probable linkages.
- Speculation (use of theory).
- Prediction as to future.
- Prioritisation of Plan
Summary: two to three sentences.

- **Presentation:** “Janet is a 20 year old nursing student who presented a week ago after an overdose with intent to die”.

- **History:** “She describes a six month depressive episode in the context of a relationship breakdown and failing her course last year”.

- **Your findings.** “At presentation she states she is a failure and is useless. She cannot see a future. She is ruminating on the end of her relationship.”
Linkages.

- “Sarah has had a previous depression, and appears to worry overmuch. She may have GAD, which would predispose her for a further depression.

- In addition her anxiety and over worrying may have led her to be overly responsible and increase her guilt while grieving for the end of her relationship.”
Speculation.

- **Cognitive.**
  - Her ongoing use of worrying and probable use of catastrophisation as a coping skill has led an over emphasis on her negative cognitions and therefore her grief has spiraled into depression.

- **Developmental**
  - Sarah's worry has been lifelong. It may be that being a carer, a nurse, has allowed to maintain a sense of control and competence that has been destroyed by her perceived “failure” in the loss of this relationship.
Making it fit.

- **Cognitive.**
  - If we consider that she has, for many years, worried and also has had previous depressions she is at some risk more severe symptoms, even suicidal ideas, when (as now) she suffers a loss).

- **Dynamic.**
  - Given that she has suicidal ideas and is considerably distressed, exploration of underlying dynamics shouldn't occur until her self is strengthened and her coping skills improved. This loss has removed her usual coping skills, and this has been reinforced by becoming a patient, not a carer.
How

- What are the MAIN THINGS that are wrong with the patient?
  - ONE, or at most TWO problems.
  - Priorities for treatment.
- What does not fit?
  - What symptoms are unexplained?
  - What else do you need to know?
  - What coping skills do you have?
Look at the personality, background, risk, coping.

Link to beginning.

- (DO mention coping styles in MSE – “her insight is distorted by her use of ….”)

Conclusion should lead to five axes: for Janet

I MDE, probable co occurring GAD
II Defer
III Nil
IV Loss relationship, failed nursing course
V Currently suicidal, poor function last six months.
The Royal Australian and New Zealand College of Psychiatrists, however, continues to have a long case in their exams for Fellowship as well as OSCEs. The form of the long case is a 50-minute interview by the candidate who is observed by two examiners. After the interview the candidate has 20 minutes to produce a formulation and management plan, which they then discuss with the examiners.

We have persisted with the long case because it is a valid test of important skills. The most important skill it tests is the ability to prioritise information and ‘make sense of a case’ – the time limits force the candidates to work out what are the key issues for the patient. The long case gives trainees and supervisors an important message that interviewing and formulation are skills fundamental to the practice of psychiatry and it also provides an incentive for supervisors to observe their trainees’ interview.

Simon Hatcher, The Psychiatrist (2008) 32: 151-152. doi: 10.1192/pb.32.4.151a
Practise.

- 3 paragraph formulation
- 5 axes.
  - ALL new assessments
  - ALL presentations at meetings and for supervision
- Expand for grand round, formal cases.
- Fit with therapy type for college long case.
- Shorten for clinical reviews.
- It takes hours of practice for mastery – (or prior preparation prevents poor performance under stress)