Clinical Case Formulation

Varieties of Approaches

Edited by

Peter Sturmey
Clinical Case Formulation
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Peter Sturmey
For Tony Crisp
Someone who knows how to formulate cases
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Preface

When mental health practitioners are faced with a new client they have to predict the best treatment for this particular person. This is not an abstract question concerning the efficacy of treatments in general, but a highly specific question about one particular person and his or her unique set of circumstances right here and now. Many mental health practitioners answer this question by using psychiatric diagnosis as a predictor of best treatment. But for many reasons, mental health practitioners often reject this approach. Rather, the clinician takes the information he or she has concerning this specific person’s unique set of problems, assets and circumstances, and using the clinician’s experience, knowledge of the outcome literature, theoretical perspective creates a hypothesis or series of hypotheses that will guide them to the most effective treatment for this person.

Case formulation is a commonly taught clinical skill and many clinicians use it routinely. Although there is some agreement about the general features and common general principles that underlie case formulation, the content of different formulations is often quite different depending upon the theoretical orientation of the clinician. Clinicians may make formulations from cognitive, cognitive-behavioural, behavioural, psychodynamic, psychiatric and eclectic approaches. Even within each of these orientations, the specific technologies and concepts used to develop a formulation may vary considerably.

This book provides examples of contrasting formulations of the same case for five different clinical problems: depression in a middle-aged woman, psychosis, an eating disorder, hoarding in an older adult and anger in a person with intellectual disabilities. Each pair of formulations is followed by an independent commentary and the final chapter in the book comments upon the entire volume and endeavour of case formulation.
I thank all the authors of the chapters, especially those who wrote case formulations. The authors of case formulation chapters were brave enough to expose their clinical skills to the world, to knowingly write a formulation that would be contrasted with another unknown formulation and that would be critiqued both by the authors of the commentary chapters as well as book’s readers. The authors of the commentator chapter also deserve special thanks: they had to balance honesty with tact. I asked the authors to carry out very specific tasks: they all succeeded in doing so.
PART I

Overview
Case Formulation: A Review and Overview of This Volume

PETER STURMEY

Case formulation is a basic clinical skill for many mental health professionals. It is often included in professional training (Page and Stritzke, 2006; Page, Stritzke and McLean, 2008) and continuing education for many mental health professionals (Kendjelic and Eells, 2007; Kuyken et al., 2005; Sim, Gwee and Bateman, 2005). Various professional bodies, such as the British Psychological Society (British Psychological Society Division of Clinical Psychology, 2000, 2001), the American Psychiatric Association (2004) and the American Psychological Association (APA) (2005), identify this as a professional competency that practitioners should have and the professional training courses should teach. Within cognitive-behavioural approaches to mental health, case formulation is seen as a core skill for all practitioners. The first part of this chapter provides an overview of what is meant by case formulation. The second part of the chapter describes how authors in this book made their case formulation and highlights some of the links and contrasts across different formulations in this book.
health disorders. Clinicians may well be perplexed as to which treatment to select for each particular client.

One approach to solve this problem is to use psychiatric diagnosis to predict treatment. The terms used to describe both pharmacological and psychological treatments often refer to diagnosis. Psychotropic medications are called ‘anti-depressants’, ‘anti-psychotics’ and ‘anxiolytics’. Psychological treatments also often refer to diagnosis, for example when we refer to treatment groups as ‘anxiety management groups’ or ‘support groups for eating disorders’ and so on. Treatment algorithms, randomized controlled trials (RCTs), reviews of the outcome literature and reviews of evidence-based treatment, such as Cochrane reviews, National Institute for Clinical Excellence guidelines and the APA guidelines (APA, 2005), all are organized around diagnostic categories. Many mental health advocacy groups are also organized around specific diagnostic groups. Thus, the notion that diagnosis predicts effective and ineffective treatment is pervasive. This model suggests that diagnosis 1 predicts that treatment A will be relatively effective for this diagnosis and treatment B will be relatively ineffective for this diagnosis, and diagnosis 2 predicts that treatment A will be relatively ineffective and treatment B will be relatively effective for this diagnosis. Thus, we might recommend anti-depressants for people with Major Depression, but not for a Psychotic Disorder. Likewise, we would place people with anxiety disorders in an anxiety management group, not in a support group for people with eating disorders. This model is based on an interaction between diagnosis and treatment.

This model of predicting treatment efficacy has many limitations. First, most outcome research using RCTs does not address the question of diagnosis by treatment interaction. Rather, most RCTs merely compare one treatment with some other procedure, such as a waiting list control, or, more rarely, some placebo or perhaps a second treatment. Researchers select participants to ensure that they all meet the same diagnosis. Thus, these kinds of RCTs permit us to conclude that treatment A may be effective for diagnosis 1. They tell us nothing about the effectiveness of this treatment for diagnosis 2 and nothing about whether this treatment is the most effective treatment for this diagnosis. Wilson (1996) proposed a contrary argument. He has noted that some standardized, manualized treatments for eating disorders are highly effective. He suggested that treatment determined by diagnosis might be highly desirable because the clinician can learn one highly effective treatment procedure to a high degree of proficiency. Further, there may be little room left for individualization of treatment – which in any case might be unreliable and capricious – to improve over this standard treatment. (Ghaderi [2006] presented some evidence to the contrary.)
A REVIEW AND OVERVIEW OF THIS VOLUME

A second limitation to this model of predicting which treatments might be effective is that response to treatment is highly varied. RCTs emphasize statistical significance – changes that are unlikely to be due to chance – and changes in the score of the average, but non-existent, subject. Statistically significant results may emerge from many patterns of response to treatment. For example, a statistically significant result might occur if 50% of the treatment group have a large, positive response to treatment, 25% have no response and 25% have a modest negative response to treatment, if the experiment has a large enough number of participants and if the dependent measures are sufficiently sensitive. A statistically significant result may also emerge if most of the participants make a modest improvement but one that has no practical significance for any particular person. The average client does not exist: the clinician will never treat this mythical person. The clinician treats specific clients. Even when there is a strong evidence base for a particular treatment, it may be unclear at the outset of treatment if the clinician is working with someone who will respond positively, not respond or respond negatively to this particular treatment.

A third limitation is that clinicians frequently work with clients who have apparently already had standard, diagnosis-based treatment and who did not respond to any meaningful degree. For example, it is common for clinicians to work with people who have taken anti-depressants or anxiolytic medication for many years and still have significant problems; indeed their failure to respond to standard treatments is often the reason for referral. Further, after standardized psychological treatments, such as anger management, cognitive behaviour therapy for depression and so on, a significant proportion of clients have residual problems, did not respond or responded badly to standard treatment.

A fourth limitation in diagnosis predicting the most effective treatment for each client is that many clients meet diagnostic criteria for more than one diagnosis. When a clinician works with a client who meets diagnostic criteria for Major Depression, Substance Abuse and Generalized Anxiety Disorder, which of these three diagnoses predict the most effective treatment for this client? If all three predict effective treatments, in which order should the clinician implement these treatments? Will effective treatment of the Major Depression result in a generalized improvement in the client’s functioning, or will treatment of the Generalized Anxiety Disorder result in the broadest spread of treatment effects?

The ability of psychiatric diagnosis to predict the most effective treatment depends on the reliability and validity of that diagnosis. The developers of the third edition (revised) of the Diagnostic and Statistical Manual (DSM) trumpeted its arrival as a triumph of science (Kutchins and Kirk, 1997). The number
of psychiatric diagnoses has expanded considerably with each edition of DSM (Houts, 2002) and the developers of DSM did not conduct reliability trials for almost all the hundreds of diagnoses in DSM-III-R (Kutchins and Kirk, 1997). Where researchers did conduct diagnostic trials, they were conducted after the diagnostic criteria had already been set; thus, the results of reliability trials did not inform the development of the diagnostic criteria. Indeed, careful examination of the reliability of DSM-III-R revealed that the reliability of the new diagnostic criteria may not have been very much different from the reliability of the old criteria (Kutchins and Kirk, 1997). In any case, this may be of limited relevance, since the reliability of diagnosis by routine practitioners may have little to do with the diagnostic practices of eager, well-trained government-funded researchers. Some structured clinical interview procedures may result in quite high reliability. However, most clinicians do not use these assessment methods routinely. In any case, the validity of these measures to differentially predict an effective treatment is still little researched.

Clinicians may often work with clients with rare, idiosyncratic, subclinical problems or other problems that do not meet diagnostic criteria. In these situations too, psychiatric diagnosis may be of limited use to predict treatment.

Finally, some clinicians often feel that they have something more to offer than skilled, but technocratic, application of diagnostic algorithms and manualized treatment. Whether true or not, many clinicians believe that their input into understanding the case and designing treatment for each individual client has something to contribute to treatment.

These limitations to predict treatment based on diagnosis, if true, are serious. Consequently, clinicians and professional training standards have argued that case formulation is a better way to guide selection of the most effective treatment. So what is case formulation?

Definitions of case formulation

There are many definitions of case formulations. Eells (2007a) defined case formulation as

a hypothesis about the causes, precipitants, and maintaining influences of a person’s psychological, interpersonal and behavioral problems ... [which] helps organize information about a person, particularly when that information contains contradictions or inconsistencies in behavior, emotion and thought content ... it contains structures that permit the therapist to understand these contradictions ... it also serves as a blueprint guiding treatment ... It should help the therapist experience greater empathy for the patient and anticipate possible ruptures in the therapy alliance ... The nature of this hypothesis can vary widely depending on which theory ... the clinician uses ... (p. 4)