frontal lobe tumours. In retrospect, the team, with its social orientation, may have made it more difficult to focus on, and exclude, possible organic pathology at an early stage.

REFERENCES

[1] RATNA, L. (1976) The practice of psychiatric crisis intervention. League of Friends, Napsbury Hospital, 1.

[2] COOPER, J. (1979) Crisis Intervention in Tunbridge Wells and Southborough: A study of the first six months of operation. Unpublished paper.

[3] SHEPHERD, M., COOPER, B., BROWN, A. & KALTON, C. (1966) *Psychiatric Illnesses in General Practice*. London: Oxford University Press.

[4] GROVE, W. & TUDOR, J. (1973) Adult sex roles and mental illness. *American Journal of Sociology*, **78**, 812–35.

[5] HAJNAL, P. (1981) Crisis intervention in Tunbridge Wells and Southborough: Views of general practitioners in the area. Unpublished paper.

Formulating a Psychiatric Case

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Interest in the process of formulating a psychiatric case continues unabated (Greenberg *et al*, 1982). We report the findings of a brief survey conducted in an attempt to begin publicizing examiners' expectations in this contentious area.

In Australia and New Zealand formulations are regarded as an important part of case writing for the Membership examinations (RANZCP, 1980). Neither the English viewpoint eschewed in Scribe's Column (Royal College of Psychiatrists, 1979) nor the Canadian report of Ben-Aron and McCormick (1980) appear sufficiently detailed to guide teachers and psychiatric trainees.

To provide background information which would assist clinicians, supervisors and trainees to develop their views and to stimulate further debate, we set out to collect the views of psychiatric postgraduate examiners on the optimum format and content of a formulation, and to establish the consistency of their views.

Method

Twelve 'statements' about patients were collected. Six of these were written for the purpose by psychiatric registrars. The material written under the heading 'Formulation' in completed postgraduate case histories comprised the remainder. All twelve were rigorously rendered non-identifiable.

These twelve formulations (A to L) were sent to 40 senior Australian and New Zealand psychiatrists who have examined postgraduates. Twenty of these were frequent examiners (over at least three years) and 20 were occasional examiners. All were asked to: (a) give each formulation a mark out of ten; (b) complete a structured questionnaire for each formulation which they had marked as better than 6 out of 10, or worse than 4 out of 10; (c) make any comments they wished about the concept or format of formulating.

The questionnaire allowed the examiners to record as 'good', 'unremarkable', or 'a problem area' aspects such as content (including history, premorbid personality, mental state and physical examination), aetiological understanding, diagnosis, management and prognosis. They were also invited to comment on the style, use of English and clinical logic of the formulations.

For each examiner the formulations were ranked from 1 to 12 according to the mark given. The mean rankings were determined and the Kendall Coefficient of Concordance (W) calculated (Siegel, 1956). An attempt was made to summarize the viewpoints conveyed.

Results

Twenty-four (60 per cent) examiners replied to our request, of these 12 were frequent and 12 were occasional examiners. Overall, the ratings of the examiners are significantly correlated ($P < 0.001$). The strength of this is greater for the frequent than for the occasional examiners (although both at the 0.001 level).

The formulation (Appendix) which averaged the highest ranking was rated highly in most areas except 'dynamic understanding', with 41 per cent of examiners commenting adversely on this aspect. The presentation of data and the proposed management were highly rated, but assessors were evenly divided on prognosis, use of English, style and clinical logic. Typical favourable comments centred around the formulation being concise, comprehensive and well set out, without 'jargon'. Unfavourable comments related to insufficient attention to dynamic and social factors and discussion of differential diagnoses.

When the three lowest-ranked formulations were grouped together, it was clear that almost all aspects were rated poorly by between 50 per cent and 75 per cent of the examiners. Inadequate data, unjustified diagnoses and differential diagnoses and management stood out as particular problem areas. On the other hand, the use of English, style and clinical logic (or lack of it) were not notably criticized.

Typical unfavourable comments in one of these formulations were as follows: 'so condensed as to be incomprehensible'; 'no understanding of multiple factors to explain the

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illness'; 'inadequate in substance and grasp of psychological connections'; 'too many gaps'; 'incomplete'.

One other formulation is worthy of special comment; it contained little in the way of historical data, mental state information or diagnosis and was essentially an attempt to explain the patient's problems in 'psychodynamic' terms. The examiners were almost unanimous in their criticism: 'naive'; 'jargon'; 'pseudo-psychologizing'; 'does not tell us anything about the patient'; 'shows no real understanding'; 'ill-informed use of psychodynamic model'.

Comments by examiners on their concept of formulation

Ten examiners described their views of formulations. One commented that a formulation was an answer to a number of questions, *viz:* Who is the patient? How did he get to treatment? What is wrong with him now? How did the illness develop? Why is he ill? What can be done about the illness? What is the likely outcome?

Some examiners thought that the concept of formulation was 'non-specific, ambiguous and imprecise' and that because of wide disagreement the term ought to be abandoned. There was considerable disagreement on the length and the kind of information to include. Some insisted that management was not properly included in a formulation and one that it should include the essential facts upon which a diagnosis is made and nothing else. Another thought that a formulation should be contained in a single, fairly short paragraph which should mention the diagnosis and differential diagnosis and be followed by a brief account of aetiological factors, but excluding management.

One examiner differentiated between an initial assessment formulation, when a brief but comprehensive overview was needed, and the formulation of a thoroughly well-known and investigated case when psychodynamic and management issues would be concentrated upon.

Another pointed out that a formulation given at the end of a case presentation would be different from one that was expected to stand on its own. In the former it would be repetitious to go over features of history and examination while in the latter, it would make sense to do so.

Discussion

Psychiatrists may well question the necessity for formulation given the apparent lack of consensus on its function or content. Would not diagnosis be sufficient?

Kendell *et al* (1978), in arguing for the importance of diagnosis and classification, point to the longstanding controversy between those who favoured diagnosis and those who argued that each individual was unique and ought to be treated as such. Karl Menninger (1963) argued that diagnosis should be replaced by a formulation of the patient's problems, which would be different for each individual and incorporate an individualized treatment plan. Kendell *et al* point out that both diagnosis and such a formulation are equally necessary. It is important to take into account the events and characteristics that are unique to a person, but we also need to note what that person has in common with others of a particular class. In the diagnostic formulation psychiatrists attempt to do both.

The concept of a formulation is not likely to disappear. It is well enshrined in English, Canadian and Australasian practice and indeed the fact that examiners responded to our questions indicates the need to refine ideas in this semantic and conceptual mire.

We had hoped to be able to claim that this work represented the views of Australasian examiners. A response rate of 60 per cent does not allow that. It may be that responders have firmer views than non-responders, but there is no way of demonstrating this.

While examiners' comments on the style of a desirable formulation included a wide range of statements, practising clinicians and trainee psychiatrists must take heart from the consistency demonstrated in practice by the 24. It must also be remembered that in this study the examiners were asked to mark the formulations only. They had no access to full case histories. This makes their degree of concordance even more satisfactory.

It is our impression that a good formulation needs to be able to stand on its own. It should include a meaningful summary and make sufficiently defensible diagnostic and dynamic statements to allow the development of a coherent, planned approach to management. The English definition (*Bulletin* (Scribe's Column), 1979) comes close to this, even if the examples given do not.

The formulation which ranked the highest (Appendix) in the present study is clearly deficient in many respects; it is not published as an example of an ideal formulation. The fact that it ranked highest means no more than that it represents a consensus among 24 examiners of the ranking of the formulations available to them.

It is difficult to give clear guidelines as to the kind of data required for the summary, except to say that it should be succinctly presented in order to develop an argument about diagnosis, aetiology and management and include such information as enhances this aim. The guidelines written by Greenberg *et al* (1982) appear excellent in principle, but perhaps rather overinclusive and so long as to represent a full case presentation.

If a statement on aetiology is made, and particularly if a dynamic understanding is attempted, this should be stated in ordinary language, avoiding the use of jargon. It should rely on the information presented in the case and not some presumed theory of aetiology thought to be generally applicable. In this light it is worth noting that although some statement on aetiology is thought by many to be essential to a formulation, in this study the formulations ranked 1, 2 and 4 did not carry any specific statement on aetiology, although pathogenesis could be inferred from the data.

It has been noted that there was some disagreement between the assessors as to whether management and prog-

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nosis should be included. The second ranked formulation, the fifth, and to a lesser extent, the fourth, were strongly criticized for inadequate attention to management and prognosis. This criticism did not seem to mark down these formulations to any great extent.

The concept of formulation that finds agreement among examiners is different from the so-called 'psychodynamic formulation', which may be more appropriate in a psychotherapeutic setting. This study cannot throw any light on such a formulation, but the description by Aveline (1980) is worth noting.

Bibliography

AVELINE, M. (1980) Making a psychodynamic formulation. *Bulletin, The Royal College of Psychiatrists*, December, 192–3.

BEN-ARON, M. & MCCORMICK, W. O. (1980) The teaching of formulation. *Canadian Journal of Psychiatry*, **25**, 163–65.

GREENBERG, M., SZMUKLER, G. & TANTAM, D. (1982) Guidelines on formulation. *Bulletin of the Royal College of Psychiatrists*, **6**, 160–62.

KENDELL, R. E., AFFLECK, J. & ZEALLE, A. (1978) Diagnosis and classification. In *Companion to Psychiatric Studies* (eds. A. Forrest *et al*). London: Churchill Livingstone.

MENNINGER, K. (1963). *The Vital Balance: The Life Process in Mental Health and Illness*. New York: Viking Press.

ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS (1980) *Examination Booklet of Information for Candidates*, p. 8.

ROYAL COLLEGE OF PSYCHIATRISTS (1979) Scribe's Column: Diagnostic formulation. *Bulletin of the Royal College of Psychiatrists*, June, pp. 108–9.

SIEGEL, S. (1956) *Non-Parametric Statistics for the Behavioural Sciences*. New York: McGraw-Hill.

Appendix

Formulation

A 34-year-old married mother presented with increasing self-denigration and doubt over her mothering since the birth of her second son, three months previously. Over this time she had become indecisive and unable to assess her behaviour appropriately. She ruminated obsessively, doubting that she was a good mother and feeling that her children would suffer because of this in the future. She felt very guilty, had contemplated suicide and infanticide. There was a one and a half month history of anorexia, loss of weight, early morning waking, guilty ruminations, diurnal mood variation, spontaneous weeping, decrease in libido, and constipation.

There were no other somatic symptoms nor any other significant psychological stress or physical illnesses.

There was no family history of treated psychiatric illness, although both her parents suffered from mild stress-related depression.

She never felt close to her parents or siblings and had always felt shy. She had always had a small circle of friends and did not describe any significant difficulties with adolescent heterosexual relationships. Academically she had done well and trained as an anaesthetic sister.

She had no past history of psychiatric treatment nor any evidence of a cyclothymic personality. She exhibits an obsessional personality—characterized by perfectionism in her work, conscientiousness and rigidity of thinking, and a need to keep proving herself by continually setting unattainable goals.

Mental state examination showed an intelligent woman with no evidence of schizophrenia or organic deficit. She had only mild depressive affect, but was agitated. Her thoughts were marked by obsessional circumstantiality and overvalued ideas centering on doubts and guilt about her ability as a mother. Her most obvious defence mechanisms were denial and rationalization.

Physical examination was normal.

The provisional diagnosis is a severe *post-partum depressive illness* in a woman with an obsessional personality.

I did not feel that there was any other diagnosis applicable at the time. As this was her first severe depressive illness, there is no past history of cyclothymic mood swings, and her family history indicates depressive reactions, I would provisionally call this a unipolar affective illness.

Management plans

1. Admit with her baby. Observe closely on non-specific management for several days.
2. Further assessment of the patient, and her relationship to her son.
3. History from husband.

Public Lectures Organized by the British Psychoanalytical Society

1982 marked the 50th anniversary of the Public Lectures Committee of the British Psychoanalytical Society. Over this period various events have been held to introduce psychoanalytic concepts to a wider audience in related professions and disciplines. For example, many will remember the Winter Lectures that were held in the 1960s.

More recently, the trend has been to hold one-day events in London aimed at a wider audience. Recent topics have been: basic psychoanalytic concepts; psychoanalysis and women; the mind of the criminal; problems in the class room; self-destructive acts; and child abuse. In the last year the day-course on basic psychoanalytical concepts has also been held in Leicester, Birmingham and Belfast, by the invitation of the local professor of psychiatry in each centre. The aim has been to stimulate interest in any local teaching programmes, and to mitigate the centralization of psychoanalytic resources in London.

If any Department of Psychiatry outside London would be interested in such a day event, they should get in touch with the Public Lectures Committee at the Institute of Psychoanalysis, 63 New Cavendish Street, London W1.

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