SIX

Individualized Case Formulation and Treatment Planning

Case formulation develops out of the assessment process and will sometimes guide it. As your experience grows, it becomes increasingly apparent that certain features occur together, and so you will inevitably be particularly interested in eliciting them. The subgroups that we delineated in Chapter 1 emerge from such a process. However, it is very important not to prejudge people: they do not necessarily fit the patterns we weave for them. Assessment and formulation need to be an open frank exchange of views, and it is particularly important to cover all relevant areas of personal and mental health history.

A case formulation provides a framework from which to develop therapeutic interventions, and constructing it in itself can be therapeutic. Providing a way of understanding the different elements in the person's life that have combined to lead to the current problems can allow the person him- or herself with—or sometimes without—further support to address them. Usually a collaborative process of focusing on specific issues develops.

The specific formulation that you deduce can be written down on a white board or large paper sheet, but you do need to be aware of how such an approach will be viewed by the person. Some find it intimidating, particularly where:

- Schooling has been a negative experience,
- Their literacy is limited.
- They have problems with authority figures and see this as a "teaching" approach.
- Where a particularly painful episode is being reviewed.

What is included in the formulation presented to the person also needs consideration. For some people, a simple diagram linking stress to vulnerability may be sufficient (see Figure 6.1): This can be explained by demonstrating, using the diagram, that some people have a very low level of vulnerability but a level of stress so high that they become ill (A in Figure 6.1), whereas others may be very vulnerable, in which case rela-

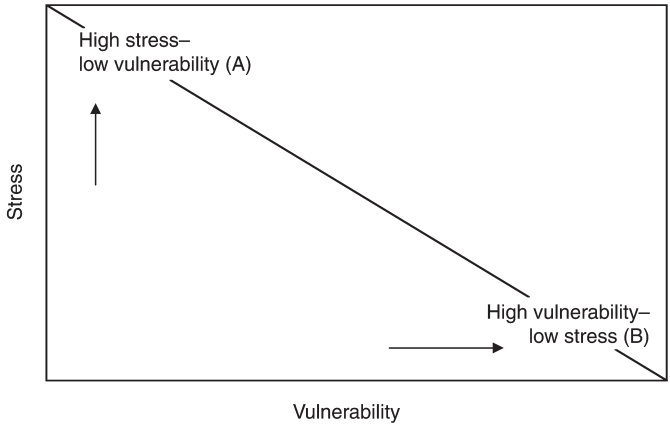

FIGURE 6.1. Stress–vulnerability.

tively low levels of stress can lead to illness (B). For some people, an awareness of the link between pressure and negative symptoms, especially motivation, may be enough to understand, at least initially.

But, whatever is presented, the therapist does need a clear balanced formulation from which to work. Understanding the person's background is the first step, including:

- *Predisposing or vulnerability factors*: those issues that may make the person more sensitive to stress and specifically to developing a psychotic illness (e.g., family history of mental health problems, especially psychosis; personality characteristics, such as tending to be very solitary ["schizoid"], sensitive, or paranoid; or brain injury, which may contribute to developing symptoms).
- *Precipitating factors*: those relevant experiences that immediately preceded the person becoming ill—a detailed discussion of the period building up to the first episode allows identification of factors that the person also identifies or agrees were relevant.
- *Perpetuating factors*: those issues that make full recovery more difficult or relapse more likely (e.g., lack of income, poor housing, poor treatment adherence, isolation, and difficult relationships).
- *Protective factors*: the strengths which can aid recovery (e.g., intelligence, relationships, interests, and aptitudes).

Next, identify current problems. Check whether the initial presenting problem (even if it occurred years before) remains a problem to be dealt with.

Next, clarify which thoughts, feelings, and behaviors predominate and are relevant to illness. Similarly, physical symptoms and social circumstances of relevance—whether or not identified as problems—need to be included in the formulation.

Finally, have any underlying concerns been identified? This is a more difficult area, and it may be that schematic beliefs, rules for living, or more simply general social or psychological factors that seem to be driving delusional beliefs and behavior (e.g., "I

need a girlfriend," "My parents hate me") will be included here (see Chapter 9 on delusions for further discussion of this).

The formulation may then take the form of a paragraph or be set out diagrammatically (e.g., Appendix 5.1, "Making Sense"). It may be that some components (e.g., thoughts, feelings, and actions) will be particularly emphasized and others provided in less detail, but this will vary from person to person. Its content needs to be checked with the person with whom it has been developed, but the way in which this is done needs careful consideration. Factual matters may be clarified, connections discussed, and for some the diagram used in full, but it is important not to overwhelm the person. A copy may be given to the client, as well as perhaps a tape of the discussion describing it.

There will be times when the formulation cannot be agreed upon completely with the client, but establishing where the differences lie can be valuable. It is important not to be challenging over this, and if the person wants parts removed it will generally be best to do so—or, better, develop a compromise way of expressing the key disagreement(s).

TREATMENT PLANNING

Engagement and assessment are continuing processes throughout therapy that will ensure that the person remains engaged and collaborative in the evolution of the formulation. Specific work on symptoms comes out of the formulation, for example, the initial issues leading to delusions or hallucinations will emerge, and discussion of these will almost inevitably ensue. There will then be exploration of them and alternative explanations by gathering relevant information from the person's own knowledge, that of the therapist, or sought from elsewhere (e.g., friends or libraries). Figure 6.2 illustrates the sequence of therapy in very broad terms, and further chapters will describe the components in more detail.

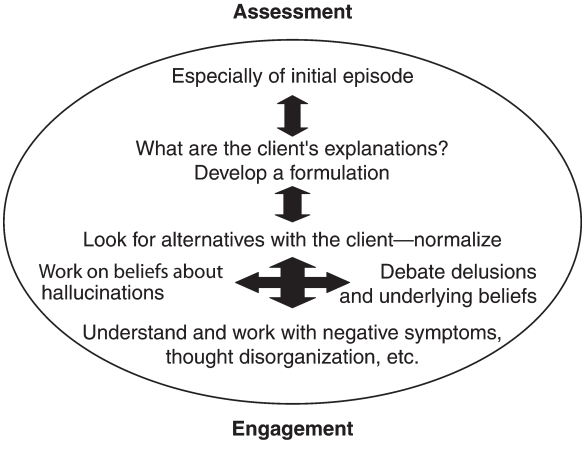

FIGURE 6.2. The therapeutic process.

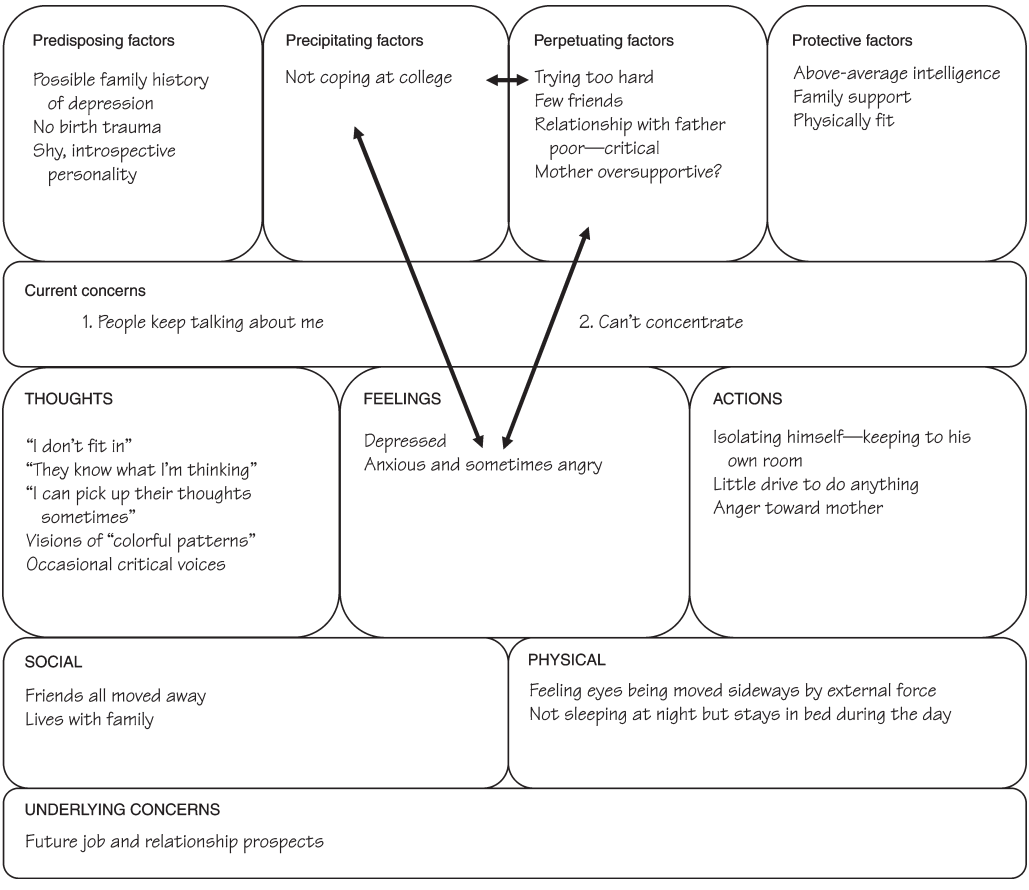

FIGURE 6.3. Gordon's *(sensitivity psychosis)* formulation.

USING THE FORMULATION

The process of developing the formulation with the client can be therapeutic in itself as a structure begins to emerge from an often disorganized group of symptoms and experiences. For Gordon and his family, as will be discussed later, a major step forward was developing an understanding of key elements, particularly the "vicious cycle" developing between deteriorating performance, "trying too hard" to compensate, and then increased anxiety and eventually demoralization, worsening performance still further (see Figure 6.3). Other factors were also relevant (e.g., isolation and poor social performance), and a treatment plan also included them.

Frequently a few linked thoughts and experiences form a key axis to work with—for example, as illustrated in the formulation in Figure 6.4, the link between flashbacks and the initial drug experience has been very important for Craig. There are other links of significance, but being able to reconceptualize the voices and control as being a "flashback" to previous drug-precipitated episodes aided his insight considerably.

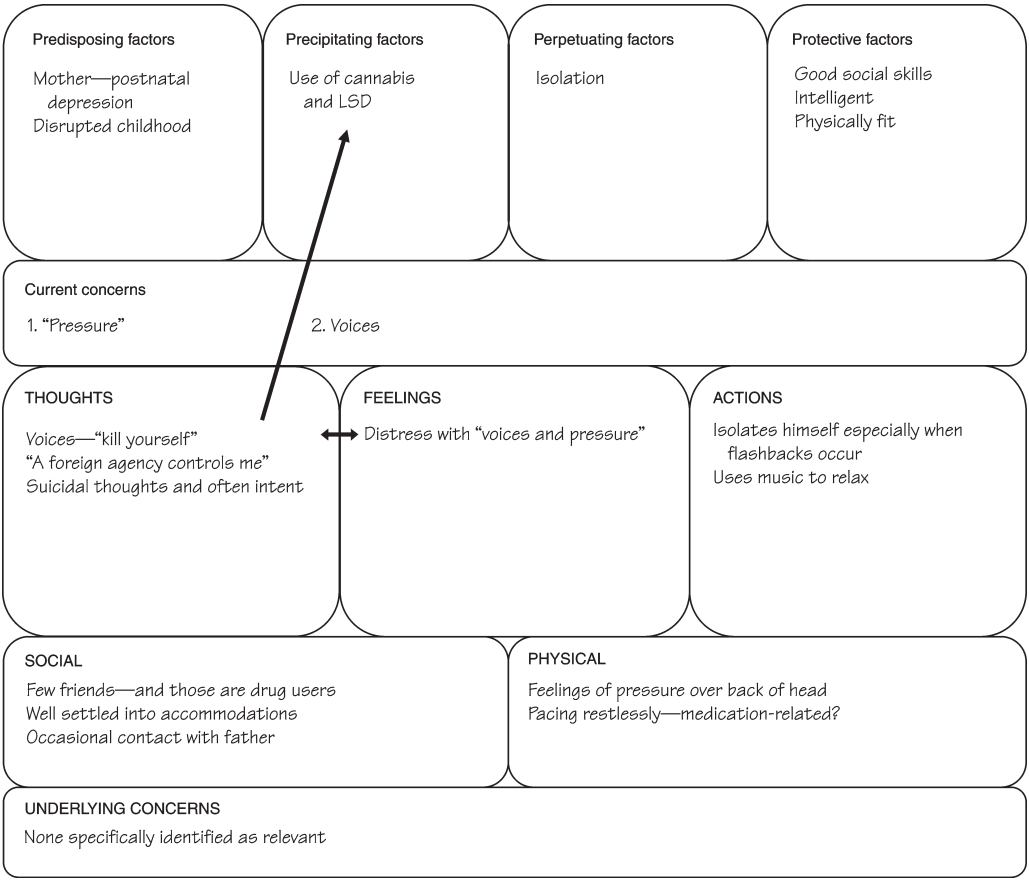

FIGURE 6.4. Craig's (*drug-related psychosis*) formulation.

Finding relevant connections can assist in reattributing symptoms—as can specific work described in later chapters on delusions and hallucinations. Strengths can be mobilized and maladaptive behaviors can be identified. However, the formulation developed with the client may need to be very simple, even though the therapist may need to build a more detailed understanding; for example, a simple diagram making the key connections was most appropriate with Gillian (see Figure 6.5).

With the client it is possible to identify and agree on key areas to work on, for example, voices, isolation, or weight loss—or all three. These can be addressed individually or (as described in later chapters) through work on underlying beliefs. This turned out to be the situation with Paul, as usually occurs with anxiety psychosis (see formulation in Figure 6.6). He was able to eventually see links between his symptoms and his situation—and possible precipitants for his illness. The conviction in his delusional beliefs persisted, but he allowed the therapist to work with him on his underlying concerns about his sexuality and his future as distinct issues.

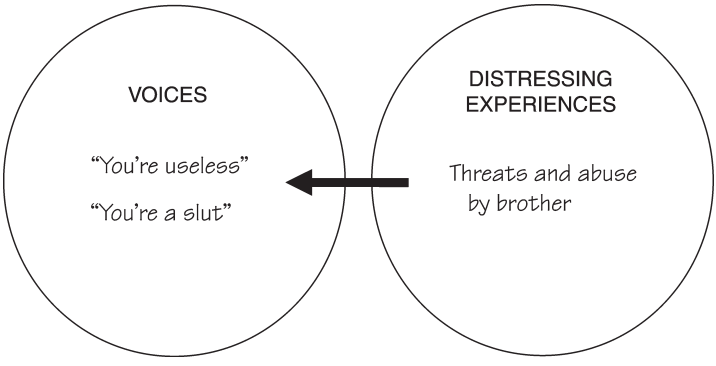

FIGURE 6.5. Gillian's *(traumatic psychosis)* formulation.

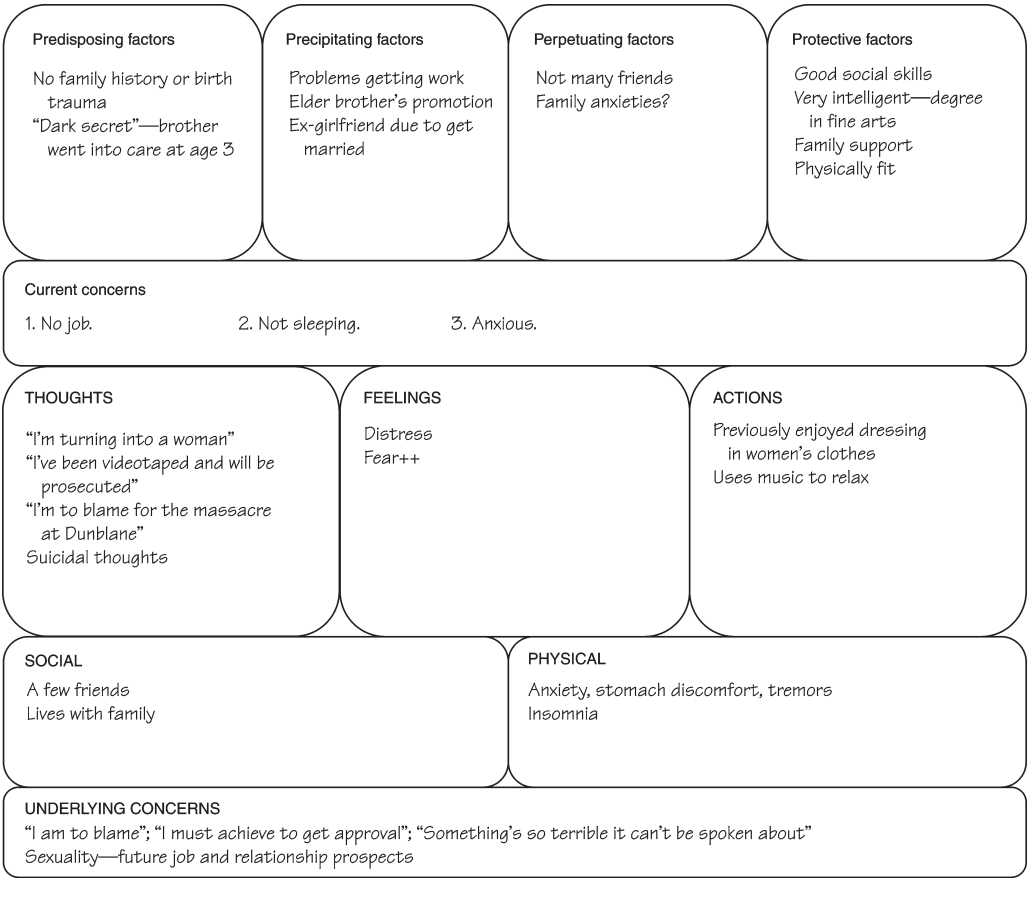

FIGURE 6.6. Paul's *(anxiety psychosis)* formulation.

SETTING TARGETS

Target setting needs to be cautious, as failure to achieve targets can affect engagement, morale, and subsequent performance. Initially the process of establishing the key concerns of the client is important, and it may then be sufficient just to convey that "what we want to do is deal with these concerns in any way we can."

As engagement is established and formulation develops, other targets may emerge—for example, "to be able to go out and cope better with other people talking about me." The therapist's goals may be "insight," but an explicit target "to stop you from believing people are talking about you" would not be collaboratively developed or appropriate at this stage for the client. Agreeing about "coping" is often a reasonable compromise position to take while not colluding in the belief.

Goals may be practical—for example, "to get a job or girlfriend"—or emotional—for example, "to reduce the distress caused by my voices." Clients may suggest targets that may be overambitious, for example, "getting rid of my voices." Negotiation can usually lead to "coping with my voices" as a more realistic goal, at least in the short term (even though some people do become free of voices over time). Setting goals for negative symptoms is discussed in detail in Chapter 12.

MANAGEMENT OF CLINICAL SUBGROUPS

Consideration of the clinical subgroups previously described can assist in identifying the type of work that is likely to be successful. It is, however, very important to ensure that it is consistent with the formulation and rooted in it. With sensitivity psychosis, negative symptoms are particularly prominent as an issue and often the prime focus of caregiver concern. Providing a clear rationale for action and sharing the formulation can overcome caregiver objections and improve collaboration with the person him- or herself. Positive symptoms frequently involve delusions of reference, thought interference, and paranoia, although a range of other disparate symptoms can present, but often with fluctuating conviction. Thought disorder can sometimes confuse communication and be exacerbated by the therapists focusing too energetically on delusional beliefs and voices (see Figure 6.7).

Work with the drug-related group involves identification and full description of the initial episodes, which enables comparison between current symptoms and earlier experiences to be made, there by facilitating reattribution. Personality factors such as schizotypal, schizoid, and antisocial traits can be prominent etiological and maintaining factors. People with schizoid and schizotypal personalities often start using drugs as part of a mystical search for meaning. Those with antisocial personalities often begin using hallucinogens as part of a personal rebellion against society. Both the search for meaning and the rebellion can be addressed within-session, with the aim of leading to a reduction in hallucinogen use. Caregivers have often been through serious crises themselves, often through relationship difficulties, and these need to be sensitively taken into account when working with clients. This is especially true where work with critical expressed emotion is an issue, as frequently it is. Collaboration over issues such as medication and activity scheduling needs a patient, negotiated, and consistent approach, which can put a strain on the therapeutic relationship from both sides (see Fig-

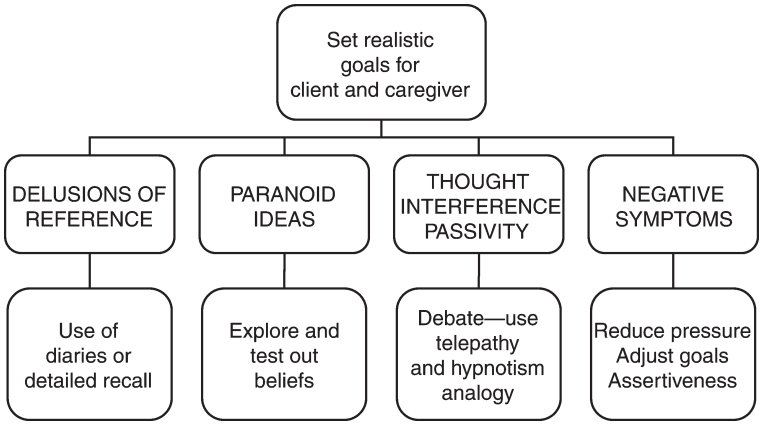

FIGURE 6.7. Management of sensitivity disorder.

ure 6.8). Continuing work on drug misuse, where needed, utilizes principles described in Chapter 13.

The dominant symptoms with traumatic psychosis, as described previously, tend to be abusive, commanding hallucinations and depressive episodes related to the past traumatic events. Work involves reattribution and work on content and underlying beliefs (see Chapter 10). Unfortunately, these voices often seem, to be resistant to medication, at least in part. Exposure work on the traumatic events themselves can be too distressing for many clients, but work on the beliefs surrounding them can be possible and successful with time (see Figure 6.9).

With anxiety psychosis (see Figure 6.10), the predominant problems tend to be the delusional beliefs, which are often systematized. Work with these is described in Chapter 9. Normalizing and developing alternative explanations are often useful, especially early on and in engagement, but techniques for dealing with resistant delusions (e.g., inference chaining and work with underlying beliefs), are usually employed to good effect.

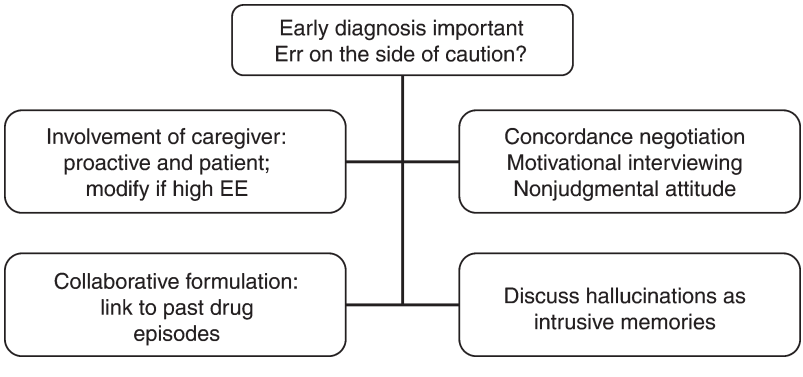

FIGURE 6.8. Management of drug-related psychosis.

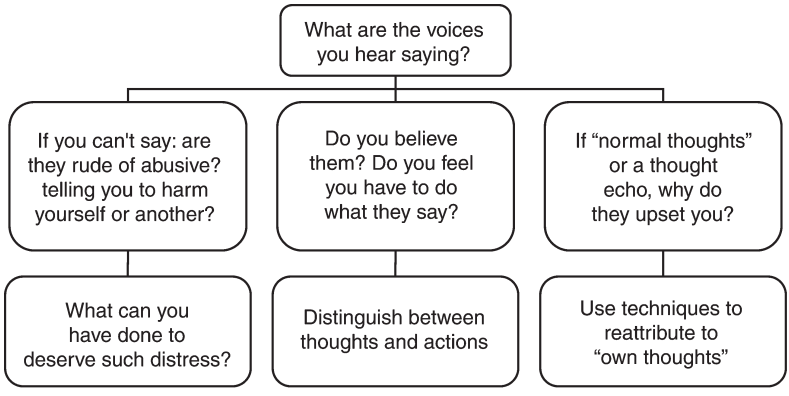

FIGURE 6.9. Management of traumatic psychosis.

INDIVIDUALIZED CASE FORMULATION AND TREATMENT

Gordon (*sensitivity psychosis*): The key issue arising from the formulation was the need to connect Gordon's stressful circumstances (i.e., school pressures and college work) to vulnerability (i.e., his quiet contemplative personality, with perpetuating factors such as the family atmosphere and expectations). A conceptualization of the problems in terms of stress sensitivity was credible to Gordon and his family. A full written formulation (Figure 6.3) was used to explain this.

Craig (*drug-related psychosis*): The essential elements involved the initial precipitant—drug misuse—and vulnerability from limited family support (Figure 6.4). The term "flashbacks" helped link the perceptions experienced to the initial episode, which was a key element in the formulation.

Gillian (*traumatic psychosis*): As assessment evolved, a simple formulation (Figure 6.5) was developed, with Gillian linking together the abusive events that had occurred and the voices she was hearing. Her vulnerabilities—associated with her limited emotional and practical skills—were included, but in a noncritical supportive way, with the emphasis on actions that could be taken to diminish them.

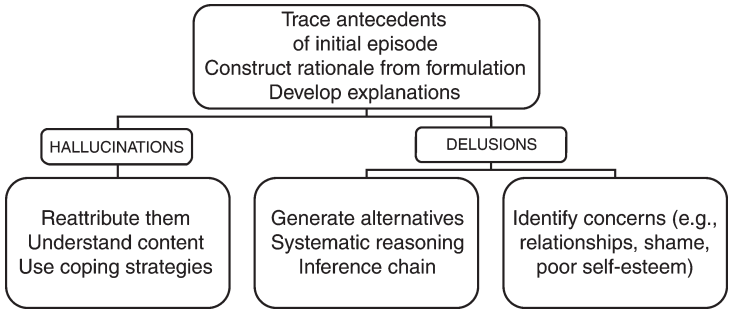

FIGURE 6.10. Management of anxiety psychosis.

Paul (*anxiety psychosis*): The importance of formulation in work with Paul can hardly be overstated (Figure 6.6). Its development was fundamentally important in allowing him to understand and appreciate the context in which his beliefs had developed. It assisted in the development of the therapeutic relationship, as the holistic approach circumvented direct confrontation over his beliefs. This enabled him to begin to examine his beliefs with the therapist. Underlying concerns about his future and sexuality played a major role in the generation and perpetuation of his symptoms which, once identified, he became prepared to work on.