Duquesne University  
Department of Psychology

CLINICAL FORMULATION

Course: 640-01 and 02  
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Room: LB 604  
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INTRODUCTION

What makes one a clinical psychologist is the ability to draw together information from a wide variety of sources and to organize this information into a comprehensive case formulation, or conceptualization, and treatment plan. It is the clinical psychologist who, more than anyone else, approaches a professional situation with an informed appreciation of these interrelated factors. One thinks developmentally, culturally, familially and systemically, cognitively and neuropsychologically, medically and psychiatrically, diagnostically, dynamically, behaviorally, and socioeconomically. The clinical psychologist routinely bears all these factors in mind when thinking about a case and planning treatment. This course is designed to help you think in this way, systematically and comprehensively, in your clinical work.

Comprehensive case formulation and treatment planning, implementation, and evaluation, require not only a sound knowledge base in psychology, interviewing skills, etc., but also a self-reflective knowledge of one's own evolving position. Where you are "coming from" is the backdrop which informs what you emphasize and how you integrate the information. The course should thus mark a significant step towards your own developing position as clinical psychologists.

The general orientation in this course is existential phenomenological. I want to help you develop a consistently phenomenological grounding for your case formulations and clinical work. It is true that phenomenology is an approach that can draw together and ground existentially a range of theoretical orientations and make use of these in clinical work (Van Kaam, A. Existential Foundations of Psychology, Pittsburgh: Duquesne University Press, 1966). However, it is my impression that unless this critical integration is rigorously maintained the phenomenological perspective deteriorates into being merely preparatory to theoretical explanation, which is then privileged as being more useful. It also deteriorates into becoming merely one perspective among many, in which case the entire epistemological project of existential phenomenology has been abandoned. I am reminded here of the pioneering Dutch phenomenologist, J.H. Van den Berg, who repeatedly argued that theorizing begins when the phenomenological description of reality has been abandoned too soon (Van den Berg, J., A Different Existence, Pittsburgh: Duquesne University Press, 1972). To sustain a consistently phenomenological perspective is demanding and difficult, such is the inertia of those cultural-historical habits of thought Husserl called the "natural attitude." This course is to that end, as we shall try, in our case conceptualizations and therapeutic conduct, to maintain a fidelity to the client's experience within his or her cultural, familial, and personal contexts.
Because the revealed phenomena of psychological life are embedded in developmental histories, and because human temporality (lived time) is deeply historical, we shall draw significantly from the psychodynamic tradition as well.

As psychologists we should be properly aware of the relevance to people, and to our discipline, of the medical, sociological, economic, religious, cultural, and political worlds. Not all problems are primarily psychological. However, our primary vocation is to bear witness to the psychological dimensions of human experience, behavior, and discourse. Especially as psychotherapists, we are attuned to the complex dimensions of our clients' suffering and healing. This perspective marks out an area of care and professional accountability, but it also sets limits upon us. Bearing this in mind helps us avoid the temptation to conflate our boundaries of authority and expertise, or to psychologize issues in a way that is reductionistic or unwittingly abusive.

We shall be sensitive to epistemological issues that are crucial in maintaining humility and discipline in our professional work. This is especially clear when dealing with persons from another culture or sub-culture, but it is equally important when dealing with persons from our own culture. The blind spot, after all, is in the center of one's vision. While it might be easy to understand the issues with which a client from our own culture is struggling, it might be just as easy to remain stuck within our cultural prejudices. We might have the same difficulties as our clients. Although we shall not have a separate seminar on cultural issues, they will be thematic throughout the course and case discussions.

AIMS AND OBJECTIVES

The general aim of the course is to introduce you to case formulation in clinical practice within a broadly existential phenomenological orientation. By the end of the course you can expect to have a growing sense of your clinical position, from which you are able to conduct initial interviews, then conceptualize and report on your cases at a level of basic professional competence. This course is not directly about psychotherapy, but we shall be addressing therapeutic issues throughout the semester, especially when you present your cases. Clearly your treatment plan and processes proceed from your case conceptualizations. It is thus expected that your case conceptualizations will directly inform what you do and say in your treatment sessions.

The more specific objectives are that, by the end of the course, you will satisfactorily have demonstrated the following competencies:

1. Psychological self-awareness regarding your clinical position: ie. better understand those fantasies (schemas) and assumptions, both personal and theoretical, which organize your work and structure a therapeutic frame;
2. Be self-reflectively sensitive to numerous epistemological and cultural issues when trying to understand people psychologically, especially if they are from a culture (or sub-culture) other than your own;
3. Be able to conduct the initial clinical interviews, which means:
   - taking a presenting problem in differentiated detail
   - taking a history
   - conducting a mental state examination
identifying organic factors masquerading as primarily psychological
building a therapeutic alliance for further work.

4. Be able to organize clinical material into a coherent, psychodynamically informed, comprehensive case formulation at a level of basic competence.

5. Be able to consider critically questions of accountability and therapeutic effectiveness with regard to psychotherapy your work, and to be familiar with some of the literature on empirically supported treatments and evidence based practice.

The course is thus somewhat eclectic, reflecting the eclectic nature of being a clinical psychologist. I have divided it into the following sections.

1. TOWARDS A CLINICAL POSITION AND THERAPEUTIC STANCE

Weeks 1-3

1 The realm of the psychological and the therapeutic stance: the existential and cultural ground, its imaginal threads, and a phenomenological approach to being psychological

2 The therapeutic stance continued: theories as organizing fantasies, both revelatory and defensive: eg. Midwife, shaman, hero, friend, coach, servant

3 Organizing images of the therapeutic stance and frame: eg., father, mother, trickster, friend. Theory and therapies as rooted in imagination.

The pressures brought to bear on our professional work - by patients themselves, insurance companies, economic factors, and the technological fix-it-quick zeitgeist - are tremendous, and, although such factors need to be addressed, it is easy to lose one's bearings as a clinician and psychotherapist. Therefore, we shall begin this course by becoming more grounded in a rigorously articulated and professionally steady clinical position and therapeutic stance in your work, one that is self-reflectively aware, on the way to being theoretically sound, and relatively steady. I hope to facilitate this by situating the work we do in its cultural-historical and philosophical contexts, and by helping you deepen your understanding of where you are “coming from” and what you are offering as clinical psychologists.

By the end of this section, you can expect to be able to:
• Describe the ontological structure of being human as the existential ground of what calls for psychotherapy (humans as being-in-the-world, situated, historical, revealing/concealing, meeting a fellow human being);
• Understand the imaginal dimensions of psychological life, i.e., those organizing fantasies (schemas) which are interpreting us in our daily lives;
• Understand the importance of the phenomenological attitude in approaching psychological distress;
• Be aware of the guiding images and fantasies that have lead you into this field of work, i.e., what is the dream that lead you into this work?--and what might be its hopes and anxieties?
• Be able to describe some of the archetypal images supporting the therapeutic frame;
• Be able to discern the organizing fantasies within various theoretical positions (e.g., Freud, object relations theory, cognitive behavioral therapy, family therapy models, social constructivism).
Required readings for this section
Recommended:
Any other readings from your course on diversity.

2. THE INITIAL INTERVIEWS AND HISTORY TAKING

Week 4 & 5
The main task of the first interview is to ensure that your client has felt understood by you. It requires building rapport (but not trying to get too close) and providing an hospitable, warm spaciousness in which the client can feel safe enough to start talking about things that may range from being merely difficult to talk about to being unbearably painful or dreadful. Some of your initial assessment is implicit, as your clients communicate more than is deliberately intended when talking about their problems.

We shall focus on the following areas in assessment interviewing: the presenting problem and differential diagnostic questioning, family and personal history, mental state examination. Training in mental state examination will include suicide risk assessment, and psychiatric findings. This aspect of training is an essential complement to both psychotherapy and testing. It assists the psychotherapy by helping you discuss your cases fully, with clarity and focus; it assists testing because your test selection is best when it emerges from your assessment interviews, in order to answer questions that interviews alone cannot answer.

You will find in hospital work, internships, and in reports to colleagues in private practice, that differences in the theoretical background of the case formulation are less important than the similarities in the general format and language of case reports. It is our expectation that before you apply for internships you will be able to conduct fairly competent assessment interviews and written reports that will stand professional scrutiny anywhere. You will be conducting your interviews in the Psychology Clinic with these assessment questions and competencies in mind.

You will be conducting interviews and taking histories with these issues in mind throughout the semester, and will be presenting the results of these interviews in class.
4. MENTAL STATE EXAMINATION, ORGANIC CONDITIONS AND NEUROPSYCHOLOGICAL SCREENING

Weeks 6 - 8

It is important for a clinical psychologist to be able to distinguish "organic" from "functional" disorders. Phenomenology typically provides a description of existential functioning that precedes the question of organic causality in the genesis and presentation of clinical phenomena. However, valid that may be, it is nevertheless crucial that you as clinicians have the conceptual tools to make practical distinctions that can be life saving and which, in any event, significantly influence case management decisions. Psychologists cannot simply rely on medical authority that a person's problems are psychogenic. In one study, reported by Taylor (see below) the family physician failed to identify moderate to severe brain syndrome in more than 80% of his cases! Especially with regard to cerebral pathology, our own diagnostic tools are generally more sensitive than even the neurologist's, so it is clinical psychologists who can pick up cerebral problems the earliest. Fortunately the warning signs for organic pathology are not difficult to understand and learn. In addition to reading Taylor's book, we shall discuss the mental state examination in detail and I shall introduce you to some basic neuropsychological assessment tests that are excellent for screening purposes.

We shall routinely consider organic factors in case presentations throughout the semester, and they will be addressed with regard to the case presented in the examination.

Required reading for this section


Required reading for this section


See Chapter 2: "Orientation to interviewing."

Brooke, R. (undated) Comprehensive Case History, Mental State Examination, and Case Formulation. Unpublished. (We shall go through this in detail in class.)


Recommended:


Recommended:

4. **PSYCHODYNAMICALLY INFORMED CASE FORMULATION**

(Week 9 I shall be away. Workshop on a movie.)
Weeks 10 - 11.

Week 12  Working with psychodynamically informed focus (Film: the case of Jan)
An objective of the course is to help you develop a psychoanalytically informed understanding of the structural and dynamic organization of your client's experience. Psychodynamics is a human science, concerned with the exploration of meaning, its genesis and organization, and with the multiple levels of human motivation. Like phenomenology, psychoanalytic psychotherapy is at best "experience near." Phenomenology, for its part, is increasingly reliant on hermeneutic understanding, which may draw from psychoanalytic theory. Freud's energetic metaphors and even his Cartesian assumptions have largely been dropped from much of contemporary psychoanalytic discourse, with the result that the perspectives of psychoanalysis have become more accessible to the ordinary empathic imagination of insightful people, and directly relevant to the process of case conceptualization. You should find that they complement and deepen descriptive (DSM) diagnosis in useful ways. Psychodynamically informed case formulation is
- comprehensive and multileveled,
- it always leads to an individual, ideographic understanding of the client and his or her problems,
- it promotes empathic engagement and the development of a therapeutic alliance, and
- it is helpful whatever kind of intervention follows.

In class we shall use some training material and exercises developed by Gavin Ivey to develop a procedure for developing and sharpening a psychodynamic case formulation. We shall also develop a psychodynamic case formulation for the cases presented each week in class.

**Required readings for this section**

**Recommended:**

5. **EMPIRICALLY SUPPORTED TREATMENTS, EVIDENCE BASED PRACTICE, AND EXPERTISE**

Weeks 13 - 14

It is an essential aspect of professional and academic accountability that we are able to evaluate critically our own therapeutic endeavors, as well as the claims of our colleagues. Where our work is ineffective, we need to change it in line with approaches that have been shown to be preferable. It is also important, however, that you be appropriately suspicious and rigorously critical of the numerous claims that are made concerning the experimentally validated efficacy of some approaches to psychotherapy. Criticism involves empirical questions of design and the interpretation of results, as well as more fundamental questions of an anthropological and ethical nature.

Since 1992, when Division 12 of APA adopted the "empirically validated treatment" model of approved approaches to psychological and behavioral treatment and effectiveness research, there has been much controversy. One result has been that the term "validated" has been softened to "supported." More recently the notion of evidence based practice has become standard. It provides a general orientation in which the questions of empirically supported treatments, client factors, and individual context can be professionally integrated. In any event, you need to understand these developments, as they concern the dominant model of professional accountability in the United States (and elsewhere). As a licensed psychologist, it is an ethical and professional obligation to practice within a tradition that has an evidence base in terms of outcome measures of effectiveness, and you need to keep abreast of the literature in this regard.

On the other hand, what are ostensibly academic and professional concerns regarding questions of effectiveness and accountability are controversial, and from our point of view as human scientists--or even as citizen recipients of mental health care--highly problematic. Serious methodological objections to the EST approach have been raised. Moreover, there are powerful economic and political forces at work, and the fact is that your professional future could be in jeopardy if you do not understand and know how to respond to these factors. The term, evidence based practice, has become more of a political and rhetorical weapon used by its advocates than a term describing an informed and reasonable position. On the other hand, in 2005 an APA Presidential Task Force on Evidence Based Practice produced ground-breaking policy and position papers, which are of profound significance for competent practice. Of special significance is the reinsertion of expertise as a significant factor in effective treatment (instead of being regarded as a confounding variable in comparative experimental trials).

We shall discuss this material and issues in class and in relation to your cases presented through the semester.

This is also an appropriate section in which to discuss the question of psychotropic medications. An excellent blog my my former colleague, David Edwards, is helpful in this regard.
Required readings for this section

Recommended:

ATTENDANCE AND GRADES
Attendance is compulsory. Students are expected to have read the readings before coming to class and to be prepared for case presentations and seminar discussions as required. Repeated absence or lack of preparation may result in failure of the course.

I shall call on students to initiate discussions of the readings. These discussions count towards your final grade. Each class will include a case presentation. Most of you will present twice over the course of the semester.

Most classes will roughly follow the following structure:
12.15 - 1.00 Discussion focused on the readings
1.10 - 1.50 Further discussion of conceptual issues
2.05 - 2.55 Case presentation

Professional conduct in clinical discussions is expected at all times. Serious breaches or repeated lapses will be viewed in a serious light and may result in failure of the course. Final versions of your case reports are expected to be up to professional standards of acceptability for a passing grade (B). Having said that, let me reassure you that I do not expect you to be experts or to make no errors. Errors and a feeling of groping in the dark are par for the course and appropriate to the profession. You will have feedback on your case presentations and an opportunity to work your material into competent form.

The final examination will take the form of answering questions about a case that I shall present, where the questions will test your knowledge of the readings and your ability to integrate that knowledge in terms of the case. All the course competencies will be addressed in these questions (except being able to conduct an interview). It is an open book, take home examination, and you can have the questions beforehand.

- Final examination 40%
- Case reports and presentation 30%
- Class participation 30%

Total 100%

DISABILITIES

If you have any disability which may effect your functioning in the course please let me know, and I shall do what I can to accommodate you.

You are all welcome to email me or phone me with questions or concerns.

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