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Over-formalising the formulation?

Invited commentary on: Teaching psychodynamic formulation to psychiatric trainees

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Abstract In their recent articles in *APT* Mace & Binyon described a four-level approach to the teaching of the psychodynamic formulation. The fourth level requires development of confidence in the use of an operationalised psychodynamic diagnostics (OPD) manual. Here I critically reconsider the aspects necessary to develop the ability to arrive at a psychodynamic formulation. I argue that as one develops more sophistication and clinical confidence, one needs to move from a manualised to a more open-minded reflective mode.

Chris Mace & Sharon Binyon's consideration in *APT* of the teaching of psychodynamic formulation (Mace & Binyon, 2005, 2006) is to be welcomed as highlighting a very important and often neglected part of psychiatric training. Part I of the Royal College of Psychiatrists' membership examination currently emphasises diagnosis and the eliciting of phenomena such as first-rank symptoms. This encourages trainees to postpone developing skills with the psychodynamic formulation until faced with part II of the membership examination.

In the first of their two articles (Mace & Binyon, 2005), the authors describe the purpose of making a psychodynamic formulation and how it differs from making a diagnosis. Although diagnosis is often seen as a summarising label, the psychodynamic formulation includes additional information on how the patient feels and responds in a variety of situations and carries a predictive value for future behaviour and likelihood of response to treatment.

The four-level model

Mace & Binyon contend that, although the content expressed may be unique to the individual patient, it is still possible for the psychodynamic formulation to follow a systematic method. They introduce a four-level model of approach to the psychodynamic formulation. Level 1 is identified as recognising a psychological dimension. For example, a case of depression can be seen in terms of the relationship of the internal to the external world, rather than merely being diagnosed as unipolar depression.

Level 2 involves the construction of an illness narrative, building up a more comprehensive picture. For example, what current stresses evoke earlier conflicts, leading to an increase in feelings of shame, resentment, rejection and guilt?

Level 3 is linked to developing a model for the formulation. This includes using the traditional framework of predisposing, precipitating and maintaining factors, together with a selective reorganisation of information gathered by systematic inquiry.

Level 4 is described as a more theoretically sophisticated formulation of identified dynamics. Mace & Binyon refer to the template for this formulation as the operationalised psychodynamic diagnostics (OPD). It incorporates three dynamic dimensions: structures (e.g. self-perception, self-regulations and defence mechanisms); interpersonal relations (patient's experience of self and others, and others' experience of patient) and primary types of conflict (e.g. dependence *v*. autonomy, submission *v*. control, Oedipal/sexual and identify conflicts).

In their second article (Mace & Binyon, 2006), the authors describe the teaching methods needed to implement their four-level model in clinical practice. At the first level the aim is to achieve a 'basic psychological mindedness'. They argue that this can be developed in medical students by encouraging human responsiveness within the general ward setting. At level 2, constructing an 'illness narrative' would be an early teaching aim, beginning in the foundation year. At level 3, the objectives can be explored within senior house officer (SHO) groups, where arriving at a group consensus can help to structure the observations.

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Achieving level 4 is seen as an essential aim of all specialist registrars (SpRs) in psychotherapy and desirable for those who will be working in other specialties. The authors recommend that initially each trainee should use a copy of the OPD manual as a checklist to aid in organising and recording their thoughts, paying particular attention to recording the patient's interpersonal relations and conflicts.

Strengths and weaknesses of this approach

There is a need at times for systematised teaching and Mace & Binyon describe a clear basic framework of approach within the first three levels. Few would disagree with these elements. However, there is a balance to be maintained between systematic teaching and the encouragement of psychiatric SHOs to develop their own questionings and sensitivities. In this sense, there may be a danger that a level 4 manual such as the OPD could lead trainees to move too quickly towards a systematised approach as they seek more advanced understanding.

Mace & Binyon also rightly point out that the success of any teaching technique will rely heavily on the motivation and enthusiasm of local advocates. I think that this will very much apply to the OPD approach. Only time will tell whether it achieves widespread national popularity.

A psychoanalytic perspective

In psychoanalytic psychotherapy, specialist training has moved away from a systematised approach and towards the development of a more reflective attitude in the trainee. It is noteworthy that all advanced trainings follow the same format. First there is infant observation, to encourage observational skills, and a general psychiatric placement, to become familiar with psychosis. Then two clinical cases are seen at least three times a week under weekly supervision for 2 years, together with intensive ongoing personal therapy. There are also weekly theoretical and clinical seminars.

Following controversial discussions within the British Psychoanalytical Society (King & Steiner, 1991), all analytical trainings seek to include differences in emphasis and technique, so that students can with time develop their own views rather than being provided a didactic approach. This may be in marked contrast to trainings in other areas: cognitive–behavioural therapy, for example, may lend itself more comfortably to systematised guidelines.

From time to time, new approaches have been introduced within the field of analytic psychotherapy in an attempt at simplification. Malan's model for brief psychotherapy would be a case in point (Malan, 1979). More recently there has been the introduction of concepts and models of mentalisation and attachment theory, with its application to borderline states (Fonagy & Bateman, 2006). Although these may become incorporated into the psychoanalytic psychotherapy trainees' teaching seminars, the essential format of training, as described already, has remained the same over the past 50 years and is unlikely to change in the future.

Other important elements of training

Aside from highlighting their personal enthusiasm for OPD as part of an advanced teaching programme, the second article by Mace & Binyon (2006) considers many other aspects involved in developing an ability to arrive at a psychodynamic formulation.

Shared group experience among psychiatric SHOs remains an important element in learning about aspects of the psychodynamic formulation, as does later experience with individual supervised cases. Problems may arise when there is a shortage of suitably trained staff to run such groups. The group leaders will need specialised knowledge of the psychodynamic aspects of psychosis, as the initial experiences of SHOs will predominantly be with patients encountered in their general psychiatric posts or while on emergency duty. Patients with psychosis tend to disown troublesome feelings through projection. It will therefore be important to help trainees to decipher the meaning in delusions and make sense of their countertransference experience, in order to arrive at a meaningful formulation that can be shared with the treating team (Garelick & Lucas, 1996).

One area not covered by Mace & Binyon relates to the need for trainees to develop confidence in linking the formulation derived from contact with the patient with the act of making interpretations. As a consultant in general psychiatry once shared with me, trainees are often taught how to diagnose depression and prescribe medication, but not how to talk to the patient. The challenge remains of helping the SHOs and SpRs to develop confidence and skill in talking to the patient once they have made the formulation.

In developing confidence in relating to the inner world, it should be emphasised at specialist training level, as well as for some SHOs, that there is no substitute for experience gained through personal individual therapy.

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Conclusions

Psychotherapy and psychiatry are both very complex areas and I believe it is important to integrate, rather than keep separate, diagnostic and psychodynamic aspects, incorporating them into an overall treatment plan (Lucas, 2004). We need to recognise that the dominant underlying internal psychodynamics can differ in people with depression, borderline states and schizophrenia and these differences need to be incorporated into the formulation.

In any individual case there will be a constant shifting of the formulation as new situations arise in the therapy, and therefore we must take care not to impose over-structured models at the highest levels of psychotherapy training. At times we can become too preoccupied with evidence-based rather than experience-based practice. For all psychiatrists and psychotherapists, learning is a life-long experience, even if at first it means having to rely heavily on one's teachers (Britton, 1998).

We need to encourage confidence and individual open-minded creativity in our trainees if we are to produce a healthy state for psychiatry in the future. How best to apply this aspiration in the area of teaching the psychodynamic formulation remains a challenge for all trainers.

Declaration of interest

None.

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