

# Formulation as an alternative to psychiatric diagnosis

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# Critiques of psychiatric diagnosis

‘The critique of diagnosis *is* the critique of psychiatry’ Brown 1990

‘Diagnosis is the Holy Grail of psychiatry and the key to its legitimation’ Kovel 1981

...thus, diagnosis provides the foundation for the biomedical language we use....

*illness, patient, treatment, prognosis, remission, symptom, etc*

....which in turn shapes our assumptions about mental distress and how we deal with it

*doctors, nurses, wards, clinics, hospitals, medication etc*

- The act of diagnosis is also the crucial first step in the career of any psychiatric patient
- It turns 'people with problems' into 'patients with illnesses'
- Meaning is first and greatest casualty of diagnosis and biomedical psychiatry (cf Karl Jaspers)
- 'In the final analysis, power is the right to have your definition of reality prevail over all other people's definition of reality' (Rowe 1990)

## Service user quotes

‘I walked into (the psychiatrist’s office) as Don and walked out a schizophrenic...I remember feeling afraid, demoralised, evil.’

‘The diagnosis becomes a burden...you are an outcast in society. It took me years to feel OK about myself again.’

‘The killing of hope....it almost feels like, well, your hands are tied, your cards laid and your fate set.’

‘I think schizophrenia will always make me a second class citizen....I am labelled for the rest of my life.’

‘Once it was known that I had spent time in the “nutters” hospital, my neighbours gave me hell.’

Most service users see their problems in psychosocial terms...

‘Being treated in a medicalised way, as if they had physical illnesses, formed the basis of negative evaluations and complaints on the part of most users in every aspect of their management... In summary, the professional discourse and the lay discourse about personal distress are incompatible.’

‘A doctor treats a *patient*... and my contention is that I get mentally ill because of social problems.... and so it’s an eternal conflict!’

Rogers, Pilgrim and Lacey 1993

.....and so do most members of the public

‘The public, internationally, continues to prefer psychosocial to biogenetic explanations and treatments for schizophrenia.’

Read et al 2006

# Practical consequences

Obscures contexts (relationship and social)

Individualises problems

Removes responsibility ('sick role')

Stigmatises and disempowers

Keeps relationships stuck

Medical consequences (medication etc)

Social/practical consequences/discrimination  
(unemployment etc)

**REMOVES MEANING**

‘In the early 1980s I was diagnosed as schizophrenic....In 1993 I gave up being schizophrenic and decided to be Ron Coleman. Giving up being a schizophrenic is not an easy thing to do,for it means taking back responsibility for yourself, it means that you can no longer blame your illness for your actions...but more important, it means that you stop being a victim of your experience and start being the owner of your experience.’

Ron Coleman, 1999

# Could we replace psychiatric diagnosis with formulation.....?

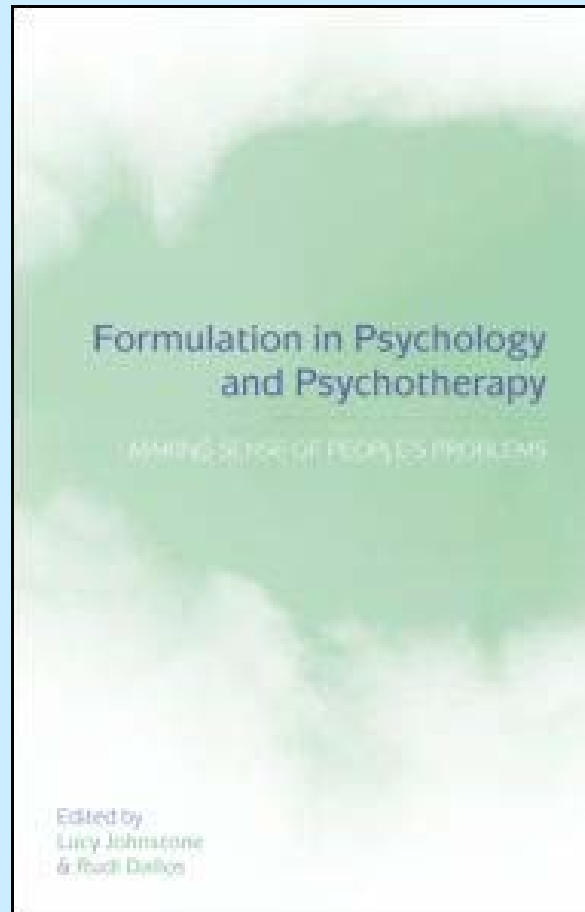
All formulations.....

- Summarise the client's core problems
- Show how the client's difficulties relate to one another, by drawing on psychological knowledge
- Explain, on the basis of psychological theory, why the client has developed these difficulties, at this time and in these situations
- Give rise to a plan of intervention
- Are drawn up collaboratively with the client
- Are open to revision and re-formulation

- ‘Formulations can best be understood as hypotheses to be tested.....  
.....at some level it all makes sense’ Butler 1998
- **RESTORES MEANING**
- **RESTORES RESPONSIBILITY**

# Formulation in psychology and psychotherapy: Making sense of people's problems

eds L Johnstone and R Dallos, Routledge 2006



# Mary aged 75

- Mother died when she was 5
- Sent to live with cold, strict grandparents aged 8
- Unhappy marriage
- 3 children, all refusing contact with her
- Worked as a receptionist till 1995
- In residential home but given notice to leave

- First breakdown after birth of eldest child
- Low moods roughly twice a year ever since
- Experienced by staff as extremely difficult, demanding, controlling, verbally abusive
- Describes all interventions as useless but continues to demand services, medication etc
- Professionals feel angry, stuck, helpless, frustrated

45 year psychiatric history!

- Diagnoses: depression, manic depression, post-natal depression, anxiety, depressive personality, borderline personality disorder
- 20+ admissions plus daycare and many other resources
- More than 20 different medications (anti-depressants, minor tranquillisers, neuroleptics, lithium) in various combinations
- 6 courses of ECT

Nothing has made much difference.....

Mary suffered a major rejection when she was sent to live with her strict grandparents after her mother's death, and has been searching for care for herself ever since. She did not have the emotional resources to cope with her own children, and indeed has spent much of her life trying to get them to look after her. Small events that are perceived as rejections (eg her son going on holiday) trigger her 'depression', which is perhaps better understood as a deep fear of being alone and abandoned.

Mary's early rejection left her not only needy but very angry. The only way she knows how to get care is by inducing guilt and making threatening demands. This, of course, tends to alienate others, who then confirm her worst fears by rejecting her, which feeds further into her anger and neediness.

In relation to the psychiatric services, Mary has (not consciously) found a false solution to this situation by gaining care through her 'symptoms'. At some level she does not want to benefit from interventions since this might result in care being withdrawn, so she carries on demanding even while declaring everything is useless. Her identity as a patient with an illness enables her not to take (or be given) responsibility for her actions.

# Intervention

- Share formulation with all staff, including new residential home – and Mary as appropriate
- Predict challenging behaviour until Mary feels accepted
- Draw up agreed boundaries of acceptable behaviour with Mary and staff
- Promote security by attention, time etc
- Anticipate rejection triggers
- Give regular support to staff
- Find valued non-patient roles for Mary
- Liaise with Mary's children
- Rationalise medication
- Review and re-formulate as necessary

# Diagnosis versus formulation

## Diagnosis

- Removes meaning
- Removes responsibility ('sick role')
- Removes social contexts
- Individualises
- Keeps relationships stuck
- Disempowering
- Stigmatising
- Medical consequences
- Social consequences

## Formulation

- Finds meaning
- Promotes responsibility
- Can include social circumstances
- Includes relationships
- Looks at relationship change
- Collaborative
- Non-stigmatising
- Non-medical
- No social consequences

# Moving away from diagnosis...we are in good company

## Finnish 'need adapted' model for 'schizophrenia'

'The systemic and psychodynamic orientations of the need-adapted model make diagnosis problematic..(and) of limited use....The integrated and need-adapted approach is founded on being problem-oriented.'

Identity crisis; separation crisis; double-bind crisis; acute crisis; stagnated crisis

## Bradford Home Treatment team

‘The home treatment service attempts to work with a “needs-led” approach and does not...seek to diagnose the service user’s problems in a medical way...Drugs are generally used on a symptomatic basis and not with the belief that they are curing a psychiatric “disease” of some sort.’ Bracken 2002

## Hearing Voices Network

‘Our vision is to create an acceptance that hearing voices is a valid experience for which there are many possible explanations....Although the Network is open to many diverse opinions we accept the explanation of each voice hearer.’

## Japanese model

‘Mind-split disease’ replaced in 2004 by ‘Integration disorder’

‘...a syndrome...whose etiology and physiology are not yet firmly established...not a disease defined by a specific etiology, symptomatology or pathological findings.’

Sato 2006

## Trauma work

The argument that much ‘psychosis’ is best understood as the long-term effects of trauma and abuse

Cf Herman: Complex PTSD

# Campaign to abolish the schizophrenia label (CASL) [www.asylumonline.net](http://www.asylumonline.net)

- The concept of schizophrenia is unscientific and has outlived any usefulness it may once have claimed
- The label schizophrenia is extremely damaging to those to whom it is applied
- ‘A single word can ruin a life as surely as any bullet, and schizophrenia is just such a word.’

And of course.....

Remember that formulation can be  
misused as well

***Formulation as an alternative to,  
not an addition to, diagnosis***

So that we can see service users as.....

***People with problems, not  
patients with illnesses***

## *Some pitfalls on the horizon.....*

Simply replacing one nonsensical term with another

Cf Prof Robin Murray 'dopamine dysregulation disorder'

Re-drawing the boundaries of the increasingly discredited diagnosis of 'schizophrenia'

Borderline personality disorder and bipolar disorder

Using formulation as an addition to, not an alternative to, psychiatric diagnosis

- Can obscure social contexts; be individualising; remove responsibility; be pathologising and non-collaborative; overlook the role of relationships
- Dangers of 'psychological diagnosis' eg 'challenging behaviour'. ("Problem" is not an objectively identifiable natural category, and it is often not possible to see any particular behaviour or experience as inherently problematic' Boyle 2001)

# Challenges for psychiatrists

## 1. Using genuinely integrated formulations

Eells (1997) 'Handbook of Psychotherapy Case Formulation'

Weerasekera (1996) 'Multiperspective Case Formulation'

Campbell and Rohrbaugh (2006) 'The Biopsychosocial Formulation Manual'

# Weerasekera's integrative model

Biological	Behavioural	Cognitive	Psycho dynamic	Couple	Family	Occupation	Social
Gene for psychosis	Flashbacks and fears	Beliefs of self-blame	Insecure attachment	Marital discord	Abuse by father	None	Poor housing
Diagnosis and medication	EMDR	Cognitive therapy	Psychotherapy	Couples therapy	Group therapy	Employment advice	Housing advice

But don't we use more holistic models nowadays?

- Diagnosis based on a biopsychosocial or vulnerability-stress model is equally problematic!
- Weak sense – obviously true in a general sense, but ‘by explaining everything they explain nothing in particular’ (Skrabanek 1984)
- Strong sense – the ‘bio’ or ‘vulnerability’ bit (for which there is no evidence) seen as primary causal factor
- This preserves medical assumptions by reducing psychological and social factors to the ‘trigger’ of an underlying ‘illness’
- Divests them of their personal meaning

## Using diagnosis and formulation together....?

- You have a medical illness with primarily biological causes’
- VS
- ‘Your problems are a meaningful and understandable response to your life circumstances’
- *This is a mixed message about personal responsibility.....*
- ‘You have an illness which is not your fault BUT you retain responsibility for it and must make an effort to get better BUT you must do it our way because we are the experts in your illness.’

- .....which leads to all the familiar contradictions of everyday psychiatric practice
- Not compliant vs Too dependent
- Won't accept they're ill vs Sick role behaviour
- Too demanding of services vs Not engaging with services
- These contradictions are inherent in the combining of two models with fundamentally incompatible core assumptions