Formulation: A Multiperspective Model*

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This paper presents a model of formulation that can be used by psychiatrists and other mental health professionals. A review of the literature indicates a need for a more comprehensive approach that can accommodate a variety of perspectives, suggest treatment and can be easily recalled. These issues are addressed by the multiperspective grid presented in this paper.

The teaching of case formulation to residents in psychiatry differs from program to program, as well as within programs, depending on the emphasis given to this area. Although educators may differ in their opinions of the usefulness of this exercise, residents struggle when asked to formulate a case. They present either an elaborate psychodynamic formulation or a superficial integration of the "biopsychosocial" model. Rarely does this formulation suggest an approach to treatment. It is viewed as a separate intellectual exercise that contributes little to the practice of differential therapeutics (1). Residents in psychiatry are not alone in this struggle; most psychiatrists and other mental health professionals are also in need of an approach to formulation that is pragmatic, able to examine a variety of perspectives, and most of all, clinically useful.

Defining the term "formulation" has been difficult, resulting in the decision to remove the term from the Canadian fellowship oral examination (2). Although many have written on this topic, it is surprising to find only one paper that defines the term. According to Cleghorn (3), a formulation is "a description and hypothetical explanation of data that the system ignores or cannot explain." A formulation is recommended to supplement a DSM-III diagnosis since this classification system does not infer pathogenesis or predict the course of an illness. Cleghorn's view is supported by this paper and an alternate definition that takes into account the complexities of the formulation is presented.

In this paper, a formulation is defined as a tentative explanation or hypothesis of the way an individual with a certain disorder or condition comes to present at a particular point in time. A number of factors may be involved in understanding the etiology of the disorder or condition. These may include biological, psychological and systemic factors. All these factors can interact under certain conditions to produce a specific condition or phenomenon, which can be expressed biologically, psychologically and systemically; the mode of expression does not infer a specific etiology. A comprehensive formulation therefore needs to carefully examine all three modes of expression. This new definition takes into account the complex phenomena that must be considered to arrive at a comprehensive formulation.

Over the past ten years, studies have provided the following: survey information regarding the teaching of formulation in the various residency programs (4,5); a variety of psychodynamic models of formulation that are being empirically studied (6,7); and three comprehensive models that include other non dynamic perspectives (3,5,8). Although these studies have refined the area of case formulation, their relevance to teaching trainees and their ability to provide mental health professionals with a comprehensive, clinically useful approach is questionable. Primarily, they fail to provide a cognitive schema or framework of formulation that can be easily recalled. Most of these papers focus on the psychodynamic perspective and (except for a few) exclude the biological and other non dynamic psychological perspectives, and none of the papers discusses ways in which formulation can lead to treatment.

This paper will provide a model of formulation that attempts to deal with the difficulties discussed above. The model is an elaboration of the common grid used by residents in psychiatry in many settings. A more elaborate discussion of the model, the theoretical perspectives it represents, and it's clinical application illustrated through a case example, has been extensively described elsewhere (9). The purpose of this paper is to briefly introduce the reader to the model.

The Multiperspective Model

Table I displays the model proposed in this paper. The model is eclectic in that it applies a multiperspective view to understanding psychological phenomena. The x-axis of the grid is divided into two major headings: individual and systemic. Under these headings are subheadings that encompass different perspectives and systems. There are four subheadings under "individual factors": biological, behavioural, cognitive and dynamic. The latter three were chosen because they are theoretically distinct in their view of human behaviour and are representative of the major forms of psychotherapy used to treat psychiatric disorders. Under the heading "systemic factors" are the four significant systems in an individual's life: the couple, family occupation/school and social system. The term "system" in this model refers to the areas outside the individual that have a significant impact on

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day-to-day life. Although the individual can also be viewed as a biological system, the term, as it will be used in this paper, refers to the systems encountered outside the individual.

The y-axis contains six headings, four of which are already familiar to the resident in psychiatry. The four "P"s — predisposing, precipitating, perpetuating and protective factors — have been used to evaluate biological, psychological and social factors in the commonly used grid. It is the synthesis of these four factors that comprise the formulation.

The multiperspective model offers two additional dimensions: coping-response style and treatment. Coping-response style has been described extensively by Lazarus (10) and Mechanic (11), but in this paper, it will be used to refer to the individual's unique style of dealing with stress. This dimension allows individual differences to be taken into account when making treatment decisions. For example, an action-oriented individual is more likely to respond to a behavioural approach, while a more psychologically oriented individual may benefit from a cognitive or dynamic approach to treatment. There is evidence that when treatment and a patient's coping-response style are matched, the outcome is more likely to be positive. Michelson (12) found a more favourable outcome when behavioural and cognitive therapies were matched to corresponding styles in the patient's expression of their anxiety disorder. Congruency between treatment and the patient's coping-response style may also increase compliance. Attention to individual variables may also facilitate a better therapeutic alliance, a variable that accounts for a significant proportion of the variance in the outcome of psychotherapy (13).

This grid also includes treatment. By following the eight columns, clinicians can make decisions regarding specific individual therapies, systemic therapies, or the integration of a variety of therapies. A brief description of how to use this grid follows. The individual and systemic factors will be discussed briefly with respect to assessment, the four "P"s, coping response style and treatment. The order in which this is discussed parallels actual clinical practice. One needs to assess all factors before formulating and then treating a given case.

The formulation made at assessment needs to be tested and revised as new information is learned through therapy. Therefore, it is seen as a hypothesis that is confirmed or refuted as therapy progresses. The formulation at termination may be very different from the initial assessment. Formulation is therefore considered to be a dynamic process.

Before proceeding with a discussion of each column, I would like to offer a word of caution. The comprehensiveness advocated by the model does not imply that one become an expert within each perspective. This is an unrealistic and unnecessary expectation. The grid is presented simply as a guide to: 1. increase awareness of alternative perspectives; 2. offer a method of collecting and organizing data; and 3. encourage a richer conceptualization of clinical cases that may contribute to more effective treatments.

Individual Factors

Biological Factors

The first column (See table I), the biological perspective, is most familiar to psychiatrists and residents in psychiatry; they are exposed to this perspective prior to residency. Assessment within this perspective includes a comprehensive medical and psychiatric history, physical and mental status examinations and relevant investigations. Some of these variables are listed under the biological heading as determined by the four "P"s. For example, a positive family history of mood disorders, may biologically predispose an individual to depression. A medical illness may both precipitate and perpetuate the expression of depression. Chronic substance abuse may also perpetuate this condition, while pregnancy could protect against depression in some cases. An individual with a biological coping-response style may interpret his or her condition as a medical illness and may therefore be more likely to contact a physician for medical attention. Medications and other medical treatments may be sought, resulting in greater compliance with this type of therapy. A biological treatment is indicated when the assessment yields sufficient evidence for a strong biological formulation, a biological coping response style and the availability of an effective biological therapy. It is also indicated when it is superior to other therapies and can be integrated with a variety of psychotherapies.

Behavioural Factors

The next column shows the behavioural perspective. According to this view, psychological problems are behavioural problems that have been learned through classical or operant conditioning. Assessment within this perspective involves obtaining the frequency of various types of behaviours, reinforcers and punishers. These data are gathered through self-monitoring or observation. Behaviour that have received clinical attention include avoidance behaviour, self-injurious behaviours (in BPD and other disorders), tantrums, or acting-out (conduct disorders), inactivity, eating behaviours, and many others. The history of reinforcement and punishment, and prior classical conditioning are important to examine in order to identify significant behavioural predisposing factors. For example, a history of low rate of reinforcement may predispose one to depression. By definition, a reinforcer is a stimulus that increases the frequency of the behaviour that precedes it. It can be positive or negative. A punisher decreases the behaviour that precedes it. Decrease, loss, and inability to access reinforcers have been implicated in depression, making these important precipitating or perpetuating factors, depending on whether they are acute or ongoing (14). Significant punishers such as social rejection may precede the development of social phobia or avoidant personality disorder. The ability to use a variety of reinforcers may protect against depression. These concepts can be used to understand etiology and guide treatment. Research indicates a positive outcome with these approaches (15,16).

Table I

Multiperspective Grid

	Individual Factors				Systemic Factors			
	Biological	**Behavioural**	**Cognitive**	**Dynamic**	**Couple**	**Family**	**Occupational/ School**	**Social**
Predisposing	– family history – genetics – prenatal/ postnatal – developmental	– history of reinforcement and punishment – classical conditioning history	– dysfunctional assumptions – irrational beliefs – maladaptive shcemas	– early attachment – resolution of developmental stages – traumatic life events – sense of self – good/bad objects	– projective identification – negative behaviour exchange – negative attributions – lack of intimacy	– family structure – communication – family intimacy – open system	– employment history – learning difficulties – IQ – schools	– history of social relation – availability of network – social skills – cultural – gender
Precipitating	– trauma – toxins – vascular events	– loss of significant reinforcement – significant punisher – classical conditioning to novel stimuli	– activation of dysfunctional assumptions – increase in negative automatic thoughts	– relationship losses or difficulties – significant events activate dynamic process	– affair – children – individual changes	– individual or family crises ◦ illness/death ◦ finance ◦ moves ◦ separation/ divorce	– loss or change in job – failure at school – change in school – decreased finance on job	– loss of social support network – immigration – social violence
Perpetuating	– chronic substance abuse – chronic illness – handicaps – disabilities	– chronic low reinforcement environment – difficulty accessing reinforcement – family/social reinforcement	– negative automatic thoughts – chronic negative beliefs	– repetitive patterns/themes – chronic primitive defenses – lack of insight	– chronic problems ◦ children ◦ finance ◦ communication ◦ sexual – poor problem solving skills – chronic distance or decreased intimacy	– chronic marital discord – chronic illness – chronic occupational stress – chronic child problems – financial problems	– chronic dissatisfaction at work – undiagnosed learning disabilities – relationship with work/school mates	– individual É shyness ◦ social problems – environmental ◦ isolation ◦ disruption
Protective	– good physical health – absence of family psychiatric history – medications	– variety of reinforcement – availability of reinforcement	– adaptive beliefs in early years – capacity to change thinking pattern	– corrective experiences – avoid destructive relationships – insight – use of therapy	– increased intimacy – individual flexibility – commitment – equal power	– open system – flexible – intimacy and autonomy – adapts to change	– job satisfaction – financial security – high academic achievement – good schools – high IQ	– individual ◦ attractive ◦ extrovert ◦ empathic – environment ◦ access
Coping-response style	– visits MDs – medication oriented – somatizer	– action oriented – activity oriented – likes "to do"	– capacity to be introspective – reflect on thoughts	– introspective – motivation for self-understanding	– relationship provides major support	– family provides major support	– work provides ◦ support ◦ increased self-esteem	– social support network
Treatment	– medication – ECT – surgery	– behavioural therapy ◦ relaxation exercise ◦ systematic desensitization ◦ exposure ◦ increased activity ◦ biofeedback	– cognitive therapy ◦ thought stopping ◦ disputing ◦ countering techniques	– psychodynamic psychotherapy – psychoanalysis – experiential – client-centered, etc.	– couple therapy ◦ dynamic ◦ behavioural ◦ cognitive-behavioural ◦ systemic	– family therapy ◦ structural ◦ strategic ◦ systemic ◦ behaviour ◦ experiential ◦ dynamic	– occupational therapy – vocational counselling – special education – tutoring	– group therapy ◦ social skills training ◦ self-help group ◦ community programs

An individual with a behavioural coping-response style could be described as an action-oriented individual. He or she may prefer "to do" something to get well rather than take medications or talk about their problems. This person may do well with behavioural therapies, which include biofeedback, relaxation exercises, activity scheduling, systematic desensitization and exposure and response prevention. Recently, behavioural therapy has been integrated with cognitive therapy, resulting in cognitive-behavioural therapy. In this paper, these two therapies are discussed separately.

Cognitive Factors

The cognitive perspective attributes distressing emotional states to a maladaptive thought process, such as misattributions, irrational beliefs and automatic thoughts (17). Assessment in cognitive therapy requires self-monitoring of thought processes. Attitudes, assumptions or core residual beliefs (schemas) are cognitive factors that predispose an individual to a particular condition. Cognitive distortions, such as negative fortune telling, have been identified in depression. Various cognitive distortions have been associated with different conditions and disorders (18,19). Certain precipitating events, such as failure and loss, can activate these maladaptive thoughts and produce emotional distress. Some automatic thoughts can remain chronic and resistant to change. This is evident in personality disorders, where certain self-schemas are well ingrained. An individual with a positive self-schema, or few cognitive distortions, may be protected from various conditions, such as anxiety and depression.

Individuals with a cognitive coping-response style would be able to reflect on how they think and use various self-statements to alter their maladaptive thoughts. They may already see the relationship between their thoughts and various distressing emotions and may be using various cognitive techniques to cope. Cognitive therapy offers a variety of techniques to alter maladaptive thinking. These include disputing, countering, challenging and many others (20).

Psychodynamic Factors

The final column in the individual section is the psychodynamic perspective, for which there are many psychodynamic models. The three models most frequently encountered by the resident are drive-conflict theory, object-relations theory and self-psychology. Cleghorn and colleagues (21) have described "central enduring themes" common to all these theories that can be used with all patients when trying to understand them from a psychodynamic point of view. They suggest three broad categories: key relationships, conflict and experience of the self.

In completing the grid, one can look at these general themes or choose a specific theory that is most useful in understanding a particular patient. For example, drive-conflict theory may be helpful in understanding anxiety and depressive disorders, object-relations theory for BPD, and self-psychology for narcissistic disorders. These are just examples, and each theory may lend itself to many other conditions. Significant predisposing dynamic factors include fixations or arrests in primitive developmental stages, inadequate self-object experiences, poor containing environments, lack of a good-enough mother, attachments to bad objects, lack of early good object experiences, and insecure attachment with the primary caretaker. These experiences may predispose an individual to use excessive primitive or immature defense mechanisms such as projection and splitting, which lead to a less differentiated experience of self and other, necessary for a mature relationship. Precipitating events, such as the loss of a significant relationship, activate these dynamic processes established early in life. Perpetuating factors may be persistent primitive defense mechanisms, repetition of destructive relationships, or other ongoing dynamic mechanisms. Protective factors could be the presence of a primary figure, who, early in life was able to contain primitive projections, provide the necessary self-object functions, promote self-other differentiation and provide a secure attachment relationship (22-25).

An individual with a coping-response style that involves introspection and motivation for self-understanding would likely be amenable to psychodynamic therapy, or psychoanalysis. The therapist may focus on transference, good and bad objects, projective identification, splitting, projection, mirroring and idealizing transferences, cohesion, self-object functions and other processes, depending on the therapist's orientation. Alternate psychotherapies, such as client-centered, Adlerian, Gestalt, experiential, reality and interpersonal, also focus on inner experiences without adhering to the more traditional psychodynamic models (26,27). All these approaches are considered under the dynamic column.

Systemic Factors

The next section of the grid focuses on the systemic factors. Four systems require assessment: the couple, the family, the school or occupation and the social network.

Factors Related to the Couple

Difficulty in relationships is cited as the most common reason that individuals seek psychotherapy. Marital and couple problems account for 40% of patients admitted to mental health clinics in the US (28), making this an important area to assess. In couples, predisposing factors are factors related to the individual or couple that predict relationship difficulties, such as individual difficulties with intimacy, inability to compromise, destructive projective identification patterns and dysfunctional interactional cycles (for example, pursue withdrawal). Precipitating factors are events that stress the relationship, such as an extramarital affair or the birth of a child. Perpetuating factors may be either extra-relationship factors (for example, in-laws) or intra-relationship factors (for example, sexual problems) that maintain a chronic level of stress in the relationship. Protective factors are the positive aspects of the relationship that promote good feelings within the relationship, such as shared interests, mutual goals and respect for each other's individuality.

Various theoretical models, similar to those related to the individual factors (for example, object-relations, behaviou-

ral, cognitive) (28-31), and constructs (for example, intimacy) (33) may be used to conceptualize difficulties in relationships. Although not a specific coping-response style, the degree to which the dyadic relationship is used as a support or coping system may be important to assess, so that, if needed, it can be strengthened through couple therapy. The specific therapy chosen will depend on the therapist's orientation. Meta-analysis and other research support the effectiveness of marital therapy (34).

Factors Related to the Family

Interest in the role the family plays in individuals' psychiatric disorders is re-emerging (35,36). A variety of models similar to those described in the previous section exist in the literature on the family (37). Families predisposed to individual or family pathology have been described as having the following: diffuse boundaries, poor communication and poor self-other differentiation (38-40). Precipitating factors are individual or family events that change the system, for example, serious illness in a family member. Family crises which may be intrafamilial (for example, divorce) or extrafamilial (for example, a move, neighbourhood problems) also stress the system. Perpetuating factors include those factors that perpetuate a dysfunctional family system, such as child behavioural problems (intrafamilial) or inadequate housing (extrafamilial). Protective factors which promote optimal family functioning and individual growth are a strong commitment to the family, an open family system and minimal individual pathology.

An individual who uses the family as a secure base or major support could be viewed as having a familial coping-response style. A change in the availability of this buffering system would make this individual more vulnerable to stress. These individuals may be more likely to benefit from family therapy if the presenting problem has important systemic issues relevant to the onset or maintenance of the disorder. The model of family therapy chosen depends on the level of skill and the orientation of the therapist. Behavioural approaches have been studied extensively by Patterson (41) and found to be useful with families with child behavioural problems. Other approaches are beginning to be studied (37).

Occupational Factors

Since the majority of an individual's time is spent at work (either inside or outside the home), university, college or school, this area can contribute greatly to stress, by precipitating or exacerbating a disorder. In the case of a child, success at school has been found to be an important buffer against the development of child psychiatric disorders (42). Assessment includes obtaining a complete educational and occupational history. The number and types of jobs held, sense of satisfaction in these jobs, and the importance of the job to the individual need to be assessed. Learning disabilities, grades missed or failed and attendance at school all affect children's and adolescents' school performance.

The grid lists some of the predisposing factors in this area. In an adult, this includes a poor employment history or chronic dissatisfaction with employment. In a child, this may involve learning difficulties or behavioural problems at school. Precipitating occupational factors include loss of employment, change in the status or location of the employment or change in present job circumstance. For children, this may include a change in school or difficulties at school, such as problems with a particular teacher. Perpetuating factors include chronic occupational problems, such as dissatisfaction with work or difficulty relating with others. In school, these could be ongoing social or academic problems such as an undiagnosed learning disability that interferes with school performance. Protective factors are occupational factors that increase self-esteem and improve the quality of life. In adults this could be secure gainful employment or a high level of job satisfaction. In children and adolescents, this includes good academic achievement, above average IQ and good social relationships in school.

For some individuals, involvement in work or school can be seen as a coping-response style, in that it is a distraction from other personal problems and promotes self-esteem. For a child, good performance at school may help to alleviate family problems at home by providing an environment that is supportive and free of conflict (42). Treatment could include occupational therapy, self-help groups or vocational counselling for adults, and special education and tutoring at school for children.

Social Factors

The last column on the grid examines the individual's social system. This includes variables such as social support, which refers to the availability of confidants, recreational playmates or groups to share experiences. Lack of social support can result in vulnerability to certain psychiatric disorders (43). Also under this column, one can assess the importance of cultural factors and the ways in which they influence etiology and treatment. For children, social relationships are important for developing autonomy, gender-role identity and self-esteem (44). In assessing an individual's social network, two areas need to be explored: the frequency of social contact and the quality of that contact. Social behaviour is also affected by gender, and these gender issues can also be discussed under this section.

Predisposing social systemic factors are: the perceived availability of a social support network, the individual's capacity to engage in social relationships and the number and quality of previous social support networks. Precipitating social factors are a reduction, loss or change in significant supportive social relationships. Perpetuating factors are those that prevent ongoing social relationships. These could be within the individual (for example, shyness, poor self-esteem, fear of intimacy) or outside the individual (for example, social isolation, deficient community resources). Protective factors include individual factors that will increase the probability of exposure to a social system (for example, physical attractiveness, extroversion, empathic ability) and extra-individual factors that make social support more easily accessible (for example, supportive workplace or neighbourhood).

Individuals who use social support on a regular basis to deal with stressful life experiences could be described as having a coping-response style that is socially oriented. They may be vulnerable during periods when there has been a significant loss of social support. Treatment depends on the difficulty experienced by the individual within his or her social system. Individual or group therapy may help remove the barriers to supportive social relationships. This may include social skills and assertiveness training groups, or community programs that increase contact among members.

From Formulation to Treatment

After completing the grid along the four "P"s, and the coping-response style is evaluated, one can move to treatment. The ability to complete the grid will depend on the person's level of training and knowledge of the various perspectives. With more experience it may become easier to complete more of the boxes on the grid. It is not essential that all boxes be filled in. Only those areas that offer a plausible explanation or hypothesis need to be completed. As therapy progresses, more information may become available that will either fill in an empty box or change one that has already been completed. By going down each column after the grid is completed, a variety of treatment options should be evident, from individual biological to social systemic therapy. Although each of these perspectives have been discussed separately, they can be combined creatively into a wide range of therapeutic options. The decision to choose one therapy or to integrate several therapies should be based on the most probable formulation, the patient's coping-response style and the availability of therapies that have shown some evidence of effectiveness. This movement toward integrating therapies has been discussed elsewhere (45). A brief discussion of integration and how this model can be used as a first step towards this process is presented below.

Integrating Treatment

The concept of integration and eclectism has been discussed extensively in the literature on psychotherapy (46,47). The past ten to 15 years have witnessed a growing interest and clear delineation of this area as distinct within psychotherapy. Initial discussions centered on defining terms such as "eclectism" and "integration". Eclectism is defined as a technical, empirical, atheoretical mixing of various clinical methods borrowed from a variety of therapies (48,49), a definition advocated by Lazarus (50). An eclectic draws from a variety of therapies using techniques without adhering to a particular theoretical perspective. An integrationist is more theoretically oriented and draws from a variety of theories to create a new integrative theory and conceptually superior therapy (46). Although there is some disagreement regarding the division between eclectism and integration, some consider eclectism to be a form of integration, since it brings together clinical techniques from a variety of perspectives (46).

There are numerous examples of integrative therapies in the literature, including the integration of cognitive and behavioural therapy (51), psychoanalytic and behaviour therapy (52,53), interpersonal and cognitive therapy (54,55), and cognitive, interpersonal and psychoanalytic therapy (56). Although it is not the purpose of this paper to present an extensive discussion of treatment integration, a discussion of how this multiperspective grid can be used as an aid or first step towards treatment integration is warranted.

1. The grid promotes the learning of a variety of perspectives. This is the first step toward eclectism or integration. Prior to using any psychotherapeutic technique, the therapist must become familiar with the theory and therapy derived from a particular perspective. Once this has been learned, a new psychotherapy schema is added to the clinician's clinical repertoire. If a variety of therapies are learned, the psychotherapy schema is broadened, and new ways of organizing and using this information are possible.

2. The clinician is able to consider a wide range of therapeutic options if clinical techniques are learned from a variety of perspectives. In some cases, it may be necessary to start with one therapy and build on it as necessary. The patient's coping-response style may help this process by suggesting a starting point. If additional therapies are needed, they can be sequentially added or be integrated simultaneously. In the first instance, one therapy would follow another; in the second, therapies would be combined to provide a truly integrated therapy.

3. Therapeutic integration can proceed as follows. While carrying out the first therapy recommended by the grid, the clinician remains alert to emerging material that corresponds to other perspectives on the grid. For example, during a behavioural intervention, an individual previously unaware of his or her thoughts and feelings may, as a result of the behavioural intervention become more aware of the various thoughts and feelings associated with the problem behaviour. This marker (new awareness of thoughts) may alert the clinician to shift to, or integrate a cognitive component into the behavioural intervention, thereby creating a cognitive behavioural therapy. This is also demonstrated when integrating behavioural and psychodynamic therapy. An important finding demonstrated in the literature is the increase in spontaneous insights that occur during behaviour therapy making an individual more aware of conflictual issues (52). This marker (increased insights) could signal the integration of behavioural and psychodynamic therapy. The behaviour therapy would continue and be used to increase awareness of dynamic issues that may then be "worked through" with psychodynamic psychotherapy. The psychodynamic therapy works at the characterological level, while behaviour therapy is aimed at changing behaviour, since insight does not necessarily lead to behavioural change. In a sense, the two therapies, once integrated, enhance the effectiveness of both and may create a superior therapy. The concept of

a "marker" and its usefulness in psychotherapy has been discussed by Greenberg and Safran (57).

4. In addition to integrating individual therapies, the grid takes into account and points toward integrating treatment modalities. For example, an individual suffering from depressive and anxiety symptoms in the presence of chronic, severe marital distress may benefit from individual (medication plus cognitive behavioural therapy) and systemic (marital) therapy (58). The individual therapy may be done first, and after some improvement, marital therapy can be added. In some cases, if there is significant marital distress leading to a crisis, it may be helpful to treat the depressed spouse in the context of marital therapy. A pharmacological treatment of depression can be integrated with marital therapy, whereby the same therapist administers the medication and conducts the marital therapy.

Summary

The initial formulation provides a preliminary hypothesis of how an individual's presenting problem can be understood. As more data become available, through the patient's greater awareness and a better therapeutic alliance, the initial formulation is re-examined and modified accordingly. For example, if the original formulation is weak in the cognitive or psychodynamic areas, additional information obtained in therapy may flesh out these areas and offer a new formulation that might suggest a new focus or shift in the therapy. A self-schema or dynamic conflict may require time and an increase in the therapeutic alliance before it emerges in therapy.

The grid guides the clinician by first suggesting a place to begin that takes into account the patient's characteristics that encourages a good therapeutic alliance. As therapy progresses, attention is paid to other emerging themes that either fit the initial formulation or lead to a modification of the initial formulation. Therefore the formulation is viewed as a dynamic process that changes as therapy progresses, as new information becomes available. Learning and becoming aware of these perspectives is the first step toward treatment integration. Without this knowledge, treatment integration is not possible.

Conclusion

This paper presented a multiperspective formulation model aimed at helping psychiatrists and other mental health professionals develop case formulations. A review of the recent literature indicates a need for a more comprehensive grid. The multiperspective grid is able to comprehensively examine individual and systemic issues, focus on the patient's coping-response style and explores a variety of treatment options. This grid can be easily recalled and is therefore more accessible to the clinician in a variety of situations. To complete the grid, the clinician requires knowledge in a variety of areas, and gaining this will undoubtedly take time. Residency training and graduate school provides ample time to acquire this knowledge, and the learning process continues after the formal training period is completed. Clinicians can continue to learn a variety of therapies or at least be aware of their existence so that they may provide their patients with the best possible treatment.

The grid presented in this paper could also be used to assess trainees' knowledge base in different areas, allowing deficiencies to be identified early and educational goals to be set. It is not recommended that residents or clinicians develop expertise in all these areas, but that they be exposed to them in training so that they are at least aware of the existence of alternate therapies.

The practice of psychiatry is becoming more challenging, as research in pharmacology and psychotherapy evolves. Assessing and formulating with a multiperspective approach will increase the chances of exploring all treatment options, which is a step towards better treatment integration. This paper is an attempt to help the clinician with this difficult yet exciting process.

The use of systematic case formulation has been incorporated as a regular teaching exercise for some time at one of the McMaster University teaching units. This has allowed faculty from different theoretical perspectives to come together and model this multiperspective approach. Residents have found this to be not only useful but unique, in that it discourages polarization and encourages integration.

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Résumé

L'auteur propose une formulation modèle dont peuvent se servir le psychiatre et d'autres professionnels de la santé mentale. L'examen de la documentation révèle qu'on a besoin d'une approche plus générale en mesure d'accommoder divers points de vue, de suggérer un traitement et susceptible d'être récupérée par la grille à perspectives multiples présentée par l'auteur.