On formulation

DEAR SIRS

In the *Bulletin* for August 1983 (**7**, 140–2), Julie Hollyman and Loic Hemsi present a study of what psychiatric clinicians understand by 'formulation'. It may be of interest that formulations were part of the routine at the Phipps Clinic in Baltimore at the time when I served as an intern there in 1928–30. A case history was not considered complete until the important facts had been formulated, the principle being that a formulation should cover the needs of those for whom it was written. There resulted a series of formulations, the most important being: formulation for Dr Meyer (also for the staff of the clinic); formulation for the nurses; formulation for the patient's family; and formulations for the patients.

Each formulation could cover a half to two typewritten pages, and would contain all essential facts. They thereby served the practical purpose of relatively easy access to the case history without necessarily having to study the complete history—which at the Phipps could be of considerable length. It also served the important matter of secrecy, in that it kept the principle of 'intraclinical discretion' in our mind.

For me as (I guess) for most Meyer pupils the standard of clinical work at the Phipps has been an ideal, difficult to reach, and in my own hospital a complete set of formulations has been the exception rather than the rule. But I can state with confidence that the principle of formulating a case has been one of the guiding stars of my clinical work—more or less!

ØRNULV ØDEGÅRD

Gaustad Psychiatric Hospital
University of Oslo
Oslo 3, Norway

DEAR SIRS

We would like to make some brief comments on two recent contributions to the *Bulletin*. First, Julie Hollyman and Loic Hemsi's paper (August 1983, **7**, 140–3) on what constitutes a psychiatric formulation, whilst very interesting, is not the first publication of this type, and unless her survey of College examiners reveals a high level of agreement (unlikely), we will still witness the frantic last-minute consultations of utterly confused examinees in the 'sweat-box', or the calmer deliberations of those on beta-blockers. In the absence of strict guidelines from the College, we recommend that examinees ask the examiners if they require the 'short' (summary of positive points only—in the manner of a good resumé by a registrar to his consultant over the telephone) or 'long' (as for a discharge letter sent from one psychiatrist to another) formulation. In this way, the onus for definition is appropriately shifted in the direction of the immediate policy-maker. It may be of interest that one of us was not asked for either the 'history' or the 'formulation', but rather for the 'diagnosis' and a discussion of the research basis for same (psychopathic personality with secondary alcoholism).

Regarding Hugh Koch and Richard Scorer's paper on the training of psychiatric trainees in psychotherapy (August 1983, **7**, 146–7), we would like to draw the reader's attention to a recently published piece (O'Shea *et al*, 1983) on the attitudes to psychotherapy and its training among trainees in the Eastern Region (with 94 postgraduate students) of Ireland. Using a postal questionnaire, it was found that there was a strongly positive attitude to psychotherapy, but, unhappily, formal training was uncommon and inadequate. It is interesting to note that trainees, on average, reported that 11 per cent and 91 per cent of their patients were treated predominantly with psychotherapy 'alone' and psychopharmacology 'alone' respectively. We have also prepared a report on the same subject for Northern Ireland. In conclusion, we would urge that instead of increasing the ideological gulf which exists between psychotherapy and somatotherapy, and in agreement with Freud's dictum of 1905, the emphasis should be placed by the teacher on a sound match of client and therapy, rather than fitting a patient to suit any dogmatically limited treatment repertoire.

BRIAN O'SHEA
AIDAN MCGENNIS
MICHELE CAHILL
MARY HAYES

St Brendan's Hospital
Rathdown Road, Dublin 7

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DEAR SIRS

The correspondence about formulation drags out interminably, but I for one am not sure why such a mystery is made of the whole thing. A good formulation is simply an assessment of the patient in terms of past, present and future, and can be taken both logically and comprehensively under these three headings:

Past: How did the patient get to where he is? Follow here a temporal sequence as in the general plan. What were the remote (hereditary, childhood), intermediate (personality, marital, occupational) and more immediate (recent stresses, medical illness) factors that have brought the patient to his present position?

Present: Where is the patient now? Mental and physical state, differential diagnosis.

Future: Where does he go from here? Investigations, treatment and prognosis.

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