

# **THE CASE FORMULATION CONTENT CODING METHOD: MANUAL FOR CASE FORMULATION AND TREATMENT PLAN CODING**

## **A. DESCRIPTIVE INFORMATION**

This section is used to record descriptive, factual, non inferential information.

Almost everything coded in this section will be in the vignette (although the clinician need not use the actual wording from the vignette) usually it will be easy to determine whether a statement is descriptive or explanatory.

### **1. Identifying information**

Age, gender, marital status, education etc (usually appears at the beginning)

### **2. Symptom identification**

A symptom includes any complaints and other significant subjective reports of dysfunction offered by the patient. Includes any datum suggesting the presence of a mental disorder, e.g. sleep disturbance, feelings of anxiety, poor energy level, or mood disturbance. (code problems under specific area – e.g. under section C if possible).

### **3. History of present or previous episode of mental health problem (including alcohol and drug use)**

Consideration of current episode or previous episode of mental health problems or care. Includes onset and sequence of problems; any treatment; attempts to cope; and consequences in the individual's marital, social, work history, etc. (include childhood/adolescent mental health care or problems here as well).

### **3.1 Family psychiatric history**

Consideration of possible mental health problems (treated or not) in other members of the patient's family.

## **4. Medical/Health history adulthood**

Anything about the individual's health or medical condition in adulthood.

Included are frequency of visits to the doctor, hospitalizations, operations, other medical treatments, absences from work or school due to illness, chronic or major illnesses, allergies, current (non psychiatric) medications, side effects. (note: code childhood or adolescent medical history (e.g. genetic constitutional factors under 6)

### **4.1 Medical history in current family**

Same as above, except the focus is on the health of members in the patient's current family, e.g spouse, children, elderly parents.

## **5. Developmental history (individual or family)**

Information about genetic, constitutional, familial, and environment influences as well as relevant medical or neurological deficits. The focus is on childhood and adolescent nuclear family and on other childhood and adolescent events. May include life situation into which the patient was born and brief details about the background of both sides of the family. A discussion of the family members living in the home at the time of the patient's birth is significant as are the socioeconomic circumstances of the family at the time. A brief description of the patient's mother and father, parent surrogates may also be included. [MacKinnon, 1991#331]. (Note code childhood and adolescent mental health history under 3)

## **6. Adult life history (18+) (Current and past relationships)**

Information about the individual's past or recent adulthood, including social, family, education, work, military, religious and legal history. This can be problematic or not. The distinction between 5 and 6 is a temporal one.

### **7. Mental status information/appearance**

Consideration of thought processes, thought content, level of arousal, attention, verbal articulateness, interpersonal manner, grooming, style of dress, posture etc., as observed during the interview. This information will usually be drawn from the last paragraph of each vignette.

### **8. Other descriptive information**

Use this category for descriptive information referenced from the vignette that does not fit other categories.

### **9. Need for more descriptive information on:**

(code as 9 if subcategory does not apply)

This is a residual category used only if one cannot better score and IU elsewhere.

If a subject says he'd get the information in therapy, then code under *therapeutic intervention* as well as 9.x. However do not assume the subject will address the issue in therapy unless it's pretty clearly stated or implied. If the subject says, "There's no information on X", assume she is requesting extra information on X.

Example: "There's a lot more information I need" (without further elaboration)

Explanation: Code as 9 because it is a general statement about needing more information and because no subcategory applies.

Example: "I'm not sure how those symptoms are manifesting themselves in her life now"

Explanation: Code as 9.2 because the strong implication is the subject wants more information about symptoms.

Example: "There's no information about sexual history"

Explanation: Code as 9.6 based on the assumption that the subject wouldn't make such a comment unless s/he wanted information on sexual history.

## **9.2 Symptom identification**

## **9.3 History of present or previous episode of mental health care or problems (include drug and alcohol abuse and family history of mental health care or problems)**

## **9.4 Medical history- adulthood or current family**

## **9.5 Developmental history (infancy through adulthood)**

## **9.6 Adult life history (including social and sexual history)**

## **B. DIAGNOSTIC INFORMATION**

### **11. Axis I DSM-III-R or DSM-IV diagnosis**

Consideration of one or more DSM-III-R or DSM-IV- Axis I current diagnoses. If a person addresses or considers diagnosis in a general way code as 13. Subject need not mention a specific DSM diagnosis. Sometimes it is difficult to distinguish a diagnosis from symptoms. If an IU refers to a “feeling” it is probably a symptom. If IU refers to the patient having anxiety or depression, it is probably a diagnosis. (the task then becomes coding as 11 or 12) exception: code substance abuse diagnosis as 14)

Example 1: “I don’t think this person has a diagnosis or meets criteria for diagnosis”

Explanation: The subject has considered diagnosis, but rejected it. S/he gets credit for diagnosis being “on the radar”

Example 2: “I would say this person has a situational depression”.

Explanation: although a diagnosis is not mentioned

### **12. Axis II DSM-III-R or DSM IV diagnosis**

Consideration of one or more current DSM-III-R or DSM IV Axis II diagnoses or character problems. If the clinician uses “characterological problem”, “personality dysfunction” or “borderlinish”, assume an Axis II disorder is being considered.

### **13. Axis I & Axis II Diagnosis in same IU**

Code 13 when the subject mentions an Axis I and Axis II diagnosis in the same IU.

### **14. Alcohol/substance abuse or dependency**

Consideration of possible current alcohol and/or substance abuse or dependency that is inferred as contributory to present difficulties or given as a diagnosis. Code as 3 or 9.3 when past history is concerned.

## **C. FORMULATION / INFERRED INFORMATION**

Code for the presence of each factor in the overall formulation. This section is used to code formulation statements offered as explanatory. The statement must contain new information, that is information not included in the vignette

### **15. Problems in global psychological, social, or occupational functioning**

Subject considers the individual's overall level of functioning. S/he can refer to global functioning in terms of longevity (chronicity versus acuteness) and/or severity (severely disabling versus mildly disabling). Includes only psychological, social, or occupational (or school) functioning. Any reference to DSM Axis V is coded here. A GAF scale score need not be given. Do not code 15 if a more specific (i.e non global) code better fits the IU. Code global strengths under 22.

Example 1: "This patient can obviously persevere as she earned a PhD."

Explanation: Code as 22.1 because subject mentions a strength, not a problem.

### **16. Symptom/problem identification inferred from the vignette**

This code is for formulations statements about symptoms and problems that go beyond the information provided in the vignette. Use this code when 17-23 do not seem appropriate.

### **17. Predisposing experiences, events, traumas, stressors inferred as explanatory**

These include events or experiences in the person's life history that have contributed to his or her vulnerability towards developing problems of symptoms. If the time reference is not clear in the formulation, code under the most appropriate general category.

### **17.1 Childhood and/ or adolescence (0-18 years)**

Antecedent experiences, stressors, life events, and traumas that occurred during infancy, childhood or adolescence (ages 1-18years). Code as 17.1 if it is unclear whether the clinician is referring to infancy, childhood or adolescence.

### **17.2 Adulthood**

Antecedent factors, stressors, life events and traumas that occurred in adulthood. If these stressors are identified as factors precipitating current symptoms code as 18.

## **18. Precipitating or current stressors and/or events**

Stressors, life events, traumas that the clinician links to the individual's current symptoms or problems. (These include stressors that have precipitated the onset of symptomatology or exacerbated existing problems/symptoms).

This is a high priority coding. Whenever a subject explicitly mentions something as a precipitant to the current symptoms or problems, even if another code also applies, code as 18.

### **Inferred mechanisms: Psychological**

This is the clinician's conceptualization of the mechanisms or processes that are inferred to be causing, contributing to, or maintaining the individual's symptoms and /or problems. This mechanism may be presented from many perspectives including: maladaptive/dysfunctional thoughts or beliefs, unresolved conflicts, view of self and others, fixation in psycho social stages, factors reinforcing



problematic behaviour, and biological vulnerabilities. [If the IU contains multiple subcodings of 19 [i.e. 19.1 + 19.2 + 19.5, then code 19

### **19.1 Problematic aspects/traits of the self**

This category involves both relatively stable, maladaptive characteristics of the self as well as the person's ability to maintain a coherent, stable, and positive self evaluation. It includes an individuals' capacity for responsibility, maintaining a cohesive self- identity, stable self-esteem, and self-competence. Appropriate formulation statements might include maladaptive/ dysfunctional and/or beliefs about the self, a core conflict, problematic behaviours, or incongruence between the real and the ideal self. Are ideals, goals, ambitions congruent with abilities? Is the individual overly susceptible to extreme fluctuations or inflation, or deflation of self-esteem? How vulnerable is the person to precipitous drops in self-esteem? Note: These problematic aspects are only about the self and do not explicitly include others. Problematic aspects that include others should be coded under "Problematic aspects of relatedness to others"

### **19.2 Problematic aspects of relatedness to others**

Consideration of the individual's capacity to accurately perceive, relate to, and understand others. Code this category when there is a reference to problems in the individual's capacity for intimacy, empathy, ability to maintain separateness between self and others (i.e maintain appropriate interpersonal and role boundaries). Distorted perceptions of others (e.g., idealized or devalued) are coded here as well as the capacity for basis trust. Appropriate statements may be presented as maladaptive/dysfunctional thoughts and/or beliefs about others, distorted perceptions of others (e.g. "all good" versus "all bad", or as "victimizers" versus "potential victims"), or as problematic behaviours involving others. These

are aspects about the person's concept of others that are maladaptive or contributing to the person's difficulties.

Note: These problematic aspects are only about relatedness to others. Problematic aspects about the self, that do not include others, should be coded under "Problematic aspects of the self".

### **19.3 Dysfunctional thoughts and/or beliefs (not specifically self or others)**

Unconditional and conditional (if then statements) beliefs that are presented as part of the underlying mechanism causing the person's problems, but not explicitly referring to the concept of self or others.

### **19.4 Affect regulation or Disregulation**

Consideration of how the individual manages emotions or of a mechanism used to control, avoid, or otherwise manage affect. (Note: if a readily recognized defense mechanism is used code, code as 19.5)

### **19.5 Defense mechanisms or coping style**

Consideration of defense or coping mechanism habitually used by the individual. These must be identified as such or readily recognized as common mechanisms of defense or coping. The reference must be explicit and clear, e.g. a subject mentions the words "defense" or "copes by" or uses a specific defense mechanism (the use of these words is not required however)

Example 1: "I think that superficial cut on her arm may have been a strategic aspect, but it's a lot more than a cry for help".

Example 2: "Cutting herself is a strategy for handling stress across life, and I'd be really worried about her".

Explanation: These IU's do not contain the expression "coping style" but do seem to suggest that the patient cut herself as a strategy for coping with stress.

Example 3: "She seems to be a person who is more intellectual and perhaps has a problem getting in touch with her feelings, expressing her feelings and rather will intellectualise about her problems".

Explanation: Intellectualisation is a common defense mechanism.

### **19.6 Skill, social learning, or behavioural deficit**

Skill, social learning, or behavioural deficit identified as contributing to the individual's current problems or difficulties. A skill or social learning deficit is a social ability the individual is inferred as never having learned adequately. These are skills that the individual may be able to learn, but has not yet acquired. A behavioural deficit refers to applying a social skill that has been learned. Score 19.6 if a person explicitly frames an interpersonal problem (which ordinarily would be coded 19.2) in terms of learning theory, learning deficit etc.

### **20. Inferred underlying mechanisms: Biological**

Consideration of genetic or acquired biological influences contributing to the individual's problems.

### **21. Inferred underlying mechanisms: Social or cultural factors**

#### **21.1 Absence of or poor psychosocial support**

A lack of psychosocial support that contributes to or exacerbated the individual's difficulties. These include a lack of support from spouse or immediate family members and few or no close friends or confidants.

### **21.2 Demographic/cultural factors (e.g., SES, gender) as a source of problems**

Cultural or demographic factors that contribute to the individual's functioning include SES, gender, unusually strict religious or moral views, a member of an "outgroup" when inferred as problematic.

### **21.3 Role conflict: role strain, role transition, role dispute**

These are problems in which the individual's social roles are emphasized more than his/her internal psychological organization. They include

Conflict with others or within the self about the social roles the individual plays or should play, e.g. employee versus spouse, or as one type of spouse versus another type of spouse.

Developmental changes e.g. adolescent to adult, status as single to status as married, status as married to status as divorced, non parent to parent. These may be framed as identity problems, which would be coded 19.1 unless the coder infers a social role context as primary. Role transitions encompass major life events such as graduation, marriage, retirement, moving, changing jobs, being diagnosed with a severe illness, divorce etc.

Always consider 21.3 when the formulator emphasized conflicts related to socially prescribed roles.

*Code as 17 if the explanatory focus is more on past events, traumas, or experiences that are specific to the individual or as 19. x if the focus is on an intrapsychic or interpersonal pattern or organization.*

## **22. Positive treatment indicators**

### **22.1 Strengths/adaptive skills, aspects, or traits of self**

Features of the individual that are identified as strengths or adaptive skills that are currently helping or are expected to help the individual's overall level of functioning. Include aspects of the individual's self-concept that are adaptive or beneficial in the person's functioning are presented.

### **22.2 Adaptive perceptions of others**

Aspects of the person's concept of others that are adaptive or beneficial in the person's functioning are presented.

### **22.3 Positive motivation for treatment**

Clinician considers individual's positive motivation towards treatment.

### **22.4 Adaptive wishes, or hopes or goals**

Goals wishes, or hopes attributed to the individual, not the therapist, that appear to be helpful or beneficial in nature.

### **22.5 Good psychosocial support**

Qualities of the individual's social support network that are seen as strengths by the interviewer, such as close friends or confidants, a supportive spouse, supportive siblings of family members.

## **23. Identification of potential therapy-interfering events**

Items identified as obstacles or possible obstacles to successful treatment outcome.  
Include references to the risk of premature drop out.

## **D. TREATMENT PLANNING**

### **29. Type of treatment recommended**

- 29.1 Individual (no specific type stated)
- 29.2 Individual cognitive behavior therapy
- 29.3 Individual psychodynamic or interpersonal therapy
- 29.4 Group therapy
- 29.5 Couples, marital and/or family therapy
- 29.6 Inpatient psychiatric hospitalization
- 29.7 Refer elsewhere for psychotherapy
- 29.8 No psychotherapy recommended

### **30. Evaluation Assessment (Pre-therapy, extra-therapy, or concurrent with therapy)**

- 30.1 Referral for physical/ general medical evaluation (not psychiatric medication evaluation)
- 30.2 Referral for psychometric testing
- 30.3 Further develop the case conceptualization
- 30.4 Ongoing use of scales to monitor symptoms, problems, progress

### **31. Specific structured techniques**

- 31.1 Relaxation exercises
- 31.2 Exposure: in vivo or in session
- 31.3 Assign homework
- 31.4 Role playing
- 31.5 Provide explicit psychoeducation
- 31.6 Provide explicit biopsychosocial education

## **FOCUS ON/ EXPLORE/ ATTEND TO**

**32. Possible current red flag issues (include danger to self or other; suspect physical/sexual abuse or neglect; suspect organic problems; suspect drug and alcohol abuse; confidentiality or privilege issues; ethic or legal issues)**

**33. Treatment contract/expectations (e.g. length of treatment, frequency of meetings, prognosis, goals)**

**34. Therapist-patient relationship (e.g. rapport, transference, therapist-patient gender match)**

If the clinician addresses treatment and mentions “transference” code as 34 unless you have good evidence otherwise.

**35. Signs and symptoms**

**36. Predisposing experiences, events, traumas ( code 36 if referent is unclear)**

36.1 Childhood and/or adolescence

36.2 Adulthood

36.3 Precipitating or current stressor

36.4 Past therapy relationships

36.5 Family psychiatric history

**37. Psychological Mechanisms**

37.1 Problematic aspects / traits of self

37.2 Problematic aspects of relatedness to others

37.3 Dysfunctional thoughts , schemas, automatic thoughts, or core beliefs (not self and other)



- 37.4 Affect regulation or dysregulation; encourage expression of painful emotions
- 37.5 Defenses/ coping mechanisms
- 37.6 Skills or social learning deficit

**38. Social and/ or cultural factors (role conflicts, poor psychosocial support, demographic)**

**39. Biological factors / psychopharmacology**

**40. Strengths in global psychological, social, or occupational functioning**