

The clinical report and the design of individualized treatment. An overview of the literature on clinical case formulations.

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Introduction

In this paper we will analyse a part of the international literature, to be specific, that produced in the USA and Germany, taking into consideration the way the clinical case is dealt with both in contexts of certification of the clinical practice in the psychotherapist-patient relationship, and in those of legitimation of this practice in a broader domain which sees the intervention of subjects other than the couple engaged in therapy.

The works considered, dealing with the function of the clinical case in the domains just mentioned, talk about “formulations or conceptualizations of a clinical case”; in other words, about translating it from ordinary language into a formalized language. What is discussed is therefore the conceptualization of cases, trying to establish methods and strategies. For this reason our analysis will not touch on works that set out to present a case, but will examine those that focus on the way cases are structured.

The approaches to which the works refer are: *Functional*, *Cognitive*, *Behavioral*, *Cognitive-Behavioral* and that of *Descriptive Psychology*. In all of them, the writing up of the clinical case serves for the planning and the design of treatment and assumes a clear “diagnostic” function. Through the reporting of the clinical case, it is possible to reorganize and sum up a client’s situation on the basis of a theory, and later, to plan the treatment itself.

The decision to explore these works arises from a broader interest in *reporting*, considered as a clinical psychology tool. Underlying our viewpoint there is also the hypothesis that reporting a clinical case is related to the clinician activating the organization of the process shared with the client. Our attention however, unlike what is proposed by the Authors under study, is focused on the relationship which develops progressively during the work between clinician and client. The formulation of a case is in our opinion the outcome of a process of reflection and reorganization of what emerges from this relationship by means of clinical psychology criteria and categories².

Reading this psychological literature showed various ways of looking at reporting and different terms used to indicate the practice in which the clinician reports the process shared with the client. These ways seem to be related both to the professional function that clinicians think they are activating when working with their patients and to the goals they pursue in practice, both in the socio-political and organizational contexts within which clinicians operate.

Starting from an initial analysis we see that the terminology used connects directly to the position taken by the clinician in relating to the client, and is the first clue as to the clinician’s way of focusing on the latter. It certainly is not the report on a relationship; it would seem that the relationship is being used to acquire information about the other, and is not being explored in itself. This view of the report finds its place in a mainly psychotherapeutic field and within the services designed for the care of mental health; the professional is identified with the therapist, the client with the patient. These works provide guidelines or propose criteria on how to organize case formulations so as to have a practice that can be assessed; the interlocutors are the academic scientific community, the community of professionals and the various actors designated to the certification of the health services.

The socio-political context

In exploring the area of the professional community to whom the literature being examined is addressed, we found that there are difficulties in understanding it unless it is placed in the broader socio-political context. Reference is made to territorial contexts like the US and Germany, which in

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² On this, see Carli’s article “Notes on the report”, published in this journal, n. 2, 2007.

the last forty years have gone through radical transformations in models of organizing and financing the system handling mental health. From a single simple system they have passed to one characterized by a multiplicity of professional figures who provide services in complex and often fragmented organizations (Grob, 1991; Hadley, Schinnar, & Rothbard, 1991; Rothbard, Hadley, Schinnar, Morgan, & Whitehill, 1989; Schlesinger, 1986). In the US, from a major state role they have moved more and more towards the privatization of the services related to mental health and to a growing involvement of the community in the planning of the services. The change in the health management system has radically modified the relationships between health care providers, insurers and the consumers of health products (Petermann & Müller, 2001). The decision-making power in clinical practice has shifted from service providers to the health organizations, which have transformed the traditional, free service into a system of retroactive refunds. With the transformation of the health system into a business, access to specialists and to those who provide mental health services is regulated by GPs and nurses, who have the role of “doormen” (Petermann & Müller, 2001). In this changed context, other figures take on an important role: consumer organizations make themselves heard about the working of the system, voluntary groups and associations try to influence health policy decisions.

With the system of Managed Care Organizations there is a growing emphasis on controlling the quality of the services offered by the facilities and a parallel attention to the protection of consumer rights. Information is increasingly monitored with the aim of developing Total Quality Management (Forquer & Muse, 1996). The criteria for Quality Assurance (QA), reflecting the indications of the International Standardization Organizations (ISO, standard 9000), consisting of a series of norms and guidelines, represent a management system for quality designed to monitor business processes, directing them towards client satisfaction. In this perspective, it is always the consumer who decides whether or not the product or service responds to the expected standards. Quality certification touches three levels: the structural level, for example the mental health system; the process level, for example the treatment of a patient; the personal level, for instance the therapist as a person (Petermann & Müller, 2001).

The conceptualization and formulation of the clinical case concerns the process level, thus representing a way of certifying the quality of the treatment in the mental health field. In this sense it comes under “controlled practices”. This term refers to the definition and description of the problem, of the therapy, and of the monitoring and documentation of the process based on the therapeutic contract. The concept of controlled practice emerged in the tradition of the Scientist-Practitioner model, which holds: clinical psychologists are scientists who evaluate their work and their theories with rigor and practitioners who utilize a research-based understanding of human behavior in social contexts to aid people in resolving psychological dysfunction and enhancing their lives (Kendall, Flannery-Schroeder & Ford, 1999). Controlled practice is therefore “a compromise between scientific demands for exactness - which are deemed unrealistic in clinical practice - and the intuition of many clinicians to ‘want to help only’” (Petermann & Müller, 2001, p. 2).

The conceptualization of cases: the different approaches.

Various Authors have tried to define the conceptualization of the clinical case. Below we show some of the definitions established in the scientific area under study.

In *the behavioral approach*, the conceptualization of the clinical case: “is the link between clinical assessment data and the design of individualized treatment programs. The clinical case conceptualization is an integration of multiple judgments about the client's behavior problems and their causes” (Haynes, Leisen & Blaine, 1997, p. 335). Or: “the term clinical case formulation can be defined as the process of operationalizing target behaviors (determining the form), of evaluating relationship among target behaviors and potential controlling factors (determining the function) for an individual client” (O'Brien, Collins & Kaplar, 2003, p. 164). The accent is on behavioral problems and their causes; the formulation of the clinical case has the main aim of planning behavioral treatment. The information deemed “valid”, obtained in the assessment phase, takes on great importance.

In these definitions there is no reference to a theory on which to organize the information; there is such a reference, however, in the *cognitive* and *cognitive-behavioral approach*, where the

theoretical conceptualization guides the identification and exposition of the causal relations between events, problems and factors maintaining the problems. In this case, the emphasis is on the client's problems in general and not only on specifically behavioral problems. What the formulation aims to achieve remains, as in the approaches we summed up earlier, the design of treatment by the therapist. According to Persons and Tompkins (1997), the conceptualization of a case is characterized by two levels of analysis: one of the "case", the other of the "situation". On the first level of analysis all the client's problems are described, with their interrelations, and the mechanisms that underlie and explain them. On the second level, one particular problem situation is examined and a hypothesis that might explain it is put forward. For Eells, Kendjelic and Lucas (1998) case formulation is "a hypothesis about the causes, precipitants, and maintaining influences of a person's psychological, interpersonal, and behavioral problems. [...] A tool that can help organize complex and contradictory information about a person" (Eells *et al.*, 1998, p. 146) and support the therapist in his choice of intervention; the formulation is therefore a structure that enables the therapist to understand the client better and to predict events and behaviors that might interfere with the therapy (Stenhouse & Van Kessel, 2002). Again: "Case formulation aims to describe a person's presenting problems and use theory to make explanatory inferences about causes and maintaining factors that can inform interventions" (Kuyken *et al.*, 2005, p. 1188). The definitions put forward differ, though they have some points in common. First of all, the conceptualization of the clinical case concerns the identification of the client's problems and enables the causes and the factors influencing such problems to be identified; the formulation is of primary importance for gathering valid information in the initial stage of treatment and its aim is to plan the treatment itself. Moreover, the definitions place the conceptualization of the case exclusively within the therapeutic relationship and focus on the individual or individuals requiring treatment. Underlying the definitions analysed is the cognitive paradigm, which sees an individual's cognitive, emotional and behavioral problems from a cause-effect viewpoint and entrust the therapist the function of discovering the causes of such problems. Consistently with this approach, the psychological intervention is anchored to the relationship (not to understanding the acting out that sustains the relationship, as in other approaches) and aims at the elimination, where possible, of the causes and factors maintaining the problems.

Case formulation: the different models

According to Hans Westmeyer (2003b) of the University of Berlin, the term "case formulation" refers to the process of formulating a case, as well as to the result of this process. As a process, case formulation can be considered either from a prescriptive or normative point of view, or from an empirical one. A prescriptive or normative view deals with questions like "how to proceed when formulating a case to arrive at a case formulation (as a result) which satisfies certain criteria of adequacy, (e.g. validity, correctness, usefulness?" (De Bruyn, 1992, 2003; Westmeyer, 1975; 2003a; Westmeyer & Hageboeck, 1992 quoted in Westmeyer 2003a, p. 162).

The empirical point of view concerns questions like: "How do psychological assessors really proceed when formulating a case?", "How can the process of formulating the case be modelled", and "What are the conditions which influence case formulations?" (Westmeyer, 2003b, p. 210). Below we shall discuss the models of clinical case formulation dealt with in the approaches we have examined so far.

These models, in part, propose a prescriptive view of the criteria to follow to obtain an optimum formulation of the clinical case and, in part, adopt an empirical point of view. In some, clinical case formulation is considered a bridge between practice, theory and research, and are a milestone in the evidence-based practices of cognitive-behavioral therapy.

The Functional Analytic Clinical Case Model (FACCM)

II FACCM (Functional Analytic Clinical Case Model) was developed by Haynes and his group at the Department of Psychology at the University of Hawaii in Manoa, US. For these Authors, clinical case formulation is part of the tradition of conceptualization of behavioral analysis (Westmeyer,

2003a) and represents “an integration of multiple judgments about the client’s behavior problems and goals, causal variables, and variables that affect treatment outcome” (Haynes & Williams, 2003 p. 164).

The model was first created in the behavioral field, in the functional approach proposed by Kanfer and Saslow (1965). This approach introduces behavioral analysis, considering motivational and developmental aspects as well as environmental and social aspects concerning the description of the person and of his ways of functioning. More specifically, FACCM is based on Functional Analysis, a technique aimed at identifying, among the individual’s specific behaviors, the main functional causal relations that can be more easily monitored (Haynes & O’Brien, 2000; Haynes et al., 1993; O’Brien & Haynes, 1995). It is basically a graphic-vectorial model that enables all the major elements related to the client to be illustrated and quantified. The information reorganized through clinical case formulation can come from empirical research, as well as from tests, interviews and clinical assessments. Once the components of the clinical assessment have been quantified, FACCM allows the factors relating to the client’s behavioral problems to be identified and the size of the impact of the causal variables to be estimated. The factors are systematized and quantified using a system of coefficients and of variables calculated by the clinician, based on interrelations, predominating causality, modifiability, importance, and moderating variables. FACCM provides an evaluation of the client’s behavioral problems, of their interrelations and their various facets. It includes the variables that the clinician considers functionally connected with the behavioral problems – the estimated magnitudes, type, and direction of relationships - and the modifiability of the causal variables (Haynes, Leisen & Blaine, 1997). This formulation is a behavioral problem identification tool which should be looked at carefully so as to establish the treatment and understand the variables which most significantly affect both the problems and the outcomes of the treatment. The formulation also enables the information considered useful in treatments to be selected and the treatments best suited to the specific traits of the client to be identified (see Haynes, 1998; Haynes & O’Brien, 2000; Westmeyer, 2003a; Haynes & Williams, 2003).

The role of formulating the clinical case with FACCM is therefore to support the clinician’s decision in choice of treatment and goals. This choice will be determined by the assessment of the modifiability of the causal variables.

The clinician, for instance, will not decide to direct the treatment to historical, genetic or structural variables, but will decide to intervene on modifiable aspects. In this perspective, non-modifiable causal variables often have modifiable consequences; for instance, a childhood sexual abuse can be a causal factor in mood problems and marriage difficulties. Even though these precocious experiences cannot be modified, a clinician may be able to modify the outcomes of the experience which act as causal variables, such as guilt feelings springing from the abuse. The assessment of the modifiability of a causal variable is represented by a coefficient between 0 and 1, with 0 indicating a causal variable that cannot be modified and 1 a causal variable that is totally modifiable.

Decisions about treatment can be taken by the clinician on the basis of the overall evaluation of the assessments provided by formulating the case with FACCM. In this decision, great weight is given to assessing the importance that the behavioral problem has for the clients. This assessment is obtained by considering the seriousness of the problem (for example, occasional versus frequent, serious versus slight), its danger level for the patient (for example, head banging versus stereotyped movements in autistic children), the danger level for other people (for example, physical violence versus critical verbal behaviors), the possibility of causing anxiety for the patients themselves, or of interfering with their quality of life and their happiness. All these assessments are given a numerical value by the clinician. These scores are not important as absolute values, but insofar as they enable the importance attributed to the various problems to be compared to the estimated size of the effects.

Beck’s Case Conceptualization Diagram (CCD)

The CCD model (Case Conceptualization Diagram) first emerged in the cognitive approach. It was drawn up by A. T. Beck around the mid-1950s, and then developed by Beck’s daughter, J.S. Beck. The CCD uses the individual’s developmental history and the situations considered prototypical, of

the situation-thought-emotion-behavior type, to enable the therapist to formulate hypotheses on a nucleus of beliefs, dysfunctional assumptions and disadaptive compensatory strategies. In cognitive theory the individual's key beliefs influence the development of a class of beliefs consisting of attitudes, rules and assumptions; they influence his vision of a situation which in turn influences his thoughts, feelings and behaviors. In other words: in a specific situation, a person's implicit beliefs influence his perception, which is expressed through automatic thoughts. In turn, these thoughts affect his emotions. Going beyond this, automatic thoughts also influence behavior and often lead to a psychological response (Beck, 1997). The CCD shows how core beliefs, intermediate beliefs and automatic thoughts going on are related and helps to organize the mass of complex information about the client. To maximize its usefulness, the therapist is committed to identifying a small number of implicit beliefs and processes that can explain the patient's behavior and problems (Persons, 1989).

The CCD is made up of four quadrants in which the clinician places the information about the client:

- Important information about childhood. This information concerns the client's significant childhood events, such as parents' divorce, sexual abuse, or situations like poverty, racial discrimination etc. It may also be "less obvious" information, such as the perception of being a rejected child, or of not living up to others' expectations.
- Key beliefs, i.e. unconditioned beliefs about oneself, the world and others.
- Assumptions, beliefs and conditioned rules. These are intermediate beliefs, rules, implicit attitudes or assumptions that help the patient to deal with painful core beliefs.
- Compensatory or coping strategies, that is, strategies that help the patient deal with core beliefs.

In the conceptualization of the diagram, Beck J. (1995) suggests starting from the bottom, that is, from the situation, and proceeding upwards to identify the automatic thoughts aroused by the situation itself, seeking the key situation of these thoughts and lastly indicating the client's emotional and behavioral reactions. The meaning of the automatic thoughts triggered by different situations must be consistent with the quadrant of core beliefs. To complete the representation, the therapist indicates in the uppermost quadrant the origin and persistence of the core beliefs. According to Beck (1995) the CCD must follow the same logic both for the client and for the therapist and must be constantly updated as fresh information is collected. In this approach, the interlocutors of the conceptualization are both the therapist and the client; it is considered important, in fact, for the therapist to share the conceptualization with the client and to explore with him in a climate of great cooperation (Stenhouse & Van Kessel, 2002).

3. The Action Formulation: heuristics for the formulation of the clinical case.

The Action Formulation was created by Shahar³ and Porcerelli⁴ (2006). This is based on a theory of action which holds that individuals actively create their own environment and contribute to the construction of their own well-being, generating risk factors and protection factors. The aim of TAF is to identify such actions in the process of client assessment. To this end TAF uses several tools, including open and semi-structured interviews, interviews with significant others, so-called objective questionnaires and projective techniques.

From the pragmatic point of view four guidelines are proposed for the formulation of a clinical case:

- Outline the client's social background and the role it plays in the current situation, focusing on the resources present in his daily life, on the interpersonal difficulties and on the positive and negative events in his life. The Authors refer to what has been shown by research: there is a "positive" correlation between socio-personal factors and the origin, as well as the development, of physical and mental problems.
- Understand how individuals influence their own environment. After identifying the interpersonal circumstances triggering the client's difficult personal situation, the evaluator can try to understand the position adopted by the client in these circumstances. The focus at this point is on the

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psychopathological and personality configurations generating both personal risk factors and strong points that enable protective interpersonal factors to be constructed.

- Differentiate between disadaptive and risky interpersonal factors and those that are adaptive and potentially protective; numerous studies (Wender, 1968; Shahar, 2006) show in fact that both the former and the latter can create retroactive circuits that accentuate both the risk factors and the protective factors.

- Adopt integrative techniques to short-circuit the risky cycles and support the adaptive ones. The Authors' proposal is to integrate psychodynamic techniques and object relationships with cognitive-behavioral techniques. In this sense, the application of TAF would help clinicians in the choice of the most successful psychodynamic and cognitive-behavioral techniques.

For the Authors of TAF, in short, the writing up of the clinical case is directed both at therapists and at their patients. From this viewpoint, regarding the patients as interlocutors first of all makes it possible to help them understand how they actively, though unconsciously, create conflict and stress and how they are unable to produce positive interpersonal interactions; secondly, it puts the patients in a position to seek ways in which to strengthen their social skills, generating positive life events (Shahar & Porcerelli, 2006).

Persons and Tompkins' CB model

In the *Handbook of Psychotherapy case formulation* by Ells (1997), Persons⁵ and Tompkins⁶ claim that clinical case formulation in cognitive-behavioral therapy (CB, Cognitive-Behavioral) enables hypotheses of clinical work to be made. This approach consists of three key elements: assessment, formulation and intervention. The information obtained in the assessment is used to develop a formulation, that is, a hypothesis about the causes of the patient's disorders and problems; this hypothesis is used as the basis for the intervention. As the treatment proceeds, the therapist constantly returns to the evaluation stage, collects information to revise the process and go ahead with the therapy and uses this information to adjust, if necessary, the formulation and the intervention. The Authors start from the TAF and CCD models to then define their own method, which makes reference to the DSM IV diagnostic system. The method proposed emphasises the use of nomothetic evidence-based formulations (for instance, the general laws on the functioning of the individual) for the development of idiographic formulations (theories applicable to a specific case) (Persons & Tompkins, 1997).

The CB clinical case formulation has several qualities (Persons & Tompkins, 1997):

- it has good *treatment utility*, that is it contributes to the effectiveness of the treatment;
- it is *parsimonious*, in the sense that it provides a minimum detail necessary to accomplish the task of guiding effective treatment;
- it is *evidence-based*, in the sense that it attaches great value to information from experimental situations and from the use of objective measuring tools.

The formulation concerns different levels, from the description of the symptom to that of the problems or disorders, and lastly that of the case. The Authors refer to the manifest difficulties that the patient has both in the form of psychological/psychiatric symptoms, and as interpersonal, occupational, scholastic, medical, financial, legal or other problems. Fundamental for the formulation is the therapist's knowledge of all the problems and his understanding of the way they are interrelated. The heart of case formulation is the description of the mechanisms that are causing or favoring the patient's problems; these mechanisms can be both psychological (favored by the CB) and biological; later the more obscure causal factors are described..

The Authors indicate step-by-step the operations needed to organize the case. These are given below, but for a more detailed analysis, see their work:

- Obtain a complete list of problems.
- Formulate a diagnosis according to the five DSM axes.

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- Choose an “anchoring” diagnosis, identifying the diagnosis that accounts for the majority of problems listed.
- Select a nomothetic formulation to use as the idiographic case formulation model; if this is not possible, the Authors suggest some alternative procedures.
- Individualize the nomothetic model, collecting details on the somatic, cognitive and emotional aspects characterizing the patient’s problems.
- Make a hypothesis on the underlying mechanisms.
- Describe the episodes of the illness or of intensification of the symptoms.

The Linchpin⁷ concept

A case formulation based on the concept of “fulcrum” was thought up by Raymond Bergner⁸ (1998) and it is positioned in the conceptual framework known as Descriptive Psychology. According to the Author, clinical assessment ideally culminates in the construction of an empirically grounded case that can sum up all the key facts around a “fulcrum”. In this perspective the conceptualization of a clinical case should provide an organization of the *facts* that not only integrates all the information obtained, but also leads to the identification of the central nucleus of the problem situation on which the intervention will be made. The declared aims are always those of helping the clinician and the client in the choice of a therapeutic focus, in identifying an objective, and in carrying out the intervention. Thanks to this formulation, the clinical intervention focuses on that specific factor which when implemented has a positive effect on the client’s problems. According to the Author, recognizing the existence of fulcrum-factors does not contradict the theory that attributes multiple causes to human problems, arguing that problems cannot be put down to one single factor. The concept of “fulcrum” takes on the force of “shared path” (Bergner, 1998 p. 290); metaphorically, it represents what keeps the causes and their present consequences together. Eliminating it could therefore lead to disaster (Bergner, 1998).

For the Author the optimum clinical case formulation has three characteristics:

- *It organizes the facts around a fulcrum.*

Clinical work consists of organizing an amalgam of data provided by the client into a useable cognitive unit (Bergner, 1998); it is therefore necessary to separate what is relevant from what is not, distinguish causes from effects, identify links among the pieces of information that the client had not considered, find the fulcrum amidst the cognitive complexity, underlining the factor that organizes all the information obtained and identifying the kernel of the client’s difficulties. The identification of the organizing source of all the client’s difficulties will have the status of an empirical hypothesis the adequacy of which will be determined by how adaptable it is to all the facts of the case and by the success of the treatment.

- *It identifies the factors that can be treated by the intervention.*

The case may be constructed around a fulcrum in an essentially credible way but it may not be useful enough from the therapeutic point of view if the formulation links all the facts back to the client’s past experiences, or to general personality traits, or to mental disorders, or at any rate to general, untreatable aspects. In this case the facts and the descriptions, though important, may not be decisive for the persistence of the client’s dysfunctional state and cannot be directly traced back to the therapeutic intervention.

Clinical case formulation is the final moment of the assessment and should lead to the identification of the factors which, at the time of writing, determine the problem and are at the basis of a successful therapy; such a formulation guides the therapist in the choice of the treatment that will have the greatest likelihood of success.

- *It promotes the use of the case by the client.*

Sharing the formulation with the client allows the latter to organize an idea of his own problems. Initially the client may identify a central factor, later he may see in this factor the focal point on which to base his strategies for change. If it is well done, the clinical case formulation empowers the patient: he does not perceive his problems as something incomprehensible or uncontrollable

⁷ Literally the linchpin is the pin used to keep a wheel on its axle.

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(like his own individual history, his personality traits, his mental disorders), but as something that he is doing or thinking and that he can, in principle, stop doing or thinking.

The Author makes some suggestions on how to correctly formulate a clinical case, underlining the importance of the clinical competence involved in following a series of procedures.

The first step in writing up the case consists of carefully checking the truth of the facts. The clinician's way of proceeding should be inspired by the "model of the detective", who first determines the exact nature of the crime to solve and then uses it as a guide to establish which evidence is relevant and which is not. The clinician will thus start to construct a clear picture of the questions that are gradually brought to light, while in assessment the information to look for is determined *a priori*. Once a clear enough picture has been built up, the information obtained should be organized in an explanatory account. At this point there are two lines of action that can be followed: the first is to ignore the details and look for a broad pattern (Ossorio, 1976 in Bergner, 1998), the second is to link the facts back to well-known explanatory forms, such as the main psychological theories.

The last step consists of the therapist asking himself whether the formulation is consistent with the facts observed, exhaustive, suited to the theory that explains them, and lastly whether it prescribes interventions that have a good chance of success. If only one of these aspects were considered unsatisfactory, then the formulation should be revised; otherwise, one can go ahead and implement it through clinical interventions.

Conclusions

In the models discussed, the interlocutor of the clinical case formulation is mainly the clinician himself, who from his report can take a guide for his own practice and for the decisions to be taken. Often among the interlocutors one also sees the client, in the belief that he may be helped by the interpretation of his case, and can focus his resources on the points that the clinician deems crucial. The case is a tool for the analysis of the individual's problems and the prediction/quantification of the effects of the possible treatments. It does not serve for the explanation of a story or a theory, or of a treatment technique. In fitting with the definitions, in the models discussed the clinical case is centred on the "there and then" of the client's personal story, from the environment he comes from and on the relationships he has had in his life. There is no reference to the clinical relationship in which the information is collected, nor does it contain information on the "here and now" of the psychologist-client relationship, apart from the degree to which what happens in the therapeutic relationship is starting to be part of the client's own story. This means that episodes can be reported that take place inside the therapeutic setting, if the therapist believes they are indicative of behavior patterns in the client.

If we keep in mind the organization of the health system we were talking about at the outset, it can be hypothesized that among the interlocutors of the conceptualization of a clinical case, besides those already mentioned, there are interlocutors that are *external* to the therapeutic relationship, with the role of controlling, monitoring and protecting, to whom one must "be accountable" for the practice activated. These are the quality certification bodies, the insurance companies that have to decide whether or not to refund the treatment, and "consumers" who assess the service provided. In this perspective, the conceptualization of the clinical case assumes a function of documentation and justification of the practice put in place by clinicians; this means that it acquires meaning within other relationships rather than in the relationship between clinician and client. The Authors' aim is to put forward ways of "standardizing" the clinical case and making its structure uniform, and at the same time of treating as far as possible the specificity of each single client, going beyond the limits of standardized treatments. This is achieved via the operationalization of an individual situation by means of theories, or with a judicious summing up, an operation often indicated as the individualized formulation of a clinical case.

Referring to standardization and quantification/prediction of the effects of the treatment, according to the Authors, enables the professional's discretionality and margins of error to be reduced. To underline the importance of this aspect, some Authors refer to cases where the client finds himself in high-risk situations for his own life (suicide attempts) or for his personal safety (self-destructive

acts). As one can see, this is an aspect that seems to highlight yet again the function of legitimizing the specific psychological practice adopted when there is the risk of attack.

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