



**The University
of Queensland**

- THE CLINICAL PROCESS**
- DIAGNOSTIC REASONING**
- THE DIAGNOSTIC FORMULATION**
- GOAL-DIRECTED TREATMENT PLANNING**

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THE CLINICAL PROCESS

1. Referral



THE CLINICAL PROCESS

1. Referral



2. Intake



THE CLINICAL PROCESS

1. Referral



2. Intake



3. Diagnostic Encounter



THE CLINICAL PROCESS

1. Referral



2. Intake



3. Diagnostic Encounter



4. Diagnostic Formulation



THE CLINICAL PROCESS

1. Referral



2. Intake



3. Diagnostic Encounter



4. Diagnostic Formulation



5. Treatment Plan



THE CLINICAL PROCESS

1. Referral



2. Intake



3. Diagnostic Encounter



4. Diagnostic Formulation



5. Treatment Plan



6. Negotiation



THE CLINICAL PROCESS



THE CLINICAL PROCESS



THE CLINICAL PROCESS

1. Referral
↓
2. Intake
↓
3. Diagnostic Encounter
↓
4. Diagnostic Formulation
↓
5. Treatment Plan
↓
6. Negotiation
↓
7. Implementation
↓
8. Termination

THE CLINICAL PROCESS

1. Referral
- ↓
2. Intake
- ↓
3. Diagnostic Encounter
- ↓
4. Diagnostic Formulation
- ↓

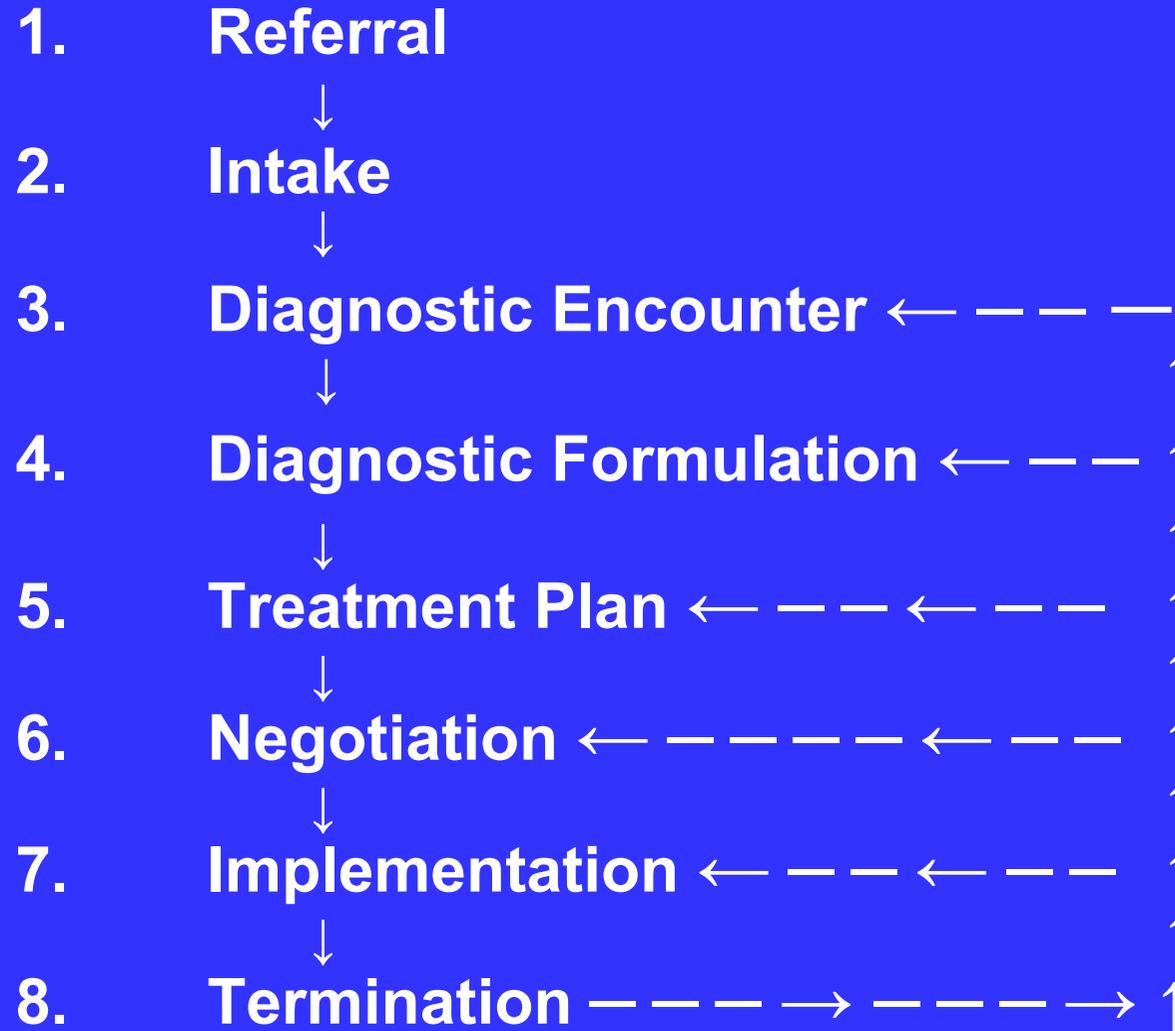
**DIAGNOSTIC
PHASE**

-
5. Treatment Plan
 - ↓
 6. Negotiation
 - ↓
 7. Implementation
 - ↓
 8. Termination

**TREATMENT
PHASE**

THE CLINICAL PROCESS

Feedback



THIS LECTURE

1. Referral



2. Intake



3. Diagnostic Encounter



4. Diagnostic Formulation



5. Treatment Plan



6. Negotiation



7. Implementation



8. Termination

DIAGNOSTIC REASONING

Tactics

1. *Recognize salient cues*
2. *Derive inferences from cues*
3. *Assemble patterns of cues and inferences*
4. *Generate an array of alternative hypotheses*
5. *Design an inquiry plan*
6. *Elicit secondary evidence*
7. *Revise hypotheses in accordance with the evidence*
8. *Weigh the evidence*
9. *Reach a conclusion*

DIAGNOSTIC REASONING

Strategy

- 1. Tolerate uncertainty, consider alternatives, avoid premature closure***
- 2. Give preference to negative evidence and adequate weight to late evidence***
- 3. Be prepared to revise inferences, hypotheses, formulations and plans if the secondary evidence fails to support them***
- 4. Separate observation from inference***

DIAGNOSTIC REASONING

Strategy

(Continued)

- 5. Don't go on interminably. Reach a conclusion but keep your mind open for fresh evidence***
- 6. Be aware of your personal reactions to the patient / family. Avoid stereotyping.***

SOURCES OF EVIDENCE

- **Information from referring agent**
- **History**
- **Mental status examination**
- **(Physical examination)**
- **Information from collateral sources**
 - **Teacher**
 - **Relatives**
 - **Medical / educational / mental health documents or clinicians**

SOURCES OF EVIDENCE

(Continued)

- **Special investigations**
 - **Consultations**
 - **Psychological testing**
 - **EEG, Neuroimaging**
 - **Laboratory testing**

INTEGRATING THE DATA AS A DIAGNOSTIC FORMULATION : THE DIAGNOSTIC MATRIX

	Predis position	Precip itation	Pattern	Perpet uation	Potential
Physical					
Psychological					
Familial / Social					

QUESTIONS

- 1. What Physical / Psychosocial factors predisposed the individual to becoming sick?**
- 2. What Physical / Psychosocial factor(s) precipitated the illness?**
- 3. Why are they coming to see me now?**
- 4. What does the current (biopsychosocial) pattern mean?**
- 5. What (physical / psychosocial factor) perpetuates the pattern?**

QUESTIONS

(Continued)

6. What potentials does the person have?
7. What is the prognosis with / without treatment?

TREATMENT PLANNING

1. *Treatment-oriented planning*

- natural
- efficient
- but no mechanism to determine if treatment is on track
- danger of therapeutic drift

TREATMENT PLANNING

(Continued)

2. *Problem-oriented planning*

- **all problems listed**
- **all problems have a plan**
- **but danger of unintegrated laundry lists**

GOAL-DIRECTED TREATMENT PLANNING

- 1. Identify pivotal problems / potentials from the diagnostic formulation**
- 2. Rewrite the problems / potentials as goals**
- 3. For each goal estimate time to reach goal**
- 4. For each goal identify at least two objectives**

GOAL-DIRECTED TREATMENT PLANNING

(Continued)

5. For each goal decide which treatment(s) will be delivered, in accordance with:
 - evidence-base
 - resources
 - sociocultural appropriateness

6. For each goal / objective identify a monitor to determine:
 - if treatment is progressing
 - if the goal has been attained

GOAL-DIRECTED PLANNING



GOAL-DIRECTED PLANNING

Disadvantages

- **Not the “natural” way**
- **Has to be learned**
- **Not easy to write goals / objectives for psychodynamic or social / familial problems**
- **The extraction of pivotal problems is an art**

GOAL-DIRECTED PLANNING

Advantages

- **Once acquired, very flexible**
- **Provides a common intellectual scaffold for team planning**
- **Facilitates quality improvement, treatment outcome monitoring, and services research**

EXAMPLE : INPATIENT

- Pivotal Problems:***
- Depressive Mood / Suicidal Ideation
 - Unresolved grief re estrangement from father

- Goals:***
- Alleviate depression / suicidal ideation
 - Resolve grief re estrangement from father

EXAMPLE : INPATIENT

(Continued)

Objectives:

- No depressive mood or suicidal ideation on mental status examination for 7 successive days
- Nursing staff report patient is making friends and involved with peer group
- Patient is collaborating with parents in making plans for post-discharge

EXAMPLE : INPATIENT

(Continued)

Time:

- Three weeks (inpatient)
- Three months (outpatient)

Treatments:

- Antidepressant medication
- Psychodynamic psychotherapy
- Family therapy

EXAMPLE : INPATIENT

(Continued)

Evaluation:

- Daily mental status examinations
- Daily nursing observation
- Content of psychotherapy sessions and family therapy

DIAGNOSTIC REASONING : PATHOLOGIES

- **Failure to elicit or recognize salient cues (experience)**
- **Unwarranted inferences**
- **Deficient pattern**
- **Inaccurate diagnostic hypotheses**
- **Failure to generate alternative hypotheses**
- **Excessive emphasis on DSM-IV-style categorical diagnosis**
- **Inadequate inquiry plan**
- **Preference for confirmatory evidence**

DIAGNOSTIC REASONING : PATHOLOGIES

(Continued)

- **“Cookie-cutter”** :., standard inquiry plan not directed by diagnostic hypotheses
- **Failure to test all hypotheses consistently**
- **Inability to reach a conclusion (“no stone unturned”)**
- **Failure to identify strengths and potentials**

GOAL-DIRECTED TREATMENT PLANNING : PATHOLOGIES

“Old-Style Behaviour Therapist”

- Inability to generate abstract goals that capture the gist of the problem

“Dreamer”

- Inability to pin down abstract goals with behavioural objectives

“Just fill out the form”

- Empty goals e.g., *“Improve self esteem”*

GOAL-DIRECTED TREATMENT PLANNING : PATHOLOGIES *(Continued)*

“Make it easy”

- Avoidance of psychodynamic or family system goals in preference for purely behavioural goals

“Confused”

- Inclusion of diagnostic goals in the treatment plan (e.g., “Obtain EEG”)

GOAL-DIRECTED TREATMENT PLANNING : PATHOLOGIES *(Continued)*

“Just Paperwork”

- Failure to use goal-direction operationally (i.e., perfunctory goal-directed planning)

“Democracy”

- Expecting the family to set the goals

“How long does it take to learn the piano?”

- Unwillingness to estimate the time required to reach goals

GOAL-DIRECTED TREATMENT PLANNING : PATHOLOGIES *(Continued)*

“One size fits all”

- Failure to select therapy or therapies based on goals, evidence, resources, and appropriateness

“Drift”

- Failure to select an effective monitoring system or to monitor progress on a regular basis

GOAL-DIRECTED TREATMENT PLANNING : PATHOLOGIES *(Continued)*

“Mystification”

- Failure to negotiate diagnosis / plan effectively with family, assuring their understanding, consent, and collaboration

“Impracticality”

- Failure to set practicable goals / objectives given the potentials of the child / family, the effectiveness of the therapy chosen, the capability of the clinician / team, or the time available

GOAL-DIRECTED TREATMENT PLANNING : PATHOLOGIES *(Continued)*

“Deficit Reasoning”

- Failure to harness strengths and potentials to compensate for problems