Division of Clinical Psychology

The British Psychological Society

Good Practice Guidelines on the use of psychological formulation

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Contents

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Foreword

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Acknowledgements

1. Executive summary

- Formulation is a core skill for clinical psychologists at all levels and in all specialties. These guidelines outline best practice for the profession of clinical psychology.
- This document defines psychological formulation as a hypothesis about a person's difficulties, which links theory with practice and guides the intervention.
- Psychological formulation can serve a large number of purposes for individuals, teams and organisations.
- Formulation can be understood as both an event and a process, and it summarises and integrates a broad range of biopsychosocial causal factors. It is based on personal meaning and constructed collaboratively with service users and teams.
- The document recognises the value of all types of formulation, while recommending that clinical psychologists always formulate from a broad-based, integrated and multi-model perspective which locates personal meaning within its wider systemic, organisational and societal contexts.
- Current research findings are reviewed, along with ethical considerations relating to the use of formulation.
- Recommendations are made for future developments in theory, practice and research.
- Principles for best practice formulation and formulating are summarised in a checklist.

2. Introduction

The guidelines have been developed for the Division of Clinical Psychology for the purpose of promoting best practice in psychological formulation, which is a core competence for clinical psychologists. The guidance is intended to be of benefit to clinical psychologists and clinical psychology training courses. Briefer versions suitable for other stakeholders (e.g. commissioners, service users and carers) are currently being developed.

3. Structure of the document

There is no universally agreed definition of formulation, and it is understood and used in varying ways by different professional groups. For this reason, a relatively large proportion of the document is devoted to outlining definitions, purposes and general principles of formulation in relation to clinical psychology. These sections may or may not be directly applicable to other professions (psychiatrists, nurses, etc.).

Formulation raises some areas of debate for the profession of clinical psychology, such as the use of integrative as opposed to single-model formulations, the use of psychiatric diagnosis alongside psychological formulation, and the role of formulation within its wider organisational and societal contexts. While these guidelines are not prescriptive about individual practice in any of these complex areas, they do attempt to establish some broad principles for best practice psychological formulations in order to inform the debate.

Current evidence on the theory and practice of formulation, which is an under-researched area, is summarised. Ethical considerations relating to formulating are also discussed.

The document concludes with a summary and recommendations for further development and research. Appendix 1 consists of a checklist of good practice for clinical psychologists in formulation and formulating.

4.   Brief historical context of formulation

In a broad sense, constructing meaning out of mental distress has a very long history. For example, Freud wrote:

I was trained to employ local diagnoses…and it still strikes me myself as strange that the case histories I write should read like short stories and that, as one might say, they lack the serious imprint of science… Case histories of this kind…have, however, one advantage…namely an intimate connection between the story of the patient's sufferings and the symptoms of his illness. (Freud & Breuer, 1895/1974, p.231)

The roots of formulation as a core skill of the profession of clinical psychology can be traced back to the 1950s and the emergence of the scientist-practitioner model. In this, clinical psychologists are seen as applied scientists, drawing on the science of psychology in order to generate hypotheses about individual clients (Kennedy & Llewelyn, 2001). The presenting problems became a puzzle to solve which engaged the clients in the process. Influential clinicians such as Hans Eysenck, Victor Meyer, Monte Shapiro and Ira Turkat used the principles of classical and operant learning theory to develop individualised alternatives to psychiatric diagnosis. These summaries later came to include thought processes, in line with the emergence of cognitive-behavioural therapy (see Bruch & Bond, 1998; Crellin, 1998; Corrie & Lane, 2010, for a more detailed history).

The term 'formulation' was first included in clinical psychology regulations in 1969 (Crellin, 1998), and it is now one of the core competencies of the profession, along with assessment, intervention, evaluation, audit and research, personal and professional skills, communication and teaching skills, service delivery skills and transferable skills (Division of Clinical Psychology, 2010). Formulation is also practised by health, educational, forensic, counselling, and sports and exercise psychologists, as described in the Health Professions Council regulations (Health Professions Council, 2009). It features in the curriculum for psychiatrists' training in the UK (Royal College of Psychiatrists, 2010), although, as discussed below, there are some differences of emphasis in psychiatric as compared to psychological formulation.

5. Formulation in clinical psychology professional documents

Formulation as a core competency within clinical psychology is referenced in a number of professional documents which define clinical psychologists' standards, activities and skills. Examples are listed below (see Appendix 1 for details).

Management Advisory Service (MAS) (1989). *Review of clinical psychology services.* London: Department of Health.

Health Professions Council (HPC) (2009). *Standards of proficiency: Practitioner psychologists.* London: Health Professions Council.

British Psychology Society (BPS) (2010). *Accreditation through partnership criteria: Guidance for clinical psychology programmes.* Leicester: British Psychological Society.

Division of Clinical Psychology (2010). *Clinical Psychology: The core purpose and philosophy of the profession.* Leicester: British Psychological Society.

Skinner, P. & Toogood, R. (Eds.) (2010). *Clinical psychology leadership development framework.* Leicester: British Psychological Society.

The recommendations from these documents can be summarised as follows:
- Psychological formulation is a core competency for clinical psychologists at all levels, starting with training, and in all aspects of their work.
- Clinical psychologists' formulations should draw on and integrate a wide range of interpersonal, biological, social and cultural factors.
- Clinical psychologists should be using, sharing, promoting and offering training in formulation and formulating within multi-disciplinary teams and organisations as well as with individual service users and their families and carers.

6. Defining formulation

Despite the widespread use of the term in key clinical psychology documents, there is no universally agreed definition of formulation, and different professions bring their own characteristic perspectives to the subject (see Corrie & Lane, 2010, pp.10–12; and Johnstone & Dallos, 2006, ch.1). For the purposes of these guidelines, definitions will be drawn from the field of clinical psychology.

A recent clinical psychology textbook (Johnstone & Dallos, 2006) lists the essential features of formulations across different therapeutic modalities. All formulations:

● summarise the service user's core problems;

● suggest how the service user's difficulties may relate to one another, by drawing on psychological theories and principles;

● aim to explain, on the basis of psychological theory, the development and maintenance of the service user's difficulties, at this time and in these situations;

● indicate a plan of intervention which is based in the psychological processes and principles already identified;

● are open to revision and re-formulation.

(NB: The term 'service user' in this document may include family/carers, especially in Child and Adolescent and Learning Disability settings where systemic formulations are commonly used.)

Clinical psychologist Gillian Butler (1998, p.2) puts this succinctly:
A formulation is the tool used by clinicians to relate theory to practice… It is the lynchpin that holds theory and practice together… Formulations can best be understood as hypotheses to be tested.

The Core Purpose and Philosophy of the Profession (DCP, 2010, pp.5-6) states:
Psychological formulation is the summation and integration of the knowledge that is acquired by this assessment process that may involve psychological, biological and systemic factors and procedures. The formulation will draw on psychological theory and research to provide a framework for describing a client's problem or needs, how it developed and is being maintained. Because of their particular training in the relationship of theory to practice, clinical psychologists will be able to draw on a number of models (bio-psycho-social) to meet needs or support decision making and so a formulation may comprise a number of provisional hypotheses. This provides the foundation from which actions may derive… Psychological intervention, if considered appropriate, is based upon the formulation.

Both Health Professions Council criteria and British Psychological Society criteria for training courses state that clinical psychologists should: *Be able to use professional and research skills in work with clients based on a scientist-practitioner and reflective-practitioner model that incorporates a cycle of assessment, formulation, intervention and evaluation (HPC, 2009; BPS, 2010).*

The influence of our core professional identity as scientist-practitioners can be seen in the emphasis, in these definitions, on applying psychological principles and theory in order to develop hypotheses about service users' difficulties. The assumption is that this process will render even the most unusual or disturbing behaviour and experiences understandable: '…at some level it all makes sense' (Butler, 1998, p.2).

As the definitions indicate, clinical psychology also draws on the tradition of reflective practice (Schon, 1987). Reflective practice is a loose term, but implies that the subject matter of our discipline, human beings and human distress, is not best served by the narrow 'technical-rational' application of research to practice. Rather, it requires a kind of artistry that also involves intuition, flexibility and critical evaluation of one's experience. In other words, formulation is 'a balanced synthesis of the intuitive and rational cognitive systems' (Kuyken, 2006, p.30).

This approach allows for the view of formulation as a shared narrative, or a story that is 'constructed rather than discovered' (Harper & Spellman, 2006). These unique individual stories are centrally concerned with the *personal meaning* to the service user of the events and experiences of their lives, and it is the personal meaning that is the integrating factor in the narrative. A formulation is not an expert pronouncement, like a medical diagnosis, but a 'plausible account' (Butler, 1998, p.1), and as such best assessed in terms of usefulness than 'truth' (Butler, 1998; Johnstone, 2006).

The task of the clinical psychologist is to use their clinical skills to combine these two aspects, psychological theory/principles/evidence on the one hand, and personal thoughts, feelings and meanings on the other, through 'a process of ongoing collaborative sense-making' (Harper & Moss, 2003, p.8) in order to develop a shared account that indicates the most helpful way forward.

It should be acknowledged that all human beings are meaning-makers who create narratives about their lives and difficulties. Formulations differ from this kind of explanation by being strongly rooted in psychological theory and evidence. Given the widespread dissemination of psychological ideas in the media, self-help books and so on, this is a relative rather than an absolute distinction.

7. Purposes of a formulation

Clinical psychologists use formulation with individuals, couples, families and groups. There is also a growing trend for using formulation in multi-disciplinary teamwork, both inpatient and community-based. In this, a group of staff is supported to construct a shared formulation for and with service users known to some or all of the team members. Formulations may also be developed and shared with professionals from other agencies and services – wards, hostels, schools, day centres, care homes, courts, and so on – and with the wider organisation in which the psychologist is employed.

The quality of a formulation is dependent in large part on the quality of the assessment and the information derived from it. Clinical psychologists are expected to be competent to use a range of procedures such as psychometric tests, risk assessments and structured interviewing. Information may also be gathered from relatives and carers, other professionals, diaries, medical notes, observation, feedback from homework tasks, and so on. Quality also depends on supporting the service user (and sometimes family/carers) to convey their understanding of the difficulties as fully as possible, along with strengths and resources. High quality formulations should also be informed by the most recent evidence, as summarised in NICE guidelines, Cochrane reviews and scientific journals.

The main purpose of a formulation in any setting is:
● identifying the best way forward and informing the intervention.

Reviews and practice-based reports have suggested that formulation can serve a range of other purposes, including:
● clarifying hypotheses and questions;
● providing an overall picture or map;
● noticing gaps in the information about the service user;
● prioritising issues and problems;
● selecting and planning interventions;
● minimising decision-making biases and increasing transparency, by making choices and decisions explicit;
● framing medical interventions;
● predicting responses to interventions; predicting difficulties;
● thinking about lack of progress; troubleshooting;
● determining criteria for successful outcome;
● ensuring that a cultural understanding has been incorporated;
● helping the service user (and carer) to feel understood and contained;
● helping the therapist to feel contained;
● strengthening the therapeutic alliance;
● encouraging collaborative work with the service user (and carer);
● emphasising strengths as well as needs;
● normalising problems; reducing service user (and carer) self-blame;
● increasing the service user's sense of agency, meaning and hope.

(Based on Butler, 1998; Johnstone & Dallos, 2006; Kuyken et al., 2009; Corrie & Lane, 2010.)

Clinicians have reported additional benefits from using formulation in teamwork in order to develop a shared understanding of a service user's difficulties:
- achieving a consistent team approach to intervention;
- helping team, service user and carers to work together;
- gathering key information in one place;
- generating new ways of thinking;
- dealing with core issues (not just crisis management);
- understanding attachment styles in relation to the service as a whole;
- supporting each other with service users who are perceived as complex and challenging;
- drawing on and valuing the expertise of all team members;
- challenging unfounded 'myths' or beliefs about service users;
- reducing negative staff perceptions of service users;
- processing staff counter-transference reactions;
- helping staff to manage risk;
- minimising disagreement and blame within the team;
- increasing team understanding, empathy and reflectiveness;
- raising staff morale;
- conveying meta-messages to staff about hope for positive change.

(Based on Summers, 2006; Clarke, 2008; Lake, 2008; Kennedy, 2009; Whomsley, 2009; Berry et al., 2009; Hood, 2009; Craven-Staines et al., 2010; Wainwright & Bergin, 2010; Walton, 2011; Christofides et al., 2011.)

Formulation does not necessarily lead to intervention; it may indicate that no further input from professionals is needed. It should also be noted that developing a formulation can be a powerful intervention in itself, and may be enough on its own to enable the service user or team to move forward and make changes.

Team formulation is in keeping with the profession's wider remit to work at a team, service and organisational level. The clinical psychology leadership framework lists one of the roles of a qualified psychologist as: *Lead on psychological formulation within your team* (Skinner & Toogood, 2010). This might include supervising and training other members of the multi-disciplinary team in formulation. It has been suggested that using formulation in teamwork is a particularly effective way of achieving culture change and promoting a more psychosocial perspective in services as a whole: ('A good formulation can be a powerful systemic intervention', Kennedy et al., 2003; 'Taking formulation into a wider setting can be a powerful way of shifting cultures towards more psychosocial perspectives', Onyett, 2007). Another purpose of formulation is, therefore:
- facilitating culture change in teams and organisations.

8.   Clinical issues: When is a formulation a formulation?

The boundaries of what actually constitutes a formulation are somewhat arbitrary. There is no absolute or definite cut-off point on the dimensions listed below.

Formulation as a process and formulation as an object or event (Cole & Johnstone, in press; Ingram, 2006).
Formulations are developed through a recursive process of assessment, discussion, intervention, feedback and revision. At some point this may be summarised in writing or a diagram, although these two aspects are not completely distinct from each other.
In practice, 'formulation-as-a-process' may be the more common clinical activity. However, formulations in letters to referrers and training coursework are likely to be presented as a one-off 'formulation-as-event.' Written versions might also take the form of a letter to the service user; a section of a psychologist's letter to the referrer; a summary for the team which will be added to the medical notes; a section on a CPA form or in the electronic record; and so on.

A partial formulation and a full formulation.
There is always the possibility of re-formulation in order to include new information and insights, and in this sense all formulations are partial and dynamic; in the words of one psychologist, they are 'broad snapshot summaries of complex evolving stories' (Cole & Johnstone, in press). However, some formulations are necessarily and appropriately more comprehensive and detailed than others. For example, a coursework assignment may be several paragraphs long and focus on a complex set of difficulties in the context of a person's whole life story; this is suited to its main purpose of assessing a trainee's competence. In contrast, a qualified psychologist may find that simple diagrammatic formulations (e.g. demonstrating how automatic thoughts lead to anxiety which leads to avoidance) are often more suitable for routine clinical practice. CBT-based formulations typically develop through a sequence of descriptive summaries, cross-sectional formulations and longitudinal formulations, as more information is gathered (Kuyken et al., 2009; Persons, 2008).

Another type of partial formulation is evident in the formulation-informed thinking that, evidence suggests, is used by clinical psychologists in almost every aspect of their daily practice and seen by them and other multi-disciplinary team members as an invaluable aspect of their role (Christofides et al., 2011; Hood, 2009).
For example, a psychologist may suggest during a team discussion that a service user's behaviour can be understood in the light of their history of rejection. This kind of on-the-spot contribution to case discussions, ward rounds, CPA reviews and team meetings is not necessarily documented in writing, or defined as formulation in a formal sense.

In order to decide how full a formulation needs to be, whether or not it should be documented in writing and where its main focus should lie, a psychologist will need to consider factors such as: where the most pressing concern or 'stuck point' is; the extent to which wider systemic factors seem relevant; the stage of the therapy or intervention; the amount of information available; the likely receptiveness of the service user, family, team or service; and the usual constraints of time and resources.

While the principles outlined in this document will be broadly relevant to formulation used in a more partial, informal or evolving way, for obvious reasons it will not always be possible, necessary or appropriate to incorporate them in full. Clinical judgement must be exercised in making these decisions. However, the guidelines can still be seen as a useful reference point and checklist of good practice for all stages and versions of formulation and formulating.

9. Principles of formulation in clinical psychology

For the purposes of these guidelines, psychological formulation will mainly be used in its 'formulation-as-an-event' sense (i.e. the written or diagrammatic version which is developed with service users/teams/referrers, and appears in letters/medical notes/electronic records.) However, the written formulation necessarily evolves, and continues to evolve, out of 'formulation-as-a-process.' For this reason close attention will also be paid to the process of formulating. Thus, best practice in both formulation and formulating will be addressed. (A complete set of criteria is presented in the checklist in Appendix 1.)

The following principles of psychological formulation in clinical psychology are widely accepted:
● it is grounded in psychological theory and evidence;
● it is constructed collaboratively, using accessible language;
● it is constructed reflectively;
● it is centrally concerned with personal meaning;
● it is best understood in terms of usefulness than 'truth'.

In addition, it will be argued that best practice clinical psychology formulation and formulating has the following characteristics:
● it is person-specific not problem-specific;
● it draws from a range of models and causal factors;
● it integrates, not just lists, the various possible causal factors through an understanding of their personal meaning to the service user;
● it is not premised on functional psychiatric diagnoses such as schizophrenia or personality disorder. Rather, the experiences that may have led to a psychiatric diagnosis (e.g. low mood, hearing voices) are themselves formulated;
● it includes a cultural perspective and understanding of the service user's presentation and distress;
● it is clear about who is the service user and who are the stakeholders in any given situation;
● it starts from a critical awareness of the wider societal context of formulation, even if these factors are not explicitly included in every formulation.

(NB: 'service user' will include carers if a systemic/family formulation is employed.)

These additional principles raise some complex issues that merit discussion in more detail. The first five items are expanded in the sections below, while the last two are covered in the sections on **Formulation and the service/organisational context** and **Formulation and the wider social/societal context**.

In discussing these potentially controversial aspects, the guidelines start from the general position that all types and versions of formulation can be valuable in the appropriate circumstances and settings. Any increase in the integration of psychological theory,

principles and evidence into clinical practice is to be welcomed. Simpler, single-model formulations may be a useful starting point for training purposes: for example, on clinical psychology doctoral programmes or with members of a multi-disciplinary team. In seeking to promote culture shift in teams and organisations, it may be helpful and strategic for clinical psychologists to use 'list-of-factors' formulations, or formulations that include psychiatric diagnosis, as a first step. Additionally, it is acknowledged that it will not be relevant or necessary to include a complete range of causal factors and contexts in every psychological formulation. However, the fullest use of clinical psychologists' professional skills implies a broad-based, integrated and multi-model perspective which locates personal meaning within its wider systemic, organisational and societal contexts. Best practice should be based on a considered choice about what to include or exclude in any given formulation, in line with the principles discussed in these guidelines, and adapted as necessary to the service user's or team's particular circumstances and contexts.

Person-centred and problem-specific formulation

This refers to the difference between a standardised *formulation of a problem* as opposed to a *formulation of a particular person's problematic experiences.* As examples of the former, CBT protocols have been developed for typical cognitive processes in anxiety, depression, personality disorders, PTSD, psychosis and so on (e.g. Ehlers et al., 2004; Wells, 2004).

Problem-specific formulation has its place, especially with less complex difficulties (for example, in the Increasing Access to Psychological Therapies programme for anxiety and depression). It has strong links to the evidence base, and can serve as a starting point for a more broadly-based formulation. However, as it stands it does not fulfil all of the principles of psychological formulation as outlined in this document because it allows for only a limited range of causal and process factors. For example, it may overlook or downplay the significance of transference, cultural, service/organisational and social/societal factors. In addition, it does not allow for debate about who is the service user and who are the stakeholders; and it is based on problematic diagnostic categories. (All these aspects of psychological formulation are discussed further below.) Problem-specific formulation thus typifies Level 2 skills (MAS, 1989) rather than the Level 3 skills that are said to be the defining feature of the profession.

Multiple-model and single-model formulation

Although not all therapies use formulation (e.g. person-centred, narrative) it is a core feature of the main therapies used by NHS clinical psychologists: CBT, systemic, psychodynamic and cognitive analytic therapy. Each of these approaches draws on a particular set of concepts in their formulations (e.g. negative automatic thoughts, problem-maintaining patterns, the unconscious.) In addition, they each use particular terms for formulation which entail different theoretical assumptions (e.g. 'case conceptualisation' (Beck, 1995), 'dynamic formulation' (Malan, 1979) and 'reformulation' (Ryle, 1995). However, it has been argued that differences are not as great as commonalities, and that a shared conception of formulation, independent of theoretical orientation, is preferable (Butler, 1998; Goldfried, 1995).

In practice, the majority of clinical psychologists describe themselves as integrative/eclectic. Options for combining different approaches include the use of an 'off-the-shelf' over-arching model (e.g. cognitive analytic therapy: Ryle, 1995); or theme (e.g. the therapeutic relationship: Kahn, 1997); or set of techniques (e.g. Egan, 2006); or a personal synthesis of preferred approaches (Dallos et al., 2006).

Clinical Psychology training criteria require all training courses to teach at least two evidence-based models of psychological therapy, one of which must be CBT (BPS, 2010.) There is mixed guidance within the profession about whether psychological formulations should be based on the integration of two or more *therapeutic models*, or should more simply include a wide range of *factors*. The MAS (1989) report claimed that the former was a central defining feature of the profession ('Level 3 skills'.) The Division of Clinical Psychology (2010) definition states that psychologists will be able to draw on a number of different models as required, but does not imply that more than one model will necessarily inform any given formulation. The British Psychological Society criteria for training courses (BPS, 2010) require the incorporation of 'interpersonal, societal, cultural and biological factors' rather than models. HPC (2009) criteria include: 'Understand psychological models related to how biological, sociological and circumstantial or life-event-related factors impinge on psychological processes to affect psychological well-being' (3a.1) but make no mention of integration as such.

It should be noted that despite a number of books on the subject (Norcross & Goldfried, 2005; Palmer & Woolfe, 2000) the theoretical integration of different therapeutic models is very much a work in progress and there are currently no completely satisfactory frameworks for achieving this. It follows that the same is true for integrative formulations.

Causal factors that are sometimes neglected or downplayed in clinical psychologists' formulations are:
● transference and counter-transference (especially relevant in team formulations; Meadon & van Marle, 2008);
● the personal meaning and service user experience of medical interventions such as diagnosis, medication and admission (Martindale, 2007);
● the potentially traumatising effects of medical and psychiatric interventions (Lu et al., 2011; Johnstone, 1999);
● the influence of stigma, discrimination and the 'mental patient' role (Barham & Hayward, 1995);
● recent work on the causal role of trauma and abuse in psychosis (Larkin & Morrison, 2006; Moskowitz et al., 2008). The impact of abuse is often overlooked in clients with learning difficulty as well;
● social factors such as class, poverty, unemployment, and power relations;
● ethnic and cultural factors.

For the purposes of these guidelines, the consideration and inclusion of relevant *factors* from individual, interpersonal, biological, social and cultural domains is recommended, and it is left to individual preference as to whether this is done by drawing from more than one therapeutic *model*. In practice there may be little to distinguish the resulting

formulation, especially given the trend for all therapeutic models to absorb ideas and perspectives from each other.

It is also noted that not all formulations are based on specific therapeutic *models*, although within the definition used in this document, they should all draw on psychological *principles and evidence*. These might derive from, for example, attachment theory, or research into the impact of racism or domestic abuse, or evidence about the psychological effects of head injury, chronic pain, developmental disorders, alcohol abuse and so on. Psychological formulations will also draw upon the current evidence-base as summarised in NICE guidelines, Cochrane reviews and elsewhere.

As previously noted, part of the clinical skill in developing a formulation is deciding how inclusive it needs to be to meet the required purpose at any given time. Clearly, most formulations in day-to-day practice will not cover the whole range of possible contexts and causal factors listed above, and nor would this necessarily be the most appropriate way to use formulation in every situation. However, a narrower or single-model formulation needs to be a conscious and justifiable choice from a wider field of possible models and causal influences.

Integration-through-personal-meaning formulations and list-of-factors formulations

While the inclusion of causal factors from a number of different dimensions and models is desirable, this does not necessarily result in integration. Some well-known approaches to formulation advocate the use of templates for filling in lists of relevant factors from biological, social, interpersonal and other domains (e.g. Weerasekera, 1996). Psychologists sometimes use a similar template known as PPPP (predisposing, precipitating, perpetuating and protective.) This format is also used in psychiatric training (Royal College of Psychiatrists, 2010) in order to '…integrate information from multiple sources to formulate the case into which relevant predisposing, precipitating, perpetuating and protective factors are highlighted' (p.27).

While these kinds of templates may be a useful starting point, they have two limitations: firstly, they do not require the various factors to be synthesised into a coherent narrative, as opposed to simply being listed in an additive fashion (X happened, then Y happened, in the context of Z.) In other words, these formulations are not necessarily integrated, although they are sometimes described as such. Secondly, the templates do not necessarily include the *personal meaning of the factors and life events*, as opposed to a list of external triggers (abused by stepfather; diagnosed with cancer; bullied at school; etc.). Psychological theory suggests that the impact of difficult circumstances or events is mediated through the meaning they hold for the individual (Kinderman et al., 2008). As noted in Section 9, *personal meaning* is the integrating factor in a psychological formulation as defined in this document.

(NB: In some client groups, for example, people with a severe learning disability or older adults with advanced dementia, personal meaning may need to be inferred by the clinician and/or a Best Interest procedure.)

One of the risks of the list-of-factors approach is the conjoining of incompatible theoretical models. This is true of some versions of the widely-used diathesis-stress or biopsychosocial model, as discussed below.

Formulation and diagnosis

Medical conditions such as cancer, Down's syndrome, Alzheimer's disease, head injury and various kinds of physical disability frequently play an important causal role in presentations in Clinical Health, Learning Disability, Older Adults and Neuropsychology specialties, and to a lesser extent in Child and Adolescent and Adult Mental Health. Clinicians may also have to take account of the psychological effects of alcohol, street drugs, stroke, starvation, and so on, depending on specialty. These medical/organic/developmental factors are an essential part of a holistic biopsychosocial formulation. The clinical psychologist will aim to construct a formulation that explores the personal meaning and impact of the condition, and that also includes the service user's wider interpersonal and environmental context. This is consistent with Kinderman et al.'s (2008) model of psychological processes as a mediating factor and final common pathway in all cases of mental distress, whatever the particular combination of biological, psychological and social factors in any given situation.

The use of so-called 'functional' psychiatric diagnoses such as schizophrenia, bipolar disorder and personality disorder is more contentious (Boyle, 2002; Bentall, 2003). There is no space within these guidelines to repeat the long-standing debates about the validity of such diagnoses (but see forthcoming Division of Clinical Psychology position statement on classification). However, psychological formulation starts from the assumption that 'at some level it all makes sense' (Butler, 1998, p.2). From this perspective, mood swings, hearing voices, having unusual beliefs and so on can all be understood as psychological reactions to current and past life experiences and events, in the same way as more common difficulties such as anxiety and low mood. They can be rendered understandable in the context of an individual's particular life history and the personal meaning that he or she has constructed about it. They may also be understandable within a cultural context – for example, beliefs about supernatural possession or witchcraft.

Describing these experiences within an illness model is based on the very different assumption that the primary causal factor is biological dysfunction. This obscures the personal meaning of difficult events by framing them as 'triggers' of an underlying biological vulnerability, which lead to 'symptoms' rather than understandable responses to overwhelming life circumstances. It also reduces agency, or the service user's belief in their ability to work towards their own recovery, rather than simply waiting for medical treatment to take effect. Psychological formulation's meta-messages about personal meaning, agency and hope can act as a helpful corrective to some of the well-documented negative consequences of receiving a psychiatric diagnosis, such as increasing a service user's sense of powerlessness and worthlessness (Rogers et al., 1993; Barham & Hayward, 1995, Mehta & Farina, 1997; Honos-Webb & Leitner, 2001). A label of learning disability can also have a profound impact on a service user's sense of identity.

This does not imply that biological factors should be excluded from formulations in mental health settings. Clearly we have bodies and brains as well as minds, and there is an increasing amount of evidence about how they shape each other (e.g. the effect of trauma and attachment styles on the developing brain; Schore, 2009). This growing area of research contributes to a genuinely integrated version of a biopsychosocial model that is not based on unwarranted prioritisation of biological factors but which recognises, in the words of biologist Steven Rose, that 'every aspect of our human existence is simultaneously biological, personal, social and historical' (2001).

Psychiatric formulation and psychological formulation
A psychiatric formulation, in other words a formulation that is partially based on a psychiatric diagnosis such as schizophrenia or personality disorder, differs in several important ways from a psychological formulation. The curriculum for Specialist Core Training in Psychiatry (Royal College of Psychiatrists, 2010) requires trainee psychiatrists to 'demonstrate the ability to construct formulations of patients' problems that include appropriate differential diagnoses' (p.25). Psychiatric formulation as described in the curriculum is based on the description of 'the various biological, psychological and social factors involved in the predisposition to, the onset of and the maintenance of common psychiatric disorders' (p.27). Thus, it may take the form of 'bipolar disorder triggered by the stress of bereavement' or similar.

Psychiatric diagnoses are sometimes included in the types of formulation discussed above: problem-specific protocols, 'list-of-factor' frameworks, and some diathesis-stress and biopsychosocial formulations. However, with the exception of conditions of clearly organic origin such as dementia, it is recommended that best practice psychological formulations in mental health settings are not premised on psychiatric diagnosis. Rather, the experiences that may have led to a psychiatric diagnosis (low mood, unusual beliefs, etc.) are themselves formulated. If this is carried out successfully, the addition of a psychiatric diagnosis becomes redundant. In Bentall's words (2003, p.141): 'Once these complaints have been explained, there is no ghostly disease remaining that also requires an explanation. Complaints are all there is.'

Since some service users and carers find psychiatric diagnoses helpful, it is in keeping with the spirit of respectful and collaborative work to include this perspective. In such a case, the formulation might recognise their views by, for example, noting that 'You find the diagnosis of bipolar disorder a useful way of explaining your difficulties to family and friends.' For others, the meaning may be less positive, and this too needs to be acknowledged; for example, 'The diagnosis of personality disorder seemed to confirm your feelings of being unacceptable', and so on. What is important is that enough common ground can be agreed between psychologist and service user to provide a basis for the intervention, if one is required. The process of formulating provides an opportunity to discuss and negotiate a shared psychological perspective with the service user (and his/her family and carers if appropriate) – one that may not have been offered before. One of the advantages of psychological formulation over diagnosis is that it allows for this kind of negotiation.

Formulation and culture

Culture can be defined as a framework that guides and bounds our lives, and through which actions are filtered or checked as individuals go about daily life. These cultural frameworks are constantly evolving and being reworked (Anderson & Fenichel, 1989). It is important to remember, however, that even people sharing the same race or ethnicity can differ in their cultural backgrounds; for example their values, spiritual and religious beliefs, health beliefs and so on. It is therefore important to consider cultural issues with every service user.

Research has shown that black and minority ethnic groups are disadvantaged groups within health services in general and are less likely to be referred to psychological services (Karlsen, 2007; Keating et al., 2002). Refugee and asylum seeker populations are especially vulnerable to developing mental health problems due to the experience of famine, war, persecution and other traumatic events in their home country. Language differences may create an additional barrier to the communication of distress. There can also be cultural variance in how distress is expressed.

Western models of psychology and psychological therapy, and, therefore, the formulations that are based on them, often privilege ideas of independence and self-actualisation as indicators of good mental health, and focus on the individual as the basic unit of therapy. In contrast, non-Western cultures tend to focus more on notions of spirituality and communality and see the individual as secondary to the family (Webster, 2002). Mental health may not be seen as separate from physical, emotional and spiritual well-being, and there may be very different ideas about causation and intervention (Kanwar & Whomsley, 2011). Formulations may, therefore, need adaptation for use in a culturally appropriate way. One framework for this is the Cultural Formulation model, which has been used in relation to psychiatric diagnosis (Lewis-Fernandez & Dias, 2002) but also has wider relevance. It includes the effect of culture on the service user's difficulties in four key areas:

● cultural identity of the service user, including their language preference and degree of involvement with both the culture of origin and the host culture;
● the service user's preferred explanation of their difficulties;
● cultural factors related to both stresses and levels of support in the service user's psychosocial environment;
● cultural elements of the relationship between the individual and the clinician, and their impact on the therapeutic relationship.

The concept of formulation, especially an individual one that prioritises internal causal factors, is itself culturally-based. Much work remains to be done to develop culturally-appropriate forms of formulation, along with mental health interventions in general (Fernando, 2002).

10. Formulation and the service/organisational context

Formulation is carried out within a service/organisational context. There are stakeholders at all levels of the services, and their interests may not coincide. Formulation 'is not a neutral, impartial, non-political statement of fact based on evidence leading to the best possible intervention for the client. Rather, it is a story told to meet specific needs – an account agreed between the stakeholders to access whatever change process seems to them to be appropriate at that time' (Corrie & Lane, 2010, p.21). One of the essential tasks facing the psychologist at the start is to clarify who these people or organisations are (relatives, schools, GPs, managers, teams, and so on), whether/how to take their interests into account, and what the likely consequences will be (Kennedy, 2009). A skilled and sensitive approach may be needed to ensure that the formulation is accepted in its wider systemic context. For example, there may be resistance at various levels, and for various different reasons, to a formulation which re-frames a problem as a marital/family conflict or a trauma reaction, rather than as an illness to be diagnosed and treated. It may be even harder to locate the apparent problem at a service or organisational level rather than at an individual one.

In relation to psychiatric services in particular, it is important to remember that medical interventions such as diagnosis, medication and admission have their own psychological meanings for the individual (Johnstone, 2000; Martindale, 2007) as does the 'mental patient' role itself (Rogers et al., 1993; Barham & Hayward, 1995). These meanings may compound the difficulties that the service user initially presents with. For example, psychiatric interventions can be re-traumatising (Lu et al., 2011; Johnstone, 1999); many service users with learning difficulty have been affected by institutionalisation; and poor standards of care in Older Adult settings may exacerbate confusion and distress. Service users have attachment styles to services as well as to individual clinicians, and staff counter-transference responses sometimes replicate earlier damaging relationships (Meadon & van Marle, 2008). These possibilities must be considered, especially when formulating with inpatients and multidisciplinary teams.

Research suggests that, in keeping with the general principles of formulating, a formulation-based approach is best presented to teams and wider systems tentatively and with respect for existing views (Christofides et al., 2011); in other words offered rather than imposed. At the same time, the Leadership Framework makes it clear that it is a clinical psychologist's duty to 'advocate a psychological stance in conjunction with or instead of other health care models even in difficult circumstances, demonstrating ethics and values' (Skinner & Toogood, 2010). This can be a difficult balance to achieve.

The principle that emerges from these considerations is that clinical psychologists should at all times:
●   be clear about who the service user is and who the stakeholders are in relation to any given formulation.

11. Formulation and the wider social/societal context

Accreditation criteria for clinical psychology doctorate programmes require trainees to incorporate societal and cultural factors in their formulations (BPS, 2010). The HPC (2009) regulations state that clinical psychologists should 'understand social approaches such as those informed by community, critical and social constructivist perspectives' (3a.1.) These place formulation within a wider context of social inequalities and power relationships (Miller & McClelland, 2006), and remind us that service users are almost always survivors of immensely difficult personal and social circumstances. Interventions will be ineffective if wider causal factors are located at an individual level, thus pathologising the service user and increasing their sense of hopelessness. While it may not be possible to intervene at a more distal level, 'switching attention from supposed (and feared) personal deficiencies to injuries inflicted by a damaging environment…may nevertheless constitute a form of 'demystification', bringing with it a significant relief of distress' (Hagan & Smail, 1997a, p.266).

There is a careful balance to be struck between acknowledging the very real limitations and pressures that people face, while not diminishing their sense of hope or agency. Hagan and Smail's power-mapping (Hagan & Smail, 1997a, 1997b) and Holland's (1992) model are examples of how to integrate more distal influences into formulations, rather than simply including social factors as an 'add-on'.

The community/social inequalities/human rights perspective is often poorly integrated into practice. Recent research underlines the importance of this dimension. Wilkinson and Pickett (2009) have presented compelling evidence that a society's level of social inequality is causally related to its rates of mental illness: 'If Britain became as equal as the four most equal societies (Japan, Norway, Sweden and Finland), mental illness might be more than halved' (p.261). Particularly relevant to formulation is their suggestion that inequality has its most damaging impact at least partially through its personal meaning to the individual, in terms of feeling devalued, shamed, trapped and excluded. This underlines the importance of being aware of the wider contexts of formulations and clinical work.
In the words of a World Health Organisation report on mental health: '…levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice' (WHO, 2009, p.111).

The implication is that clinical psychologists need to:
- have a critical awareness of the wider societal context within which formulating takes place, even if this dimension is not explicitly included in every formulation.

12. The ethics of formulation

As already noted, psychological formulation gains much of its credibility and usefulness from being rooted in evidence and psychological theory. This has both benefits and risks. Research suggests that adult clients find it hard to disagree with formulations that are presented to them (Johnstone, 2006). One reason may be that:

…what is often obscured is that a psychological perspective also offers a story, albeit, at least initially, a more coherent story as it is grounded in a theoretical framework. Moreover, as the psychological story is rooted in the meta-narratives of science and professionalism, it is likely to be more powerful than the client's story. (Strawbridge in Corrie & Lane, 2010, p.xxiv)

This applies even more strongly with potentially vulnerable groups such as older adults, children and people with learning disabilities. In Learning Disabilities services, it may be important to seek the service user's consent to work with carers whom they trust. If the person does not have the capacity to give consent for this, then a best interest process may need to be considered.

Formulation has potential limitations and drawbacks. It can be influenced by decision-making biases such as the availability heuristic and the anchoring heuristic (Kuyken et al., 2009; Corrie & Lane, 2010). Reflectiveness provides some safeguard against bias by ensuring that our practice-based choices are underpinned by a systematic, psychologically-informed account of the service user's circumstances and needs which can be articulated and, therefore, challenged if necessary.

Formulation can be used in insensitive or disempowering ways (Johnstone, 2006). There is evidence that as well as finding formulations helpful, encouraging and reassuring, service users can also (sometimes at the same time) experience them as saddening, upsetting, frightening, overwhelming and worrying (Chadwick et al., 2003; Evans & Parry, 1996; Morberg Pain et al., 2008). While it is possible that the longer-term impact is beneficial overall, much more research is needed into service user and carer reactions to formulation.

Some specific issues arise in relation to team formulation. Frequently the request for a formulation is made because staff are stuck or struggling, or have strong counter-transference feelings about a service user. In team formulation the primary client is often, in effect, the team. While the team may need their reactions to be included and formulated, it will not always be helpful for the service user to be presented with these responses. The team formulation may, therefore, not be shared with the service user in its entirety. This would follow the same principles of information shared in a professionals' meeting or in supervision. However, it is good practice for a parallel formulation to be drawn up with the service user, with staff feelings and reactions only incorporated and added to the official records if appropriately phrased.

Working collaboratively with service users (and where relevant, families and carers), using everyday language, emphasising strengths as well as needs, and making good use of supervision will help to minimise formulation's potentially unhelpful aspects. Special care is needed with children and people with learning disabilities for whom the use of clear language, pictures or tapes/CDs will increase accessibility. These groups may be particularly vulnerable to being 'formulated' without their knowledge or consent.

A formulation that is not understood by, or acceptable to, the service user is not a useful formulation, and implies, at the very least, the need for further collaborative discussion in order to develop a shared perspective. Complete agreement may not be achieved, or may be the subject of negotiation throughout the intervention (see May's 2011 discussion about 'Relating to alternative realities'). However, it is essential to try and identify some common ground, and to respect the service user/team's right to differ in other areas.

Reflectiveness is seen by many clinical psychologists as an essential aspect of formulating, enhancing collaboration, sensitivity, flexibility, and awareness of one's own assumptions, and avoiding the danger of 'a diagnostic style of formulation which is just a list of problems…an inflexible and concrete bunch of ideas' (Ray, 2008).

As discussed above, awareness of the service/organisational and social/societal contexts of formulation will help to guard against meta-messages of blame and individual deficiency. It will also alert clinicians to be prepared to question assumptions about who has 'the problem.'

To avoid the risk of objectifying the service user, the phrase 'Formulation for/with X' rather than '…of X' is recommended. This makes it clear that the formulation is collaboratively constructed and at the service of the person.

13. Formulation: Areas for development

Formulation is a developing field. Three areas that need more work are research, inclusion in electronic records, and formulation-based alternatives to psychiatric diagnosis. These are discussed briefly below.

Research into formulation

Clinical psychologists, like other health professionals, are committed to practice that is based on the best evidence. Evidence-based practice can be understood in two different ways in relation to formulation. Firstly, there is the research into the theoretical content and psychological principles on which formulation is based. This is extensive, particularly in areas such as CBT, attachment theory, developmental psychology, and the therapeutic relationship. In addition, there is substantial evidence about the psychological effects of trauma, bereavement, poverty, discrimination, domestic abuse, head injury, physical disability, stroke, alcohol, illicit drugs, and so on. Secondly, there is the question of whether there is evidence to support formulation as a specific intervention. Currently, most of this evidence, that is for reliability, usefulness, effect on outcomes, positive impact on the service user/family/carers and on teams and so on, is lacking. This is despite the fact that formulation is considered to be a central component of the psychological therapies that are most commonly practised within NHS settings, and a starting point for the process of intervention.

The lack of a service user perspective is a major gap in the literature, as is an understanding of the process by which clinicians draw up formulations (although some attempts have been made to fill this gap, Corrie & Lane, 2010; Kuyken et al., 2009). Further research is needed in order to develop formulations in a way that is respectful of service users' and carers' experiences, and that maximises benefits while minimising potential negative effects. We also need to know much more about whether and how formulation enhances interventions and care packages, facilitates recovery, improves outcomes, and fulfils the many other purposes claimed for it. Margison et al. (2000) have recommended that evidence for the effectiveness of psychological therapy, including formulation, should come from practice-based evidence as well as evidence-based practice. (See Appendix 2 for a fuller summary of existing research on formulation.)

Formulation and electronic records.

Many NHS Trusts now use electronic information systems for mental health services, and the aim is for this to become universal. Every patient will have an electronic clinical record (ECR) containing clinical information and demographic, care and outcome data. The aim is for the ECR to contain all the information necessary to support the business, policy, and research requirements for NHS organisations in England (Department of Health, 2010).

Some Adult Mental Health electronic systems, for example, Rio, do include a space for formulation. However, initial research has found that without specific training, most CMHT staff are likely to use leave this section blank or use it incorrectly (Thomas, 2008).

As Berger (in press, a) has pointed out:

Making the ECR the primary, if not sole source of future NHS information requirements means that if something is not available for processing in the electronic record, it is unlikely to be taken into account in the analyses and decisions that underpin NHS services. Hence, unless the ECR records psychology involvement in a way that reflects psychology thinking and practices, psychology will be off the record, not just literally, but in other important ways. The overarching challenge, therefore, is to make psychological perspectives part of the ECR.

He makes proposals for psychology-specific datasets which code the information from assessment and formulation, among other aspects of a psychologist's work (Berger, in press, b). This task is still at a very early stage.

SNOMED CT has recently been approved as the standard clinical terminology for the NHS in England. SNOMED CT stands for the 'Systematised Nomenclature of Medicine Clinical Terms', and it is used in more than 50 countries. It consists of a recognised set of clinical terms for ECR systems and can be utilised across all care settings and all clinical domains. *www.connectingforhealth.nhs.uk/systemsandservices/data/uktc/snomed*

As with all types of ECRs, much work remains to be done on incorporating psychological activity in general, and formulation in particular, in a meaningful way with due regard for confidentiality (see *Guidelines on the use of electronic health records*, BPS 2011.)

Formulation-based alternatives to psychiatric diagnosis

Psychiatric diagnosis is deeply embedded in practice, research and clinical governance, as well as in other areas of public life such as the criminal justice system and the benefits system. This is likely to remain true for the foreseeable future. For example, Trusts are required to return Mental Health Minimum Data Sets based on psychiatric diagnoses. The IAPT initiative is based on diagnostic criteria for depression and anxiety disorders (with others to be included soon). NICE recommendations and most outcome measures are diagnostically-based, and a diagnosable mental illness is a pre-requisite for access to mental health services. Court reports and risk assessments are based on psychiatric diagnoses. Most evidence-based practice is based on classification by psychiatric diagnosis, despite the fact that these terms are not evidence-based themselves; that is, they have poor reliability and validity (Boyle, 2002; Bentall, 2003). Although it could be argued that formulation is a viable alternative to some psychiatric diagnoses at an individual level, there is no agreed system of non-medical terms to replace psychiatric diagnosis for broader, clustering purposes.

Some clinical psychologists and psychiatrists have suggested new categories that incorporate recent evidence about the causal role of trauma, and can perhaps be seen as occupying a place halfway between functional psychiatric diagnoses and formulation. For example, it has been proposed that in many cases 'personality disorder' is better understood as 'complex PTSD' (Herman, 2001). Similarly, Callcott & Turkington (2006) have suggested 'traumatic psychosis' as an alternative to some diagnoses of 'schizophrenia'.

These terms have the obvious advantage, from the point of view of documents and records, of brevity. They do not necessarily imply wholesale rejection of existing psychiatric diagnoses. They do, however, represent initial attempts to develop coherent, credible alternative forms of categorisation which are based on psychological theory and which have direct implications for both aetiology and intervention. In fact it could be argued that some current psychiatric diagnoses, for example, bereavement reaction, adjustment disorder and dissociative disorder, are better understood as broad-level formulations, implying primarily psychosocial rather than medical/biological causes.

Among a number of new developments is the concept of 'trauma-informed' services in the USA (Harris & Fallot, 2001). These are based on the recognition that violence, trauma and abuse are causal factors across the whole range of psychiatric presentations and need a common, trans-diagnostic approach grounded in a different model of service delivery. Although the model has yet to make an impact in the UK, it implies a much greater role for formulation-based categorisation of mental distress.

14. Summary and recommendations

1. Best practice psychological formulation is a highly skilled process that combines scientific principles with intuition and reflectiveness. It serves a range of purposes in psychological work with individuals, carers, teams and organisations, and has the potential to enhance core aspects of clinical work across roles and specialties. It helps to ensure that our interventions are evidence-based by linking theory with practice. It can be seen as a prime example of 'level 3 skills' in action.

2. A distinguishing characteristic of psychological formulation is its sophisticated, multiple-model perspective which integrates theory and evidence from psychological, biological, social/societal, and cultural domains through a shared understanding of their personal meaning to the service user.

3. Clinical psychologists receive the most in-depth training in formulation, and are well-placed to promote its use through practice, teaching, supervision, consultancy and research.

4. Emerging evidence suggests that formulation is highly valued by other MDT members. Further research into the impact of formulation on team functioning and on the quality of care is needed.

5. Formulation also has the potential to promote collaborative work with service users by enhancing the therapeutic relationship and increasing their sense of meaning, agency and hope. More research is needed into service user and carer experiences of formulation in order to ensure that it is used sensitively, respectfully and productively.

6. Formulation can facilitate culture change by promoting a more psychosocial perspective in services as a whole. New evidence about common psychosocial causal factors across psychiatric diagnostic categories suggests the potential for formulation to take a more central role in mental health settings, including the development of formulation-based categorisation systems.

7. Although much of the theory and research on which formulation draws is firmly established, to date there is only limited evidence to support it as a specific intervention in its own right. This is a significant gap that needs to be filled.

8. Culturally-sensitive formulation is another underdeveloped area which is ripe for research. This, along with other aspects of formulation, is recommended for clinical psychology trainees' doctoral projects.

9. Clinical psychologists need to ensure that formulation has a central place in electronic records so that it can be integrated into care packages and pathways.

10. The checklists in this document are recommended as a means of enhancing good practice in clinical work, training, supervision, consultancy, audit and research in the field of formulation.

15. Relevant BPS documents

These guidelines should be read in conjunction with the following documents.

Division of Clinical Psychology (2000). *Clinical psychology and case notes: Guidance on good practice.* Leicester: British Psychological Society. http://goo.gl/Pwzt7

Division of Clinical Psychology (2008). *Clinical psychologists and electronic records: The new reality.* Leicester: British Psychological Society. http://goo.gl/IxjHb

Division of Clinical Psychology (2010). *The core purpose and philosophy of the profession.* Leicester: British Psychological Society. http://goo.gl/RXi8K

Division of Clinical Psychology (2010). *Clinical psychology leadership development framework.* Leicester: British Psychological Society. http://goo.gl/YOhuD

British Psychological Society (2009). *Code of ethics and conduct.* Leicester: British Psychological Society. http://goo.gl/RLwDU

Newton, S. (2008). *Record keeping: Guidance on good practice.* Leicester: British Psychological Society. http://goo.gl/EcVqH

Division of Clinical Psychology (2001). *Working in teams.* Leicester: British Psychological Society. http://goo.gl/3sfiQ

Onyett, S. (2007). *Working psychologically in teams.* Leicester: The British Psychological Society.

Appendix 1:
Checklist of good practice in the use of formulation

This checklist summarises the principles of recommended best practice in formulation and formulating. The phrase 'service user' should be taken to encompass families/carers where appropriate.

As noted in the main body of the guidelines, while these principles and standards will be broadly relevant to formulation used in a more partial, informal or evolving way, for obvious reasons it will not always be possible, necessary or appropriate to incorporate them in full. Clinical judgement must be exercised in making these decisions. However, the criteria can still be seen as a useful reference point and checklist of good practice for all stages and versions of formulation and formulating.

Clinical psychologists may use this checklist for the following purposes:
● Supporting and evaluating their clinical practice in relation to formulation, in order to maintain the highest standards throughout their careers.
● Aiding supervision and appraisal within the profession.
● Informing supervision and consultation to other professionals and to teams.
● Teaching and assessing trainees on clinical psychology doctorate courses.
● Teaching and training with other professional groups.
● Checking the quality of formulations for inclusion in records and other paperwork.
● As psychology leads and managers, for auditing psychology services.
● As a basis for research into formulation, either clinician-led or jointly with service users.

Rationale for audit

Date ....

Clinician's name .... Job title..

Assessor's name .... Job title..

Brief description of the area being audited..

....

Characteristics of the formulation

	Standard met?	Comments
Grounded in an appropriate level and breadth of assessment		
Based on psychological theory, evidence and principles		
Informed by a range of models and/or causal factors		
Integrates, not just lists, the models and causal factors		
Makes theoretical sense		
Includes service user's strengths and achievements		
Important aspects of the history and the problems are accounted for		
Indicates how the main difficulties may relate to each other		
Suggests explanations for the development of the main difficulties, at this time and in these situations		
The personal meaning to the service user is an integrating factor (either directly or through an indirect or 'Best Interest' procedure)		
Provides a basis for making decisions about intervening/moving forward		
Suggests how to prioritise interventions, if indicated		
Can be used to make and test predictions, including risks		
Can be used to anticipate responses to the intervention, including setbacks		
Can be used to set goals and desired outcomes		
Is not premised on a functional psychiatric diagnosis (e.g. schizophrenia, personality disorder)		
Is person-specific not problem-specific		
Is culturally sensitive		
Is expressed in accessible language		
Takes a non-blaming stance towards service user and others		
Considers the possible role of trauma and abuse		
Includes the impact and personal meaning of medical and other health care interventions		
Considers possible role of services in compounding the difficulties		
Informed by awareness of service/organisational factors		
Informed by awareness of social/societal factors		
Has clear links backward to the assessment and forward to the intervention		

Characteristics of formulating: The clinician

	Standard met?	Comments
Is clear about who the formulation is for (individual, family, team, etc.)		
Is clear about who has the 'problem'		
Is clear about who are the stakeholders and their interests		
Is respectful of the service user/team's view of what is accurate/helpful		
Constructs the formulation collaboratively with service user/team		
Paces the development and sharing of the formulation appropriately		
Can provide a rationale for choices within formulation (integrative, single model or partial)		
Is reflective about own values and assumptions		

Appendix 2:
Professional guidelines and criteria in relation to formulation

Division of Clinical Psychology (2010):
'Core purpose and philosophy of the profession'

'Psychological formulation is the summation and integration of the knowledge that is acquired by this assessment process that may involve psychological, biological and systemic factors and procedures. The formulation will draw on psychological theory and research to provide a framework for describing a client's problem or needs, how it developed and is being maintained. Because of their particular training in the relationship of theory to practice, clinical psychologists will be able to draw on a number of models (bio-psycho-social) to meet needs or support decision making and so a formulation may comprise a number of provisional hypotheses. This provides the foundation from which actions may derive… Psychological intervention, if considered appropriate, is based upon the formulation.'

Core competencies of a clinical psychologist:
● 	 psychological assessment;
● 	 psychological formulation;
● 	 psychological intervention;
● 	 audit and evaluation;
● 	 research;
● 	 personal and professional skills;
● 	 communication and teaching skills;
● 	 service delivery skills;
● 	 transferable skills.

Health Professions Council (2009) criteria:

● 	 *Be able to develop psychological formulations using the outcomes of assessment, drawing on theory, research and explanatory models.*
● 	 *Be able to use psychological formulations to plan appropriate interventions that take the client's perspective into account.*
● 	 *Be able to use psychological formulations with clients to facilitate their understanding of their experience.*
● 	 *Be able to use psychological formulations to assist multi-professional communication and the understanding of clients and their care.*
● 	 *Be able, on the basis of psychological formulation, to implement psychological therapy or other interventions appropriate to the presenting problem and to the psychological and social circumstances of the client.*
● 	 *Be able to decide how to assess, formulation and intervene psychologically from a range of possible models and modes of intervention with clients and/or service systems.*
● 	 *Be able to use professional and research skills in work with clients based on a scientist-practitioner and reflective-practitioner model that incorporates a cycle of assessment, formulation, intervention and evaluation.*

Accreditation through partnership handbook (2010): Guidance for clinical psychology programmes

2.1 Required learning outcomes

1. The skills, knowledge and values to develop working alliances with clients, including individuals, carers and/or services, in order to carry out psychological assessment, develop a formulation based on psychological theories and knowledge, carry out psychological interventions, evaluate their work and communicate effectively with clients, referrers and others, orally, electronically and in writing.

2.2 Learning outcomes

3. Clinical and research skills that demonstrate work with clients and systems based on a scientist-practitioner and reflective-practitioner model that incorporates a cycle of assessment, formulation, intervention and evaluation.

2.3.1 Transferable skills

1. Deciding, using a broad evidence and knowledge base, how to assess, formulate and intervene psychologically, from a range of possible models and modes of intervention with clients, carers and service systems.

2.3.3 Psychological formulation

Developing formulations of presenting problems or situations which integrate information from assessments within a coherent framework that draws upon psychological theory and evidence and which incorporates interpersonal, societal, cultural and biological factors.

2. Using formulations with clients to facilitate their understanding of their experience.

3. Using formulations to plan appropriate interventions that take the client's perspective into account.

4. Using formulations to assist multi-professional communication, and the understanding of clients and their care.

5. Revising formulations in the light of ongoing intervention and when necessary reformulating the problem.

2.3.4 Psychological intervention

1.   On the basis of a formulation, implementing psychological therapy or other interventions appropriate to the presenting problem and to the psychological and social circumstances of the client(s), and to do this in a collaborative manner with:
● 	individuals;
● 	couples, families or groups;
● 	services/organisations.

2.   Understanding therapeutic techniques and processes as applied when working with a range of different individuals in distress, including those who experience difficulties related to: anxiety, mood, adjustment to adverse circumstances or life events, eating, psychosis and use of substances, and those with somatoform, psychosexual, developmental, personality, cognitive and neurological presentations.

Clinical Psychology Leadership Development Framework (2010)

'Clinical drivers' for all levels of the profession include:

To sensitively and confidently lead on psychological assessment and formulation in teams.

'Use of leadership skills' includes:

Trainee: Take a lead in MDT meetings regarding psychological formulation of a client's care.
Qualified clinical psychologist: Lead on psychological formulation within your team.
Consultant clinical psychologist: Ensure psychological formulation work is appropriately shared.
'Outcome for practitioners': Show psychological formulation skills that integrate social, cultural, religious, ethnic factors as well as age, gender and ability level.

NB: The first criterion also applies to health psychologists and educational psychologists, while counselling psychologists must be able to 'make formulations of a range of presentations' and 'be able to formulate clients' concerns within the chosen therapeutic models'. Sports and exercise psychologists must 'be able to formulate clients' concerns within the chosen intervention models' and forensic psychologists must 'be able to use psychological formulations to assist multi-professional communication and the understanding, development and learning of service users.'

Appendix 3: Formulation and research

What we know so far is:

Most of the limited body of available research focuses on establishing whether formulation is reliable. A review of research using standardised methods to assess inter-rater reliability in psychodynamic formulations found moderate-to-good agreement (Luborsky & Diguer, 1998). A review of cognitive case formulation research found more mixed results for inter-rater reliability, concluding that it was 'modest at best' (Bieling & Kuyken, 2003, p.52). The emerging consensus is that reliability is compromised as clinicians move from descriptive to more inferential levels. However, it is unclear whether problems in establishing reliability are due to difficulties in the process, such as the use of heuristics that affect clinical judgement (see Dumont, 1993), or to methodological issues, such as the absence of information available to practitioners in normal service conditions (including the possibility of developing the formulation in collaboration with the client). Moreover, as Bieling and Kuyken (2003) concede, reliability does not imply validity. It is unclear how, if at all, psychologists reliably formulating in the same way relates to the 'truth' or accuracy of the formulation. In addition, formulation could be reliable and valid but have no impact in terms of helping the client; conversely, it could be unreliable and invalid but lead to improved outcomes.

For these reasons, another strand of research has tried to establish whether formulation leads to positive change for clients. A few studies (Jacobson et al., 1989; Emmelkamp et al., 1994; Schulte et al., 1992) have attempted to compare individualised treatments (which are, by implication, formulation-driven) with standardised treatments (which are not). Taken together, the results do not support claims that formulation improves outcomes, although they are all under-powered studies from which little can be safely concluded. Furthermore, it is unclear how closely the individualised conditions in these studies correspond to practice, since they were defined as treatment plans that combined the standardised components more flexibly.

Qualitative data from structured interviews suggest that clients are ambivalent about formulation. As finding formulations helpful, encouraging and reassuring, and increasing trust in their psychologist, clients can also experience them as saddening, upsetting, frightening, overwhelming and worrying (Chadwick et al., 2003; Evans & Parry, 1996; Hess, 2001). A content analysis of 13 clients' experience of formulation in CBT for psychosis indicated that individuals' reactions to receiving a formulation were complex, involving apparently opposing emotional and cognitive responses, which changed over time (Morberg Pain et al., 2008).

Professional guidelines recommend the use of a formulation based approach when working within multidisciplinary teams (Division of Clinical Psychology, 2010). Additionally, service users are reported to value the role of psychologists in teams as offering an alternative perspective to the 'medical model' (Onyett, 2007). Christofides' (2011) qualitative study of clinical psychologists working within adult mental health teams found that formulation was used in many different ways, often unacknowledged, within

teams. Research on the use of formulation in teams has so far been limited to relatively small practice-based studies in inpatient settings. For example, Kennedy et al. (2003), evaluating a new inpatient service in which a key intervention was the collaborative production of a formulation, concluded that it was a powerful systemic intervention in itself which was regarded positively by both service users and staff. Summers (2006) explored staff views of the impact of introducing psychological formulations to a high dependency rehabilitation service and found that they believed that formulation benefited care planning, staff-patient relationships, staff satisfaction and team-working, through increasing understanding of patients, bringing together staff with different views and encouraging more creative thinking. Wainwright and Bergin (2010) provided a similar assessment of staff views on the effectiveness of introducing formulation meetings onto an acute inpatient ward for older adults. Lake (2008) has described a team formulation approach facilitated in regular meetings by a psychologist, which was evaluated very positively by all staff (2008). Berry et al. (2009) found that formulation meetings resulted in staff feeling increased confidence in their work, and perceiving service users more positively and optimistically.

Among the conceptual and methodological hurdles to be overcome in researching formulation are:

- Defining formulation (process versus event).
- Separating the effects of the formulation from the therapy of which it is an integral part. (Although team formulations avoid this problem because they are by definition separate from individual therapy; in fact therapy may not be a feature of the intervention at all.)
- Deciding the terms in which formulation is evaluated. A narrative/personal meaning approach would see 'usefulness' as a more appropriate criterion than 'truth', or reliability, validity etc., although 'usefulness' immediately raises the questions: useful to whom? and how would this be assessed? On the other hand, the 'truth' perspective implies a consensus on what it means to say that a formulation is 'valid', and who makes this judgement. Suggestions for assessing the quality of formulations have been made by Butler (1998) 'Ten tests of a formulation'; Lane (1990) 'Stopthengo' checklist; Kuyken (2006) 'Evidence-based guidelines'; and Persons (2008) 'Five tests'.

Margison et al. (2000) have recommended that evidence for the effectiveness of therapy, including formulation, should come from practice-based evidence as well as evidence-based practice.

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