AN INTRODUCTION TO PSYCHOLOGICAL FORMULATION

DR DAVID BLADON-WING

CONSULTANT CLINICAL PSYCHOLOGIST

COMMUNITY THERAPEUTIC SERVICES

CONTENT:

PART 1.

- Definitions
- Single / Team Formulation
- Essential Features
- HCPC Standards
- Some Contentious Issues

PART 2.

- Some Models of Formulation
  - Bio-Medical
  - Cognitive Behavioural Therapy
    - (5 P's) structure
- Evaluation of Formulation

WHAT DO WE MEAN BY: **'PSYCHOLOGICAL FORMULATION'?**

- ***Some definitions***:
- *Formulation is a provisional explanation or hypothesis of how an individual comes to present with a certain disorder or circumstance at a particular-point in time.* **(Weerasekera, 1996)**
- *A formulation is a 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 a hypothesis to be tested.* **(Butler, 1998)**
- *Formulation will draw on psychological theory and research to provide a framework for describing a client's problems or needs, how it developed and is being maintained.* **(Division of Clinical Psychology, BPS, 2010)**

AN EVOLVING WORKING DEFINITION:

- **The Division of Clinical Psychology Good Practice Guidelines (DCP, 2011)**
- *Formulation… summarizes and integrates a broad range of* ***biopsychosocial*** *causal factors. It is based on personal meaning and constructed collaboratively with service users and teams.*

TEAM FORMULATION:

- '**Formulation**', first appeared in clinical psychology publications in the 1950's (**Crellin, 1998**). However, no single definition of '***formulation***' currently exists.
- It is now widely used by many other mental health practitioners including, nurses, applied psychologist, psychotherapists and psychiatrists.
- A recent development is to use '***formulation in teams***', in order to facilitate a group or multi-disciplinary team of professionals to develop a shared understanding of the service user's difficulties.

TEAM FORMULATION:

- *It has been suggested that using formulation in teamwork is a particularly effective way of achieving cultural change and promoting a more psychosocial perspective in services as a whole.* **(Kennedy et al., 2003)**

- *Taking formulation into a wider setting can be a powerful way of shifting cultures towards a more psychosocial perspective.* **(Onyett, 2007)**

THE ESSENTIAL FEATURES:

- Summarizes the service user's core problems;
- Suggests how the service user's difficulties may relate to one another, by drawing on psychological theories and principles;
- Aims 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;
- Indicates a plan of intervention which is based in the psychological processes and principles already identified;
- is open to revision and re-formulation.
- **(Johnstone & Dallos, 2006)**

PSYCHOLOGICAL FORMULATION:

- **The Health Care and Professionals Council (HCPC), (2015).**
- **Standards of Proficiency for Practitioner Psychologists** states that:

….that formulation should be used to assist multidisciplinary working and communication, shared with service users to support an understanding of their experience, revised as necessary in light of new information, used to assist and plan interventions considering client perspectives and form part of a therapeutic cycle adhering to a ***scientist-practitioner model****.*

Specifically….Practitioners (applied psychologists) must be able to formulate service users' concerns within chosen therapeutic models and to implement therapeutic or alternative interventions appropriate to the presenting problem and to the psychological and social circumstances of the service user.

SOME CONTENTIOUS ISSUES:

SOME CONTENTIOUS ISSUES:

1. Whether formulation can be considered as fact or opinion?
2. Are there common cohesive factors or irreconcilable differences across therapeutic approaches to formulation?
3. Who is included in the creation and sharing of formulations?

FACT OR OPINION

1. FACT OR OPINION:

- ***Some Questions:***
- *Can formulation ever be accurate, objective and factual, or if they always remain a subjective account of a person's experience, what external factors or biases may influence those creating a formulation?*

- This questions the validity of the scientist-practitioner model and the usefulness of hypothesis testing.

1. FACT OR OPINION:

- Can a ‘formulation’ stand apart from the phenomenological or constructivist stance to human nature and enquiry?
- To what extent is our knowledge and understanding of mental disorder socially-constructed?
- To what extent should our formulations incorporate the cultural beliefs of our client (and us) or, does ‘***mental disorder***’ exist as an independent factor?

1. FACT OR OPINION:

- *These are relevant themes, particularly if you hold a fundamental appreciation of the subjective, phenomenological experience of both the practitioner and the client, and understand the philosophical concerns around notions of accuracy and objective measure,* (Ponterotto, 2005).

1. FACT OR OPINION:

- Does '***accuracy***' matter, or rather should formulations be judged more on their usefulness?
- There is evidence that the effectiveness of the various psychotherapeutic traditions, i.e. CBT, person-centered, psycho-dynamic, systemic, are considerably more effective if the client is also in agreement with the therapeutic approach, regardless of which approach is chosen.

1. FACT OR OPINION:

- **Is 'formulation' an event or process?**
- *Formulation has been described as either an '**event**' or '**process**', and questions therefore surround which characterization is more appropriate or useful?*

  - **Formulation as an event:** can provide a definitive statement such as a diagnosis, which provides a more prescribed approach. However, it can only be a snap-shot in time.

  - **Formulation as a process:** suggests that the relational aspects of the therapeutic relationship inform a collaborative and evolving formulation, which is flexible and responsive to the client's developing and shifting processes.

1. FACT OR OPINION:

- An aspect of formulation relating to validity and representativeness regards the '***when'***, *of when* the formulation is undertaken.
- **Antaki et al. (2005)**, *describes formulation as an ongoing process within the therapy room, which is constantly open to editing and reformulation. However, many practitioners may be required to create formulations after one or perhaps two initial meetings.*

1. FACT OR OPINION:

- **Crellin (1998)**, argues that if the purpose of formulation is for '***the client to arrive at a meaningful narrative'***, the only true formulation can only be done at the end of therapy, as this is when the full picture is revealed.
- This position, however, negates the use of formulation as a tool for assisting in intervention planning, turning it into more of a story of the client's journey.

1. FACT OR OPINION:

- As previously discussed, an attempt to reconcile the afore-mentioned philosophical criticisms of assessing formulations by their validity or accuracy, is to consider formulations in terms of their usefulness.

- **<u>The Division of Clinical Psychology Guidelines (DCP, 2011) states:</u>**

  *….that one of the principles of formulation in clinical psychology is that this is best understood in terms of '**usefulness**' than '**truth**', meaning that formulation is not an expert diagnosis or pronouncement, but rather a '**plausible account**'.*

1. FACT OR OPINION:

- This raises a debate between the differences and complexities between **formulation** and **diagnosis.**
- There is also the question as to whom or for what should the formulation be useful and whether it facilitates positive clinical change in the client?

COHESIVE OR DIVISIVE

2. COHESIVE OR DIVISIVE:

- Do the various theoretical approaches have unifying factors or are they ultimately irreconcilable and should, thus, always adhere to one theoretical or psychological approach?
- Each major paradigm has addressed the use of formulation based upon their theoretical and philosophical structures.
- It is possible for various approaches to be integrated to create tailored therapies or '*fusion theories*', or does this create philosophical conflict and confusion?

2. COHESIVE OR DIVISIVE:

- **Questions that may be helpfully asked:**
- To what extent does the underpinning psychological theory and formulation encourage an expert or co-produced position?
- Can a service user easily understand the theoretical knowledge and engage in the co-construction of the formulation?

2. COHESIVE OR DIVISIVE:

- Do you adapt a ***generalist*** or ***specialist*** approach to psychological and formulation knowledge and practice?

- **The Division of Clinical Psychology (DCP, 2011)**
  - has attempted, in its professional formulation guidelines, to reconcile the issues facing pluralistic or integrative practitioners. The guidelines note that, given the tendency for therapeutic theories to draw upon and reflect each other to varying degrees, formulation will share similarities regardless of approach.

2. COHESIVE OR DIVISIVE:

- Alternative stances arising from the literature attempted to create formulations based on more over-arching theories, such as the ***biopsychosocial*** model, or the widely used psychological approach of the ***'four (or five) P's'*** model, or through a '***common-language***' approach.
- **The DCP (2011)** guidelines state that whilst psychological theories such as the **four P's** (*predisposing, precipitating, perpetuating and protective factors*) or **biopsychosocial** models utilize theory from several domains and consider factors from several life sources, they often still lack personal meaning of the client within them.

INCLUSIVE OR EXCLUSIVE

3. INCLUSIVE OR EXCLUSIVE:

- There is a fundamental question of who should be included in the development of a formulation.

- Much of the literature suggests that formulation should be collaborative with the client. However, there is little if any research on whether this is beneficial or not to the client.

3. INCLUSIVE OR EXCLUSIVE:

- **Redhill et al. (2015)** was a qualitive research project looking at 10 clients.
- They found that formulation helped some clients to understand their problems; leading to feeling accepted and understood; leading to an emotional shift; enabling the client to move forward.
- They also found that the emotional shift was not always positive for the client; with experiences of distress regarding increased awareness of one's difficulties and with being presented a formulation which does not match one's self-identity or is perceived as inaccurately being reported.
- However, they went onto find that some of the distress was temporary and resolved; however, some was also enduring.

3. INCLUSIVE OR EXCLUSIVE:

- **Pain et al. (2008)** also investigated service user reactions to being presented with their formulations (n=13).
- Having examined the formulations, the clients revealed feeling far more mixed in their reactions including positive, negative and neutral reactions. Reactions varied from feeling sadness, relief, daunting or helpful, seeing them as having therapeutic value or as confusing.

3. INCLUSIVE OR EXCLUSIVE:

- In conclusion, despite mixed and narrow results from both these small-scale studies, positive reactions and effects cannot be assumed for clients sharing in the creation and experience of formulation.
- **MacDonald and Mikes-Liu (2009)** raise concerns as to whom the formulation is for; it seems that if for the therapist it is a clinical tool, then collaboration and sharing may not be deemed necessary; however, if that tool guides interventions and it is to be shared with other professionals, ethical questions regarding the exclusion of the client during this process may be born **(HCPC, 2016).**

3. INCLUSIVE OR EXCLUSIVE:

- **Barry et al. (2009)** investigated how staff perceptions of service users may be modified by discussing formulations regarding issues the staff were experiencing with individual clients under the guidance of a clinical psychologist.
- While the results were positive, it is important to note that the study only measured staff perceptions not behavior towards the service user.
- The study suggested that enabling staff to see alternative psychological ways of viewing the service user's experiences can in some circumstances positively effect their experience of this side of the relationship.

3. INCLUSIVE OR EXCLUSIVE:

- **Team Formulation:**
  - This idea of being open to alternative ways of viewing a client regarding formulation is demonstrated in the concept of multidisciplinary or team formulations.

- **Johnstone, (2014)** proposes that team formulations bring several benefits: they can enable varied inputs across practitioners and professions so that therapists can incorporate a broad range of theories and be less likely to miss important factors; it can enhance work with complex clients; challenge myths about service users; help staff to manage risk and raise moral. However, the usual problems of professional power, opposing opinions and personality clashes, as well as, practical problems of arranging meetings will always exist.

3. INCLUSIVE OR EXCLUSIVE:

- **The HCPC (2015)** states that formulation should be used to assist multi-disciplinary team working and communication with **West et al. (2012)** suggesting that decisions made by mental health teams of this nature are of '*higher quality*' than teams consisting of single-profession members or individuals alone.

3. INCLUSIVE OR EXCLUSIVE:

- **Christofides, Johnstone and Musa (2012),** found that clinical practitioners value input from others in their professional teams, and that this is often undertaken in an informal manner, in casual conversations as opposed to formally planned meetings with this purpose in-mind. Overall, the authors state that it appeared that sharing information regarding clients in this manner was beneficial to client work and team cohesion.

SOME MODELS OF FORMULATION

SOME MODELS OF FORMULATION:

- Bio-Medical Model
- The Cognitive-Behavioural Model: *(4 (or 5) P's)*

THE BIO-MEDICAL MODEL

MEDICAL MODEL:

- 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.
- **NICE** recommendations and most outcome measures are diagnostically-based, and a diagnosable mental illness is a pre-requisite for access to mental health services.

MEDICAL MODEL:

- Mental disorder is embedded in the same paradigm of disease and physical illness.
  - **Presenting Symptoms**
  - **Biological Signs or Markers**
  - **Diagnosis**
  - **Prognosis**
  - **Treatment**

BIO-MEDICAL MODEL:

- *I was trained to employ local diagnoses….and it still strikes me 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)**

BIO-MEDICAL MODEL:

- *There are very few disorders whose definition was a result of specific research data…For borderline personality disorder there was some research that looked at different ways of defining the disorder. And we chose the definition that seemed most valid. But for the other categories rarely could you say that there was research literature supporting the definition's validity.*
- **Dr Robert Spitzer, 2013**, (who led the team of psychiatrists who developed DSM III)

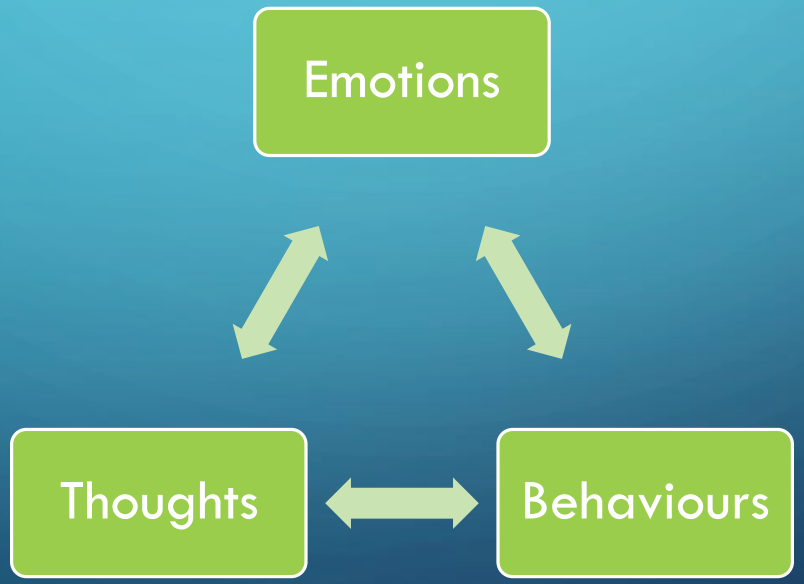
MEDICAL MODEL:

- **(Royal College of Psychiatrists, 2010)**
- Formulation features in the curriculum for psychiatrists' training in the UK.
- 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.
- 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.

THE COGNITIVE-BEHAVIOURAL MODEL

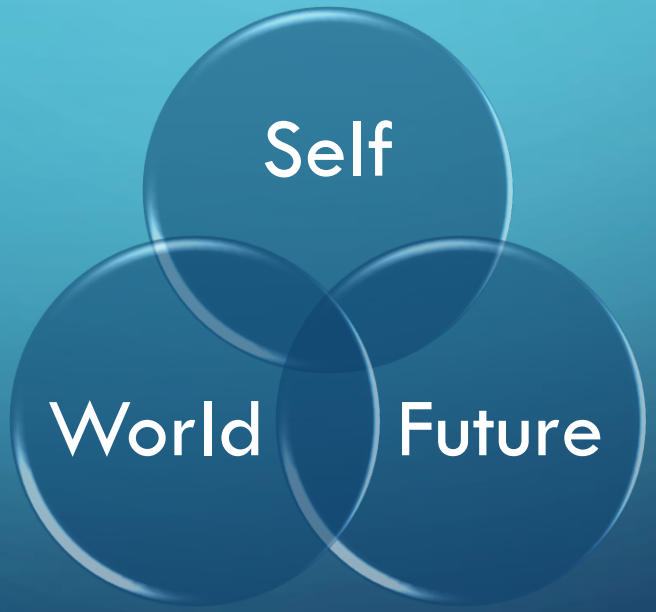
THE CBT MODEL:

- The core model of CBT is defined in collaboration with the service user as part of the assessment process in terms of:



THE CBT MODEL:

- CBT is based on the simple idea that how we view ***ourselves***, the ***world*** and the ***future*** shapes, and is shaped by, our emotions, thoughts and behaviours.



THE CBT MODEL:

- **Case Formulation in Cognitive-Behavioural Therapy**:
- Case formulation is described as the '*lynchpin*' of Cognitive-Behavioural Therapy (CBT). **(Butler, 1998)**
- Formulation is seen as one of the key elements of CBT **(Beck, 2011)**

5 P'S MODEL:

- It is suggested that a framework for CBT formulation that helps link the person's experiences to the cognitive model using the 5 Ps:
  1. ***Presenting Issues***
  2. ***Perpetuating***
  3. ***Precipitating***
  4. ***Predisposing***
  5. ***Protective.***

1. PRESENTING ISSUES:

- This process compliments psychiatric diagnosis in that we begin to define the current problems the person faces.
- This introduces the ***specific*** and ***individualization***.
- We also define **short, medium and long-term goals** that can helpfully identify the end point of therapy.
- There is a focus on developing the therapeutic relationship through shared understanding, clarifying problems and installing hope.

1. PRESENTING ISSUES:

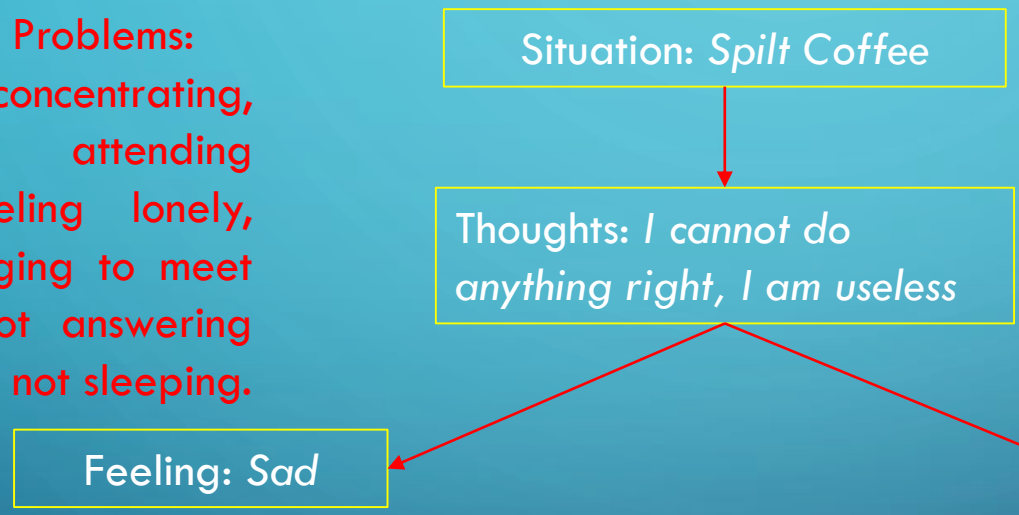
- Despite the initial focus on current problems and goals, CBT is also interested in the developmental origins of the difficulties.
- An initial assessment would normally include relevant background and context to the presenting issues (***onset of the problem, family, education, occupational and psychiatric history, personal and social resources***), which allows for a more in-depth understanding.

1. PRESENTING ISSUES:

- As we establish the nature of the presenting problems, we can start to agree on the order and prioritize.
- We can also begin to explore whether the presenting problem-behaviours are triggered by ***internal, external*** or a ***combination*** of events that are embedded in ***time*** and ***place***.

1. PRESENTING ISSUES:

Presenting Problems: difficulty concentrating, problems attending work, feeling lonely, not arranging to meet friends, not answering the phone, not sleeping.



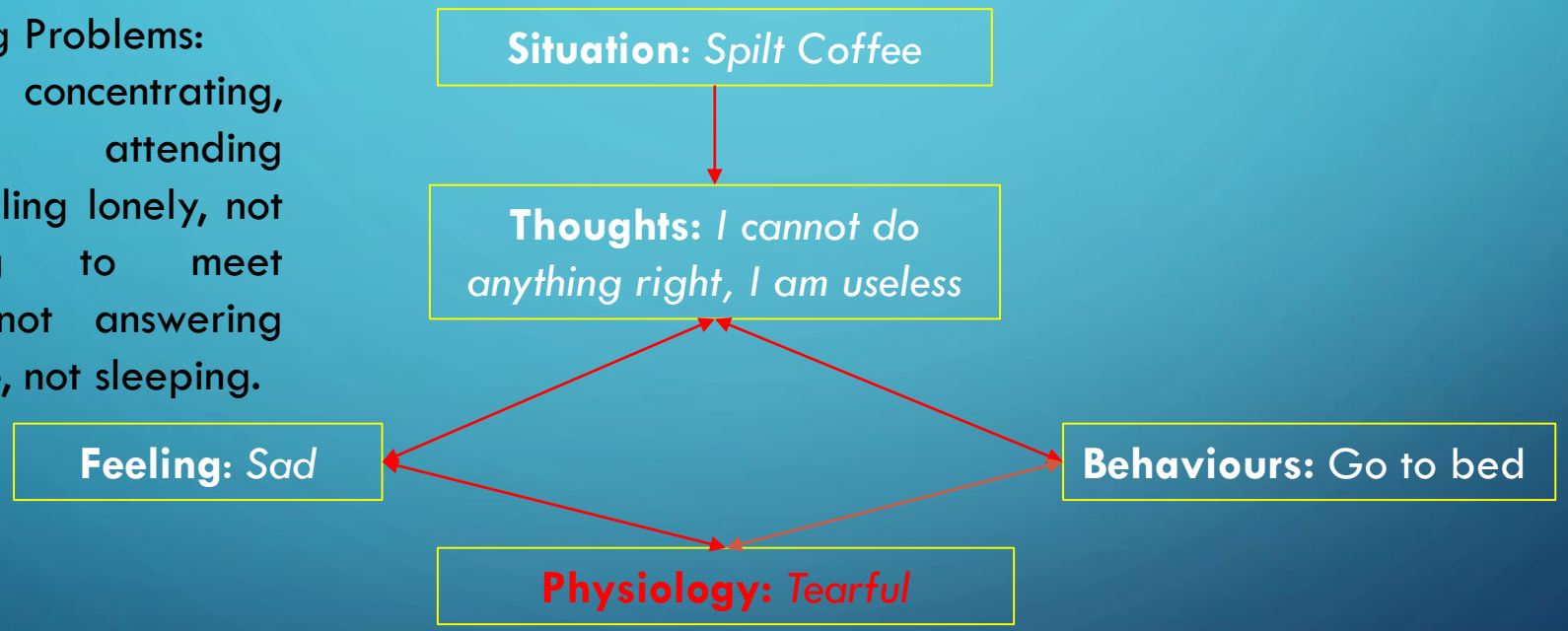
The cognitive model emphasizes that it is not the events themselves, but a person's view of the events, that explains their reaction

2. PERPETUATING FACTORS:

- Although the initial descriptive model is a useful heuristic device it does not really explain what ***maintains*** the issues in the long-term. Hence, we draw upon an expanded model that articulates the relationship between the elements and helps to show the **reinforcing nature** of the problems.
- In such a model, ***the direction of the arrows*** is important, and the initial phase of therapy must provide a defensible rationale for the links between components.
- This model often includes more explicit information about the ***physiological responses*** to a situation.

2. PERPETUATING FACTORS:

Presenting Problems: difficulty concentrating, problems attending work, feeling lonely, not arranging to meet friends, not answering the phone, not sleeping.

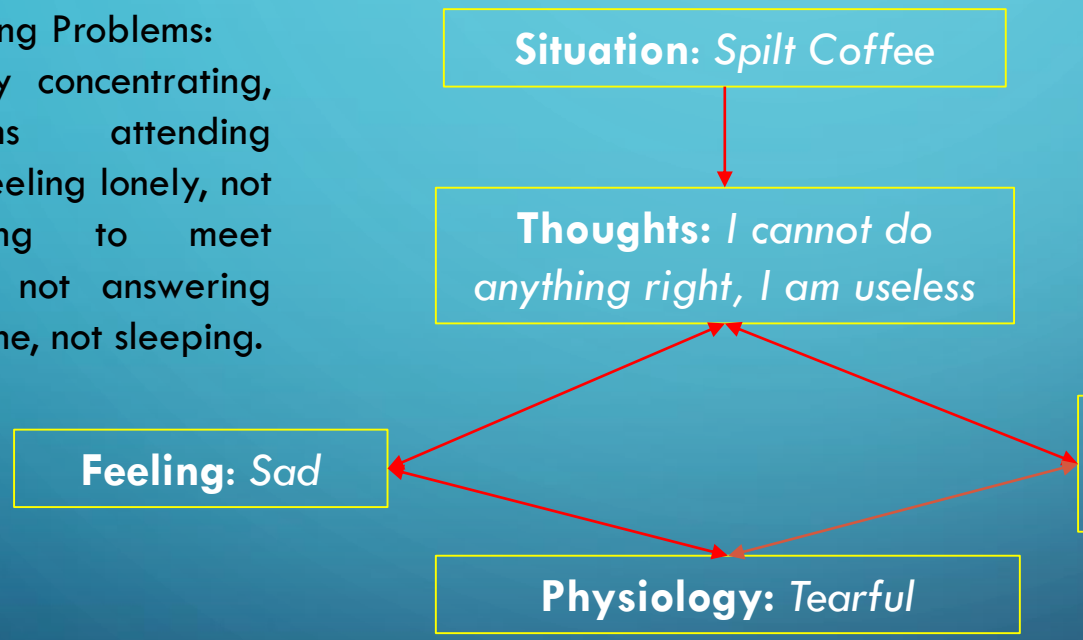


2. PERPETUATING FACTORS:

- Within CBT there is an increasing emphasis on understanding the specific and key features unique to each different disorder. However, there are several core cognitive and behavioural mechanisms that are common to a range of different types of psychopathology **(Harvey et al., 2004).**
- These include various forms of emotional and behavioural avoidance, attentional processes such as vigilance for threat, and cognitive processes like rumination and worry **(Dudley et al., 2010)**

2. PERPETUATING FACTORS:

Presenting Problems: difficulty concentrating, problems attending work, feeling lonely, not arranging to meet friends, not answering the phone, not sleeping.



By avoiding going to work the person may confirm a view of him or herself as 'useless'. Avoiding situations can also lead to a loss of rewarding behaviours and thus help to maintain problems like feeling sad (depression)

3. PRECIPITATING FACTORS:

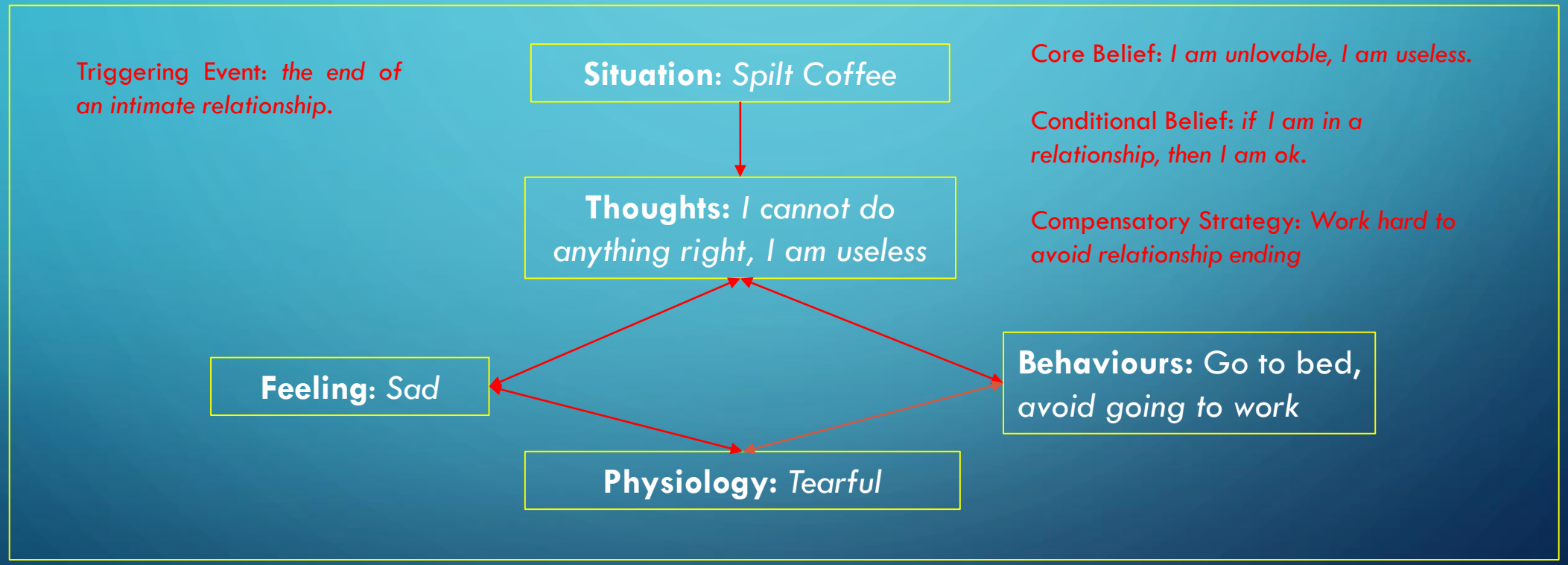
- Exploring and establishing the maintenance factors involved helps us to better understand the presenting problems. However, we may still be unclear what led to the ***onset*** of the difficulties.
- We introduce the notion of a longitudinal or historical formulation that identifies ***precipitant (setting conditions) or triggers*** to the onset of the difficulties.
- These typically turn out to be particularly ***stressful events*** in ***time and place***.

3. PRECIPITATING FACTORS:

- **The Quantity of Stressors:** Stress-Vulnerability models help us to understand that we are all susceptible to stressors in our lives and our vulnerability specifies the point at which we can no longer function or cope.

- **The Quality of Stressors:** Precipitating factors trigger access to a deeply seated view of oneself (core beliefs or schema) that was learned through formative developmental experiences.
  - *For example, a person may see her or himself as fundamentally unlovable and ineffectual (core belief) owing to early experiences of abuse and/or neglect.*

3. PRECIPITATING FACTORS:



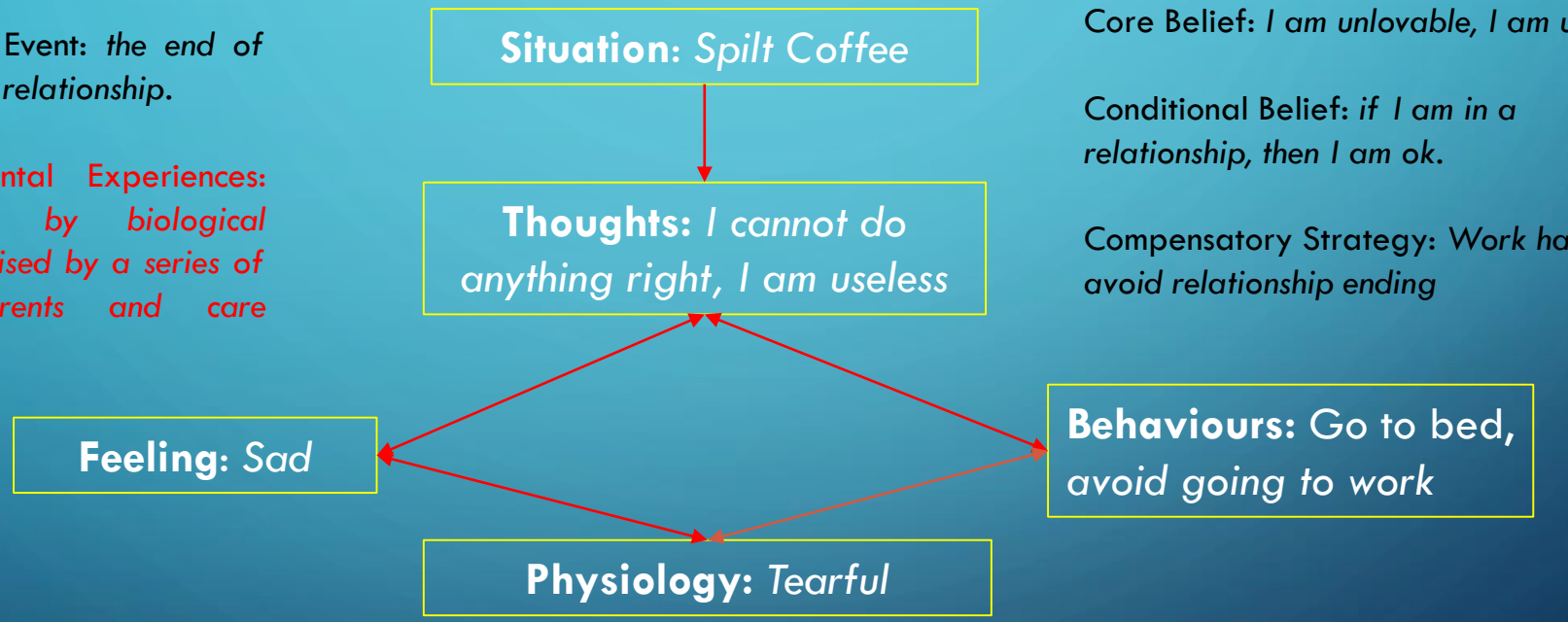
4. PREDISPOSING FACTORS:

- **The Quantity of Historical Events:** We have long understood that there is a cumulative effect of trauma. The earlier its onset and frequency during development the more potentially detrimental the effect.
- **The Quality of Historical Events:** the nature (physical, sexual, psychological) and severity of the trauma or negative psychosocial abuse the more damaging.
  - Adverse Childhood Experiences (ACEs) and the effects on physical and psychological health.

4. PREDISPOSING FACTORS:

Triggering Event: *the end of an intimate relationship.*

Developmental Experiences: *abandoned by biological parents. Raised by a series of foster parents and care institutions.*



Core Belief: *I am unlovable, I am useless.*

Conditional Belief: *if I am in a relationship, then I am ok.*

Compensatory Strategy: *Work hard to avoid relationship ending*

5. PROTECTIVE FACTORS:

- **A Focus on Protective Resources:**
  - Supportive adoptive Mother and Sister
  - Good friend
  - Good job, reasonably well paid
  - Interest in sports
  - Good sense of humor

5. PROTECTIVE FACTORS:

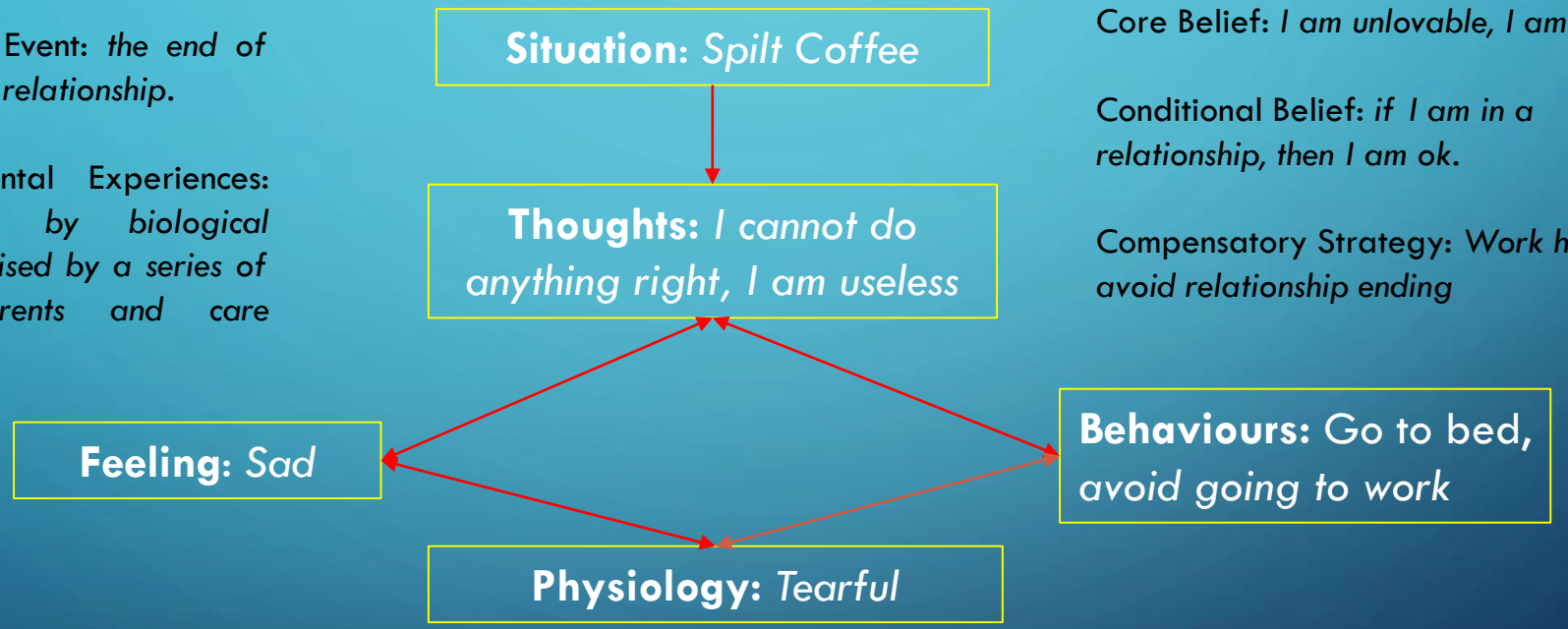
- Include the service user's strengths and conceptualize resilience.
- Goals may include not just reducing distress but increasing strengths or positive values (eg. To enjoy more time with your friends).
- Develop additional and alternative coping strategies.
- Enquire about cultural values or identity that can serve as a source of strength.

4. PREDISPOSING FACTORS:

Presenting Problems:
difficulty concentrating, problems attending work, feeling lonely, not arranging to meet friends, not answering the phone, not sleeping.

Triggering Event: *the end of an intimate relationship.*

Developmental Experiences: *abandoned by biological parents. Raised by a series of foster parents and care institutions.*



Core Belief: *I am unlovable, I am useless.*

Conditional Belief: *if I am in a relationship, then I am ok.*

Compensatory Strategy: *Work hard to avoid relationship ending*

Protective Factors: supportive Mother & Sister, good friend, good job, likes sport, good sense of humour

SOME TESTS FOR A GOOD FORMULATION:

- Does it make theoretical sense?
- Does it fit with the evidence?
- Does it account for predisposing, precipitating and perpetuating factors?
- Do others think it fits?
- Can it be used to make predictions?
- Can you work out how to test these predictions?
- Does the past-history fit?
- Does treatment based on the formulation progress as would be expected theoretically?
- Can it be used to identify future sources of risk or difficulties for the person?
- Are there important factors left unexplained?
- **(Butler, 1998)**

THANK YOU

- Contact details:

Dr David Bladon-Wing,

Consultant Clinical Psychologist,

Community Therapeutic Services.

Primary Reference:

Formulation in Psychology and Psychotherapy (Johnstone & Dallos). Routledge