**A different kind of chemistry?**
**Reformulating 'formulation'**

Dave Harper
University of East London


Duncan Moss
East Sussex County N.H.S. Trust




Address for correspondence:

Dave Harper
School of Psychology
University of East London
Romford Road
London  E15 4LZ

d.harper@uel.ac.uk

Tel:  020 8223 4021

*Is 'formulation' the essential ingredient of our practice as clinical psychologists? If you are a trainee, or involved in supervising or training clinical psychologists you could be forgiven for coming to that conclusion.*

In the DCP's *Core Purpose and Philosophy of the Profession* document (Division of Clinical Psychology, 2001), formulation is seen as one of the four core skills of a clinical psychologist. The ability to come to a clear formulation of a client's difficulties, their history and maintaining factors and from there to develop a treatment plan as part of an assessment process appears to be at the forefront of clinical psychology training. Yet despite the fact that formulation is now considered central to the professional practice of clinical psychology (e.g. Kinderman, 2001), neither of us remembers it being mentioned in any detail during our training as clinical psychologists in the late 1980s and early 1990s. Although Clare Crellin (1998) has noted that the term began to appear in clinical psychology texts in the UK from the 1950s it does not seem to have come to be seen as central until recently.

We do not think we are alone in feeling that formulation had a minimal influence on our development as clinical psychologists and it is perhaps testament to our profession's ability to regularly reconstruct its identity that formulation, barely heard of a decade ago, is now seen as a central defining characteristic. Indeed, Crellin (1998) has argued that the increasing importance of the concept has been influenced by what she sees as the desire of the profession of clinical psychology to define a unique and separate body of knowledge and skills and this, no doubt, serves a function of promoting clinical psychology as a unique discipline. This history has led to a curious situation. For example we have been struck by how much anxiety surrounds discussions of formulation. Trainees talk of anxiety in struggling to come to a formulation and in how to best represent something that is always under construction in the somewhat linear formats required in case reports. Similarly, supervisors talk of anxiety in helping trainees come to formulations since a) many were never taught about it (at least if they trained more than a decade ago) and b) they may not be required to produce a formulation in their everyday work. Of course, Mollon (1989) reminds us that the anxiety of being 'found out' as a fraud is endemic in clinical psychology.

We have been moved to write about this since both of us have seen formulation rise in importance with some ambivalence. These issues appear to come most to the fore in the context of training and it is our experience as both a supervisor and assessor of case reports which has prompted us to write this article. It is trainees who experience most keenly the difference between the rhetoric of our profession and their lived experience of reality (Bostock, 1990; Spellman & Harper, 1996). In this article we would like to pose some questions about formulation. We do not think there are any easy answers to the questions we raise and we are certainly not the first to note dilemmas in the turn towards formulation (Boyle, 2001; Crellin, 1998; Johnstone, 2002). Ways of addressing these concerns will, no doubt, largely reflect readers' theoretical persuasions. Our own debt to ideas from what have come to be termed social constructionist and critical psychology traditions will become evident in what we think might be possible ways forward.

**Some questions about formulation**

1. When can a full formulation of a client's difficulties occur? Is it only at the end of therapeutic work (Crellin, 1998)?

2.  Is there only one correct formulation of a situation? If so, how do we know when we have found it?

3. *What* are formulations for?  In other words, what do they enable us and our clients to do that we were unable to do before the concept was in common use?

4. *Who* are formulations for?  Us as practitioners, our clients or others?  Do clients come to us asking for formulations?

5. Why is it that most formulations are generally individualistic when we know that psychological difficulties arise in a social context (Boyle, 2001; Johnstone, 2002)?

6. What is a formulation, a formulation *of* (Boyle, 2001)?  Do formulations only have to be about problems?  How might this fit with theoretical traditions which are not based on theories of pathology?

7. Do formulations only have to be causal and historical?  How might this fit with traditions which are not based on causal theories of problems?

8. Is a formulation true over time or is it only true of and at a particular time?

9. By what criteria do we judge the quality of formulations?  By their 'truth' or by more pragmatic considerations like the notion of 'fit'?  If the latter, then fit for whom and what (Bob, 1999)?

10. Does our everyday clinical practice reflect straightforward categories like 'assessment', 'formulation', 'intervention' and 'evaluation'?  If not, why then is it that we require this of trainee case reports?


**The meaning(s) of 'formulation'**

One difficulty, noted by Lucy Johnstone (2002), is that although lots of people use the term 'formulation', they seem to mean different things by it.  Moreover, we suspect that whilst people might claim fidelity to a particular definition of formulation, actual formulations might be different in practice.  As some have asked of those appearing implicitly, if not explicitly, to claim that there can be a 'correct' formulation: would an inter-rater reliability of formulations be as poor as the low reliabilities of psychiatric diagnoses of which our profession has been rightly critical over the years?  The different meanings of formulation can lead to confusion (and, in a training context, failure, low marks or contradictory feedback) especially when there is an implicit assumption that there is only one true formulation of a person's difficulties.  One could argue that the very flexibility of the term serves a useful function for the profession in serving to unite differing factions and potentially contradictory schools of thought in clinical psychology.

Of course clinical psychology cannot claim ownership of the term 'formulation' and it may be that we could learn something from its more general definition.  The *Concise Oxford Dictionary* defines 'formula' in two ways:  firstly as a definition or enunciation of principle in a particular form of words.  This sense includes a 'principle serving to reconcile difference of aim or opinion (diplomats seeking a formula)' (1986, p.386); and, secondly, in its mathematic and chemical senses (hence 'formaulae'), 'formulate' is defined as to 'reduce to or express in a formula, set forth systematically' (p.386).  In the difference in meaning between the former and the latter we can perhaps again see reflected the differences between the public and private faces of practice in clinical psychology.

The notion of scientific description resonates with aspects of clinical psychology's history: disinterested observation, a world of objectivity and neutrality with objects that conform to laws of behaviour. Such a style of science is a strong part of the heritage of psychology and keeps us closer by association with domains like mathematics, physics and chemistry.  Yet simplistic and naïve versions of scientific realism have experienced a crisis of legitimacy in recent years.  These days we do not see much evidence of committed naïve realism.  Rather there seems a fuzzier softer version expressed in a kind of:  'well of course one cannot be absolutely objective and disinterested in assessments, formulations and so on but still one can be relatively objective and that's good enough' way.

This kind of 'objectivity lite' approach is understandable in the face of a broader culture that legitimates only certain kinds of knowledge for example in the rhetoric of 'evidence-based practice' (Harper et. al., in press; Neiboer, et. al., 2000; Priebe & Slade, 2002).  However at the same time it can serve to obscure under its coat tails arguably important epistemological and ethical dilemmas highlighted in a number of the questions we noted above.

In comparison, the notion of formulation in the second sense seems to hold open a quite different kind of 'chemistry'.  The developments of peace formulas, for example in Northern Ireland, are explicitly predicated on negotiation and collaboration, what social constructionists might call co-creation. In such examples one sees how constructing a formula can be fluid, messy, subjective and passionate yet those involved are still admirably engaged in the task of trying to build a structure, a reasonably clear way to go forward. In TV documentary interviews with participants about the negotiations involved in constructing the Good Friday Agreement, there seemed to be evidence of not just a chemistry but almost an alchemy at work in the process; a combination of grit, grace and reason to formulate a coherent and workable process in the boiling mixture of Northern Irish politics.


**Reformulating formulation**

We feel that the formulations we, in clinical psychology, develop, are closer to this other kind of 'chemistry'. Rather than our work being an objective or semi-objective formulation of a problem 'out there', instead we could see ourselves as engaged in a process of ongoing collaborative sense making.  In this context we would see 'formulations' partly as stories for therapists (clients generally don't come to see us asking for formulations) which help orient us in some way to the client, and partly as a description of the collaborative process itself.  Formulations, then, are situated in particular contexts and oriented to particular purposes; they are perspectives.  If clinical work is seen as a series

of dialogues or conversations then a practitioner's formulation is one person's account of that conversation.

This definition may seem unnecessarily vague but it is our best attempt since it needs to cover a range of approaches from the more conventional conceptualization of biographical and historical causes of problems to non-causal and non-pathological understandings. This flexibility is important since clients come to us requesting different things (Street et. al., 1991). Many times an implicit wish is for a coherent understanding leading to some kind of resolution but our response to this will be influenced both by our clients (who will be influenced by background, culturally available discourses like popular psychology and so on), our own theoretical orientations and our service contexts. This does not mean that we do not ever draw on theories – good theories are, after all, often very good stories – rather it is about emphasizing that those theories are servants of a larger engagement in collaborative 'sense making' rather than masters of a scientific eye whose gaze assumes a questionable objectivity over a person's experience (Moss 2002).

In systemic terms we are suggesting that a formulation is a map rather than the territory and so it is its usefulness rather than some notion of value-free accuracy which is most important (Carr, 2000; Johnstone, 2002). We would see formulations as 'thick' and rich descriptions rather than the superficial 'thin' descriptions which diagnosis offers.

Collaborative work, then, becomes not us fitting the client into our model (Johnstone, 2002) and selling it to them, but us sharing our expertise of various kinds and learning from clients' expertise on themselves and their experience. This entails our being more transparent and reflexive about our knowledge, experience and ideas – our view is a view from somewhere (a particular time, place and person). The material which forms the basis for these shared constructions with clients comes from a rich storehouse that may include the kind of professional knowledge found in journal articles but may also include our own lives, fiction and film (Newnes, 2001). Such transparency, what some have called a 'not knowing' approach (Anderson & Goolishian, 1988), means that we need to be open about the commitments which can lead us to favour some ideas more than others. It also means that we need to be open to challenge by clients, for us to be aware of our blind spots and attempt to make these more visible to ourselves and our clients.

**What makes a 'good' formulation?**

Obviously criteria will depend on the aim of the formulation. Beyond the fairly obvious notion that a formulation should help the client and therapist make sense of the client's difficulties in the context of their lives and lay out key issues to be addressed, however, we feel that criteria developed for assessing the quality of qualitative research can be of help here. Yardley (2000) has argued that good research should: have a sensitivity to context (theoretical, empirical, social etc); show commitment and rigour (e.g. an in-depth engagement with the topic and a breadth and depth of analysis); be transparent and coherent (eg use transparent methods, show clarity and reflexivity); and have impact and importance (though this latter criterion is more applicable to research).

We might also add that marks of a good formulation might include: that it is explicit and understandable by the client; is based on the evidence of what the client has said (but makes a distinction between what the client has said and the practitioner's interpretation

of it); incorporates the client's own account, and places the client's concerns in a social context (e.g. Hagan & Smail, 1997a, 1997b).

Our spoken or written formulations could also allow more space for image and metaphor and there should be a greater attention to formulation as poesis (Mair, 1989) an approach that sees all language as metaphorical. Thus *all* of a formulation could be said to be metaphorical. Again this approach to language would be a different kind of chemistry, closer again to a kind of alchemy (Jung, 1967). This need not mean we are advocating an abandoning of co-creation to some kind of wholly unreasoned magic, or what David Smail (2002) rightly criticises as naïve Social Constructionism where we can simply co-create any reality we want to and where 'anything goes'. When we give up a commitment to the kind of naïve realism which leads to an expert model of therapy, we don't at the same time give up our expertise or our sense of having deeply held ideas and values. Rather, we simply give up the illusion that we can have either a 'view from nowhere' or a 'God's eye-view' of our clients' difficulties. The Bunsen burner is under us both.

## Acknowledgements

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