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Doctoral Thesis:

An exploration of psychiatrists' understanding and use of psychological formulation

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Word Count

Thesis Section	Text	Appendices (including references)	Total
Abstract	280	N/A	280
Literature Review	7989	6593	14582
Research Paper	7965	9200	17165
Critical Appraisal	3987	634	4621
Ethics Section	4899	2006	6905
Totals	25120	18433	43553

Abstract

This doctoral thesis explores paradigms currently used in mental health services. The thesis comprises a literature review, a research paper and a critical appraisal. A final section is dedicated to the ethical procedures undertaken prior to undertaking the research. The literature review is a systematic review which synthesises 14 qualitative papers studying the experiences of accessing mental health services for individuals who have received a diagnosis of borderline personality disorder. The overarching theme 'bpd is a double-edged sword' is labelled along with four sub-themes: 'undeserving of care', 'disempowerment', 'safety and containment' and 'approaching recovery'. Findings suggest the need for further inclusion of service users in the development of service provision and an approach that is formulation-based and grounded in attachment theory.

The research paper explores psychiatrists' understanding and use of psychological formulation. A constructivist grounded theory framework led to an initial conceptualisation and model. Four conceptual categories were named as 'conceptualising formulation', 'singing off the same hymn sheet', 'barriers to formulation' and 'making a Frankenstein's monster'. In particular the findings suggest that psychiatrists view and use psychological formulation in a different way from that outlined by clinical psychologists and that there are multiple barriers to its use.

Finally, the critical review presents challenges encountered during the research project and personal reflections on the process. Overall the thesis highlights the need for mental health services to embrace multiple paradigms and remain open to alternative discourses around mental illness in order to provide a holistic and integrated service provision. A formulation-based approach may provide such an arena, while allowing space for individualised care. Clinical psychologists are well placed to promote such an approach via service development and consultation with multidisciplinary staff.

Declaration

This thesis records work undertaken for the Doctorate in Clinical Psychology at Lancaster University's Division of Health Research from April 2013 to May 2014.

The work presented here is the author's own, except where due reference is made. The work has not been submitted for the award of a higher degree elsewhere.

Name: Roxanna Mohtashemi

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Date:

Acknowledgements

I would firstly like to express my gratitude to the twelve participants who took the time to talk to me about their experiences of psychological formulation.

I would like to thank all three of my supervisors. Each of you have brought a unique gift to the project. I am particularly grateful to Ste for providing such consistent support and motivation over the past year. Thank you also to Eva for helping me with recruitment and to Lucy for the advice and direction.

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Section One: Literature Review

Borderline Personality Disorder: A double-edged sword.

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Abstract

Background: Borderline personality disorder (BPD) is a contentious diagnosis. A number of studies report on experiences of individuals who access mental health services with this diagnosis, however, no systematic review of the findings currently exists.

Aims: It is the aim of this paper to synthesise existing qualitative studies to further develop an understanding of how individuals who receive a diagnosis of BPD experience mental health services. An enhanced understanding may help establish any commonalities across services and inform whether the needs of this client group are being met.

Method: A systematic review of the existing literature and metasynthesis of relevant qualitative studies was carried out.

Results: Fourteen studies were included in the review. The over-arching theme ‘diagnosis is a double-edged sword’ describes the potential of a BPD diagnosis to be both helpful and harmful. Four themes highlighted the experiences reported in the studies: undeserving of care, disempowerment, safety and containment and approaching recovery.

Conclusions: Themes indicated the need for more choice and inclusion to be provided by services. Service ethos should be based on universal principles of attachment in order to offer safety and containment to consumers. Additionally a formulation-based approach may facilitate the provision of individualised, person-centred care.

Declaration of interests: None

Key Words: borderline personality disorder, mental health

Borderline Personality Disorder¹ (BPD) is a contentious diagnosis. However it also remains the most widely researched of all ten personality disorder diagnoses, which reflects its prevalence in the UK² within non-forensic mental health services (NICE, 2009). According to the current psychiatric classification system in the fifth edition of the Diagnostic and Statistical Manual (DSM-5), BPD is characterised by patterns of instability in interpersonal relationships, identity, impulsivity and affect (American Psychiatric Association [APA], 2013). Individuals who receive a diagnosis of BPD are said to experience difficulties in regulating and tolerating emotions, relating to oneself and others, a fragile sense of identity and low self-esteem (Bateman & Krawitz, 2013).

Epidemiology

Epidemiological studies offer some insight into the prevalence of BPD, its comorbidity with other axis I diagnoses and the high level of risk of self-harm and suicide attached to individuals with this diagnosis. The majority of these studies into BPD have been carried out in the United States, where it is estimated that 1-2% of the general population have a diagnosis of BPD (Lezenweger et al., 2007; Lieb et al., 2004), with figures increasing to 10% of all psychiatric outpatients and between 15 – 25% of inpatients (Gunderson, 2009). Studies demonstrate 85.4% of patients with a BPD diagnosis meet criteria for having an axis I diagnosis while 73.9% meet criteria for additional axis II personality disorder diagnoses

¹ It is noted from the outset that the researcher adopts a critical stance towards a biomedical understanding of human distress. However, due to the dominance of such language within the field of mental health, some psychiatric terms have been adopted in this study.

² This research focuses on mental health services predominantly within the UK and United States, reflecting the dominant use of the diagnosis in both countries. However, there is a difference in service provision between privatised healthcare in the United States and the UK where healthcare is free at the point of access. This discrepancy between countries has an impact on the way in which diagnostic systems are used, for example in the United States diagnostic frameworks are used for health insurance claims and fee setting. Within the UK there is more flexibility; however, some services are structured around particular diagnoses.

(Grant et al., 2008; Lenzenweger et al., 2007). There is often a high level of risk with the mortality rate from suicide reportedly between 8% and 10%, 50 times higher than the general population (Leichsenring et al., 2011). Self-harm is also common, which means individuals are often seen in non-specialist health settings such as Accident and Emergency wards.

The prevalence of BPD does not differ by gender in community samples (Grant et al., 2008); however there is an estimated 3:1 predominance of women in clinical samples (APA, 2013). There have been a number of hypotheses offered to explain why more women than men receive the diagnosis, predominantly based on gender stereotypes (Bjorkland, 1996; Nehls, 1998; Simmons, 1992). For example it has been proposed that during early childhood boys are socialized to be independent and assertive while girls are taught dependence, passivity and domesticity (Renzetti & Curran, 1995). This may lead to different expressions of distress in adulthood, women are more likely to experience difficulties with eating, mood and anxiety, accessing services where psychopharmacology and psychotherapy are provided, while men are more likely to use substances or demonstrate 'antisocial' behaviour which may lead to a diagnosis of antisocial personality disorder rather than BPD and admission to drug and alcohol rehabilitation programmes or prison settings (Sansone & Sansone, 2011).

The increased use of the BPD diagnosis over recent years since its inclusion in DSM-III (APA, 1980) has resulted in a growing body of research that attempts to establish its aetiology. Although no biological cause has been established so far (Gunderson 2009), quantitative research has established the link between early childhood trauma and BPD (Zanarini et al., 1997). A plethora of research links childhood trauma and disruptions in attachment to individuals with a BPD diagnosis (e.g., Hooley & Wilson-Murphy, 2012; Widom et al., 2009; Zanarini et al., 1997). One study found 88% of people with a diagnosis of BPD had received some form of childhood abuse (Castillo, 2000), while another study found 84% of people with the diagnosis experienced childhood neglect and emotional abuse

from both parents (Zanarini et al., 1997). Rates of reported sexual abuse are significantly higher in those with a diagnosis of BPD than those diagnosed with depression or other personality disorders (Zanarini et al., 1997). Abuse in childhood has been linked to disruption in early attachment experiences which can result in lifelong difficulties with relationships and emotional regulation (Bateman & Krawitz, 2013). Although some argue that not everyone with a BPD diagnosis has a traumatic background, a large amount of evidence indicates the impact of on-going neglect or certain styles of parenting on early attachment experiences, which may have a profound effect on relationships and emotional regulation in adulthood (Gerhardt, 2004).

Critical Perspectives on BPD

Research demonstrating the link between childhood trauma and BPD has developed alongside an uprising of voices speaking out against diagnostic frameworks, most recently in the context of the publication of the DSM-5 (APA, 2013). Within the UK, this has mainly been critical psychologists who have questioned psychiatric dominance. Such a critical position towards psychiatry originally arose from humanistic psychologists in the United States who rallied against capitalist structures of healthcare provision (Parker, 1999). Despite differences in healthcare provision across countries, there has been demonstrable similarity in published critiques on psychiatric dominance across geographical locations (Fox & Prilleltensky, 1997).

Some critiques of the diagnosis of BPD take into account the predominance of BPD diagnosed individuals who have experienced childhood sexual abuse, considering the wider context of gender inequality and social construction of 'madness' in society (Johnstone 2000). Shaw and Proctor (2005) reflect on the societal context of the silencing of childhood sexual abuse and relate this to 'psychiatry's denial of the aetiological importance of abuse, trauma

and oppression for psychological distress' (Shaw & Proctor, 2005, p. 486). In their opinion, appropriate reactions to traumatic experiences are diagnosed as 'symptoms', giving a message of something disordered within the individual, creating an 'us' and 'them' divide (Shaw & Proctor, 2005). This is in keeping with the assertion that language within mental health is more than just semantics, possessing power to shape thought and practice while limiting potential for alternative understandings (Linnet, 2004). There have been proposals to replace the label of BPD with a more trauma-focused term such as 'complex post-traumatic stress disorder' (Herman, 1992, p. 119). Moreover the survivor movement calls for a shift in focus from pathologising victims of abuse to recognising the social context within which they take place (Shaw & Proctor, 2005).

Service Provision and Policy

Gaining further understanding of the psychosocial factors that may lead an individual to receive a diagnosis of BPD has led to a shift away from pharmacology and psychoanalysis towards psychotherapeutic modalities that have demonstrable effective outcomes (Gunderson, 2009). This has meant that research has continued with a quantitative approach, focusing on randomised controlled trials (RCTs) to establish efficacy of competing therapies (Clarkin et al., 2004). As a consequence there have been considerable improvements in service provision and therapies for individuals with BPD diagnosis in recent years (Bateman & Krawitz, 2013). Psychotherapy is recommended as the main form of 'treatment' for those diagnosed with BPD (APA, 2013; NICE, 2009). Despite no clear evidence for the superiority of one model of psychotherapy (Zanarini, 2009) dialectical behaviour therapy (DBT; Linehan, 1993) is often a core part of service provision due to its claim as the 'most economically effective' psychosocial intervention for 'women who self-harm' (NICE, 2009, p. 208). This is reflected in the emphasis on DBT in the majority of studies focusing on the

efficacy of therapy for individuals with a diagnosis of BPD (Cunningham, Wolbert, & Lillie, 2004; Hodgetts et al., 2007; McFetridge & Coakes, 2010).

A number of studies have demonstrated both qualitatively and quantitatively that individuals who have a diagnosis of BPD experience more stigma from health professionals than those with alternative diagnoses (Aviram, Brodsky, & Stanley, 2006). For example, Markham (2003) used a repeated measures factorial design questionnaire study to demonstrate that mental health nurses view service users with a diagnosis of schizophrenia as less dangerous and expressed less social rejection towards them than they did towards those with a diagnosis of BPD. However, the authors considered the study design to be conservative, acknowledging the between-subjects design as a limitation to the study and recommended qualitative methodologies to add to the validity of their findings (Markham, 2003). A literature review highlighted that psychotic experiences reported by those with a BPD diagnosis are often experienced as fictitious by clinicians (Lecomte, 2010). Such staff attitudes may be a reaction to high rates of self-harm and suicide, assumed to be 'manipulative' and purposeful (Steffen, 2013). Such expressions of distress may be classed as 'bad' rather than 'sick' within a medicalised environment (Gallop, Lancee, & Garfinkel, 1989). This may account for narratives portraying individuals with a diagnosis of personality disorder as 'untreatable', leading to their exclusion from some services (Pickersgill, 2013).

Service User Voices

Quality assurance literature (Donabedian, 1998; DoH, 2008), places an emphasis upon the systematic measurement of quality of care from the "frontline up" (DoH, 2008; p. 11), including service user views on the success of their care and the quality of their experiences. Accordingly, there has been a shift in focus upon the experiences of service users who are consumers of the mental health system. In order to gain a rich understanding

of service user experiences, qualitative research has been adopted by a growing number of studies in order to understand the experiences of service users with a diagnosis of BPD who access mental health services. Interpretative phenomenological research focusing on the lived experience of service users specifically with a diagnosis of BPD was initially carried out in the United States (Miller, 1994; Nehls, 1999). Participants in these studies reported experiencing stigma as well as living with limited access to care. Recommendations included the need to confront prejudice, develop an understanding of self-harm and offer opportunities for dialogue between service users and professionals (Miller, 1994; Nehls, 1999).

In the past decade there has been a greater qualitative focus within the UK upon the lived experience of individuals with a diagnosis of BPD who have been in contact with psychiatric services (Fallon, 2003) and perspectives on the diagnosis itself (Horn, Johnstone, & Brooke, 2007). This is likely to be a result of the position paper entitled 'Personality Disorder: No longer a diagnosis of exclusion' (DoH, 2002), which promoted awareness of some of the issues surrounding the diagnosis and considered how to services could be more inclusive. Consequently it seems more attention has been given to the experience of individuals who have a diagnosis of BPD and access services within the UK in order to establish the current status quo on issues outlined by this publication.

There have also been a number of qualitative studies focus on a service user experience of a particular mental health setting; for example Rogers and Dunne (2011) carried out a thematic analysis focusing on service users' experiences of being in an inpatient unit and then later focused on service users experiences of the Care Programme Approach (CPA; DoH, 1990). However a limitation of these studies individually is that they focus on a small sample size in one specific geographical location. It is thought that a comparison across existing qualitative studies focusing on the service user perspective may offer some insight across settings, times and locations of the studies and may also highlight some of the

similarities and differences that are experienced by this particular sample. An enhanced understanding of the experiences of this client group may help to inform whether services are meeting the needs of service users. This may facilitate future service planning, delivery and implementation.

Rationale for Review

Given that previous research has indicated that the diagnosis of BPD may lead to exclusion from services (DoH, 2002) which has resulted in a growing number of qualitative studies providing insight into the experiences of services for individuals with a diagnosis of BPD across a number of different settings, it seems timely to offer a comprehensive review of the existing studies that asks how individuals with a diagnosis of BPD experience mental health services.

Metasynthesis is defined as the amalgamation of individual qualitative studies that focus on a specific topic in order to develop a new or enhanced understanding of the subject area. It has been argued that syntheses can provide an overview of a body of qualitative research and offer more explanation than a single study alone can provide, leading to greater generalizability of research findings (Hannes & Lockwood, 2012). Additionally, metasynthesis has been recommended as suitable for comparing and contrasting research across different settings, sample populations and epistemological perspectives (NHS CRD 2001). Moreover, metasynthesis is a widely adopted methodology within health care research, allowing for the development of an understanding of service user perspective of health care systems (Thorne et al., 2004). Therefore, metasynthesis is well suited to the aims of this review. In particular 'meta-ethnography' (Noblitt & Hare, 1988) will be employed as an appropriate synthesis methodology for the amalgamation of a small number of studies sharing a similar focus. Dixon-Woods et al. (2006) describe meta-ethnography as an

interpretative approach generating new theory to enhance the existing literature base (Dixon-Woods et al., 2006).

Method

Search Strategy

Initial searches were carried out on PsycINFO, CINAHL, Academic Search Complete, MEDLINE and Web of Science in December 2013. The following search terms were used: [*Client** OR *service-user** OR “*service user**” OR *patient** OR *consumer** OR *survivor** OR “*person with mental illness*”] AND [*experience** OR *perspective** OR *perception** OR *attitude** OR *view** OR *reaction**] AND [“*borderline personality disorder*”] AND [*thematic** OR *narrative** OR *interpretative** OR *interview** OR *phenomenol** OR *grounded theor** OR *qualitative* OR *ethno** OR *hermeneutic** OR *heuristic** OR “*lived experience**” OR “*content analysis*” OR “*constant comparative method*” OR “*discourse analysis*” OR “*focus group*”]. Additional searches using the same search terms were carried out in relevant journals, such as *Journal of Personality Disorders* and *Journal of Mental Health* and reference lists from papers included in the synthesis were hand searched for appropriate studies.

Inclusion Criteria

Studies were included where i) data related to the lived experience of receiving a diagnosis of BPD or consequent contact with mental health services; ii) interviews or focus groups were used for data collection iii) analyses contained both ‘first order constructs’ (quotes from participants) and ‘second order constructs’ (the views and interpretations of the authors as expressed in terms of themes and concepts). This was in keeping with the approach of meta-ethnography where ‘third order constructs’ (the views and interpretations of the researcher carrying out the synthesis) are developed from second order constructs through

the process of 'reciprocal translation' (Noblit & Hare, 1988; Britten et al., 2002). To ensure a minimum standard of quality, studies were only included if they had been published in a peer reviewed journal.

Exclusion Criteria

Articles were excluded if data were collected using qualitative methods other than interviewing (for example written data; Morgan et al., 2012; Springham et al., 2012). Studies were also excluded if, upon closer inspection, the analysis included the views of other stakeholders together with service user views (Hummelen et al., 2007; Price et al., 2009). This was because any second order constructs would be an analysis of all stakeholders together and therefore not a sole representation of service user views. Additionally, studies focusing on a range of personality disorders were excluded (Strike et al., 2006). This was because the researcher subscribed to the notion of the importance of language in diagnosis, and that a differently worded personality disorder such as anti-social personality disorder, may create a different experience for the individual. Feasibility or pilot studies focusing on interventions not widely available for the client group in the study were excluded to promote generality of findings (Frogley et al., 2013; Koekkoek et al., 2010). Finally, three of the remaining studies focusing on experiences of DBT were excluded due to the focus on evaluation of a specific therapeutic model, which was judged by the researcher as having a qualitatively different focus than the rest of the studies (Hodgetts et al., 2007; McSherry et al., 2012; McFetridge & Coakes, 2010).

Quality Appraisal

There has been some debate over the use of quality appraisal for the inclusion of papers in metasyntheses (Dixon-Woods et al., 2004). The researcher employed the Critical Appraisal Skills Programme (CASP) tool (Public Health Resource Unit, 1998) in order to

assess the quality of papers, as the tool has been previously adapted for the synthesis of qualitative research (Pound et al., 2005). A summary of the outcome of this process of quality appraisal can be seen in Table 2. Studies were not discounted for scoring poorly due to the reliance on only the published written report (Atkins et al, 2008) and because the content of the studies remained relevant to the synthesis (Yardley, 2000).

INSERT FIGURE 1 HERE

Synthesis

The search process initially retrieved 740 potentially relevant articles. The titles were then read and 387 studies were initially excluded based upon a clear indication that the study was inappropriate for review when considered against the criteria outlined above. Abstracts from the remaining 353 papers were read in order to clarify their suitability which resulted in the further exclusion of 329 articles. The remaining studies were then read in full and a further 11 studies were excluded. Additional manual searches of references lists identified one further article. The process of assessment of eligibility resulted in fourteen studies being included in the final selection and is outlined in Figure 2. Out of 178 participants across all of the studies, between 152 and 157 were female³. Demographic and methodological data are presented in Table 1. The ages reported in the studies ranged from 21 to 61 years. Seven of the studies used samples from the United Kingdom, four studies were from the United States, and the remaining three studies were drawn from (one from each) Canada, South Africa and Norway.

³ Two of the studies included in the synthesis did not include demographic information on age range. One study withheld information on the gender of participants.

INSERT TABLE 1 HERE

In accordance with Noblitt & Hare's (1988) stepped approach to meta-ethnography, the researcher read and re-read the papers in order to become familiar with the selected studies (Noblitt & Hare, 1988). As the purpose of the synthesis was to find a relationship between the selected individual studies, the method of reciprocal translation was employed (Noblitt & Hare, 1988). This method operates on the assumption that findings are presented as themes, concepts or metaphors (Sandelowski & Barroso, 2006). Key themes were taken from both first and second order constructs (i.e., direct quotes from participants as well as developed themes by the authors). Translating the studies into one another employed the technique of 'reciprocal translation' which involved comparing key themes within studies and between studies in order to identify commonalities (Noblitt & Hare, 1988; see Table 3). Third order constructs or "core concepts" identified by the researcher were recorded and are presented in Table 4. Through this process, it was possible to construct a more holistic representation of the phenomena.

Results

The process of translation generated 102 themes, which were synthesised to establish an overarching theme of 'BPD: a double-edged sword' and four core concepts: i) Undeserving of care; ii) Exclusion and disempowerment; iii) Safety and containment and iv) Approaching recovery. A diagrammatic representation of the findings is illustrated in figure two.

INSERT FIGURE 2 HERE

BPD: A double-edged sword

The overarching theme encompasses the multiple dichotomies described by participants in their interactions with services. The need for service users to understand their diagnosis was juxtaposed with the uncertainty of professionals and their withholding of information. The requirement for containment and safety was repeatedly outlined as vital for individuals during crisis, yet services and interactions with staff were often in a context of conflict and negativity which resulted in service users feeling undeserving of care. Some participants reported being in a system where they had little or no say over their care, leading them to feel excluded and disempowered. This often meant participants were ‘tactical’ in their interactions with staff. Participants were careered towards the concept of recovery where they grappled with its significance. Safety and containment were equated with being given an informed diagnosis, consistent and supportive relationships and access to hospital if needed. Participants identified inclusion (being included in decision making, being given choices, and accessing integrated services) as a key facilitator of positive changes.

Undeserving of Care

BPD was seen as a diagnosis given ‘at the end of the road’ when all alternative diagnoses or interventions had been given and had not been effective (Rogers & Acton, 2012). As a result, the diagnosis was described as a ‘label’, with no beneficial purpose in guiding treatment. The BPD ‘label’ was thought to be viewed by staff negatively and to

obscure the person behind it. For example one participant thought that staff viewed women with BPD as “bad girls” (Holm & Severinsson, 2011, p. 169). Similarly being known as a “self-harmer” meant some participants felt that staff only saw the scars not the person behind them (Walker, 2009, p. 125).

Participants spoke about contact with non-specialist services such as Accident and Emergency departments due to self-harm or attempting suicide, describing feelings of rejection and dismissal by staff (Fallon 2003; Nehls, 1994). The range of health professionals participants reported coming into contact with seemed to demonstrate the notion of being passed back and forth between services. This meant there was little time to develop meaningful and consistent relationships with staff (Fallon, 2003; Horn et al., 2007).

Professionals across health services were perceived to view people with a diagnosis of BPD in terms of the ways in which they expressed their distress, for example by self-harm and attempted suicide. Consequently participants perceived themselves as being viewed as difficult and manipulative by staff, which led to assumptions being made about the service user instead of seeing them in a person-centred way:

...they [clinicians] think borderline [personality disorder] is more of a behaviour problem or a discipline problem, rather than an actual psychological problem...that you can choose not to overdose or you can choose not to feel suicidal... ” (Nehls, 1999, p.289).

As a consequence, participants were compared to service users who had a diagnosis of schizophrenia and were classed as ‘ill’ and therefore more deserving of care: “I keep getting compared to a schizophrenic, they’re not in control but you are” (Rogers & Dunne, 2011, p.229). Such attitudes led participants to feel blamed, undeserving of care and marginalized:

Borderline personality is looked upon as hopeless, helpless, low-life, no sympathy...If someone was given a diagnosis of posttraumatic stress, it appears to me that the health professionals I've been involved with look at that with more concern or care (Nehls, 1999, p. 288).

Staff were described in some studies to be dismissive, unsympathetic and insensitive: "I said to him that I jumped out of quite a high tree to try and kill myself, he sort of laughed at me and sort of said 'well that was a bit stupid wasn't it?" (Rogers & Acton, 2012, p. 344). Furthermore, some participants reported being ignored or not believed by professionals, for example not believing that the service user had an infection (and had not taken an overdose) when trying to access Accident and Emergency (Walker, 2009).

As a result participants experienced the diagnosis as rejection to the extent that they no longer expected care: "It just made me feel very lonely and pushed out all the time" (Horn et al., 2007, p.262). A loss of hope was noted by participants in a number of studies as a result of negative attitudes and exclusion from services: "Nothing really works for BPD, you're gonna be in and out of hospital, in repeated crisis" (Rogers & Acton, 2012, p. 344). The loss of hope was also identified in one study, when a participant was told that the diagnosis was untreatable: "I didn't have a positive outlook of my future for quite a number of years" (Horn et al., 2007, p. 262). Some participants challenged professionals about their diagnosis with limited success: "...I'd be put under the hat of being a difficult client... which as it turned out kind of reinforced the label for them" (Horn et al., 2007, p. 261).

Disempowerment and Exclusion

Participants were treated as passive recipients of care within the health system, which meant they felt controlled by the system and excluded from making choices about the type of services they received. Insufficient information was given to the participants about their

diagnosis, the purpose of the appointment, the use of medication and the availability of specialist therapies : “It has been a struggle. A struggle for information” (Fallon, 2003, p.260). Some participants described feeling like a ‘guinea pig’ being tried on numerous medications as a result of uncertainty about how to work with the client group: “...they experiment on you...over the course of years they’ve experimented with loads of different drugs” (Rogers & Acton, 2012, p. 344). Across the studies a dichotomy was apparent where some participants had been told medication was not helpful and there was nothing services could do, whereas others had been prescribed different types of psychiatric medication in the hope they would be effective.

Uncertainty about the meaning of the BPD diagnosis was exacerbated for some participants by a perceived reluctance of mental health professionals to disclose the diagnosis of BPD in the first instance. For example, one study reported two participants being told their diagnosis by their consultant psychiatrist only when they were recruited for the study (Fallon, 2003), which left them questioning professionals’ skills around how to work with them.

One study described participants’ experiences within services as a journey, outlining the movement they experienced within and between services, where they were ‘passed from pillar to post’ or careered through different services with no rationale offered or consent sought (Fallon, 2003), while the rest of the studies captured participants’ experiences of entering services such as acute wards and Accident and Emergency wards for short periods of time when they were finding it difficult to manage distressing emotions. Overall, the lack of control participants perceived to have over their journey through the system was highlighted.

Participants also perceived a lack of control over the way in which their opinions of when they should be admitted and discharged into hospital were dismissed: “I’ve said ‘look I

don't wanna be here, it's making me worse' and they've said to me 'oh you need to be there'" (Rogers & Dunne, 2011, p. 229). Participants were excluded in some studies when important decisions were made about their treatment such as when they would be followed up after being discharged and being invited to Care Programme Approach (CPA; DoH, 1990) meetings: "You're just getting letters, but no actual person really telling you why it's changing or anything (Rogers & Dunne, 2011, p. 43). A lack of information sharing about decisions made on behalf of the service user was also reported: "I'm not sure I've ever had a copy of [my care plan]...in all of mental health services" (Rogers & Dunne, 2011, p. 43).

The terms "forced treatment" and "coercion" were described in a number of studies, for example Rogers and Acton (2012) described how participants were told to swallow a pill or they would have an injection (Rogers & Acton, 2012, p. 345) and "They'll end up sectioning me just because I've tried to leave..." (Rogers & Dunne, 2011, p. 229). Additionally, one study focusing on limit-setting with regard to self-harming while in hospital illustrated the coercive nature of inpatient settings and the power imbalance between staff and patients (Straker & Waks, 1997).

The lack of control participants in the study encountered during their journey through services resulted in conflict where they were caught in a 'bind'. For example, a lack of disclosure by participants was perceived as non-participation during therapy, whereas disclosure of difficulties was perceived to result in increased pressure for hospitalisation (Miller, 1994). Movement between independence and dependence was a contentious issue for individuals with a diagnosis of BPD who were accessing support from services. The need to strike a balance between feeling contained and maintaining independence was also highlighted (Fallon, 2003).

Safety and containment

The receipt of a diagnosis was reported to have potential to allow participants to make sense of their experiences (Fallon, 2003; Horn et al., 2007). The diagnosis was experienced by some as empowering, providing focus and control in their lives, which bought about a sense of safety: “I had something that I could firmly grasp...I could find out about and try to resolve it” (Horn et al., 2007, p.260). Safety and containment was also established through positive relationships with staff and brief periods of hospitalisation.

Across the studies, relationships with professionals, friends and family were identified as the most important factor in the containment of distress and provision of hope. Nominated case managers, who were consistently available to support the individual in their journey through services, facilitated containment and safety (Nehls, 2001). Furthermore, the need to be skilled in communication and offer a listening ear whenever needed was found to be vital in maintaining a positive relationship, as was the need for the service user to be treated with respect:

He listens to what I have to say and then...we'll talk about what we're going to do or what we're going to change. He doesn't tell me, “Well, you need to do this; you need to do that” (Nehls, 2001, p.6).

The need for staff to establish clear boundaries in order to provide containment was reported in one study (Fallon, 2003), whereas another study reported participants wanting their case manager to help outside of the preconceived notion of the idea of a mental health professional (Nehls, 2001): “...he always seems to be there whenever I need him...anytime if I need somebody to talk to” (Nehls, 2001, p.7). In the latter study, having a case manager seemed to provide a ‘lifeline’ when participants were in despair and feeling suicidal. The case manager, with whom they had established a relationship with over a number of years,

was reported to profoundly contain and support the service user to live in the community without needing frequent access to hospital (Nehls, 2001).

Some participants found the experience of being admitted on a brief hospital plan to be containing, offering safety in times of crisis (Nehls, 1994; 2001). The experience of hospitalisation offered participants a surrogate family: “I guess it’s sort of become a family, I mean, because everybody knows me”, as well as an opportunity to establish connections: “I guess for me the brief term plan offers just a chance to talk. I have a lot of trouble with loneliness, like other people do, and I don’t have friends in the system” (Nehls, 2001, p. 6). Hospital was also identified as a place of safety at times when being in the community did not feel safe because of thoughts of suicide and self-harm (Miller, 1994; Nehls, 1994). This was in contrast with the described experiences of feeling undeserving of care described earlier in other non-specialist services.

The provision of a diagnosis backed up with information, supportive relationships and access to hospital offered a safe and containing space for participants, which allowed them to approach ‘recovery’ should they wish to: “This place was different...I felt safe here; they believed I could manage...This was a turning point and my way to freedom (Holm & Severinsson, 2011, p. 170).

Approaching Recovery

The introduction of specialist services was identified by some participants as leading to positive changes in their experiences of care. This was attributed to increased involvement of service users as well as integrated and holistic care: “The whole CPA was based on what I wanted...it was a completely different experience” (Rogers & Dunne, 2013, p.4). However, even in specialist services when asked about their CPA, some participants felt excluded during meetings and care plan development: “Everybody’s made their decisions/choices

without any input at all” (Rogers & Dunne, 2013, p. 41). A strong emphasis was placed by participants on wanting to have a voice and to be asked by professionals what they and their families think is best for them (Rogers & Dunne, 2011).

Some of the participants who had access to specialist services reported it as the first time they had accessed support specifically relating to their diagnosis: “It wasn’t until [the Community Personality Disorder Service] was set up I was ever offered any kind of actual help for the personality disorder” (Rogers & Action 2012, p. 344). The type of support offered by the service promoted alternatives to a medical understanding of distress, for example providing evidence-based talking therapies, particularly DBT. Engaging in therapy helped participants to develop their self-understanding (Holm & Severinsson, 2011). Despite the provision of talking therapies a lack of choice of therapy and long waiting lists were noted which meant accessibility was compromised: “I’ve had to wait years to get psychology, and it’s been apparent for a long time that’s what I needed” (Rogers & Dunne, 2013, p. 43).

Multiple factors were identified as contributing to ‘recovery’ for participants including: the instillation of hope, enhanced relationships and reduced stigma, increased feelings of control over difficult emotions, an enhanced sense of identity, reduced self-harming and hospitalisation, finding meaning in life experiences and the development of self-compassion:

“I was so unhappy before...I was always appalled with myself...And now, I feel like I’ve got something to offer, more confident and I’m happy” (Katsakou et al., 2012, p.3- 4).

The achievement of practical tasks that had previously been a struggle was also associated with recovery: “Two weeks ago I achieved a great big goal – I actually went on the bus for the first time after 25 years!” (Katsakou et al., 2012, p.4).

The contrast between service-related goals and individual recovery goals was highlighted in one study (Katsakou et al., 2012). The specific focus of DBT for example, on the management of difficult emotions and reduction in self-harm could be identified as a service related target to reduce hospital admissions, whereas some participants wanted to work on other goals:

“DBT helped but it didn’t answer all of my questions...I was trying to get over my divorce and also my relationship with my mum and men, and I was trying to work through it but it was all about other things, it was about self-harming, it was about mindfulness” (Katsakou et al., 2012, p. 4).

The concept of recovery was also questioned by participants who did not always see its relevance in their own lives or in relation to their diagnosis. Relating to the lack of information noted in the theme ‘Disempowerment and Exclusion’, there seemed to be a lack of communication from staff around what ‘recovery’ meant: “Nobody explained to me what they meant by recovery” (Rogers & Dunne, 2013 p. 42). Recovery was also thought to detract from the individual experiences of participants: “Don’t treat us like everybody’s the same, whereas everybody’s individual” (Rogers & Dunne, 2013, p. 42). One study reported recovery from suicidal behaviour coming from an internal motivation to change, unrelated to care provision: “I must manage to take care of myself and not leave the responsibility to others” (Holm & Severinsson, 2011, p. 168).

Recovery was described to be cyclical in nature. Some participants felt they had not started the cycle whereas others went through phases of feeling more in control of their emotions and sometimes feeling less able to manage their difficulties. Participants identified recovery as permanently ongoing rather than a ‘final destination’ and thought it needed to be tailored to the individual (Rogers & Dunne, 2013). The notion of someone ‘fully recovered’

seemed unlikely and was identified in one study as potentially risky, as thinking things were okay could lead to a relapse (Katsakou et al., 2012).

Overall, the studies highlighted a shift in services noting specialist services to be generally more inclusive, integrated, recovery-focused, and offered access to therapy. The experience of therapy facilitated some participants in making changes; however the provision of DBT and the notion of recovery were related by some to the accomplishment of service-focused goals rather than individual goals.

Discussion

The need to add further insight into the experiences of mental health service provision for individuals who have received a diagnosis of BPD has been recognised (Bateman & Krawitz, 2013), as have recommendations that services listen to feedback from consumers, allowing them to have a “strong voice” (DoH, 2003, p.22). Synthesising the existing research identified common themes across service settings and conveys the dichotomy service users experience across the services featured in the synthesised studies. The need for safety and containment contrasted against experiences of being unheard and stigmatised, whilst participants’ wish for inclusion in their care was often met with exclusion and disempowerment. This dichotomy has not been mentioned in the individual studies included in the synthesis (original themes can be seen in Table five).

This synthesis demonstrates that authentic and meaningful relationships with professionals were desired as a way of feeling safe and contained. In keeping with previous findings, participants reported being disbelieved and ignored by staff as a result of their self-harm, leading them to feel undeserving of care. This illustrates the damaging nature of the described relationships, particularly in light of previous research highlighting trust as a requisite for therapeutic relationships (Langley & Klopper, 2005). The diagnosis of BPD also

seemed to obscure personhood and had no beneficial purpose in guiding treatment. The reported stigma attached to the diagnosis of BPD has given rise to some training initiatives in the UK (DoH, 2007), where programmes are written and delivered by staff and service users (Lamph & Hickey, 2012). However standardised training remains diagnostically-led, based on the assumption that individuals receiving a diagnosis of BPD are a homogeneous group, despite contrary evidence (Lenzenweger et al., 2007; Grant et al., 2008).

The synthesis demonstrated that although ‘specialist services’ are having a positive impact on service users’ experience of care, a lack of choice at times was still expressed. The majority of individuals with a diagnosis of BPD however, will be seen in generalist settings (Bateman & Krawitz, 2013). Therefore it is worth considering how generic health services can ensure service users are not only included, but take a lead in planning their care.

A lack of choice in accessible therapies was noted, with DBT being the only therapeutic modality mentioned, despite no evidence suggesting its superiority (Zanarini, 2009). Previous research shows that the highly structured nature of DBT means past and present issues remained unexplored (Hodgetts et al., 2007; McSherry et al., 2012). This may be experienced as “dehumanising” (McSherry et al., 2012, p. 543). Additionally, service users have highlighted the value of adopting a collaborative stance and working together to achieve the same goal, reinforcing the need for inclusion (Hodgetts et al., 2007; McSherry et al., 2012). Findings from this synthesis identified positive changes associated with increased feelings of self-compassion, as well as creating personal meaning in experiences. Alternative evidence-based approaches offer opportunities for development in these areas, for example a 16-week compassion-focussed therapy group for individuals with a diagnosis of personality disorder demonstrated significant positive outcomes on a number of standardized measures (Lucre & Corten, 2012). Furthermore, qualitative findings indicated the development of emotional regulation, self-compassion and self-understanding (Lucre & Corten, 2012).

Limitations

The subjective nature of meta-synthesis methodology is acknowledged as a limitation in this approach. The analysis was carried out by one researcher and therefore the interpretation of the studies was subjective. However, a reflexive and systematic approach was maintained throughout the study. Additionally, the original studies included in the synthesis utilised a number of different methodologies which drew on varying epistemological stances such as Grounded Theory and IPA. The differing epistemologies could be considered a limitation to the synthesis (Walsh & Downe, 2005). However, the researcher identifies with the notion that the epistemological stance is less important than capturing pertinent data (Sandelowski & Barroso, 2006) and that combining data may actually enhance the value of findings when synthesised into a coherent interpretation (Finfgeld, 2003).

The amount of information given about the inclusion of ethical considerations and the impact of the researcher upon participants were the two areas with the most negative scores across the studies. For example the relationship between the interviewer and participants was unclear in six of the studies (Fallon, 2003; Katsakou et al., 2012; Nehls, 1994, 1999, 2001; Straker & Waks, 1997), which may have led to a bias in responses.

Three of the studies incorporated in the synthesis had the same first author and another three studies shared another first author. Therefore, the geographical area and specific service recruited from was shared within each of the groups of three studies. Similarly seven out of the fourteen studies included in the synthesis used samples from the UK which reduces potential for generalizability to other geographical locations. However, the UK focus is considered relevant in light of specific government agenda “Personality Disorder: no longer a diagnosis of exclusion” (DoH, 2002).

Clinical Implications

Secure attachments are fundamental for creating a safe base from which to develop self-understanding and contemplate recovery (Ma, 2007). An attachment-based framework for the organisation of mental healthcare services (Seager, 2007; figure four), is therefore proposed. Additionally, service provision should reflect growing evidence demonstrating the role of childhood trauma in the development of difficulties which may be classed as ‘symptoms’ of BPD (Widom et al., 2009). Given the sense of containment knowledge may bring, the psychosocial contribution to receiving a diagnosis of BPD should be imparted to professionals and service users where appropriate, and a trauma-focused model (Herman, 1992) of understanding difficulties should be emphasised. Services should offer individuals the opportunity to re-construct narratives of abuse in order to promote healing within services (Nehls, 1994). Humanistic practice should be at the core of all interventions, incorporating people’s individual experiences and needs. This would enable meaning-making and enhance understanding beyond diagnosis (Steffen, 2013).

Areas highlighted from this synthesis as important for service users (safety, containment and inclusion) should be incorporated into service ethos. A centralised and collaborative formulation detailing difficulties and strengths, with the service user at the centre of planning, may address current experiences of exclusion and disempowerment. Furthermore, it may facilitate a thinking space for professionals which may in turn combat feelings of negativity and enhance empathy towards service users (Berry et al., 2009). All staff working with service users who are in need of reparative relationships should receive appropriate support and containment themselves through supervision, to ensure they are able to provide safety and containment on a consistent basis (Seager, 2006).

A formulation-based approach would also allow for self-defined goals, including individualised conceptualisations of recovery. Formulation may allow the opportunity to find meaning in traumatic experiences and signpost to the most suitable therapeutic modality if appropriate (Division of Clinical Psychology [DCP], 2011). Although DBT has been demonstrated to reduce self-harm and suicidal behaviours, the provision of alternative evidence-based therapies such as Schema Focused Therapy (Arntz, van Genderen, & Drost, 2009) and Cognitive Analytic Therapy (Ryle, 1997) would promote choice and inclusion within services.

It is worth noting that although proposals to replace diagnosis with formulation have been made as a way to individualise care and address negative discourse (Kinderman et al., 2012), the challenges to overcoming a diagnostically-led system have been well documented (Gill, Mullin & Simpson, 2013). It is acknowledged that the complete cessation of a diagnostic approach towards BPD may pose socio-ethical implications for both service users and professionals. For example, without specialist ‘personality disorder’ services, people who may be benefitting from them might be denied relevant interventions. Furthermore, without such sources of support, rates of self-harm and suicide may increase in the community. These potential consequences would conflict with the ethical principles of healthcare (i.e. beneficence, non-maleficence, autonomy and justice; Beauchamp & Childress, 2001). This then poses questions about how levels of risk may be managed in society without the current service structure.

INSERT FIGURE 4 HERE

In addition to focussing attention on the debate on psychiatric diagnosis, findings from this synthesis have highlighted the need for service users to take a lead role in decision

making regarding their care. The adoption of value-based practice (VBP; Fulford, 2004), which emphasises the need to incorporate individual values alongside evidence-based practice, may support effective healthcare decision making. In this way service users and service providers work in partnership to balance different values and perspectives (Woodbridge & Fulford, 2004).

Future research

Database searching carried out during this study revealed a lack of qualitative literature exploring service user experiences of other personality disorder diagnoses (for example, histrionic personality disorder). Further research may determine how different diagnostic descriptors are experienced and whether this has an impact on perceived stigma and access to services. Evaluation of staff training packages on personality disorder (DoH, 2007) would also highlight whether or not this initiative is having an impact on the associated stigma.

The vast majority of participants in this synthesis were female, which reflects the unequal prevalence of men with the diagnosis who access mental health services. One study focusing on the experiences of suicidal men outlined negative experiences with health care providers, leading to avoidance until they reached crisis point and were admitted into services involuntarily (Strike et al., 2006). There is a clear need for further research into men's experiences of health service provision, including their experiences of DBT, which was designed with women in mind (Linehan, 1993).

Aside from DBT, there remains a shortfall of qualitative studies exploring service users' experiences of therapies recommended for those with a diagnosis of BPD (NICE, 2009). Future research into different therapeutic modalities may seek to clarify common factors leading to change and may serve to increase their availability within services. Finally,

further research into the use of psychological formulation across services and disciplines may add weight to its utility in service design and provision.

Conclusions

The meta-synthesis enabled the synthesis of 14 studies describing experiences of accessing mental health services for those with a diagnosis of BPD. The indicated themes suggest the need for a shift in practice, to offer more choice and inclusion to service users. An individualised formulation-based approach may be one way of doing this. Finally, service frameworks should adopt universal principles of attachment, in order to offer safety and containment to consumers.

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Figure one. Figure illustrating search procedure and outcome.

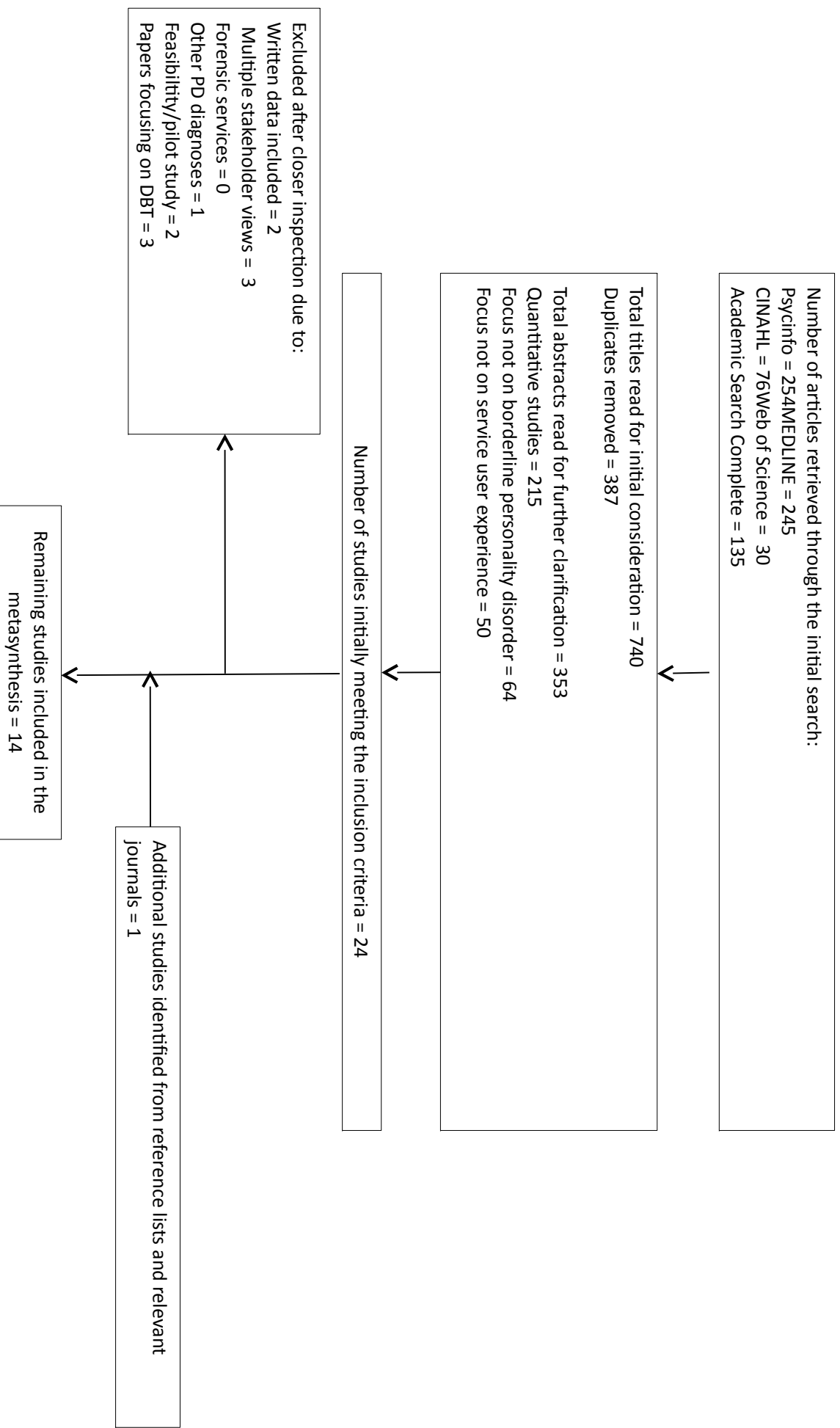


Figure two. Figure illustrating the emerging themes.

INCLUSION

The diagnosis of BPD



is a double-edged sword

EXCLUSION

Figure three. Figure summarising the five universal psychological principles of mental health, safety and well-being policy (taken from National Advisory Group on Mental Health, Safety & Well-Being Towards Proactive Policy: Five Universal Psychological Principles; Seager, 2007).

1. Human well-being depends on universal psychological needs as well as physical and social needs
2. A psychologically-informed generic policy framework is badly needed to promote psychologically safe mental health services (over and above the growing guidance on specific psychological treatments)
3. Attachment theory provides a universal evidence-base that has not yet been harnessed.
4. In mental health it is primarily relationships that can kill and cure, so all our staff must be trained and supported psychologically to promote therapeutic responses to service users.
5. Choosing between medical and psychological approaches is a false choice. Mental distress always has a psychological meaning and context. Any response to distress (including medical) conveys a psychological attitude and impact. Psychological standards for all interventions are therefore required.

Table 1
Demographic information of studies included within metasynthesis.

Study number	Study (N = 14)	Country setting	Sample N (age and gender)	Method of data collection	Type of analysis	Study aims
1	Fallon, 2003	UK	N = 7, 4 female, 3 male 25 – 45 years	Semi-structured interviews	Grounded Theory	To analyse lived experience of participants' contact with psychiatric services
2	Holm & Severinsson, 2011	Norway	N = 13 female 25 – 53 years	Semi-structured interviews	Thematic Analysis	To explore how a recovery process facilitated changes in suicidal behaviour in a sample of women with a diagnosis of BPD
3	Horn, Johnstone & Brooke, 2007	UK	N = 5, 4 female, 1 male 23 – 44 years	Semi-structured interviews	Interpretative Phenomenological Analysis	To explore service user experiences and understandings of being given the diagnosis of BPD
4	Katsakou et al., 2012	UK	N = 48, 39 female, 9 male	Semi-structured interviews	Grounded Theory and Thematic Analysis	To explore what people with a diagnosis of BPD view as recovery
5	Miller, 1994	USA	N = 10, 8 female, 2 male 21 – 50 years	Semi-structured interviews	Grounded Theory	To learn how people experience BPD and its treatment.
6	Nehls, 2001	USA	N = 18, 17 female, 1 male	Semi-structured interviews	Interpretative Phenomenological Analysis	To explore case management services from the perspective of clients in a community mental health centre

Study number	Study (N = 14)	Country setting	Sample N (age and gender)	Method of data collection	Type of analysis	Study aims
7	Nehls 1999	USA	N = 30, female Age withheld	Semi-structured interviews	Interpretative Phenomenological Analysis	To generate knowledge about the experience of living with the diagnosis of borderline personality disorder
8	Nehls, 1994	USA	N = 5, gender & age withheld	Semi-structured interviews	Heideggerian hermeneutics	To understand the clients' lived experience of brief hospital treatment plans
9	Rogers & Acton, 2012	UK	N = 7, 6 female, 1 male 21 – 43 years	Semi-structured interviews	Thematic Analysis	To explore service users' experiences of medication as a treatment for borderline personality disorder
10	Rogers & Dunne, 2013	UK	N = 7, 5 female, 2 male 21 – 61 years	Focus group	Thematic analysis	To explore service users' experiences of a care programme approach while under the care of a community mental health team
11	Rogers & Dunne, 2011	UK	N = 10, 9 female, 1 male 21 – 45 years	Focus group	Thematic Analysis	To explore the inpatient experiences of SU's with a personality disorder
12	Straker & Waks, 1997	South Africa	N = 5 female 22-25 years	Semi-structured interview	Thematic Analysis	To explore service users' experiences of limit setting in regard to self-damaging acts
13	Thérien et al., 2012	Canada	N= 9, 8 female, 1	Semi-structured	Thematic Analysis	To explore pathways to care, transitions between services and general perception

Study number	Study (N = 14)	Country setting	Sample N (age and gender)	Method of data collection	Type of analysis	Study aims
14	Walker, 2009	UK	N= 4, female, 30-54 years	Semi-structured interview		To explore the subjective experiences of women who self-harm with a diagnosis of borderline personality disorder
			male 24 – 53 years	interview		of treatments

Note: Study 4 did not provide an age range for participants.

Note: A positive rating (or 'Yes' in the case of the initial two screening questions) indicates a consideration by the original authors of this point within the CASP tool, whereas a negative indicates a lack of evidence that this point has been considered by the researchers.

Table 3. Example of initial synthesis

Study number	Receiving a diagnosis – uncertainty	Underserving of care: being judged and responded to negatively	Safety and containment via diagnosis	Safety and containment via relationships	Safety and containment via hospitalisation	Inclusion	Feeling unsafe	Playing the game	Exclusion	Approaching recovery
1	Living with BPD: Diagnosis being withheld	Service responses: Stigma: negative attitudes from A&E staff, underserving of inpatient care	Living with BPD: Making sense of feelings and behaviours	Seeking help: Flexibility Relationships: seen as most important supportive factor, clear boundaries, calm, non-judgemental	Seeking help: fast track admission to hospital Risk management	Movement (Negotiation) when involved in decision making it was thought to be helpful	Back and forth between settings of care, travelling through a maze	Proving yourself	Service responses: Conflict between control vs. independence Travelling through the system (A lack of information)	Travelling through the system: Moving on (when integrated into CPA) Negotiation: agreeing goals
		Travelling through the system. (being passed from pillar to post)		Service responses: Containment through a supportive team					Travelling through the system (When not included they felt they were not trusted)	Navigating: learn by mistakes, planned goals, strategies used to facilitate positive movement
		Relationships: Lack of relationships in services		Service responses: improving with CPA					Navigating: power and control	
		Service responses: staff anxieties:							Coercion	
		Being passed from pillar to post: No time to develop relationships								
		Seeking help (negative responses from A&E staff)								
		Relationships: Staff perceived unapproachable resulting in isolation								
2		Recovering by being able to feel safe and trusted: Being seen as 'bad girls'		Feeling safe & trusted: Feeling safe through relationships with staff				The desire to recover by searching for strength: Nurses saying to use their	Recovering by being able to feel safe and trusted	Struggling to

Study number	Receiving a diagnosis – uncertainty	Underserving of care: being judged and responded to negatively	Safety and containment via diagnosis	Safety and containment via relationships	Safety and containment via hospitalisation	Inclusion	Feeling unsafe	Playing the game	Exclusion	Approaching recovery
		Not being seen as a person but a 'disorder'							strength but making decisions on their behalf	stay alive: Starting recovery (from suicidal behaviour) process by self
3	Knowledge as power: uncertainty about what diagnosis meant	Diagnosis as rejection (by services) Diagnosis is about not fitting (dustbin label)	Knowledge as power: providing focus & control						Knowledge as power: knowledge withheld, others expert	Hope and the possibility of change: Light at the end of the tunnel vs: the killing of hope
4										Problems with the word recovery: Black and white, learning to manage emotions Balancing personal goals of recovery versus service targets Personal goals and/or achievement during recovery How do recovered people feel?
5					Hospitalisation as respite from daily struggle			Not agreeing with hospitalization: avoiding self-disclosure	Lack of control over discharge	

Study number	Receiving a diagnosis – uncertainty	Underserving of care: being judged and responded to negatively	Safety and containment via diagnosis	Safety and containment via relationships	Safety and containment via hospitalisation	Inclusion	Feeling unsafe	Playing the game	Exclusion	Approaching recovery
6				My case manager has stuck with me for years My case manager treats me like a person My case manager is more than a case manager						
7	Living with a label: diagnosis not used in treatment plan	Living with a label: Negatively viewed Feeling blamed Self-destructive behaviour perceived as manipulation							Living with limited access to care – leading to feelings of rejection	
8				Hospital as family and friends	Hospital as respite Hospital as a substitute for a meaningful life Hospital as safety					
9	Staff knowledge & attitudes (uncertainty about most appropriate treatment) Lack of resources: Lack of information Lack of info re. recovery Lack of information: Of	Staff knowledge & attitudes: negative Understanding PD: Some staff able to describe meaningfully					Being a guinea pig		Lack of involvement in recovery	Lack of resources: Specialist services leading to positive change Managing side effects of meds
10						Having a voice: joint decision	Accessing treatment:		Accessing treatment: Lack of	Moving on from services

Study number	Receiving a diagnosis – uncertainty	Underserving of care: being judged and responded to negatively	Safety and containment via diagnosis	Safety and containment via relationships	Safety and containment via hospitalisation	Inclusion	Feeling unsafe	Playing the game	Exclusion	Approaching recovery
	treatment options, failures to signpost, side effects					making, family listened to	being a guinea pig, physical health		therapies (only DBT)	(Progression vs consistency)
	Not understanding what staff mean by recovery								Not having a voice: complaints not listened to, SU opinions dismissed	Follow up (Lack of privacy & follow up)
11	Understanding PD: Lack of staff understanding	Revolving door patients: negatives staff responses					Practicalities of ward life: Poor safety Too long waiting for admission, poor availability of services		Needing stepped discharge (but not getting it)	Practicalities of ward life: orientation and positive support
		The 'PD' label: negative staff reactions							Lack of follow up after discharge	
		Comparisons to other diagnoses							Coercion	
12									The power of sectioning Limit setting: subjective experience, perceived as ineffective	
13	Pathways to care – muddling through	Not being believed		Relationships: A range of clinicians positively viewed as caring, not listening, unprofessional e.g. psychiatrist not changing prescription	Safe treatment setting: Physical space hospital as second home	Choice: supported choice vs individual choice	Feeling unsafe: 'I don't like to present myself there'	Being judged and not believed leading to withholding information	Coercion: Negative experiences of forced treatment Forced into passivity	Transitions: Feeling relief at going to PD clinic
		Relationships with clinicians: Not caring, not listening, unprofessional e.g. psychiatrist not changing prescription		Being listened to e.g. psychiatrists taking more time for meetings					Not understanding why forced into treatment: 'muddling through'	
		Transitions between programmes: being passed around							Passivity: Lack of choice, clinicians making decisions, not knowing why, belief in clinician	

Study number	Receiving a diagnosis – uncertainty	Underserving of care: being judged and responded to negatively	Safety and containment via diagnosis	Safety and containment via relationships	Safety and containment via hospitalisation	Inclusion	Feeling unsafe	Playing the game	Exclusion	Approaching recovery
14		Seeing beyond the scars: Health professions seeing the scars not the person Being known as a self-harmer: Not being believed Being treated differently Feeling unworthy						If you cut you lose your children – changing self-harm (playing the game)	Feeling coerced, rejected and abandoned	

Table 4. Example of final synthesis

Key themes, first iteration	Key themes, final iteration	Core concept, first iteration	Core concept, final iteration	Key papers
Service responses: Stigma: negative attitudes from A&E staff; undeserving of inpatient care	Negative responses from health care professionals – Being seen as a label rather than a person	Negative relationships leading to feeling rejected	Undeserving of care: being judged and responded to negatively	1, 2, 3, 7, 9, 11, 13, 14
Seeking help (negative responses from A&E staff)				
Travelling through the system: (being passed from pillar to post)	Being passed back and forth			
Being passed from pillar to post: No time to develop relationships				
Relationships: Lack of relationships in services Service responses: staff anxieties:	Lacking positive relationships in services Staff responding with anxiety			
Recovering by being able to feel safe and trusted: Being seen as ‘bad girls’	Stigma – being labelled as ‘bad’			
Not being seen as a person but a ‘disorder’				
Diagnosis as rejection (by services)				
Diagnosis is about not fitting (dustbin label)				
Relationships: Staff perceived unapproachable resulting in isolation				
Living with a label: Negatively viewed				
Feeling blamed				
Self-destructive behaviour perceived as manipulation				
Staff knowledge & attitudes: negative				

BPD: A DOUBLE-EDGED SWORD

Key themes, first iteration	Key themes, final iteration	Core concept, first iteration	Core concept, final iteration	Key papers
<p>Revolving door patients: negatives staff responses</p> <p>Transitions between programmes: being passed around</p> <p>The 'PD' label: negative staff reactions</p> <p>Comparisons to other diagnoses</p> <p>Not being believed</p> <p>Not having a voice: complaints not listened to, SU opinions dismissed</p> <p>Relationships with clinicians: Not caring, not listening, unprofessional e.g. psychiatrist not changing prescription</p> <p>Seeing beyond the scars: Health professions seeing the scars not the person</p> <p>Being known as a self-harmer: Not being believed</p> <p>Being treated differently</p> <p>Feeling unworthy</p>	<p>Information being withheld, not knowing what diagnosis means</p>	<p>Being unheard</p>	<p>Disempowerment and Exclusion</p>	<p>1, 2, 3, 5, 7, 9, 10, 11, 12, 13</p>
<p>Living with BPD: Diagnosis being withheld</p> <p>Knowledge as power: uncertainty about what diagnosis meant</p> <p>Living with a label: diagnosis not used in treatment plan</p> <p>Staff knowledge & attitudes (uncertainty</p>	<p>Information being withheld, not knowing what diagnosis means</p>	<p>Disempowerment</p>	<p>Disempowerment and Exclusion</p>	<p>1, 2, 3, 5, 7, 9, 10, 11, 12, 13</p>

BPD: A DOUBLE-EDGED SWORD

1-57

Key themes, first iteration	Key themes, final iteration	Core concept, first iteration	Core concept, final iteration	Key papers
<p>about most appropriate treatment</p> <p>Lack of staff understanding</p> <p>Lack of information</p> <p>Lack of info re. recovery</p> <p>Lack of information: Of treatment options, failures to signpost, side effects</p> <p>Back and forth between settings of care, travelling through a maze</p> <p>Being a guinea pig</p> <p>Accessing treatment: being a guinea pig, physical health</p> <p>Practicalities of ward life: Poor safety</p> <p>Feeling unsafe: 'I don't like to present myself there'</p> <p>Not understanding what staff mean by recovery</p> <p>Pathways to care – muddling through</p> <p>Navigating: power and control</p> <p>Knowledge as power: knowledge withheld, others expert</p> <p>Living with limited access to care</p> <p>Lack of control over discharge</p> <p>Lack of involvement in recovery</p> <p>Accessing treatment: Lack of therapies (only DBT)</p>	<p>Feeling uncontained and unsafe</p>			<p>1, 9, 10, 11, 13</p>

BPD: A DOUBLE-EDGED SWORD

1-58

Key themes, first iteration	Key themes, final iteration	Core concept, first iteration	Core concept, final iteration	Key papers
<p>Needing stepped discharge (but not getting it)</p> <p>Lack of follow up after discharge</p> <p>Coercion</p> <p>Service responses: Conflict between control vs. independence</p> <p>The desire to recover by searching for strength: Nurses saying to use their strength but making decisions on their behalf</p> <p>The power of sectioning: Limit setting: subjective experience, perceived as ineffective</p> <p>Coercion: Negative experiences of forced treatment</p> <p>Forced into passivity</p> <p>Not understanding why forced into treatment: 'muddling through'</p> <p>Passivity: Lack of choice, clinicians making decisions, not knowing why, belief in clinician</p> <p>Feeling coerced, rejected and abandoned</p> <p>Proving yourself</p> <p>Travelling through the system (Negotiation)</p> <p>Not agreeing with hospitalization: avoiding self-disclosure</p> <p>Being judged and not believed leading</p>	<p>Coercion and conflict: a lack of choice and power imbalance leading to disempowerment and exclusion</p> <p>Needing to play by 'the rules' – adapting to the system</p>			<p>1, 5, 13, 14</p>

BPD: A DOUBLE-EDGED SWORD

Key themes, first iteration to withholding information	Key themes, final iteration	Core concept, first iteration	Core concept, final iteration	Key papers
If you cut you lose your children – changing self-harm strategies				
Living with BPD: Making sense of feelings and behaviours Knowledge as power: providing focus & control Understanding PD: Some staff able to describe meaningfully	Increasing understanding	Safety and Containment via diagnosis	Safety and Containment	1, 3, 9
Seeking help: fast track admission to hospital Hospitalisation as respite from daily struggle Hospital as respite Hospital as a substitute for a meaningful life Hospital as safety Safe treatment setting: Physical space hospital as second home	Hospitalisation as a safe place, knowing it's there when needed	Safety and Containment via hospitalisation	Safety and Containment	1, 5, 8, 13
Seeking help: Flexibility Feeling safe & trusted: Feeling safe through relationships with staff Relationships: seen as most important supportive factor, clear boundaries, calm, non-judgemental Service responses: Containment through a supportive team	Positive relationships leading to trust and safety, having a team, range of clinicians	Safety and Containment via relationships	Safety and Containment	1, 2, 6, 8, 13

BPD: A DOUBLE-EDGED SWORD

Key themes, first iteration	Key themes, final iteration	Core concept, first iteration	Core concept, final iteration	Key papers
<p>Service responses: improving with CPA</p> <p>My case manager has stuck with me for years</p> <p>My case manager treats me like a person</p> <p>My case manager is more than a case manager</p> <p>Hospital as family and friends</p> <p>Relationships: A range of clinicians positively viewed as caring, diplomatic, good listeners</p> <p>Being listened to e.g. psychiatrists taking more time for meetings</p>	<p>Feeling listened to</p>			
<p>Movement (Negotiation) when involved in decision making it was thought to be helpful</p> <p>Having a voice: joint decision making, family listened to</p> <p>Choice: supported choice vs individual choice</p> <p>Practicalities of ward life: orientation and positive support</p> <p>Travelling through the system: Moving on (when integrated into CPA)</p> <p>Negotiation: agreeing goals</p> <p>Navigating: learn by mistakes, planned goals, strategies used to facilitate positive movement</p>	<p>Being involved in decisions/ being given choices Inclusion leads to recovery Integrated care</p> <p>Accessing specialist services</p>	<p>Approaching recovery: Integration, inclusion, choice</p>	<p>Approaching Recovery: Inclusion and integration</p>	<p>1, 2, 3, 4, 9, 10, 11, 13</p>

BPD: A DOUBLE-EDGED SWORD

1-61

Key themes, first iteration	Key themes, final iteration	Core concept, first iteration	Core concept, final iteration	Key papers
<p>Transitions: Feeling relief at going to PD clinic</p> <p>Follow up (Lack of privacy & follow up)</p> <p>Moving on from services (Progression vs consistency)</p> <p>Managing side effects of meds</p> <p>Lack of resources: Specialist services leading to positive change</p> <p>How do recovered people feel?</p> <p>Personal goals and/or achievement during recovery</p> <p>Balancing personal goals of recovery versus service targets</p> <p>Problems with the word recovery: Black and white, learning to manage emotions</p> <p>Hope and the possibility of change: Light at the end of the tunnel vs. the killing of hope</p> <p>Enhancing self-development and reflection via psychology</p> <p>Struggling to stay alive: Starting recovery (from suicidal behaviour) process by self</p> <p>Recovering by being able to feel safe and trusted</p>	<p>Exploring recovery – Who is recovery for? Pathways to change</p> <p>DBT offered as only therapy Being motivated to change No access to other support</p> <p>Recovery is contested and individual</p>	<p>Hindering recovery: A lack of alternatives, questioning the concept</p>		

Synthesised Themes	Original Study Themes
Undeserving of care	<ul style="list-style-type: none"> - Service responses: Stigma: negative attitudes from A&E staff, undeserving of inpatient care (Fallon, 2003) - Travelling through the system: being passed from pillar to post (Fallon, 2003) - Relationships: Lack of relationships in services Service responses: staff anxieties (Fallon, 2003) - Recovering by being able to feel safe and trusted (Holm & Severinsson, 2011) - Not being seen as a person but a 'disorder' (Holm & Severinsson, 2011) - Diagnosis as rejection (Horn, Johnstone & Brooke, 2007) - Diagnosis is about not fitting (Horn, Johnstone & Brooke, 2007) - Living with a label: Negatively viewed (Nehls, 1999) - Feeling blamed (Nehls, 1999) - Self-destructive behaviour perceived as manipulation (Nehls, 1999) - Staff knowledge & attitudes (Rogers & Acton, 2012) - The 'PD' label: negative staff reactions (Rogers & Dunne, 2011) - Revolving door patients: negative staff responses Comparisons to other diagnoses (Rogers & Dunne, 2011) - Transitions between programmes: being passed around (Thérien et al., 2012) - Not being believed (Thérien et al., 2012) - Not having a voice: complaints not listened to, SU opinions dismissed (Rogers & Dunne, 2013) - Relationships with clinicians: Not caring, not listening, unprofessional (Rogers & Dunne, 2013) - Seeing beyond the scars: Health professions seeing the scars not the person (Walker, 2009) - Being known as a self-harmer: Not being believed (Walker, 2009)

	<ul style="list-style-type: none"> - Being treated differently (Walker, 2009) - Feeling unworthy (Walker, 2009)
Disempowerment and Exclusion	<ul style="list-style-type: none"> - Living with BPD: Diagnosis being withheld (Fallon, 2003) - Navigating: power and control (Fallon, 2003) - Service responses: Conflict between control vs. independence (Fallon, 2003) - Knowledge as power (Horn, Johnstone & Brooke, 2007) - The desire to recover by searching for strength: Nurses saying to use their strength but making decisions on their behalf (Holm & Severinsson, 2011) - Lack of control over discharge (Miller, 1994) - Living with limited access to care (Nehls, 1999) - Living with a label: diagnosis not used in treatment plan (Nehls, 1999) - Staff knowledge & attitudes: uncertainty about most appropriate treatment (Rogers & Acton, 2012) - Lack of staff understanding (Rogers & Dunne, 2011) - Lack of information (Rogers & Acton, 2012; Rogers & Dunne, 2013) - Back and forth between settings of care, travelling through a maze (Fallon, 2003) - Being a guinea pig (Rogers & Acton, 2012; Rogers & Dunne, 2013) - Practicalities of ward life: Poor safety (Rogers & Dunne, 2011) - Feeling unsafe (Thérien et al., 2012) - Not understanding what staff mean by recovery (Rogers & Dunne, 2013) - Pathways to care – muddling through (Thérien et al., 2012) - Lack of involvement in recovery (Rogers & Acton, 2012) - Accessing treatment: Lack of therapies (Rogers & Dunne, 2013)

	<ul style="list-style-type: none"> - Needing stepped discharge (Rogers & Dunne, 2011) - Lack of follow up after discharge (Rogers & Dunne, 2011) - Coercion (Rogers & Dunne, 2011) - The power of sectioning (Rogers & Dunne, 2011) - Coercion: Negative experiences of forced treatment (Thérien et al., 2012) - Forced into passivity (Thérien et al., 2012) - Not understanding why forced into treatment: ‘muddling through’ (Thérien et al., 2012) - Feeling coerced, rejected and abandoned (Thérien et al., 2012) - Travelling through the system (Negotiation) - If you cut you lose your children – changing self-harm strategies (Walker, 2009)
Safety and Containment	<ul style="list-style-type: none"> - Living with BPD: Making sense of feelings and behaviours (Fallon, 2003) - Seeking help: fast track admission to hospital (Fallon, 2003) - Service responses: Containment through a supportive team (Fallon, 2003) - Service responses: improving with CPA (Fallon, 2003) - Feeling safe & trusted: Feeling safe through relationships with staff (Holm & Severinsson, 2011) - My case manager has stuck with me for years (Nehls, 2001) - My case manager treats me like a person (Nehls, 2001) - My case manager is more than a case manager (Nehls, 2001) - Hospital as family and friends (Miller, 1994) - Hospitalisation as respite from daily struggle (Miller, 1994) - Hospital as respite (Miller, 1994) - Hospital as a substitute for a meaningful life (Miller, 1994) - Hospital as safety (Miller, 1994)

	<ul style="list-style-type: none"> - Understanding PD: Some staff able to describe meaningfully (Rogers & Acton, 2012) - Safe treatment setting: Physical space hospital as second home (Thérien et al., 2012) - Relationships: A range of clinicians positively viewed as caring, diplomatic, good listeners (Thérien et al., 2012)
Approaching Recovery	<ul style="list-style-type: none"> - Movement (Negotiation) when involved in decision making it was thought to be helpful (Fallon, 2003) - Travelling through the system: Moving on (when integrated into CPA) (Fallon, 2003) - Navigating: learn by mistakes, planned goals, strategies used to facilitate positive movement (Fallon, 2003) - Enhancing self-development and reflection via psychology (Holm & Severinsson, 2011) - Struggling to stay alive: Starting recovery (from suicidal behaviour) process by self (Holm & Severinsson, 2011) - Recovering by being able to feel safe and trusted (Holm & Severinsson, 2011) - How do recovered people feel? (Katsakou et al., 2012) - Personal goals and/or achievement during recovery (Katsakou et al., 2012) - Balancing personal goals of recovery versus service targets (Katsakou et al., 2012) - Problems with the word recovery: (Katsakou et al., 2012) - Hope and the possibility of change: Light at the end of the tunnel vs. the killing of hope (Katsakou et al., 2012) - Managing side effects of meds (Rogers & Acton, 2012) - Lack of resources: Specialist services leading to positive change

	<p>(Rogers & Acton, 2012)</p> <ul style="list-style-type: none">- Having a voice: joint decision making, family listened to (Rogers & Dunne, 2013)- Practicalities of ward life: orientation and positive support (Rogers & Dunne, 2011)- Follow up (Lack of privacy & follow up) (Rogers & Dunne, 2011)- Moving on from services (Rogers & Dunne, 2013)- Choice: supported choice vs individual choice (Thérien et al., 2012)- Transitions: Feeling relief at going to PD clinic (Thérien et al., 2012)
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Formatting for this journal is APA Fifth Edition.

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- a) For journal articles (titles of journals should not be abbreviated):

Grey, S.J., Price, G. & Mathews, A. (2000). Reduction of anxiety during MR imaging: A controlled trial. *Magnetic Resonance Imaging*, 18, 351–355.

- b) For books:

Powell, T.J. & Enright, S.J. (1990) *Anxiety and Stress management*. London: Routledge

- c) For chapters within multi-authored books:

Hodgson, R.J. & Rollnick, S. (1989) More fun less stress: How to survive in research. In G. Parry & F. Watts (Eds.), *A Handbook of Skills and Methods in Mental Health Research* (pp. 75–89). London: Lawrence Erlbaum.

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Section Two: Research Paper

A qualitative exploration of psychiatrists' understanding and use of psychological formulation.

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Abstract

Background: Despite recent guidance promoting the use of formulation, there is a lack of research focusing on how it is understood and used within clinical practice.

Aims: To establish an initial conceptualisation of how psychiatrists understand and use formulation within adult psychiatry practice.

Method: Twelve psychiatrists took part in semi-structured interviews. Transcripts were analysed using a constructivist grounded theory methodology.

Results: Formulation was conceptualised as an addition to diagnosis, triggered by risk, complexity, and a need for an enhanced understanding. Participants valued collaborative formulation with psychologists. Multiple contextual factors were perceived to either facilitate or inhibit the process. Barriers to formulation led to a disintegrated way of working.

Conclusions: Findings contribute to an understanding of formulation within psychiatry training and practice.

Declaration of interest: None.

This study explores psychiatrists' understanding and use of psychological formulation.¹

An overview of the conceptualisation of formulation within mental health practice will first be offered, before consideration of the existing research into formulation. Finally, a rationale for the study will be provided with aims for the research.

What is formulation?

A formulation-based approach to psychiatry was first proposed by Adolf Meyer¹ and is nowadays claimed to be the basis of Western psychiatry.² Psychiatrists must demonstrate 'the ability to construct formulations of patients'² problems that include appropriate differential diagnoses³ (p.25) and a 'careful clinical history and concise summary of the social, psychological and biological factors that may have contributed to developing a given 'mental disorder'⁴ (p. 19). Despite such guidance, a recent survey asking psychiatrists at various levels of seniority to list what should be included in a diagnostic formulation revealed a lack of consensus amongst participants.⁵ A similar finding was reported in a survey for examiners of the MRCPsych clinical exams.⁶ However, these studies are now dated and there have been no similar studies published since that may clarify whether there is still a lack of consensus on what a formulation should comprise and whether a psychological understanding is used at all.

Formulation has become more clearly defined within clinical psychology and is defined as: "a hypothesis about a person's difficulties, which links theory with practice and guides the intervention"⁷ (p. 2). The formulation should be based on psychological principles and be tentative and open to revision⁷ (p. 6).

¹ For the purposes of this paper, the term 'psychological formulation' is shortened to 'formulation' and describes *the application of psychological theory to inform hypotheses about a certain issue, for example a person's difficulties.*

² The term 'patient' is used (rather than the term 'service user' or 'consumer') throughout the paper, in order to meet the requirements of the specified journal.

Formulation may be used in a variety of contexts across mental health settings. Individual case formulations are traditionally incorporated in some form into the majority of psychotherapeutic modalities^{8, 9, 10} and developed as a 'recursive process of suggestion, discussion, reflection, feedback and revision' during therapy¹¹ (p. 4). Research into the impact of formulation during therapy suggests that it may increase levels of hope and understanding in patients.^{12, 13} Additional research into the use of case formulation is warranted although it remains difficult to disambiguate the contribution of a number of therapeutic factors within clinical practice.

Team Formulation

One way of addressing this problem is to evaluate the use of formulation outside of therapy with staff teams.¹⁴ The process of formulating with a range of professionals is commonly led by a psychologist and may promote a psychosocial understanding for professions primarily trained in a biological model of distress¹⁵, as well as facilitating shared goals, a shared philosophy and accepted roles and responsibilities.¹⁶ Such factors are demonstrated to underpin effective team working, contributing to the increasing efficacy of health care organisations.^{7, 17}

Over recent years there have been a number of small-scale evaluations investigating the process of team formulation^{17, 18, 19} Due to the difficulty of isolating the effect of any therapeutic factors and an interest in the experience of those involved in a formulation process, qualitative methodologies have been preferred.^{17, 18, 19} Craven-Staines, Dexter-Smith, and Li¹⁹ carried out an evaluation of team formulation within an older adult setting using content analysis. Participants comprised social workers, physiotherapists, psychologists, occupational therapists and nursing staff. Team formulation was demonstrated to inform the planning, implementation and monitoring of care plans, offer a clear strategy for disseminating information and enhance psychological thinking amongst the team. A pilot

study investigating the use of psychological formulation to modify psychiatric staff perceptions of service users, used Likert scales to collect data at two time points for 30 mental health nurses and support workers.¹⁸ Data showed that formulation enhanced staff understandings of patients which in turn improved the staff-patient relationships.¹⁸ Picken and Cogan²⁰ used focus groups comprising seven qualified therapists in order to explore clinicians' understandings and experiences of using formulation in an adult mental health service. An interpretative phenomenological analysis demonstrated that formulation was perceived to have significant benefits to the therapeutic process. However the authors acknowledged formulation as a concept widely used amongst other professions and recommended further research to help develop understandings of how formulation can be communicated amongst professionals.²⁰

Unfortunately, there is a lack of participation from psychiatrists within these preliminary evaluations, with either one psychiatrist participating in the study or none at all.^{18, 20, 21} Summers (2006) included two 'doctors' (out of 25 participants) in a grounded theory-based study exploring staff views of the impact of team formulation, however there was no specification about the type of doctor included in the research. The absence of psychiatrists as participants in the studies may be due to expectations of psychiatrists' roles; that they do not work psychologically or take part in team formulation. A lack of psychiatry involvement in an innovative project where formulation training has been carried out with 400 staff across ten community mental health teams and four acute wards has been named as a barrier to promoting systematic change in psychology and psychological thinking.²² Furthermore, a lack of psychiatrist input into formulations may mean that the biological aspects of emotional distress for individuals may be lost with a team of professionals who are trained predominantly in psychosocial approaches.²³ As formulation is now defined as part of the role of psychiatrists,³ a clearer understanding of how a psychological understanding is

incorporated into formulations as well as an initial exploration of psychiatrists' experience of team formulation may help to guide clinical psychologists when working using formulations in MDT's.

Rationale for the current study

There is currently no existing research to offer an understanding of how psychiatrists understand formulation and whether they value team formulation and/or consultation with psychologists to develop a psychological understanding of their patient's difficulties. In order to enhance clinical practice for both staff and patients it is necessary to have a clear understanding of what is understood by the concept of formulation and how it is used. This is in keeping with recommendations to continue to share a dialogue with other disciplines within the field of mental health practice.⁷ This study therefore asks the questions:

- i) How do psychiatrists understand formulation?
- ii) How do psychiatrists use formulation in their everyday practice?
- iii) Do psychiatrists value the process of formulation with psychologists and/or in a team?

Aims

In consideration of the lack of an existing evidence base, this study aimed to offer an initial conceptualisation how psychiatrists understand and use formulation. A qualitative approach was adopted to allow for an in-depth understanding of participants' experiences.²⁹ Given that there are no existing studies in this area, the formation of a model may allow for greater understanding of the processes involved. Consequently grounded theory³⁰ methodology was used in order to build an initial model of psychiatrists' understanding and use of formulation. It is hoped that a model describing the process of understanding and use of formulation may offer insight into ways in which psychology and psychiatry can facilitate cross-disciplinary working within mental health services, with the ultimate aim of improving experiences of services for patients and families. Findings also have the potential to inform

future incorporation of psychological and multidisciplinary formulation into the Royal College of Psychiatrists (RCPsych) and Doctorate in Clinical Psychology (DClinPsy) teaching curriculum.

Method

Design

A qualitative approach was adopted, to allow for the exploratory nature of the research question and to establish an initial conceptualisation of the subject within adult psychiatry practice.²⁹ The methodological principles of a constructivist grounded theory approach³⁰ were adopted. Grounded theory has been widely recognised as suitable for theoretical development into novel areas of research, where there is no pre-existing theory.³¹ Data were collected using semi-structured interviews with participants who had experience of the research topic. The researcher adopted a social constructionist approach to grounded theory, acknowledging an active role and therefore influencing the interview process and findings.³⁰

Participants

Participants were recruited through the RCPsych. Emails were sent to all members residing in three counties within the Northwest of England. Additionally, participants were recruited via email directly through one NHS Trust and two Deaneries within the Northwest of England. Participants were considered eligible for the study if they were qualified psychiatrists or psychiatrists in training and had experience of working in an adult mental health service where there was a clinical psychologist. Participants were recruited to cover a range of different levels of training (core trainees, higher specialist trainees and consultants).

Twelve participants working in different services across four different NHS Trusts were recruited. All participants had experience of formulation within adult services. Participants were aged between 33 and 67 and ethnicity was diverse (see table one for

demographic data). All participants chose a pseudonym for themselves, in order to ensure anonymity.

Data collection

Data were collected via one-to-one semi-structured interviews using an interview schedule developed with the support of the psychiatrist supervising the project. All interviews were audio recorded. The interview schedule was used flexibly with initial interviews, when verbal prompts and probes were necessary (see Ethics Section for the interview schedule). After the initial interviews had been conducted and initial analyses had been carried out, the interview schedule was adapted in line with the process of theoretical sampling.³² Emerging codes from initial interviews were used to enhance and re-focus the interview schedule.

Procedure

Ethical approval was obtained from Lancaster University Research Ethics Committee and NHS Research and Development approval was obtained from the relevant NHS trust prior to carrying out the research (ethical documentation can be seen in the Ethics Section). Recruitment emails included an information sheet, consent form and demographic form. The researcher's contact details were provided for any queries participants may have had. Potential participants then returned a completed consent form and demographic form by email, in order to allow the researcher to carry out interviews informed by theoretical sampling.³² Recruitment was initially targeted at psychiatrists who worked in adult services; however, because psychiatrists work across numerous specialisms during their career path, it was difficult to separate out experiences relating solely to adult services during interviews. Therefore psychiatrists were recruited across specialisms, although they all had gained most of their experience of working within adult services. Ten participants chose to be interviewed at their place of work and two at their homes. Before commencement of

interviews the researcher addressed any queries, explained issues of confidentiality and gained informed written consent from the participant. If a demographic form had not yet been received by email, participants were asked for the information verbally before commencement of the interview. Interviews lasted between 40 and 90 minutes and on average were 60 minutes long.

Analysis

Analysis was informed by constructivist grounded theory, acknowledging 'truth' as socially constructed through language and social interactions.³⁰ Interviews were analysed and coded in batches of three. The inductive technique of line by line coding was initially carried out in order to fragment and name the data. Codes were described using gerunds to make them active and identify processes.³² Next, the line by line codes were scrutinised and any significant³ codes were translated into focused codes. The focused codes were then put into an excel spreadsheet where they were sorted and re-analysed using the constant comparison method.³³ Codes were checked against one another within and between transcripts, which ensured an inductive approach to the research and illuminated the relationships between different levels of data and analysis. For example, the focused codes 'working collaboratively' and 'integrating' from two different interviews, were combined and added to the conceptualisation of 'singing off the same hymn sheet'. Examples of the development of line by line codes into focused and conceptual codes can be seen in Appendix 2-A and 2-B.

The use of memos and diagrams aided the development of categories from codes, and linked categories together³⁴ (see appendix 2C for a memo excerpt). Theoretical sampling³² was utilised once initial categories had been developed, to test out the emergent theory. For

³ Codes were considered to be significant due to their frequency and if they made the most 'analytic sense to categorize data incisively and completely' ³⁰ (p. 57).

example in earlier interviews a relationship was identified between the number of years participants had been qualified and the emphasis they placed on using formulations in teams. In order to seek clarification, the question “how has your use of formulation changed as your career has progressed?” was added to the interview schedule and participants who had been qualified for a considerable number of years were selected from the participant pool (see critical appraisal for further information on theoretical sampling).

Due to the pragmatic nature of carrying out inductive research as part of a time-limited professional doctorate, ‘theoretical sufficiency’^{4, 35} rather than ‘saturation’ was established as an initial conceptualisation of participants’ experiences of the research topic.

Reflexivity

It was important to remain reflexive³⁶ throughout the research process in order to be aware of possible biases towards the data and the emerging theory. A reflective journal was kept throughout the research process in order to facilitate reflexivity. Regular supervision provided by an academic supervisor who was experienced in grounded theory methodology, facilitated reflection upon the emerging theory. The academic supervisor also provided feedback on an audio recording of the first interview and on some of the memos and diagramming during the analytic process. The researcher discussed the emerging theory and diagrammatic representation with an additional research tutor who was well versed in grounded theory, which enabled the identification of gaps and informed the interview schedule for the final three interviews, for example finding out more about the dichotomy between using formulation and not needing formulation. A grounded theory peer group was also regularly accessed in order to explore the theoretical underpinnings of the interpretation and gain further insight.

⁴ ‘Sufficiency’ was considered when conceptual categories did not require revision in light of fresh data. This is in contrast to ‘data saturation’, which is achieved when interviews no longer offer new insights.³²

Results

The analysis identified 111 focused codes which were grouped and re-grouped into four conceptual categories of: (i) conceptualising formulation; (ii) singing off the same hymn sheet; (iii) barriers to formulation and (iv) making a Frankenstein's monster.

Psychiatrists' understanding of formulation developed during their career. Diagnosis and medication were described to be the priority within their role and a psychological understanding was not always seen as necessary. Formulation was always alongside not instead of diagnosis, as part of a psychiatric formulation, or during psychotherapy practice. When there was a perceived increase in risk, complexity or when patients frequently re-entered services, they were referred on to psychology. If psychologists were within proximity, participants described entering into a joint process of formulating, which was used to communicate with the team and inform planning. Barriers to understanding and using formulation were described, which included a lack of time, unavailability of psychologists, limited skills from training, and pressure and controversy surrounding the medical model. These barriers resulted in 'making a Frankenstein's monster' where there was a perceived lack of reflection leading to disintegrated way of working. Some participants described the pressures as dissatisfying which led them to seek alternative ways of working. The four conceptual categories are presented in narrative form below, together with supporting quotes taken from the original data.

(i) Conceptualising formulation

Participants' understanding of formulation was described as a developmental process, contingent on psychiatry training and clinical practice.

diagnosis and medication. Participants described a strong grounding in a bio-medical model of distress, instilled from undergraduate medical training. Diagnosis was noted to be the foundation of their role, prioritised alongside medication. A psychological

understanding was not always perceived as necessary; patients' difficulties were sometimes understood to be purely biological in nature: 'if someone is bipolar, it's bipolar, you know they're manic, you don't need to [formulate]...you do diagnosis' (Stephanie). However, this approach was only ever described by trainees, perhaps suggesting a lack of experience in integrated working. Other reasons given for not using formulation were if a patient was only in the service for a short time, or if they were considered to be in an 'acute' phase and not able to engage in the process. In these cases diagnosis and treatment was thought to be a sufficient course of action. Dave explained how individual differences contributed to whether or not psychiatrists used formulation:

'I think it depends on the psychiatric background of the person...I have an analytical background, so it's much more easy for me to do the formulation but if you ask me...whether it's being done regularly by all the consultants, or medics, I would say unlikely.'

Overall, diagnosis and medication were the main foci of participants' perceived roles and a psychological understanding was not always considered necessary.

psychiatric formulation. A psychological understanding was described by participants as part of a biopsychosocial³⁷ model. The term 'psychiatric formulation' or 'biopsychosocial formulation' was used interchangeably during interviews to describe an overall understanding of the patient, which incorporated the psychological and socio-historical factors contributing to a patient's presenting issues: 'I'd probably preface biopsychosocial formulation, you know, so I would probably never use the term formulation generically, and would say psychiatric or biopsychosocial formulation' (Rob). The 4 P's^{5, 38} formulation was included as a biopsychosocial understanding and reported to be used by

⁵ The '4 P's'³⁸ formulation was originally proposed by Weerasekera and incorporates predisposing, precipitating, perpetuating and protective factors.

some participants, incorporating predisposing, precipitating, perpetuating and protective factors. Psychiatric formulation always included a diagnosis and an actuarial risk assessment:

'I have a very clear model in my head which... includes a primary diagnosis, a differential diagnosis, a description of aetiology which... would include risk as well and would include then a proper formulation... aimed to link the events in somebody's life history and environment with their character and propensities to try and explain their presentation, their likely response to management and their possible prognosis and associated risk' (Zadoch).

Formulation in this context was described as a heuristic device to enhance understanding, which led to a number of different outcomes including the offering of hope, informing reports, improving medication concordance, signposting to treatment and management of care. A diagnosis was not perceived to be sufficient in this respect as Jack described:

'I might see a patient who was obsessional in nature... I can give them a DSM diagnosis... but actually I'd quite like to know where has that come from... that helps me understand the behaviour, as it does in my opinion the patient. Because giving the patient a label and a diagnosis is all very well, but helping them understand where it's come from is, I think that's part of the hope bit.'

The majority of participants described using a 'psychiatric formulation' in everyday practice.

psychotherapy (case) formulation. Participants' first experience of formulating using psychological models occurred during psychiatry training where they undertook two psychotherapy cases as a mandatory requirement of core training. Psychotherapy training was described to be an anxiety provoking time and full of uncertainty. Participants believed they 'need to get it right' (Jane) because of the impact they perceived it could have on the patient. Some participants responded to this uncertainty by using avoidance strategies:

'people shy away from it' (Jack). Others accessed support such as Balint⁶ groups and supervision in order to develop their reflective skills and psychological thinking:

'...It was a real anxiety provoking experience...it felt like there was a lot at stake...if I mess this up this could be this person's last chance but the process of actually being supervised...was a very powerful learning experience...I came out of it feeling like I'd had therapy myself' (Jane).

Some participants had further training in a therapeutic modality, for example Michael had recently trained in family therapy and Rebecca had trained as a CBT therapist.

Participants described a process of finding a therapeutic model fitting for them as well as the patient and the problem. For example Gerry chose to use CAT predominantly within his clinical practice as he described it fitting with his interests and character: '...it's always been very obvious that things happen in interaction. I'm quite interactive and so the central concept of reciprocal roles in CAT is both hugely explanatory, is fascinating, is very useful'.

Complexity, a high level of risk and patients who accessed services frequently were perceived as reasons by participants to warrant either referral to psychology or consultation with psychologists. For example, patients within Stephanie's service who self-harmed, as well as those who were "in and out of hospital" were prioritised for psychological support. This related to Jack and Rob's observation of having more psychology presence in forensic services, where there was a greater emphasis on risk.

Participants described progressing through their psychiatric career relying on the psychotherapeutic model they had received the most training in, however formal case formulation was not used by participants beyond experiences of training. Where formal case

⁶ Balint groups³⁹ are long established groups for medical doctors which explore difficult interactions they may be experiencing with patients, with the aim of enhancing the therapeutic relationship. Groups are usually facilitated by a psychoanalyst.

formulation was thought necessary by participants, they described seeking psychological support.

(ii) Singing off the same hymn sheet

Some participants described entering into a process of creating a unified understanding between psychologists and psychiatrists, resulting in the successful integration of different epistemological positions. This process was named by Jack as 'singing off the same hymn sheet' and dependent on a number of contextual factors.

facilitating contextual factors. Facilitating contextual factors included psychology being available, positive working relationships and an expressed individual interest in psychology by participants. Positive relationships with psychologists available not just within the service, but who were in close physical proximity and available to consult with when needed was an important requirement for being able to enter into a process of integration. Value was attributed to psychologists who dedicated time to training and consultation. Some participants valued and advocated for more psychological input into teams in order to facilitate shared understandings:

'I think that's a crucial role for a psychologist, to do that supportive stuff with staff, where they can help them think more psychologically about people, make certain ways of dealing with behaviour less punitive because you've got a deeper level of understanding of what's driving something' (Jane).

Some participants felt it was a misuse of resources for psychologists to spend the majority of their time delivering therapy to a relatively small number of individuals, rather than consulting with the team. One participant disagreed: 'it's a strange idea that you spend an hour protected time actually giving a psychological intervention or just talking with a patient but you spend two to three hours in meetings discussing these patients. That's the wrong way round' (Dalglish).

formulating with psychologists. Jane described a joint process of formulating with the ward psychologist, in order to facilitate and develop the most appropriate pathway out of the service for a patient with complex needs:

‘...the conversations with her [the psychologist], just kind of developed into thinking a bit more...we had an interesting meeting with him [the patient], me and the psychologist and the nursing staff and then afterwards we were able to have a ten minute conversation, the psychologist and I, about what we felt we got out of that.’

This joint understanding enabled the difficult dynamics between staff and patient to be explored with the staff team. Formulation was also used as a language to communicate with team members, professionals outside the service and patients themselves: ‘I had to get forensic commissioners on board...and speak to forensic colleagues...being able to take it back to a basic formulation really helped’ (Jane).

Dave described a positive experience of working with psychologists in the past, where shared objectives and roles were clearly defined: ‘the psychologist there was quite knowledgeable and it was easy to work with her because she understood her role as well as the role of psychopharmacology and how it’s a multi-disciplinary approach, so it was not like one person leading the team, it was much more collaborative in the true sense of the word’. This collaboration resulted in an enhanced understanding as Dave went on to describe: ‘it was much easier, especially working with some of the resistant personality disorders who resist discharge...we could work on the formulation and say well these are the exits, these are the things that are going on’.

A similar process was described within forensic settings, where HCR-20⁷ risk formulation took place. Psychologists were described to play a key role as part of the team process:

‘We use it with the psychology team... we do a formulation at the end to bring all that information together and say well where is this person likely to be going on their psychological journey and how can we prevent things from happening or understand why they’re happening. And that informs the multidisciplinary team’ (Jack).

Participants expressed a desire to see an increase in psychologists training nursing staff in basic formulation skills, for example Rebecca emphasised the need to ‘maximise the effects of individual therapy’ by equipping care co-ordinators with psychological formulation and intervention skills: ‘...I think for me what’s more important is to actually build skills within the team so that practitioners would be able to have some basic skills around formulation’ (Rebecca).

The result of collaborative working and integration of different understandings resulted in a unified understanding which was defined by participants as a formulation. The overall concept of ‘singing off the same hymn sheet’ was named by Jack and encapsulates the integration of understandings and collaborative working, as he explained: ‘the aim of it is that you are all working together, that you’re singing off the same hymn sheet. And isn’t that what the formulation is?’ As participants became more experienced, their valuation of collaborative staff formulation seemed to increase, which meant they engaged in the process with more frequency.

(iii) Barriers to formulation

⁷ The Historical Clinical Risk Management-20 Tool⁴⁰ (HCR-20) is widely used in forensic settings to assess and manage risk of violence and is based on a model of Structured Professional Judgement.⁴⁰

Participants' understanding and use of formulation was perceived to be dependent on the wider system. This was reflected in interviews where a large amount of time was spent talking about different contexts, for example the politics surrounding psychiatry and limitations within NHS services. Participants perceived themselves to be faced with multiple barriers that impacted on their ability to formulate and think reflectively.

A lack of time. The allocation of fifteen minutes for clinical appointments was described as insufficient to be able use formulation directly with the patient, resulting in a 'robotic' and risk-focused approach (Dalglish). Perhaps because of the barrier of time, participants spoke more about formulation being used to enhance their own understanding rather than directly enhancing the patient's understanding. An exception to this was Rebecca's description of a patient who had received cognitive analytic therapy and was able to bring her formulation 'map' to appointments to discuss when experiencing difficulties:

'...we'll talk about exit points in her formulation so, she kind of utilises it in a positive way and we use it when she has a crisis.'

Participants described being under immense pressure to make quick decisions within their roles, which did not allow for formulating or reflective practice. Anita noted 'we don't think; we just do', while Dave commented: 'they say you have to do reflective practice... we don't have the time'. One exception to this way of thinking was Gerry, who thought it was always possible to 'make time' for formulation within one's role. Gerry also commented that as the number of years of practice increased, so did the time he would take to see a patient: '...with that first appointment, I couldn't possibly do it in under an hour nowadays. I've got longer and longer'. It was acknowledged however that Gerry's senior role within the Trust gave him more freedom to use his time as he liked.

In cases where a patient was admitted to a ward on a short-term basis, participants thought the time taken to create a formulation was longer than the patient admission length.

Jane described the process in a Psychiatric Intensive Care Unit (PICU): 'you're trying to gather information from a variety of sources with someone you've not met before, who might not be with you for more than a few weeks so that takes a lot of time'. Jack's perception was that in acute settings this resulted in formulation not being done: 'truth is you know, Mr Bloggs is going to go home and be seen by the CPN and he may wait for psychological services for another year. So, you know what, I'd just leave it'.

The prioritisation of risk was described to be a dominant way of working within psychiatry practice, which in combination with the noted time restrictions during appointments, led to the sacrifice of a more therapeutic and person-centred approach to formulation: 'you know, you only have time to ask them whether they're suicidal...'
(Dalglish). The actuarial process of risk assessment was critiqued for its lack of integration of risk factors and overall description, whilst a more dynamic risk formulation-based approach was advocated:

'They're often just checklists for risks which ... take a purely actuarial approach but I think misses a lot of important information and discourages people from coming up with formulations for risk assessment that describe the dynamic factors....so that sort of formulation approach I think works a lot better for risk' (Zadoch).

Overall, participants identified time restrictions caused by increased case loads and reduced clinical time with patients as resulting in a more actuarial-focused approach to risk and a lack of time for psychological thinking, as well as limiting the potential to re-visit an already established formulation when seeing a patient during clinic.

Unavailability of psychologists. Participants described a general lack of psychology within adult mental health services, for example Dave reflected on his experience working on a ward where there was no psychology input due to a lack of funding. Zadoch described psychologists being 'separate' from the rest of the multidisciplinary team; for example not

training with other disciplines so not being understood by the rest of the team, resulting in their alienation. Rob also expressed a perception of 'separateness', with regard to the way psychologists seemed reluctant to share information with the team: ... 'I think a lot of the work of psychologists is hidden, so in some ways I would know... a lot more about how psychologists approach things and how they describe things if we had shared case notes' (Rob).

The referral process to psychology in another location, where there was no face-to-face contact meant there was more of a sense of separation between the disciplines. For example, Stephanie spoke about referring patients to a psychology service from her acute service, where the patient had to be an outpatient in order to be accepted. Therefore, the opportunity to develop a psychological understanding was not available until after the patient had been admitted into hospital, and had received a diagnosis and medication.

Limited skills from training. Some participants perceived a lack of emphasis on formulation and a general move away from psychological thinking in the practice of psychiatry:

'There isn't the same emphasis on the need for those kind of [formulation] skills across the board, even if you're never going to go near a psychotherapy patient, there isn't that sense for me that everyone should be able to formulate to a basic level... I'm not sure that there's ever been as much of an emphasis as there should have been...' (Jane).

This was partially attributed to a shift in training, as participants perceived that formulation skills were no longer included in examinations which impacted on learning and utilization in clinical practice:

'They shifted it out of the part one and then out of the part two [exams]... the ability of trainees who were not yet doing the part two, to formulate the second half of the formulation, disappeared, evaporated. It was like going off a cliff...' (Zadoch).

Further limitations were perceived by participants as less supervision and training from consultants and a decrease in the length of the training course for psychiatrists. Dave explained:

‘You’re required to do two psychotherapy patients under supervision and once you’ve done that, that’s it. And so the whole of your understanding and your opinion of psychology depends on the experience you get so in case you end up getting a very poor supervisor, then your opinion on psychotherapy gets coloured...’

Some participants expressed concern that the changing curriculum was having a great impact on the quality of training: ‘I think there’s a danger of it going the other way in that the quality of training I think is in danger of changing really’ (Jane).

The majority of participants wondered whether receiving teaching from psychologists during training might facilitate a more integrated way of working, as well as enhancing the learning process of formulation:

‘I think it would be very useful if...there was the psychiatrist and the psychologist, the trainee, and that you put together a one or two day workshop I think people would jump at it...because you get very little training’ (Jack).

In summary there was a shared viewpoint of insufficient training and a lack of emphasis upon formulation and psychological ways of working, particularly outside of a formal psychotherapy scenario.

the dominance of medical model: pressure and controversy. Some participants conceived a pressure to conform to using a medical model when working, needing to use diagnosis as a priority, in order to provide medication and classification. This pressure came from multiple stakeholders, from the patient to GPs: ‘Some people really want to be medicalised’ (Rob) and ‘The GP wants more a medical model. He just wants a number’ (Vivek).

Psychology was seen by some participants as a threat or attack to the profession of psychiatry, with a branch of psychologists being described as 'anti-psychiatry'. This was a barrier within the workplace as psychologists perceived as anti-psychiatry were thought to behave in a defensive way in their interactions with psychiatrists. A small number of participants described feeling attacked and responded by defending their profession during the interview, critiquing the position of some psychologists. For example, the notion that formulation could replace diagnosis was picked up on by a number of participants, who all expressed an opinion that formulation was a useful adjunct to diagnosis, but not an adequate replacement: 'psychological formulation is a helpful tool for psychotherapy etcetera, but it can't replace diagnosis for a variety of reasons, just because it's not meant to, it can't' (Dalglish).

Some participants described professional rivalry causing psychiatrists to revert to a dominantly biological understanding of distress. Rob stated that:

'...there's some people who are reacting against that [challenging diagnosis] who are seeking to define what they do and in some ways narrow their understanding of a reductionist model to a purely biological, chemical based model.'

Overall, the majority of participants thought that professional rivalry or 'guild conflict' (Dalglish) was an unhelpful factor in a successful working relationship between psychology and psychiatry and moved towards a process of acceptance and integration of both disciplines.

(iv) Making a Frankenstein's monster

The consequences of not being able to develop a psychological understanding due to one or more of the barriers described above, led to a perceived lack of reflection. This resulted in participants resorting to number of alternative approaches. Participants also spoke about the long wait for individual therapy for their patients, which meant a period of

instability for the patient where alternative interventions were offered (for example, occupational therapy or the prescription of medication).

There was a perceived over-reliance on a medical understanding of distress, as a consequence of limited resources. For example Dave reflected that '...you might end up prescribing medication because you might have to come across as doing something. But you know that it's psychological'. This was described by Michael as a 'top-down' pressure to conform to using medication, whereas Dave perceived the pressure also coming from patients themselves: 'some of the time the patient comes in and says well I can't be bothered to sit down and talk so could you give me a pill'.

Zadoch described a process of treating 'complexity' with multiple types of medication with a consequence of not knowing what had worked. Overall, the accumulation of this process resulted in interventions being separate and dis-jointed which was perceived by participants to be unhelpful and a drain on resources. For example Zadoch described trying to understand a patient with information perceived as incoherent: 'he's got some sort of impulsivity, given him some SSRI's for that, and on the other hand he doesn't get on very well with his mother and it doesn't really fit together'. Overall, the combination of a lack of integrated understanding of a service user, over-reliance on medication and general lack of resources was described as creating a 'Frankenstein's monster' (Zadoch), where the monster represented the process of disintegrated practice by psychiatrists.

The described approach maintained barriers to understanding and using psychological formulation, resulting in patients being treated without a holistic understanding, which meant that patients kept returning into the service:

'It's a false economy in my view often...because you haven't done the formulation you don't understand what's going on...you just make more work for yourself. But people don't see it like that because they're not taking an overall view' (Rebecca).

Additionally, three participants spoke of experiencing dissatisfaction with working in a pressurised environment, which eventually led them to 'seek alternatives' such as entering academia, working privately or moving into other specialisms where there was more time and resources to work in ways which they preferred. For example, Michael talked about moving from adult services into child services, as he perceived there to be less pressure to prescribe medication and more time to think psychologically.

In summary, psychiatrists' understanding of formulation developed during their career and it was used alongside diagnosis to enhance understanding. Psychological support was triggered by a perceived level of risk and complexity. If psychologists were available, participants described developing a joint understanding, however, there were a number of noted barriers to formulating which led to disintegrated way of working and dissatisfaction in participants who sought alternative ways of working. A diagrammatic representation of the findings can be seen in figure 1.

[Insert figure one]

Discussion

Findings from this study offer an initial conceptualisation of a sample of psychiatrists' understanding and use of formulation, highlighting how utilisation was dependent on experiences within both psychiatry training and clinical practice. Previous research into professionals' views of formulation comprises small-scale evaluations of staff experiences of team formulation,²⁰ psychologists' perceived roles in creating and sharing formulations within MDTs,⁴¹ and numerous opinion pieces promoting the use of formulation either alongside,²⁶ or as a replacement to diagnosis.¹¹

Formulation was defined by participants within a psychiatric framework, as an addition to, and never in place of diagnosis. This is distinct from DCP guidelines⁷, which

posit that formulation is adequate in itself to summarise and understand the experiences of the patient, without necessarily needing a diagnosis. Furthermore, although formulation seemed to give context to an individual's difficulties, the underlying understanding of the distress remained medically conceptualised. Again, this is a distinct focus from that outlined by DCP⁷; while participants drew on psychological theory to understand a patient, they applied the theory in addition to a 'disease' model to understand the difficulties. This is in contrast to a co-constructed understanding with the patient, on the premise that "at some level it all makes sense"⁴² (p. 2). These alternate understandings of formulation reflect the distinctions in professional roles; where psychiatrists seek broader patterns to enhance understanding and offer immediate support for a person, formulation as a collaborative shared understanding is a core skill for a psychologist and part of a psychological assessment and intervention. This finding is in accordance with previous speculation that although the biopsychosocial³⁷ model has been adopted by both professions, each discipline favours its own relative contributory factor.⁴³ The refutation of formulation as an alternative to diagnosis echoes Kuhn's work on paradigm shifts.⁴⁴ Kuhn proposed that within the scientific field the accumulation of knowledge progresses when anomalies in the dominant paradigm appear, which lead to a new paradigm being created. Before a new paradigm becomes dominant however, Kuhn describes a process of 'crisis', where there is incommensurability between the old and new paradigms which may put the advocates of the two mutually exclusive paradigms in a defensive position.⁴⁴ Defensiveness or 'emotional reactivity' amongst clinicians has been acknowledged to impact on professional relationships and consequently on care provision and patient experience.⁴⁵ This study offers novel insight into the impact of controversy around the medical model upon psychiatrists and how this may act as a barrier to formulation and collaborative working.

Despite conflicting theoretical perspectives between psychologists and psychiatrists, participants observed an integration of these understandings while 'singing off the same hymn sheet'. This involved clearly defined roles, working collaboratively and having space to 'think' together to develop a shared understanding. Findings not only add to the evidence base, promoting team formulation as a way of facilitating effective team working, but specifically feature psychiatrists' opinions, which have previously been either a minority in participant samples, or completely absent.^{18, 20, 21} Formulation was also used as a language to communicate with stakeholders, adding further weight to its use in diversifying discourse within a medically dominated context and offering more choice to patients.¹⁵

It is a noteworthy finding that an understanding and appreciation of formulation seemed to increase as the clinical experience of participants developed. In line with social learning theory,⁴⁶ the findings imply that the more psychiatrists are exposed to the benefits of team formulation and working collaboratively with psychologists, the more they integrate it into their everyday practice. This mirrors findings from a survey where consultant psychiatrists were more likely to incorporate a psychological understanding into a diagnostic formulation than junior psychiatrists.⁵ Not only does this emphasise the benefits of professional practice gained from MDT working, it suggests a gap in psychiatry training for team formulation.

Participants' use of formulation was dictated by a number of different contextual factors. Time was considered to be an insurmountable barrier by participants and led to the prioritisation of risk within non-forensic services which detracted from a person-centred approach. While acknowledging the existence of limited resources within adult psychiatry, the format of psychotherapy training may have led participants to consider psychological thinking to be a formal and lengthy process. A lack of opportunity for reflection amongst participants was described, leading to disintegration, which some participants found

dissatisfying and sought alternative ways of working. This finding is relevant in consideration of difficulties in recruiting and retaining psychiatrists.⁴⁷

Clinical Implications

In keeping with New Ways of Working⁴⁸ there is a need for RCPsych to recognise the role of psychologists to promote psychological thinking across disciplines. It may be beneficial to re-consider how formulation is conceptualised to psychiatry trainees; perhaps incorporating psychological ways of thinking that are outside of the traditional one-to-one psychotherapy format. Teaching from clinical psychologists alongside psychiatrists during training for both disciplines may cultivate an integrated way of working from the outset, facilitating cross-disciplinary working in clinical practice.⁴⁸

Psychiatrists should have access to supported and reflective practice throughout their continued development.⁴⁹ Psychologists could facilitate a 'thinking space' for psychiatrists to reflect and formulate. This is in keeping with guidelines promoting psychologists to integrate their work into teams while maintaining their 'unique identity and contribution (for example, offering a constructive counter-balance to the 'medical model')'¹⁶ (p. 3). Given the indicated barriers to collaborative formulation, it may be more appropriate to work informally, supporting the team and 'chipping in' with psychological thinking.⁴¹ It is important to separate ideological differences, remaining curious and offering trust, respect and clarity with regard to boundaries and roles.⁵⁰ While acknowledging no simple solution, examples of initiatives of positive practice are outlined in the BPS document *Working Psychologically in Teams*.¹⁶

Limitations

It is acknowledged that the researcher's background in clinical psychology where the context is paramount to understanding people's difficulties will have influenced the focus of the data on context and on formulation with psychologists. In response, the researcher used a

number of different strategies to maintain neutrality, as discussed in the methodology. There may also have been some bias in that participants who responded to the invitation to participate in the study may have felt more strongly about the research topic than the profession in general. Indeed, many expressed a special interest in psychology, while others seemed to have strong opinions on the debate around formulation and diagnosis.

Findings are based on the perceptions of a group of psychiatrists within the Northwest of England and largely relate to psychiatrists' experiences within adult mental health settings. Despite care being taken to recruit participants from a number of different settings, there seemed to be a lack of description of formulation within primary care services. The pragmatic nature of carrying out research on the DClinPsy course meant that a limited number of interviews could be carried out until theoretical sufficiency was reached rather than saturation³⁵. Further interviewing may have allowed for a richer and more detailed relationship between the categories to be established. Findings cannot be wholly generalised to other settings, however the developed model suggested 'internal consistency'⁵¹ (p. 91) due to interaction of codes between conceptual categories. This indicates robustness of the model and potential to transfer the findings to psychiatrists working in similar settings, which is worth exploring in future research.

Future research and conclusions

Additional research is necessary in order to identify whether the findings from this study can be generalized to other settings such as primary care. Research may also seek to clarify whether team formulation is a cost effective endeavour, focusing on outcomes such as recovery or reduced use of medication.⁵² There has so far been a lack of research demonstrating patient views of formulation and future research should seek to clarify the impact of this approach. Research focusing on whether formulation enhances the doctor-patient relationship may or may not highlight the need to think psychologically within time-

limited appointments. Finally, research should seek to further delineate understandings of formulation across mental health disciplines so it is clearly understood by team members. An evaluation of the impact of the barriers to formulation on service outcomes and cost is also warranted.

It was the aim of this study to explore psychiatrists' understanding and use of formulation. Findings indicated that psychiatrists' understanding develops over their career and is influenced by both training and clinical practice. The use of formulation is triggered by risk and complexity and used to enhance understanding. Contextual factors may influence the possibility for psychiatrists to use formulation during their clinics and as part of an MDT. It is hoped that findings will contribute to a clearer definition of formulation within psychiatry training and practice. The need to maintain an open dialogue across disciplines is paramount in creating a holistic and integrated health service provision.

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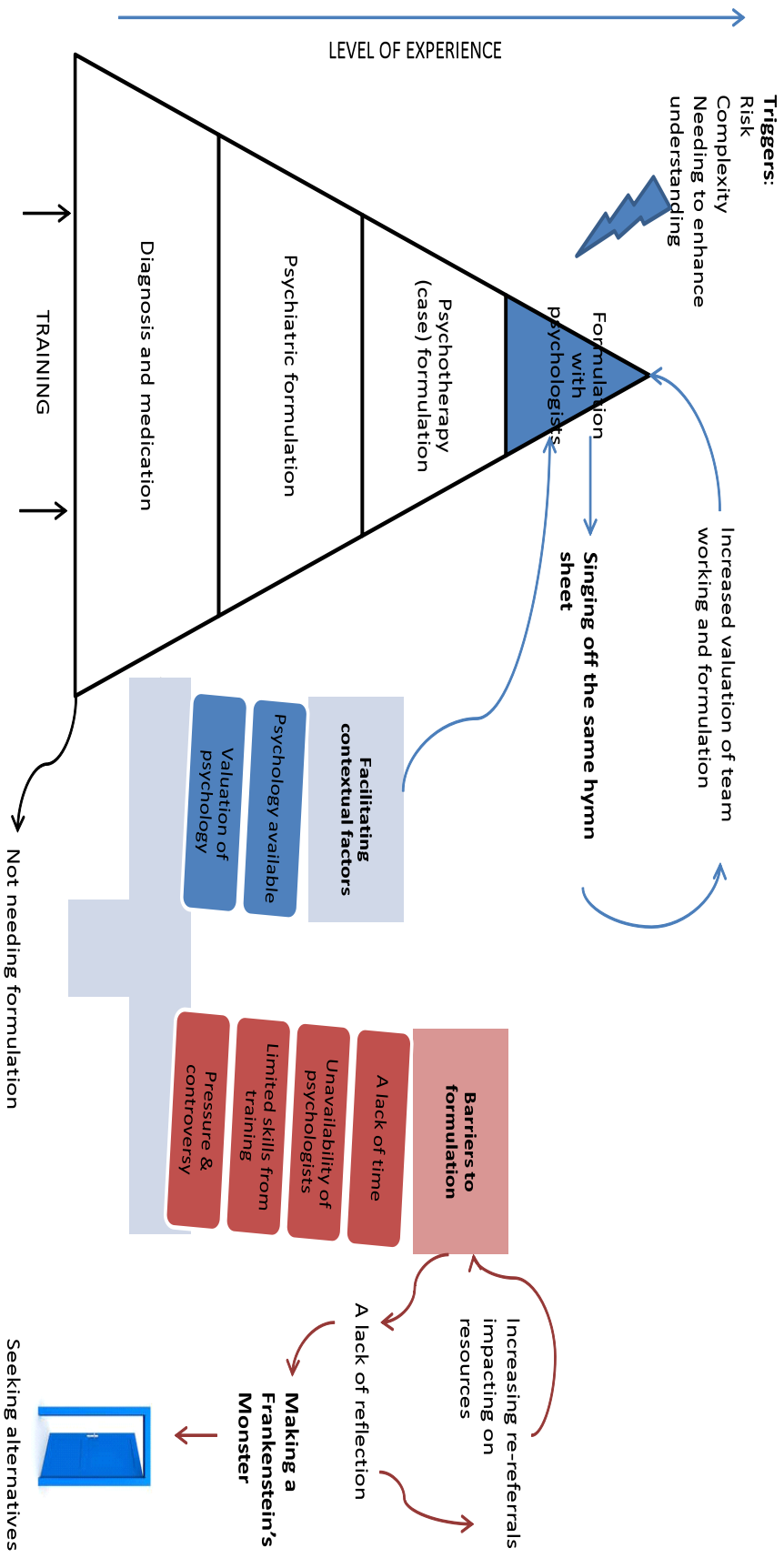
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Table 1. Participant demographic information.

Participant*	Gender	Age	Professional Grade	Years since qualified	Place of current employment
Jack	Male	40	Former Specialty Doctor in Adult Psychiatry/Higher Trainee in Forensic Psychiatry	13	Secure hospital
Stephanie	Female	33	Core Trainee Adult Psychiatry	7	Acute adult ward
Michael	Male	40	Former Specialty Doctor in Adult Psychiatry/Higher trainee in Adolescent Psychiatry	17	Early Intervention Service
Robert	Male	37	Consultant	13	Community Mental Health Team
Rebecca	Female	40	Consultant	16	Community Mental Health Team
DalGLISH	Male	43	Consultant	21	Early Intervention Service
Zadoch	Male	45	Honorary Consultant	16	Community Rehabilitation
Jane	Female	41	Consultant	18	Psychiatric Intensive Care Unit
Dave	Male	34	Consultant	10	Acute Ward
Anita	Female	Withheld	Core Trainee Adult Psychiatry	9	Learning Disabilities Service
Vivek	Male	67	Consultant	41	Mental Health Act Assessment Section 1213 Doctor (Private practice)
Gerry	Male	58	Consultant	38	General Adult

*Participants names pseudonyms and were self-selected. Demographic information was self-identified and reported by each participant on their demographic form.

Figure one. Model representing psychiatrists' understanding and use of psychological formulation



Appendix 2A

Excerpt of Transcripts with line-by-line coding and focused coding

Transcript (Zadoch)	Line-by-line coding	Focused coding (conceptual codes)
<p><i>Okay, how do you think clinical psychologists and psychiatrists can enable effective MDT working?</i></p> <p>Clinical psychologists could start joining in, then it'd be great [laughs]. For reasons I don't, I don't intuitively, I don't have a feel for, I can see an intellectual reason, there seems to be a professional rivalry that often sets in, but I think it's very easily overcome, and I think in many areas of psychiatry psychology input, maybe not presence in every CPA I mean that'd be lovely but erm, is a glaring omission, erm, from services because although I suppose I generalise from my own practice although I've some interest in using that language to try and describe what's going on it's not the same as the fluency and the depth of knowledge that they have, erm, and their different training and different approach brings all sorts of benefits and in most</p>	<p>Clin psychs needing to join in Thinking it'd be great, Not knowing intuitively Seeing an intellectual reason for professional rivalry Seeing it easily overcome Seeing many areas of psychiatry Psychology input (not meaning in every CPA), being a glaring omission in services Generalising from Own practice, having an interest using psych lang to describe not being the same as psychologists fluency & depth of knowledge Diff training & approach bringing benefits. Most areas of psychiatry Missing from the team.</p>	<p>Psychology as separate</p> <p>Professional rivalry</p> <p>Lacking psychology input</p> <p>Appreciating differences and similarities in psychology and psychiatry</p> <p>Lacking psychology input</p>

<p>areas of psychiatry they're missing from the team, they're just not there.</p>		
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Transcript (Jane)	Line-by-line coding	Focused coding (conceptual codes)
<p><i>How do you understand psychological formulation?</i></p> <p>Erm, okay. So my understanding of psychological formulation is a way of erm understanding a patient's current difficulties in the context of their whole life experience and their personality, their opportunities, their family background, so taking a holistic view of a patient with a strong emphasis on psychological issues so the meaning for the patient of both their experiences and their current difficulties and then using that to inform the care plan er, and the treatment that they may or may not require.</p> <p><i>Okay, and would you say you used psychological formulation</i></p>	<p>Describing understanding of formulation as</p> <p>Understanding patients' difficulties in life context and personality, opportunities, family background, taking a holistic view</p> <p>emphasising strongly psychological issues creating meaning for patients using formulation</p> <p>Informing care plan and treatment</p> <p>Not necessarily requiring treatment</p>	<p>Enhancing understanding</p> <p>Enhancing understanding</p> <p>Signposting</p>

<p><i>in your role?</i></p> <p>I try to, erm, I try to have a holistic approach to all patients with varying degrees of success. Sometimes I get, you get caught up in immediate issues or it might be a while before you realise actually we don't have a good narrative of this person's early life, this is what we're missing. So I wouldn't say it's a given but it's something I strive to achieve and that's my gold standard. If I had as much time as I could, access to as many resources erm, I guess particularly psychology input to help with that, to help with the more, the more technical interpretations of someone's interactions and erm, you know, reciprocal roles and things. So I do try to use a psychological approach as much as I can.</p>	<p>Having a holistic approach, varying in success.</p> <p>Getting caught up in immediate issues</p> <p>Taking a while before Realising we don't have a good narrative of early life.</p> <p>Missing a narrative.</p> <p>Striving to achieve – formulation as a 'gold standard'.</p> <p>Not having as much time and resources particularly lacking ψ input in helping with interpreting interactions and reciprocal roles</p> <p>Using a ψical approach as much as possible</p>	<p>Contextual factors impacting on formulation</p> <p>formulation as 'gold standard'</p> <p>Contextual factors impacting on formulation (time, resources, psychology input)</p> <p>Valuing psychology input</p>
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Section Two: Research Paper

A qualitative exploration of psychiatrists' understanding and use of psychological formulation.

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Abstract

Background: Despite recent guidance promoting the use of formulation, there is a lack of research focusing on how it is understood and used within clinical practice.

Aims: To establish an initial conceptualisation of how psychiatrists understand and use formulation within adult psychiatry practice.

Method: Twelve psychiatrists took part in semi-structured interviews. Transcripts were analysed using a constructivist grounded theory methodology.

Results: Formulation was conceptualised as an addition to diagnosis, triggered by risk, complexity, and a need for an enhanced understanding. Participants valued collaborative formulation with psychologists. Multiple contextual factors were perceived to either facilitate or inhibit the process. Barriers to formulation led to a disintegrated way of working.

Conclusions: Findings contribute to an understanding of formulation within psychiatry training and practice.

Declaration of interest: None.

This study explores psychiatrists' understanding and use of psychological formulation.¹

An overview of the conceptualisation of formulation within mental health practice will first be offered, before consideration of the existing research into formulation. Finally, a rationale for the study will be provided with aims for the research.

What is formulation?

A formulation-based approach to psychiatry was first proposed by Adolf Meyer¹ and is nowadays claimed to be the basis of Western psychiatry.² Psychiatrists must demonstrate 'the ability to construct formulations of patients'² problems that include appropriate differential diagnoses³ (p.25) and a 'careful clinical history and concise summary of the social, psychological and biological factors that may have contributed to developing a given 'mental disorder'⁴ (p. 19). Despite such guidance, a recent survey asking psychiatrists at various levels of seniority to list what should be included in a diagnostic formulation revealed a lack of consensus amongst participants.⁵ A similar finding was reported in a survey for examiners of the MRCPsych clinical exams.⁶ However, these studies are now dated and there have been no similar studies published since that may clarify whether there is still a lack of consensus on what a formulation should comprise and whether a psychological understanding is used at all.

Formulation has become more clearly defined within clinical psychology and is defined as: "a hypothesis about a person's difficulties, which links theory with practice and guides the intervention"⁷ (p. 2). The formulation should be based on psychological principles and be tentative and open to revision⁷ (p. 6).

¹ For the purposes of this paper, the term 'psychological formulation' is shortened to 'formulation' and describes *the application of psychological theory to inform hypotheses about a certain issue, for example a person's difficulties.*

² The term 'patient' is used (rather than the term 'service user' or 'consumer') throughout the paper, in order to meet the requirements of the specified journal.

Formulation may be used in a variety of contexts across mental health settings. Individual case formulations are traditionally incorporated in some form into the majority of psychotherapeutic modalities^{8, 9, 10} and developed as a 'recursive process of suggestion, discussion, reflection, feedback and revision' during therapy¹¹ (p. 4). Research into the impact of formulation during therapy suggests that it may increase levels of hope and understanding in patients.^{12, 13} Additional research into the use of case formulation is warranted although it remains difficult to disambiguate the contribution of a number of therapeutic factors within clinical practice.

Team Formulation

One way of addressing this problem is to evaluate the use of formulation outside of therapy with staff teams.¹⁴ The process of formulating with a range of professionals is commonly led by a psychologist and may promote a psychosocial understanding for professions primarily trained in a biological model of distress¹⁵, as well as facilitating shared goals, a shared philosophy and accepted roles and responsibilities.¹⁶ Such factors are demonstrated to underpin effective team working, contributing to the increasing efficacy of health care organisations.^{7, 17}

Over recent years there have been a number of small-scale evaluations investigating the process of team formulation^{17, 18, 19} Due to the difficulty of isolating the effect of any therapeutic factors and an interest in the experience of those involved in a formulation process, qualitative methodologies have been preferred.^{17, 18, 19} Craven-Staines, Dexter-Smith, and Li¹⁹ carried out an evaluation of team formulation within an older adult setting using content analysis. Participants comprised social workers, physiotherapists, psychologists, occupational therapists and nursing staff. Team formulation was demonstrated to inform the planning, implementation and monitoring of care plans, offer a clear strategy for disseminating information and enhance psychological thinking amongst the team. A pilot

study investigating the use of psychological formulation to modify psychiatric staff perceptions of service users, used Likert scales to collect data at two time points for 30 mental health nurses and support workers.¹⁸ Data showed that formulation enhanced staff understandings of patients which in turn improved the staff-patient relationships.¹⁸ Picken and Cogan²⁰ used focus groups comprising seven qualified therapists in order to explore clinicians' understandings and experiences of using formulation in an adult mental health service. An interpretative phenomenological analysis demonstrated that formulation was perceived to have significant benefits to the therapeutic process. However the authors acknowledged formulation as a concept widely used amongst other professions and recommended further research to help develop understandings of how formulation can be communicated amongst professionals.²⁰

Unfortunately, there is a lack of participation from psychiatrists within these preliminary evaluations, with either one psychiatrist participating in the study or none at all.^{18, 20, 21} Summers (2006) included two 'doctors' (out of 25 participants) in a grounded theory-based study exploring staff views of the impact of team formulation, however there was no specification about the type of doctor included in the research. The absence of psychiatrists as participants in the studies may be due to expectations of psychiatrists' roles; that they do not work psychologically or take part in team formulation. A lack of psychiatry involvement in an innovative project where formulation training has been carried out with 400 staff across ten community mental health teams and four acute wards has been named as a barrier to promoting systematic change in psychology and psychological thinking.²² Furthermore, a lack of psychiatrist input into formulations may mean that the biological aspects of emotional distress for individuals may be lost with a team of professionals who are trained predominantly in psychosocial approaches.²³ As formulation is now defined as part of the role of psychiatrists,³ a clearer understanding of how a psychological understanding is

incorporated into formulations as well as an initial exploration of psychiatrists' experience of team formulation may help to guide clinical psychologists when working using formulations in MDT's.

Rationale for the current study

There is currently no existing research to offer an understanding of how psychiatrists understand formulation and whether they value team formulation and/or consultation with psychologists to develop a psychological understanding of their patient's difficulties. In order to enhance clinical practice for both staff and patients it is necessary to have a clear understanding of what is understood by the concept of formulation and how it is used. This is in keeping with recommendations to continue to share a dialogue with other disciplines within the field of mental health practice.⁷ This study therefore asks the questions:

- i) How do psychiatrists understand formulation?
- ii) How do psychiatrists use formulation in their everyday practice?
- iii) Do psychiatrists value the process of formulation with psychologists and/or in a team?

Aims

In consideration of the lack of an existing evidence base, this study aimed to offer an initial conceptualisation how psychiatrists understand and use formulation. A qualitative approach was adopted to allow for an in-depth understanding of participants' experiences.²⁹ Given that there are no existing studies in this area, the formation of a model may allow for greater understanding of the processes involved. Consequently grounded theory³⁰ methodology was used in order to build an initial model of psychiatrists' understanding and use of formulation. It is hoped that a model describing the process of understanding and use of formulation may offer insight into ways in which psychology and psychiatry can facilitate cross-disciplinary working within mental health services, with the ultimate aim of improving experiences of services for patients and families. Findings also have the potential to inform

future incorporation of psychological and multidisciplinary formulation into the Royal College of Psychiatrists (RCPsych) and Doctorate in Clinical Psychology (DClinPsy) teaching curriculum.

Method

Design

A qualitative approach was adopted, to allow for the exploratory nature of the research question and to establish an initial conceptualisation of the subject within adult psychiatry practice.²⁹ The methodological principles of a constructivist grounded theory approach³⁰ were adopted. Grounded theory has been widely recognised as suitable for theoretical development into novel areas of research, where there is no pre-existing theory.³¹ Data were collected using semi-structured interviews with participants who had experience of the research topic. The researcher adopted a social constructionist approach to grounded theory, acknowledging an active role and therefore influencing the interview process and findings.³⁰

Participants

Participants were recruited through the RCPsych. Emails were sent to all members residing in three counties within the Northwest of England. Additionally, participants were recruited via email directly through one NHS Trust and two Deaneries within the Northwest of England. Participants were considered eligible for the study if they were qualified psychiatrists or psychiatrists in training and had experience of working in an adult mental health service where there was a clinical psychologist. Participants were recruited to cover a range of different levels of training (core trainees, higher specialist trainees and consultants).

Twelve participants working in different services across four different NHS Trusts were recruited. All participants had experience of formulation within adult services. Participants were aged between 33 and 67 and ethnicity was diverse (see table one for

demographic data). All participants chose a pseudonym for themselves, in order to ensure anonymity.

Data collection

Data were collected via one-to-one semi-structured interviews using an interview schedule developed with the support of the psychiatrist supervising the project. All interviews were audio recorded. The interview schedule was used flexibly with initial interviews, when verbal prompts and probes were necessary (see Ethics Section for the interview schedule). After the initial interviews had been conducted and initial analyses had been carried out, the interview schedule was adapted in line with the process of theoretical sampling.³² Emerging codes from initial interviews were used to enhance and re-focus the interview schedule.

Procedure

Ethical approval was obtained from Lancaster University Research Ethics Committee and NHS Research and Development approval was obtained from the relevant NHS trust prior to carrying out the research (ethical documentation can be seen in the Ethics Section). Recruitment emails included an information sheet, consent form and demographic form. The researcher's contact details were provided for any queries participants may have had. Potential participants then returned a completed consent form and demographic form by email, in order to allow the researcher to carry out interviews informed by theoretical sampling.³² Recruitment was initially targeted at psychiatrists who worked in adult services; however, because psychiatrists work across numerous specialisms during their career path, it was difficult to separate out experiences relating solely to adult services during interviews. Therefore psychiatrists were recruited across specialisms, although they all had gained most of their experience of working within adult services. Ten participants chose to be interviewed at their place of work and two at their homes. Before commencement of

interviews the researcher addressed any queries, explained issues of confidentiality and gained informed written consent from the participant. If a demographic form had not yet been received by email, participants were asked for the information verbally before commencement of the interview. Interviews lasted between 40 and 90 minutes and on average were 60 minutes long.

Analysis

Analysis was informed by constructivist grounded theory, acknowledging 'truth' as socially constructed through language and social interactions.³⁰ Interviews were analysed and coded in batches of three. The inductive technique of line by line coding was initially carried out in order to fragment and name the data. Codes were described using gerunds to make them active and identify processes.³² Next, the line by line codes were scrutinised and any significant³ codes were translated into focused codes. The focused codes were then put into an excel spreadsheet where they were sorted and re-analysed using the constant comparison method.³³ Codes were checked against one another within and between transcripts, which ensured an inductive approach to the research and illuminated the relationships between different levels of data and analysis. For example, the focused codes 'working collaboratively' and 'integrating' from two different interviews, were combined and added to the conceptualisation of 'singing off the same hymn sheet'. Examples of the development of line by line codes into focused and conceptual codes can be seen in Appendix 2-A and 2-B.

The use of memos and diagrams aided the development of categories from codes, and linked categories together³⁴ (see appendix 2C for a memo excerpt). Theoretical sampling³² was utilised once initial categories had been developed, to test out the emergent theory. For

³ Codes were considered to be significant due to their frequency and if they made the most 'analytic sense to categorize data incisively and completely' ³⁰ (p. 57).

example in earlier interviews a relationship was identified between the number of years participants had been qualified and the emphasis they placed on using formulations in teams. In order to seek clarification, the question “how has your use of formulation changed as your career has progressed?” was added to the interview schedule and participants who had been qualified for a considerable number of years were selected from the participant pool (see critical appraisal for further information on theoretical sampling).

Due to the pragmatic nature of carrying out inductive research as part of a time-limited professional doctorate, ‘theoretical sufficiency’^{4, 35} rather than ‘saturation’ was established as an initial conceptualisation of participants’ experiences of the research topic.

Reflexivity

It was important to remain reflexive³⁶ throughout the research process in order to be aware of possible biases towards the data and the emerging theory. A reflective journal was kept throughout the research process in order to facilitate reflexivity. Regular supervision provided by an academic supervisor who was experienced in grounded theory methodology, facilitated reflection upon the emerging theory. The academic supervisor also provided feedback on an audio recording of the first interview and on some of the memos and diagramming during the analytic process. The researcher discussed the emerging theory and diagrammatic representation with an additional research tutor who was well versed in grounded theory, which enabled the identification of gaps and informed the interview schedule for the final three interviews, for example finding out more about the dichotomy between using formulation and not needing formulation. A grounded theory peer group was also regularly accessed in order to explore the theoretical underpinnings of the interpretation and gain further insight.

⁴ ‘Sufficiency’ was considered when conceptual categories did not require revision in light of fresh data. This is in contrast to ‘data saturation’, which is achieved when interviews no longer offer new insights.³²

Results

The analysis identified 111 focused codes which were grouped and re-grouped into four conceptual categories of: (i) conceptualising formulation; (ii) singing off the same hymn sheet; (iii) barriers to formulation and (iv) making a Frankenstein's monster.

Psychiatrists' understanding of formulation developed during their career. Diagnosis and medication were described to be the priority within their role and a psychological understanding was not always seen as necessary. Formulation was always alongside not instead of diagnosis, as part of a psychiatric formulation, or during psychotherapy practice. When there was a perceived increase in risk, complexity or when patients frequently re-entered services, they were referred on to psychology. If psychologists were within proximity, participants described entering into a joint process of formulating, which was used to communicate with the team and inform planning. Barriers to understanding and using formulation were described, which included a lack of time, unavailability of psychologists, limited skills from training, and pressure and controversy surrounding the medical model. These barriers resulted in 'making a Frankenstein's monster' where there was a perceived lack of reflection leading to disintegrated way of working. Some participants described the pressures as dissatisfying which led them to seek alternative ways of working. The four conceptual categories are presented in narrative form below, together with supporting quotes taken from the original data.

(i) Conceptualising formulation

Participants' understanding of formulation was described as a developmental process, contingent on psychiatry training and clinical practice.

diagnosis and medication. Participants described a strong grounding in a bio-medical model of distress, instilled from undergraduate medical training. Diagnosis was noted to be the foundation of their role, prioritised alongside medication. A psychological

understanding was not always perceived as necessary; patients' difficulties were sometimes understood to be purely biological in nature: 'if someone is bipolar, it's bipolar, you know they're manic, you don't need to [formulate]...you do diagnosis' (Stephanie). However, this approach was only ever described by trainees, perhaps suggesting a lack of experience in integrated working. Other reasons given for not using formulation were if a patient was only in the service for a short time, or if they were considered to be in an 'acute' phase and not able to engage in the process. In these cases diagnosis and treatment was thought to be a sufficient course of action. Dave explained how individual differences contributed to whether or not psychiatrists used formulation:

'I think it depends on the psychiatric background of the person...I have an analytical background, so it's much more easy for me to do the formulation but if you ask me...whether it's being done regularly by all the consultants, or medics, I would say unlikely.'

Overall, diagnosis and medication were the main foci of participants' perceived roles and a psychological understanding was not always considered necessary.

psychiatric formulation. A psychological understanding was described by participants as part of a biopsychosocial³⁷ model. The term 'psychiatric formulation' or 'biopsychosocial formulation' was used interchangeably during interviews to describe an overall understanding of the patient, which incorporated the psychological and socio-historical factors contributing to a patient's presenting issues: 'I'd probably preface biopsychosocial formulation, you know, so I would probably never use the term formulation generically, and would say psychiatric or biopsychosocial formulation' (Rob). The 4 P's^{5, 38} formulation was included as a biopsychosocial understanding and reported to be used by

⁵ The '4 P's'³⁸ formulation was originally proposed by Weerasekera and incorporates predisposing, precipitating, perpetuating and protective factors.

some participants, incorporating predisposing, precipitating, perpetuating and protective factors. Psychiatric formulation always included a diagnosis and an actuarial risk assessment:

'I have a very clear model in my head which... includes a primary diagnosis, a differential diagnosis, a description of aetiology which... would include risk as well and would include then a proper formulation... aimed to link the events in somebody's life history and environment with their character and propensities to try and explain their presentation, their likely response to management and their possible prognosis and associated risk' (Zadoch).

Formulation in this context was described as a heuristic device to enhance understanding, which led to a number of different outcomes including the offering of hope, informing reports, improving medication concordance, signposting to treatment and management of care. A diagnosis was not perceived to be sufficient in this respect as Jack described:

'I might see a patient who was obsessional in nature... I can give them a DSM diagnosis... but actually I'd quite like to know where has that come from... that helps me understand the behaviour, as it does in my opinion the patient. Because giving the patient a label and a diagnosis is all very well, but helping them understand where it's come from is, I think that's part of the hope bit.'

The majority of participants described using a 'psychiatric formulation' in everyday practice.

psychotherapy (case) formulation. Participants' first experience of formulating using psychological models occurred during psychiatry training where they undertook two psychotherapy cases as a mandatory requirement of core training. Psychotherapy training was described to be an anxiety provoking time and full of uncertainty. Participants believed they 'need to get it right' (Jane) because of the impact they perceived it could have on the patient. Some participants responded to this uncertainty by using avoidance strategies:

'people shy away from it' (Jack). Others accessed support such as Balint⁶ groups and supervision in order to develop their reflective skills and psychological thinking:

'...It was a real anxiety provoking experience...it felt like there was a lot at stake...if I mess this up this could be this person's last chance but the process of actually being supervised...was a very powerful learning experience...I came out of it feeling like I'd had therapy myself' (Jane).

Some participants had further training in a therapeutic modality, for example Michael had recently trained in family therapy and Rebecca had trained as a CBT therapist.

Participants described a process of finding a therapeutic model fitting for them as well as the patient and the problem. For example Gerry chose to use CAT predominantly within his clinical practice as he described it fitting with his interests and character: '...it's always been very obvious that things happen in interaction. I'm quite interactive and so the central concept of reciprocal roles in CAT is both hugely explanatory, is fascinating, is very useful'.

Complexity, a high level of risk and patients who accessed services frequently were perceived as reasons by participants to warrant either referral to psychology or consultation with psychologists. For example, patients within Stephanie's service who self-harmed, as well as those who were "in and out of hospital" were prioritised for psychological support. This related to Jack and Rob's observation of having more psychology presence in forensic services, where there was a greater emphasis on risk.

Participants described progressing through their psychiatric career relying on the psychotherapeutic model they had received the most training in, however formal case formulation was not used by participants beyond experiences of training. Where formal case

⁶ Balint groups³⁹ are long established groups for medical doctors which explore difficult interactions they may be experiencing with patients, with the aim of enhancing the therapeutic relationship. Groups are usually facilitated by a psychoanalyst.

formulation was thought necessary by participants, they described seeking psychological support.

(ii) Singing off the same hymn sheet

Some participants described entering into a process of creating a unified understanding between psychologists and psychiatrists, resulting in the successful integration of different epistemological positions. This process was named by Jack as 'singing off the same hymn sheet' and dependent on a number of contextual factors.

facilitating contextual factors. Facilitating contextual factors included psychology being available, positive working relationships and an expressed individual interest in psychology by participants. Positive relationships with psychologists available not just within the service, but who were in close physical proximity and available to consult with when needed was an important requirement for being able to enter into a process of integration. Value was attributed to psychologists who dedicated time to training and consultation. Some participants valued and advocated for more psychological input into teams in order to facilitate shared understandings:

'I think that's a crucial role for a psychologist, to do that supportive stuff with staff, where they can help them think more psychologically about people, make certain ways of dealing with behaviour less punitive because you've got a deeper level of understanding of what's driving something' (Jane).

Some participants felt it was a misuse of resources for psychologists to spend the majority of their time delivering therapy to a relatively small number of individuals, rather than consulting with the team. One participant disagreed: 'it's a strange idea that you spend an hour protected time actually giving a psychological intervention or just talking with a patient but you spend two to three hours in meetings discussing these patients. That's the wrong way round' (Dalglish).

formulating with psychologists. Jane described a joint process of formulating with the ward psychologist, in order to facilitate and develop the most appropriate pathway out of the service for a patient with complex needs:

‘...the conversations with her [the psychologist], just kind of developed into thinking a bit more...we had an interesting meeting with him [the patient], me and the psychologist and the nursing staff and then afterwards we were able to have a ten minute conversation, the psychologist and I, about what we felt we got out of that.’

This joint understanding enabled the difficult dynamics between staff and patient to be explored with the staff team. Formulation was also used as a language to communicate with team members, professionals outside the service and patients themselves: ‘I had to get forensic commissioners on board...and speak to forensic colleagues...being able to take it back to a basic formulation really helped’ (Jane).

Dave described a positive experience of working with psychologists in the past, where shared objectives and roles were clearly defined: ‘the psychologist there was quite knowledgeable and it was easy to work with her because she understood her role as well as the role of psychopharmacology and how it’s a multi-disciplinary approach, so it was not like one person leading the team, it was much more collaborative in the true sense of the word’. This collaboration resulted in an enhanced understanding as Dave went on to describe: ‘it was much easier, especially working with some of the resistant personality disorders who resist discharge...we could work on the formulation and say well these are the exits, these are the things that are going on’.

A similar process was described within forensic settings, where HCR-20⁷ risk formulation took place. Psychologists were described to play a key role as part of the team process:

‘We use it with the psychology team... we do a formulation at the end to bring all that information together and say well where is this person likely to be going on their psychological journey and how can we prevent things from happening or understand why they’re happening. And that informs the multidisciplinary team’ (Jack).

Participants expressed a desire to see an increase in psychologists training nursing staff in basic formulation skills, for example Rebecca emphasised the need to ‘maximise the effects of individual therapy’ by equipping care co-ordinators with psychological formulation and intervention skills: ‘...I think for me what’s more important is to actually build skills within the team so that practitioners would be able to have some basic skills around formulation’ (Rebecca).

The result of collaborative working and integration of different understandings resulted in a unified understanding which was defined by participants as a formulation. The overall concept of ‘singing off the same hymn sheet’ was named by Jack and encapsulates the integration of understandings and collaborative working, as he explained: ‘the aim of it is that you are all working together, that you’re singing off the same hymn sheet. And isn’t that what the formulation is?’ As participants became more experienced, their valuation of collaborative staff formulation seemed to increase, which meant they engaged in the process with more frequency.

(iii) Barriers to formulation

⁷ The Historical Clinical Risk Management-20 Tool⁴⁰ (HCR-20) is widely used in forensic settings to assess and manage risk of violence and is based on a model of Structured Professional Judgement.⁴⁰

Participants' understanding and use of formulation was perceived to be dependent on the wider system. This was reflected in interviews where a large amount of time was spent talking about different contexts, for example the politics surrounding psychiatry and limitations within NHS services. Participants perceived themselves to be faced with multiple barriers that impacted on their ability to formulate and think reflectively.

A lack of time. The allocation of fifteen minutes for clinical appointments was described as insufficient to be able use formulation directly with the patient, resulting in a 'robotic' and risk-focused approach (Dalglish). Perhaps because of the barrier of time, participants spoke more about formulation being used to enhance their own understanding rather than directly enhancing the patient's understanding. An exception to this was Rebecca's description of a patient who had received cognitive analytic therapy and was able to bring her formulation 'map' to appointments to discuss when experiencing difficulties:

'...we'll talk about exit points in her formulation so, she kind of utilises it in a positive way and we use it when she has a crisis.'

Participants described being under immense pressure to make quick decisions within their roles, which did not allow for formulating or reflective practice. Anita noted 'we don't think; we just do', while Dave commented: 'they say you have to do reflective practice... we don't have the time'. One exception to this way of thinking was Gerry, who thought it was always possible to 'make time' for formulation within one's role. Gerry also commented that as the number of years of practice increased, so did the time he would take to see a patient: '...with that first appointment, I couldn't possibly do it in under an hour nowadays. I've got longer and longer'. It was acknowledged however that Gerry's senior role within the Trust gave him more freedom to use his time as he liked.

In cases where a patient was admitted to a ward on a short-term basis, participants thought the time taken to create a formulation was longer than the patient admission length.

Jane described the process in a Psychiatric Intensive Care Unit (PICU): 'you're trying to gather information from a variety of sources with someone you've not met before, who might not be with you for more than a few weeks so that takes a lot of time'. Jack's perception was that in acute settings this resulted in formulation not being done: 'truth is you know, Mr Bloggs is going to go home and be seen by the CPN and he may wait for psychological services for another year. So, you know what, I'd just leave it'.

The prioritisation of risk was described to be a dominant way of working within psychiatry practice, which in combination with the noted time restrictions during appointments, led to the sacrifice of a more therapeutic and person-centred approach to formulation: 'you know, you only have time to ask them whether they're suicidal...'
(Dalglish). The actuarial process of risk assessment was critiqued for its lack of integration of risk factors and overall description, whilst a more dynamic risk formulation-based approach was advocated:

'They're often just checklists for risks which ... take a purely actuarial approach but I think misses a lot of important information and discourages people from coming up with formulations for risk assessment that describe the dynamic factors....so that sort of formulation approach I think works a lot better for risk' (Zadoch).

Overall, participants identified time restrictions caused by increased case loads and reduced clinical time with patients as resulting in a more actuarial-focused approach to risk and a lack of time for psychological thinking, as well as limiting the potential to re-visit an already established formulation when seeing a patient during clinic.

Unavailability of psychologists. Participants described a general lack of psychology within adult mental health services, for example Dave reflected on his experience working on a ward where there was no psychology input due to a lack of funding. Zadoch described psychologists being 'separate' from the rest of the multidisciplinary team; for example not

training with other disciplines so not being understood by the rest of the team, resulting in their alienation. Rob also expressed a perception of 'separateness', with regard to the way psychologists seemed reluctant to share information with the team: ... 'I think a lot of the work of psychologists is hidden, so in some ways I would know... a lot more about how psychologists approach things and how they describe things if we had shared case notes' (Rob).

The referral process to psychology in another location, where there was no face-to-face contact meant there was more of a sense of separation between the disciplines. For example, Stephanie spoke about referring patients to a psychology service from her acute service, where the patient had to be an outpatient in order to be accepted. Therefore, the opportunity to develop a psychological understanding was not available until after the patient had been admitted into hospital, and had received a diagnosis and medication.

Limited skills from training. Some participants perceived a lack of emphasis on formulation and a general move away from psychological thinking in the practice of psychiatry:

'There isn't the same emphasis on the need for those kind of [formulation] skills across the board, even if you're never going to go near a psychotherapy patient, there isn't that sense for me that everyone should be able to formulate to a basic level... I'm not sure that there's ever been as much of an emphasis as there should have been...' (Jane).

This was partially attributed to a shift in training, as participants perceived that formulation skills were no longer included in examinations which impacted on learning and utilization in clinical practice:

'They shifted it out of the part one and then out of the part two [exams]... the ability of trainees who were not yet doing the part two, to formulate the second half of the formulation, disappeared, evaporated. It was like going off a cliff...' (Zadoch).

Further limitations were perceived by participants as less supervision and training from consultants and a decrease in the length of the training course for psychiatrists. Dave explained:

‘You’re required to do two psychotherapy patients under supervision and once you’ve done that, that’s it. And so the whole of your understanding and your opinion of psychology depends on the experience you get so in case you end up getting a very poor supervisor, then your opinion on psychotherapy gets coloured...’

Some participants expressed concern that the changing curriculum was having a great impact on the quality of training: ‘I think there’s a danger of it going the other way in that the quality of training I think is in danger of changing really’ (Jane).

The majority of participants wondered whether receiving teaching from psychologists during training might facilitate a more integrated way of working, as well as enhancing the learning process of formulation:

‘I think it would be very useful if...there was the psychiatrist and the psychologist, the trainee, and that you put together a one or two day workshop I think people would jump at it...because you get very little training’ (Jack).

In summary there was a shared viewpoint of insufficient training and a lack of emphasis upon formulation and psychological ways of working, particularly outside of a formal psychotherapy scenario.

the dominance of medical model: pressure and controversy. Some participants conceived a pressure to conform to using a medical model when working, needing to use diagnosis as a priority, in order to provide medication and classification. This pressure came from multiple stakeholders, from the patient to GPs: ‘Some people really want to be medicalised’ (Rob) and ‘The GP wants more a medical model. He just wants a number’ (Vivek).

Psychology was seen by some participants as a threat or attack to the profession of psychiatry, with a branch of psychologists being described as 'anti-psychiatry'. This was a barrier within the workplace as psychologists perceived as anti-psychiatry were thought to behave in a defensive way in their interactions with psychiatrists. A small number of participants described feeling attacked and responded by defending their profession during the interview, critiquing the position of some psychologists. For example, the notion that formulation could replace diagnosis was picked up on by a number of participants, who all expressed an opinion that formulation was a useful adjunct to diagnosis, but not an adequate replacement: 'psychological formulation is a helpful tool for psychotherapy etcetera, but it can't replace diagnosis for a variety of reasons, just because it's not meant to, it can't' (Dalglish).

Some participants described professional rivalry causing psychiatrists to revert to a dominantly biological understanding of distress. Rob stated that:

'...there's some people who are reacting against that [challenging diagnosis] who are seeking to define what they do and in some ways narrow their understanding of a reductionist model to a purely biological, chemical based model.'

Overall, the majority of participants thought that professional rivalry or 'guild conflict' (Dalglish) was an unhelpful factor in a successful working relationship between psychology and psychiatry and moved towards a process of acceptance and integration of both disciplines.

(iv) Making a Frankenstein's monster

The consequences of not being able to develop a psychological understanding due to one or more of the barriers described above, led to a perceived lack of reflection. This resulted in participants resorting to number of alternative approaches. Participants also spoke about the long wait for individual therapy for their patients, which meant a period of

instability for the patient where alternative interventions were offered (for example, occupational therapy or the prescription of medication).

There was a perceived over-reliance on a medical understanding of distress, as a consequence of limited resources. For example Dave reflected that '...you might end up prescribing medication because you might have to come across as doing something. But you know that it's psychological'. This was described by Michael as a 'top-down' pressure to conform to using medication, whereas Dave perceived the pressure also coming from patients themselves: 'some of the time the patient comes in and says well I can't be bothered to sit down and talk so could you give me a pill'.

Zadoch described a process of treating 'complexity' with multiple types of medication with a consequence of not knowing what had worked. Overall, the accumulation of this process resulted in interventions being separate and dis-jointed which was perceived by participants to be unhelpful and a drain on resources. For example Zadoch described trying to understand a patient with information perceived as incoherent: 'he's got some sort of impulsivity, given him some SSRI's for that, and on the other hand he doesn't get on very well with his mother and it doesn't really fit together'. Overall, the combination of a lack of integrated understanding of a service user, over-reliance on medication and general lack of resources was described as creating a 'Frankenstein's monster' (Zadoch), where the monster represented the process of disintegrated practice by psychiatrists.

The described approach maintained barriers to understanding and using psychological formulation, resulting in patients being treated without a holistic understanding, which meant that patients kept returning into the service:

'It's a false economy in my view often...because you haven't done the formulation you don't understand what's going on...you just make more work for yourself. But people don't see it like that because they're not taking an overall view' (Rebecca).

Additionally, three participants spoke of experiencing dissatisfaction with working in a pressurised environment, which eventually led them to 'seek alternatives' such as entering academia, working privately or moving into other specialisms where there was more time and resources to work in ways which they preferred. For example, Michael talked about moving from adult services into child services, as he perceived there to be less pressure to prescribe medication and more time to think psychologically.

In summary, psychiatrists' understanding of formulation developed during their career and it was used alongside diagnosis to enhance understanding. Psychological support was triggered by a perceived level of risk and complexity. If psychologists were available, participants described developing a joint understanding, however, there were a number of noted barriers to formulating which led to disintegrated way of working and dissatisfaction in participants who sought alternative ways of working. A diagrammatic representation of the findings can be seen in figure 1.

[Insert figure one]

Discussion

Findings from this study offer an initial conceptualisation of a sample of psychiatrists' understanding and use of formulation, highlighting how utilisation was dependent on experiences within both psychiatry training and clinical practice. Previous research into professionals' views of formulation comprises small-scale evaluations of staff experiences of team formulation,²⁰ psychologists' perceived roles in creating and sharing formulations within MDTs,⁴¹ and numerous opinion pieces promoting the use of formulation either alongside,²⁶ or as a replacement to diagnosis.¹¹

Formulation was defined by participants within a psychiatric framework, as an addition to, and never in place of diagnosis. This is distinct from DCP guidelines⁷, which

posit that formulation is adequate in itself to summarise and understand the experiences of the patient, without necessarily needing a diagnosis. Furthermore, although formulation seemed to give context to an individual's difficulties, the underlying understanding of the distress remained medically conceptualised. Again, this is a distinct focus from that outlined by DCP⁷; while participants drew on psychological theory to understand a patient, they applied the theory in addition to a 'disease' model to understand the difficulties. This is in contrast to a co-constructed understanding with the patient, on the premise that "at some level it all makes sense"⁴² (p. 2). These alternate understandings of formulation reflect the distinctions in professional roles; where psychiatrists seek broader patterns to enhance understanding and offer immediate support for a person, formulation as a collaborative shared understanding is a core skill for a psychologist and part of a psychological assessment and intervention. This finding is in accordance with previous speculation that although the biopsychosocial³⁷ model has been adopted by both professions, each discipline favours its own relative contributory factor.⁴³ The refutation of formulation as an alternative to diagnosis echoes Kuhn's work on paradigm shifts.⁴⁴ Kuhn proposed that within the scientific field the accumulation of knowledge progresses when anomalies in the dominant paradigm appear, which lead to a new paradigm being created. Before a new paradigm becomes dominant however, Kuhn describes a process of 'crisis', where there is incommensurability between the old and new paradigms which may put the advocates of the two mutually exclusive paradigms in a defensive position.⁴⁴ Defensiveness or 'emotional reactivity' amongst clinicians has been acknowledged to impact on professional relationships and consequently on care provision and patient experience.⁴⁵ This study offers novel insight into the impact of controversy around the medical model upon psychiatrists and how this may act as a barrier to formulation and collaborative working.

Despite conflicting theoretical perspectives between psychologists and psychiatrists, participants observed an integration of these understandings while 'singing off the same hymn sheet'. This involved clearly defined roles, working collaboratively and having space to 'think' together to develop a shared understanding. Findings not only add to the evidence base, promoting team formulation as a way of facilitating effective team working, but specifically feature psychiatrists' opinions, which have previously been either a minority in participant samples, or completely absent.^{18, 20, 21} Formulation was also used as a language to communicate with stakeholders, adding further weight to its use in diversifying discourse within a medically dominated context and offering more choice to patients.¹⁵

It is a noteworthy finding that an understanding and appreciation of formulation seemed to increase as the clinical experience of participants developed. In line with social learning theory,⁴⁶ the findings imply that the more psychiatrists are exposed to the benefits of team formulation and working collaboratively with psychologists, the more they integrate it into their everyday practice. This mirrors findings from a survey where consultant psychiatrists were more likely to incorporate a psychological understanding into a diagnostic formulation than junior psychiatrists.⁵ Not only does this emphasise the benefits of professional practice gained from MDT working, it suggests a gap in psychiatry training for team formulation.

Participants' use of formulation was dictated by a number of different contextual factors. Time was considered to be an insurmountable barrier by participants and led to the prioritisation of risk within non-forensic services which detracted from a person-centred approach. While acknowledging the existence of limited resources within adult psychiatry, the format of psychotherapy training may have led participants to consider psychological thinking to be a formal and lengthy process. A lack of opportunity for reflection amongst participants was described, leading to disintegration, which some participants found

dissatisfying and sought alternative ways of working. This finding is relevant in consideration of difficulties in recruiting and retaining psychiatrists.⁴⁷

Clinical Implications

In keeping with New Ways of Working⁴⁸ there is a need for RCPsych to recognise the role of psychologists to promote psychological thinking across disciplines. It may be beneficial to re-consider how formulation is conceptualised to psychiatry trainees; perhaps incorporating psychological ways of thinking that are outside of the traditional one-to-one psychotherapy format. Teaching from clinical psychologists alongside psychiatrists during training for both disciplines may cultivate an integrated way of working from the outset, facilitating cross-disciplinary working in clinical practice.⁴⁸

Psychiatrists should have access to supported and reflective practice throughout their continued development.⁴⁹ Psychologists could facilitate a 'thinking space' for psychiatrists to reflect and formulate. This is in keeping with guidelines promoting psychologists to integrate their work into teams while maintaining their 'unique identity and contribution (for example, offering a constructive counter-balance to the 'medical model')'¹⁶ (p. 3). Given the indicated barriers to collaborative formulation, it may be more appropriate to work informally, supporting the team and 'chipping in' with psychological thinking.⁴¹ It is important to separate ideological differences, remaining curious and offering trust, respect and clarity with regard to boundaries and roles.⁵⁰ While acknowledging no simple solution, examples of initiatives of positive practice are outlined in the BPS document *Working Psychologically in Teams*.¹⁶

Limitations

It is acknowledged that the researcher's background in clinical psychology where the context is paramount to understanding people's difficulties will have influenced the focus of the data on context and on formulation with psychologists. In response, the researcher used a

number of different strategies to maintain neutrality, as discussed in the methodology. There may also have been some bias in that participants who responded to the invitation to participate in the study may have felt more strongly about the research topic than the profession in general. Indeed, many expressed a special interest in psychology, while others seemed to have strong opinions on the debate around formulation and diagnosis.

Findings are based on the perceptions of a group of psychiatrists within the Northwest of England and largely relate to psychiatrists' experiences within adult mental health settings. Despite care being taken to recruit participants from a number of different settings, there seemed to be a lack of description of formulation within primary care services. The pragmatic nature of carrying out research on the DClinPsy course meant that a limited number of interviews could be carried out until theoretical sufficiency was reached rather than saturation³⁵. Further interviewing may have allowed for a richer and more detailed relationship between the categories to be established. Findings cannot be wholly generalised to other settings, however the developed model suggested 'internal consistency'⁵¹ (p. 91) due to interaction of codes between conceptual categories. This indicates robustness of the model and potential to transfer the findings to psychiatrists working in similar settings, which is worth exploring in future research.

Future research and conclusions

Additional research is necessary in order to identify whether the findings from this study can be generalized to other settings such as primary care. Research may also seek to clarify whether team formulation is a cost effective endeavour, focusing on outcomes such as recovery or reduced use of medication.⁵² There has so far been a lack of research demonstrating patient views of formulation and future research should seek to clarify the impact of this approach. Research focusing on whether formulation enhances the doctor-patient relationship may or may not highlight the need to think psychologically within time-

limited appointments. Finally, research should seek to further delineate understandings of formulation across mental health disciplines so it is clearly understood by team members. An evaluation of the impact of the barriers to formulation on service outcomes and cost is also warranted.

It was the aim of this study to explore psychiatrists' understanding and use of formulation. Findings indicated that psychiatrists' understanding develops over their career and is influenced by both training and clinical practice. The use of formulation is triggered by risk and complexity and used to enhance understanding. Contextual factors may influence the possibility for psychiatrists to use formulation during their clinics and as part of an MDT. It is hoped that findings will contribute to a clearer definition of formulation within psychiatry training and practice. The need to maintain an open dialogue across disciplines is paramount in creating a holistic and integrated health service provision.

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Appendix 2-B
Examples of Coding and Category Development

Line-by-line codes	Focused code	Conceptual category
Formulating jointly with psychology		
Seeing collaborative working as helpful		
Sharing skills is useful	Working collaboratively with psychology	Singing off the same hymn sheet
Sharing responsibility by involving psychology		
Considering both formulations together		
Seeing joint working as helpful		
Describing a small psychology team		
Describing long waiting lists for psychology	Lacking psychology input	Barriers to formulation: unavailability of psychologists
Seeing lack of psychology input as a barrier		
Seeing psychology as scarce		
More psychology funding for forensics		
Trainees not prioritising formulation		
Not having a requirement to do formulation		
Not writing case studies in training	Formulation missing from training	Barriers to formulation: limited skills in training
Not knowing about formulation during training		
Trainees not practising formulation		
Formulation not taught as important in psychiatry		
Should be formulating but doesn't have time		
Lacking time for communication with psychologist	Working under time pressures	Barriers to formulation: A lack of time
Patient admission shorter than time taken to formulate		
Having more time limits than other professionals		
Appointments being time limited, robotic and risk-led		

Appendix 2-C

Memo on professional rivalry

The conflict between psychiatry and psychology has been widely written about and is consequently an idea I have carried in my approach to the project. My experience of working in psychiatric services, where there is conflict between psychiatrists and psychologists, and reading widely around critical approaches to mental health systems leaves me with preconceived ideas of how the two professions interact.

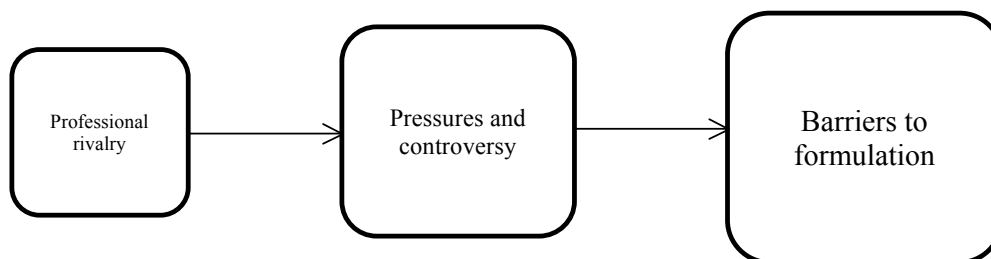
However, from the very first interview with Jack, there appeared a strong ideology of psychologists and psychiatrists as thinking differently, doing different tasks, and being at loggerheads with one another. Jack also talks about a fear that psychiatrists have about psychology; this emotional reaction can lead to a number of responses that include distancing from psychology and rejecting the profession as worthwhile.

The rivalry between psychiatrists and psychologists was again raised by Rob, who described the breakdown in communication between psychiatry and psychologists, particularly when psychologists within the service seem to keep their work "secret" and adopt an "anti-psychiatry" stance, refuting the idea that psychiatry is helpful in any way. This led me to feel that psychiatrists may feel attacked, by being told indirectly that their profession is useless. It was when I was transcribing this interview and coding Jack's interview that I thought about the notion of "professional rivalry" as a code.

During my interview with Dalglish, he spent the majority of the duration "attacking" the idea of formulation replacing diagnosis (a concept that had been introduced and refuted previously by Rob). At the end of the interview Dalglish

asked me if I felt that I had been “steam-rolled” and that’s exactly how I had felt. I wondered if that had been his aim. Drawing on psychodynamic theories of transference, I wondered if that was perhaps how Dalglish felt, flattened by the forceful attack on his profession. The idea of psychologists trying to attack and extinguish psychiatry arose from this interview and seemed to dominate Dalglish’s thoughts around formulation. . Perhaps my experience of conflict between the two professions had meant that I was sensitised to this idea, and more ready to identify it within the data, however, I went on to interview Zadoch, who expressed the interaction between psychology and psychiatry as “professional rivalry”, actually naming the code I had decided on. This seemed to act as some evidence that my conceptualisation of this code was grounded in the data, rather than only coming from my preconceived ideas of the issue.

This code is part of the wider theme of pressure and controversy surrounding the medical model that contributes to a threat-based working environment for psychiatrists and acts as a barrier to formulation.



Appendix 2-D

Guidelines for Authors for Target Journal: The British Journal of Psychiatry

The *British Journal of Psychiatry* is published monthly by [The Royal College of Psychiatrists](#). The *Journal* publishes original work in all fields of psychiatry. Manuscripts for publication should be submitted online via <http://submit-bjp.rcpsych.org>. All published articles are peer reviewed. Contributions are accepted for publication on the condition that their substance has not been published or submitted for publication elsewhere, and this includes web-based documents. Authors submitting papers to the *Journal* (serially or otherwise) with a common theme or using data derived from the same sample (or a subset thereof) must send details of all relevant previous publications and simultaneous submissions.

The *Journal* is not responsible for statements made by contributors. Material in the *Journal* does not necessarily reflect the views of the Editor or of The Royal College of Psychiatrists.

Manuscripts accepted for publication are copy-edited to improve readability and to ensure conformity with house style.

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Manuscripts for publication must be submitted online at <http://submit-bjp.rcpsych.org>. A unique account will be created for each contributor using his or her email address as identification. (Note for contributors with more than one email account: please ensure you use the same email address whenever logging on to the manuscript submission website.) Contributors may track the progress of their submissions at any time via this website. For assistance with online submission, please email bjp@rcpsych.ac.uk or telephone +44 (0)20 7235 8857. A cover letter should be included with the submission explaining why you consider the submitted article suitable for publication in the *Journal*.

To submit a [letter to the Editor](#), see below.

Fast-track assessment

Authors have the option of submitting articles for fast-track assessment. Those wishing to take this route should state this in the first or second sentence of their cover letter, together with the reasons for rapid assessment. A decision whether to approve the fast-track route will be made within 10 days of submission; those papers that are not selected for this route will be assessed in the normal way unless the authors state specifically that they want fast-track assessment only. All papers approved for the fast-track route will be assessed within 4 weeks of submission. Review articles will not be considered for fast-track assessment.

Title and authors

The title should be brief and relevant. Subtitles should not be used unless they are essential. Titles should not announce the results of articles and, except in editorials, they should not be phrased as questions.

All authors must sign the copyright transfer and publication agreement, which can be downloaded from <http://submit-bjp.rcpsych.org> once a manuscript has been accepted. One of the authors should be designated to receive correspondence and proofs, and the appropriate address indicated. This author must take responsibility for keeping all other named authors informed of the paper's progress. The contribution of each author to the paper must be stated at the end of the article; this information may be published online. Authorship credit should be based only on substantial contribution to:

- conception and design, or analysis and interpretation of data
- drafting the article or revising it critically for important intellectual content
- and final approval of the version to be published.

All these conditions must be met. Participation solely in the acquisition of funding or the collection of data does not justify authorship. In addition, the corresponding author must ensure that there is no one else who fulfils the criteria but has not been included as an author. Group authorship is permitted but individuals choosing this option will not be cited personally, as only those listed as authors on the title page of the manuscript and (on acceptance for publication) whose signed copyright agreement has been obtained, qualify for author status. It is the responsibility of the corresponding author to ensure that authorship is agreed among the study's workers, contributors of additional data and other interested parties, before submission of the manuscript.

The names of the authors should appear on the title page in the form that is wished for publication, and the names, degrees, affiliations and full addresses at the time the work described in the paper was carried out should be given at the end of the paper.

Involvement of professional writers

If a professional medical writer has been employed in connection with the work, this must be stated clearly and the writer named in the Acknowledgements section. Their contact details must be supplied, and they will be required to submit a [disclosure form](#). Details of the disclosure may be included in the published work at the Editor's discretion.

Declaration of interest

All submissions to the *Journal* (including editorials and letters to the Editor) require a declaration of interest. This should list fees and grants from, employment by, consultancy for, shared ownership in, or any close relationship with, at any time over the preceding 36 months, an organisation whose interests may be affected by the publication of the paper. It should also list any non-financial associations or interests (personal, professional, political, institutional, religious, or other) that a reasonable reader would want to know about in relation to the submitted work. This pertains to all the authors of the study, their spouses or partners and their children (aged under 18). We recommend use of the [disclosure form](#) developed by the International Committee of Medical Journal Editors for this purpose.

Publication ethics

Authors are expected to be aware of and comply with best practice in publication ethics, including (but not restricted to) avoiding multiple submission, plagiarism and manipulation of figures/data. Any concerns in this regard must be brought to the attention of the Editor. The procedures recommended by the Committee on Publication Ethics will be followed in investigating allegations of misconduct. If conclusive evidence of misconduct is found, the *Journal* undertakes to publish a correction or retraction as necessary to correct the scientific record.

Structure of manuscripts

Papers

A structured abstract not normally exceeding 150 words should be given at the beginning of the article, incorporating the following headings: Background; Aims; Method; Results; Conclusions; Declaration of interest. The abstract is a crucial part of the paper and authors are urged to devote some care to ensuring that all the important findings are within the word limit.

Introductions should normally be no more than one paragraph; longer ones may be allowed for new and unusual subjects. This should be followed by Method, Results and Discussion sections. The Discussion should always include limitations of the paper to ensure balance. Use of subheadings is encouraged, particularly in Discussion sections. A separate Conclusions section is not required.

The article should normally be between 3000 and 5000 words in length (excluding references, tables and figure legends) and normally would not include more than 25 essential references beyond those describing statistical procedures, psychometric instruments and diagnostic guidelines used in the study. All large tables (exceeding half a *Journal* page) will be published only in the online version of the *Journal* (see Online data supplements, below). Authors are encouraged to present key data within smaller tables for print publication. This applies also to review articles and short reports.

Review articles

Review articles should be structured in the same way as regular papers, but the length of these may vary considerably, as will the number of references. Systematic reviews are preferred and narrative reviews will be published only under exceptional circumstances. Reviews done for the Cochrane Collaboration, the National Institute for Health and Clinical Excellence and other groups likely to be published, or already published, elsewhere, should have the submitted paper accompanied by the latest version of the parent review and its status so that an informed decision can be made about the added value of the submitted paper.

Short reports

Short reports require an unstructured summary of one paragraph, not exceeding 100 words. The report should not exceed 1200 words (excluding references, tables and figure legends) and contain no more than one figure or table and up to 10 essential references beyond those describing statistical procedures, psychometric instruments and diagnostic guidelines used in the study. Short reports will not exceed two printed pages of the *Journal* and authors may be required to edit their report at proof stage to conform to this requirement. This may be necessary even if the report does not exceed 1200 words if the figure or table is unduly large.

Editorials

Editorials require an unstructured summary of one paragraph, not exceeding 50 words. Editorials should not exceed 1500 words and may contain no more than one figure or table and up to 10 essential references. Editorials may only exceed two printed pages in length at the Editor's discretion. A good-quality photograph of the lead author for publication alongside the editorial must be submitted with the manuscript, along with brief biographical details (up to 25 words) for all authors.

Reappraisal

This is a section following the structure of Editorials but with up to 15 essential references. These articles are mainly commissioned by the Editor and are concerned with well-known subjects in psychiatry which are going through a period of controversy or re-evaluation. Reappraisals are intended to give a long-term balanced perspective on the subject based on the latest evidence.

Debates

Authors may submit proposals for In Debate articles, providing a brief (one paragraph) outline of the issue to be debated together with the proposed motion. They may also suggest an opponent for the debate. Two debaters have three rounds of

debate (1-2-1-2-1-2), responding to each other after each round. Each author may use up to 2000 words and 15 references, divided as they wish between their three rounds. A short introduction will be provided by the Debates Editors post-acceptance. In Debate articles not adhering to this format will not usually be considered.

References

Authors are responsible for checking all references for accuracy and relevance in advance of submission. Reference lists not in the correct style will be returned to the author for correction. From January 2008, all references should be numbered in the order in which they appear in the text and listed at the end of the article using the Vancouver style (see below), in which the names and initials of all authors are given after the appropriate reference number. If there are more than six authors, the first six should be named, followed by 'et al'.

The authors' names are followed by the full title of the article; the journal title abbreviated (in italics) according to the style of Index Medicus; the year of publication; the volume number (in bold type); and the first and last page numbers. References to book or book chapters should give the titles of the book (and the chapter if selected), names of any authors, name of publisher, names of any editors, and year. Examples are shown below.

- 1 Kapusta ND, Etzersdorfer E, Krall C, Sonneck G. Firearm legislation reform in the European Union: impact on firearm availability, firearm suicide and homicide rates in Austria. *Br J Psychiatry* 2007; **191**: 253-7.
- 2 Thornicroft GJ. *Shunned: Discrimination Against People with Mental Illness*. Oxford University Press, 2006.
- 3 Casey P. Alternatives to abortion and hard cases. In *Swimming Against the Tide; Feminist Dissent on the Issue of Abortion* (ed AB Kennedy): 86-95. Open Air Books, 1997.
- 4 Lancet. Burnished or burnt out: the delights and dangers of working in health (editorial). *Lancet* 1994; **344**: 1583-4.
- 5 Pharmaceutical Research and Manufacturers of America (PhRMA). *PhRMA Guiding Principles on Direct to Consumer Advertisements About Prescription Medications*. PhRMA, 2005. <http://www.phrma.org/publications/policy//2005-08-02.1194.pdf>
- 6 Soni SD, Mallik A, Mbatia J, Shrimankar J. Late paraphrenia (letter). *Br J Psychiatry* 1988; **152**: 719-20.
- 7 Viding E, Frick P, Plomin R. Aetiology of the relationship between callous-unemotional traits and conduct problems in childhood. *Br J Psychiatry* 2007; **190** (suppl 49): s33-8.

Personal communications need written authorisation (email is acceptable); they should not be included in the reference list. Unpublished doctoral theses may be cited (please state department or faculty, university and degree). No other citation of unpublished work, including unpublished conference presentations, is permissible.

Tables

Tables should be numbered and have an appropriate heading. The tables should be mentioned in the text but must not duplicate information. The heading of the table, together with any footnotes or comments, should be self-explanatory. The desired position of the table in the manuscript should be indicated. Do not tabulate lists, which should be incorporated into the text, where, if necessary, they may be displayed.

Authors must obtain permission from the original publisher if they intend to use tables from other sources, and due acknowledgement should be made in a footnote to the table.

Figures

Figures should be clearly numbered and include an explanatory legend. Avoid cluttering figures with explanatory text, which is better incorporated succinctly in the legend. 3-D effects should generally be avoided. Lettering should be parallel to the axes. Units must be clearly indicated and should be presented in the form quantity (unit) (note: 'litre' should be spelled out in full unless modified to ml, dl, etc.). All figures should be mentioned in the text and the desired position of the figure in the manuscript should be indicated.

Authors must obtain permission from the original publisher if they intend to use figures from other sources, and due acknowledgement should be made in the legend.

Colour figures may be reproduced if authors are able to cover the costs.

Statistics

Methods of statistical analysis should be described in language that is comprehensible to the numerate psychiatrist as well as the medical statistician. Particular attention should be paid to clear description of study designs and objectives, and evidence that the statistical procedures used were both appropriate for the hypotheses tested and correctly interpreted. The statistical analyses should be planned before data are collected and full explanations given for any *post hoc* analyses carried out. The value of test statistics used (e.g. *t*, *F*-ratio) should be given as well as their significance levels so that their derivation can be understood. Standard deviations and errors should not be reported as \pm but should be specified and referred to in parentheses.

Trends should not be reported unless they have been supported by appropriate statistical analyses for trends.

The use of percentages to report results from small samples is discouraged, other than where this facilitates comparisons. The number of decimal places to which numbers are given should reflect the accuracy of the determination, and estimates of error should be given for statistics.

A brief and useful introduction to the place of confidence intervals is given by Gardner & Altman (1990, *British Journal of Psychiatry*, **156**, 472-474). Use of these is encouraged but not mandatory.

Authors are encouraged to include estimates of statistical power where appropriate. To report a difference as being statistically significant is generally insufficient, and comment should be made about the magnitude and direction of change.

Randomised controlled trials

The *Journal* recommends to authors the CONSORT guidelines (1996, *Journal of the American Medical Association*, **276**, 637-639) and their basis (2001, *Annals of Internal Medicine*, **134**, 663-694) in relation to the reporting of randomised controlled clinical trials; also recommended is their extension to cluster randomised controlled trials (2004, *BMJ*, **328**, 702-708). In particular, a flow chart illustrating the progress of participants through the trial (CONSORT diagram) must be included.

Qualitative research

The *Journal* welcomes submissions of reports of qualitative research relevant to the scope of the *Journal*. These manuscripts will be evaluated in terms of design, conduct and reporting of the study, which need to be of sufficient quality and merit to warrant inclusion in the *Journal*. The Editor recognises that the term 'qualitative research' encompasses diverse methods underpinned by various epistemological or theoretical frameworks. Accordingly, manuscripts will be evaluated on the basis of the appropriateness of the selected framework to the enquiry, the internal coherence of the report and its adherence to quality criteria consistent with the methodology and method as follows:

Epistemological and/or theoretical frameworks

- The epistemological underpinnings and/or theoretical framework is made explicit and applied consistently

Study design and method

- The research goal is clearly articulated, justified with reference to literature, and placed in context
- The approach matches the purpose of research and is justified
- Methods of sampling, data collection, data management and analysis are explicit and consistent with methodology
- Analytical and interpretative processes are described fully

Findings, discussion and implications

- Findings represent the depth and breadth of data
- Findings and interpretations are supported by the data
- Direct quotations, exemplars or other data presentations are used judiciously in a way that illustrates the findings
- Findings are presented in a way that is consistent with methodology, method and study aims
- Authors are appropriately cautious about knowledge claims
- Findings are explored theoretically and applications discussed

Process issues

- The report provides an account of reflexive practice in keeping with the methodology

The review of the manuscript will determine whether the authors present their research in such a way that the reader can evaluate the relevance, credibility and applicability of the generated evidence.

General House style

For further guidance, authors may refer to the [Royal College of Psychiatrists' house style guide](#).

Access to data

If the study includes original data, at least one author must confirm that he or she had full access to all the data in the study, and takes responsibility for the integrity of the data and the accuracy of the data analysis. We strongly encourage authors to make their source data publicly available.

Registration of clinical trials

The *Journal* recommends that all clinical trials are registered in a public trials registry. Further details of criteria for acceptable registries and of the information to be registered are available at http://www.icmje.org/index.html#clin_trials. For reports supported by industry funds, this is a requirement for the paper to be considered for publication in the *Journal*.

Case reports and consent

If an individual is described, his or her consent must be obtained and submitted with the manuscript. Our [consent form](#) can be downloaded here. The individual should read the report before submission. If it is not possible for informed consent to be obtained, the report can be published only if all details that would enable any reader (including the individual or anyone else) to identify the person are omitted. Merely altering some details, such as age and location, is not sufficient to ensure that a person's confidentiality is maintained. Contributors should be aware of the risk of complaint by individuals in respect of defamation and breach of confidentiality, and where concerned should seek advice. In general, case studies are published in the *Journal* only if

the authors can present evidence that the case report is of fundamental significance and it is unlikely that the scientific value of the communication could be achieved using any other methodology.

Online data supplements

Material related to a paper but unsuitable for publication in the printed journal (e.g. large tables) may be published as a data supplement to the online *Journal* at the Editor's discretion. For very large volumes of material, charges may apply.

Abbreviations, units and footnotes

All abbreviations must be spelt out on first usage and only widely recognised abbreviations will be permitted.

The generic names of drugs should be used.

Generally, SI units should be used; where they are not, the SI equivalent should be included in parentheses. Units should not use indices: i.e. report g/ml, not gml⁻¹.

The use of notes separate to the text should generally be avoided, whether they be footnotes or a separate section at the end of a paper. A footnote to the first page may, however, be included to give some general information concerning the paper.

Materials, equipment and software

The source of any compounds not yet available on general prescription should be indicated. The version number (or release date) and manufacturer of software used, and the platform on which it is operated (PC, Mac, UNIX etc.), should be stated. The manufacturer, manufacturer's location and product identification should be included when describing equipment central to a study (e.g. scanning equipment used in an imaging study).

Proofs

A proof will be sent to the corresponding author of an article. Offprints, which are prepared at the same time as the *Journal* is printed, should be ordered when the proof is returned to the Editor. Offprints are despatched up to 6 weeks after publication.

Copyright

On acceptance of the paper for publication, we will require all authors to assign copyright to the Royal College of Psychiatrists. You retain the right to use the article (provided you acknowledge the published original in standard bibliographic citation form) in the following ways, as long as you do not sell it (or give it away) in ways which would conflict directly with our business interests. You are free to use the article for teaching purposes within your own institution or, in whole or in part, as the basis of your own further publications or spoken presentations. In addition, you retain the right to provide a copy of the manuscript to a public archive (such as an institutional repository or PubMed Central) for public release no sooner than 12 months after publication in the *British Journal of Psychiatry* (or from the date of publication, if the open access option is chosen, see below). Only the final peer-reviewed manuscript as accepted for publication (not earlier versions, or the final copy-edited version) may be deposited in this way. Any such manuscripts must contain the following wording on the first page: "This is an author-produced electronic version of an article accepted for publication in the *British Journal of Psychiatry*. The definitive publisher-authenticated version is available online at <http://bjp.rcpsych.org>." If your funding body has a policy regarding PubMed Central deposit, our compliance guidelines are published [here](#).

Letters to the Editor

Letters may be submitted online either as responses to published articles (follow the link 'submit a response' when viewing an article online) or as general letters to the Editor (from the [general eLetter submission page](#)). A selection from these eLetters will subsequently be included in the printed *Journal*. Correspondence submitted for publication in the print edition without prior online publication as eLetters should be sent to bjpletters@rcpsych.ac.uk. Letters may be up to 500 words in length with a maximum of 5 references.

Extras

Extras are published at the end of articles where space allows. These comprise a wide range of material considered to be of interest to readers of the *Journal*. Submissions for publication as extras should not be submitted online, but sent by email to bjp-extras@rcpsych.ac.uk.

Open access

There is no submission or publication fee for papers published in the *Journal* in the usual way. All papers published in the *Journal* become freely available online 12 months after publication. In a new initiative to maximise access to original research, authors now have the option to make their papers freely available from the time of publication, on payment of an open access charge. This charge is currently £2500 (or US\$4500) per article plus VAT where applicable. If you wish to take up this option, contact the BJP Editorial Assistant once your paper has been accepted for publication. For such papers the requirement for a 12-month delay before release of the manuscript in a public archive is waived, and the final published version may be deposited.

At any time up to 5 years after publication of research in the *Journal*, authors may be asked to provide the raw data.

House style for the *British Journal of Psychiatry*

To be used in conjunction with the preceding pages of this house style guide and online 'Instructions for authors' at <http://intl-bjp.rcpsych.org/misc/ifora.shtml>

Editing in Word

BJPsych articles are usually edited on screen in Microsoft Word, then saved as rtf files. The typesetter sets direct from the Word file, without rekeying. Use angle brackets to identify styles such as headings. Identify author queries by underlining the relevant text and typing the query in square brackets, numbering AQ1, AQ2, etc. Enclose instructions to typesetter in square brackets.

Unless in headings, italics, bold, etc. will be set as seen, so correct as appropriate.

The document 'Sample on-screen edit' shows on-screen coding and table layout. Do not rely on it for points of house style (e.g. hyphenation).

Edit as heavily as necessary to give a clear, grammatically correct style without repetition of information.

Structure of papers

... Summary

Except for editorials and short reports, all papers must have a summary structured into the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The summary should not normally exceed about 150 words. Short reports require an unstructured summary of no more than 100 words, followed by a declaration of interest. Editorials require an unstructured summary of no more than 50 words, followed by a declaration of interest.

... Introduction

Papers and short reports should begin with an introductory paragraph (with no heading). Every effort should have been made before the paper's acceptance to encourage the author to restrict this to a single paragraph. If, however, the introduction exceeds two paragraphs, B-level subheadings may be used to break it up.

... Main body

After the introductory paragraph in papers and short reports, the text should be divided with the following A-heads: Method, Results, Discussion, Funding (if there is any), Acknowledgements (if there are any), Appendix/Appendices (if there are

any), References. No other A-level headings are permissible. A 'Conclusion' subsection at the end of the Discussion is not permissible. If this is present, determine whether it repeats the Conclusions section of the summary (in which case, delete) or adds new information. In the latter case, suggest an alternative subheading.

... **Editorials**

Editorials and review articles need not conform to this structure. They must have a photo of one of the authors and a very brief biography of all authors.

... **Appendices**

Appendices appear immediately before the References. If there is more than one appendix, each should be numbered in Arabic and given a title (as a B-head).

Title

The title of any paper should be brief and relevant. If the author has chosen a cute title that is not obvious, add a few explanatory words. Titles may have colons in them, if necessary. Subtitles should not be used unless they are essential. Try to remove (with AQ to author) inessential parochial detail such as "the East London Psychosis Study". Remove article (a/the) after colon if possible: 'Psychosocial interventions for eating disorders: systematic review'

Except for editorials, a paper title may not end with a question mark and must be neutral (i.e. the title must not anticipate the authors' conclusions – so 'Hippocampal structure and schizophrenia' is permissible, 'Hippocampal structural abnormalities are associated with schizophrenia' is not).

... **Footnotes to title**

- If a paper is being cross-referenced to another paper in the same issue, use a superscript single dagger at the end of the title. Insert a footnote to the first column of text reading:
[†]See pp. 00–00, this issue.
 or
[†]See editorial, pp. 00–00, this issue.
- Any other type of footnote to the title (e.g. stating that a version of the papers was previously presented at a conference) should be indicated by an asterisk.

Authors' footnotes to text

- These should be avoided if at all possible. When unavoidable, indicate with superscript lower case letters (a,b,c...) in the text and a baseline lower case letter in the footnote. Place the footnote at the base of the same column in which the citation appears.

Authors

... **Names/affiliations**

- Authors' names/affiliations at the end of a paper should be listed in the same order as they appear beneath the title, even if this means having to repeat affiliations. Show the names in bold. Commas separate a string of authors with the same affiliation, semicolons those with different affiliations. Affiliations should be as brief as possible. Spell out the names of US states in full.

- If an author has died, indicate in the authors' list below the title as 'William Smith*' and add footnote '*Deceased'. In the author details section indicate as 'William Smith (deceased), MD, FRCPsych, previously at the Institute of Psychiatry, King's College London'

Corresponding author

- When there is only one author, a separate 'Correspondence' section is not required at the end of the paper, but ensure a full postal address (including country) is included after the author's affiliation.
- Before his or her affiliation, the qualifications of the author should be stated, each abbreviation separated by a comma. If they are not given, ask the author to provide them.
- All papers, review articles, short reports and editorials must show a correspondence address comprising a full postal address (for US addresses, use the two-letter abbreviation for the state followed by the ZIP code), including country, and an email address. Remove phone/fax numbers. If a postal or email address is given that appears to be a home address, explicit permission to publish it must be obtained from the author.

Tables

Data presented in a figure should not be repeated in a table, and *vice versa*.

Data in a table should not be repeated in large part in the text, but may be discussed there.

In all papers (including review articles and short reports) large tables (exceeding half a Journal page portrait or landscape) are published only in the online version of the Journal (see Online/data supplements, below). Key data should be presented in smaller tables for print publication.

Tables may be one or two text-columns wide.

Each table should be comprehensible in isolation, so define all abbreviations used and structure the table for optimum clarity.

Do not include citations of references for psychometric instruments in the title or footnote, unless the instrument is not cited in the body of the paper.

Rules:

- insert full-width rule below table title and below final row of data (above footnotes)
- insert full-width rule below the table column heads, with spanners or part-rules as required within the column heads
- in the body of the table use horizontal rules to separate main rows, and indent 'subrows'; italic may be used to clarify structure only if unavoidable

Footnotes should be indicated using superscript lower case letters (a, b, c, ...) in the body of the table (and baseline lower case letters, followed by a full point, in the footnote). Each numbered footnote should start on a new line. When a footnote serves only to define the abbreviations used in the table, these definitions may run-on (each separated by a semicolon), do not require numbering and should be defined in the order in which they appear in the table itself.

- Standard asterisk notation may be used to signify *P*-values (single asterisk means <0.05, double asterisk means <0.01, triple asterisk means <0.001; use further symbols (see general house style guide for hierarchy) to indicate alternative comparisons).

- Footnotes should appear in the following order: definitions; numbered footnotes; explanation of significance. A footnote showing all of these features is shown below.

HRSD, Hamilton Rating Scale for Depression; GAD, generalised anxiety disorder.

a. Data unavailable for three participants.

b. Calculated according to the method of Molotov et al.²⁵

* $P < 0.05$, ** $P < 0.01$ v. control group; † $P < 0.05$, †† $P < 0.001$ v. first-onset group.

Figures

Each figure should be comprehensible in isolation, so define all abbreviations used.

Do not include reference citations for psychometric instruments in the title or footnote, unless the instrument is not cited in the body of the paper. Redrawing is kept to a minimum. Data presented in a figure should not be repeated in a table, and *vice versa*.

Edit captions and labels and mark all figures to be relabelled to house style.

Three-dimensional effects and background shading are not permissible: mark for typesetter to remove them. Figures may be up to 1 or 2 text-column width.

Size figures to look sensible on the page, rather than to fill a given space.

Alert the Scientific Editor to any figures that may be problematic, require complete redrawing, or use colour.

Declaration of interest and funding

This is defined as: fees or grants from, employment by, consultancy for, shared ownership in, or any close relationship with, an organisation whose interests, financial or otherwise, may be affected by the publication of the paper.

When a relevant interest (e.g. consultancy for a pharmaceutical company) is declared, it must be clearly stated in the 'Declaration of interest' section of the summary. If funding is the only 'interest' given, the declaration should read 'None.' No mention of funding should appear in the declaration.

Funding should not be listed under 'Declaration of interest': any funding details should appear under the A-Head 'Funding', inserted before the Acknowledgements section near the end of the paper.

... Open access

All papers arising from research with Wellcome Trust funding must be open access (free to the public). If funding mentions the Wellcome Trust (or if authors are employed by or receiving grants from the Trust) alert the Scientific Editor immediately. The Scientific Editor may ask you to add '[Typesetter: insert open access logo here]' after the reference list.

Acknowledgements

Avoid gushing thanks. 'We thank...!' rather than 'We wish to express our great appreciation of the fine work done by...!', etc.

Funding details should be given in a separate section, under the A-heading 'Funding' and preceding the Acknowledgements.

References

References should be numbered in the order in which they appear in the text and listed at the end of the article using the Vancouver style (see below). In the text make reference numbers superscripts, positioned after any punctuation except for parentheses. If the reference refers to text in parentheses, it should appear within them: '(35% in the UK²⁴)'. References appearing for the first time in Tables or Figures should be numbered sequentially as if they were in the text.

... Online supplements

References that appear in both the print text and an online supplement should be numbered and listed as normal in the print text, and the same numbers shown in the supplement; the reference list need not be repeated in the supplements. If online-only (data supplement) material such as tables includes references not cited in the reference list in the full (printed) text, number these additional references to run on from the last text-reference number. Then list only these additional references in the supplement, under the A-heading 'Additional references'.

Example 1

A paper has two online tables, DS1 and DS2. Table DS1 introduces two additional references, and Table DS2 introduces a further three. If the text references end at number 52, the Table DS1 references will be numbered 53 and 54, and the Table DS2 ones will be numbered 55, 56 and 57. Since both tables will appear in a single data supplement only one 'Additional references' list is needed (after Table DS2), showing refs 53–57.

Example 2

A paper has two Data supplements: Data supplement 1 comprises three paragraphs of text and a related graph (Fig. DS1); and Data supplement 2 comprises an interview checklist. The paper's text references end at number 34. In Data supplement 1 the three paragraphs introduce two additional references (which become 35 and 36) and Fig. DS1 introduces a further one (37); this data supplement will have an 'Additional references' list showing refs 35–37. Data supplement 2 introduces yet another reference: this will be numbered 38 and will appear as an 'Additional reference' at the end of the checklist.

... Journal titles

In the reference list, all journal titles should be abbreviated according to the style of *Index Medicus*. References to book or book chapters should give the title of the book (and the chapter if selected), names of any authors, name of publisher, names of any editors, and year. Examples are shown below, note use of punctuation and minimum digits in page ranges (see also pp. 16–20):

- 1 Kapusta ND, Etzersdorfer E, Krall C, Sonneck G. Firearm legislation reform in the European Union: impact on firearm availability, firearm suicide and homicide rates in Austria. *Br J Psychiatry* 2007; **191**: 253–7.
- 2 Thornicroft GJ. *Shunned: Discrimination Against People with Mental Illness*. Oxford University Press, 2006.
- 3 Casey P. Alternatives to abortion and hard cases. In *Swimming Against the Tide; Feminist Dissent on the Issue of Abortion* (ed AB Kennedy): 86–95. Open Air Books, 1997.
- 4 Lancet. Burnished or burnt out: the delights and dangers of working in health. *Lancet* 1994; **344**: 1583–4.
- 5 Pharmaceutical Research and Manufacturers of America (PhRMA). *PhRMA Guiding Principles on Direct to Consumer Advertisements About Prescription Medications*. PhRMA, 2005 (<http://www.phrma.org/publications/policy//2005-08-02.1194.pdf>).
- 6 Soni SD, Mallik A, Mbatia J, Shrimankar J. Late paraphrenia. *Br J Psychiatry* 1988; **152**: 719–20.
- 7 Viding E, Frick P, Plomin R. Aetiology of the relationship between callous-unemotional traits and conduct problems in childhood. *Br J Psychiatry* 2007; **190** (suppl 49): s33–8.

... Personal communication

Personal communications need written authorisation (email is acceptable); they should not be included in the reference list. Unpublished doctoral theses may

be cited (please state department or faculty, university and degree). No other citation of unpublished work, including unpublished conference presentations, is permissible.

... Debate articles

References to BJPsych 'Debate articles' should appear as:

- 1 Kingdon D/Young AH. Research into putative biological mechanisms of mental disorders has been of no value to clinical psychiatry (debate). *Br J Psychiatry* 2007; **191**: 285–90.

Online/data supplements

All tables (exceeding half a *Journal* page) and large amounts of data unsuitable for print publication may be included with the online version of a paper as a 'data supplement' (e.g. for tables) or 'online supplement' (e.g. for study questionnaire). Consult Scientific Editor if tabulated data appear to fall into this category or if the authors have indicated that a data supplement should be included with their paper.

- If a paper has online material, add '[Typesetter: insert online logo here]' after the reference list.

Correspondence (letters to the Journal): authors' names

- Show authors' forenames, if given; no comma after surname; no qualifications or titles such as Dr or Professor *before* names; only one full address for correspondence, for example:

Om Prakash, Associate Professor of Psychiatry, Institute of Human Behaviour & Allied Sciences (IHBAS), New Delhi, India. Email: drjhirwalop@yahoo.co.in

Dieneke Hubbeling, Consultant Psychiatrist, South West London & St George's Mental Health NHS Trust, UK. Email: dieneke@doctors.org.uk; **Keelyjo Hindhaugh**, ST6 Trainee, **Robert Bertram**, Associate Specialist, Wandsworth Crisis and Home Treatment Team, UK

All papers and reviews

Omit the parentheses around the first received, etc., and abbreviate months to three letters. No full point at end:

First received 1 Jan 2011, final revision 10 Jul 2011, accepted 17 Jul 2011

Some papers skip the revision stage:

First received 20 Aug 2011, accepted 28 Aug 2011

Clinical trial registration

... Registration of clinical trials

- The *Journal* recommends that all clinical trials are registered in a public trials registry. Further details of criteria for acceptable registries and of the information to be registered are available at <http://www.icmje.org/index>.

html#clin_trials. For reports supported by industry funds, this is a requirement for the paper to be considered for publication in the *Journal*.

- When **copy-editing** a clinical trial, if trial registration information is not given, a standard query should be included 'AQ: if this trial has been registered in a public trials registry, please give registration details'.
- All trials funded by the US National Institutes of Health **must** show a clinical trials registration number. If none is given, request one from the author.
- The two largest public registries are the International Standard Randomised Controlled Trials Number (ISRCTN) Registry (a not-for-profit organisation whose registry is administered by Current Controlled Trials Ltd) and Clinicaltrials.gov (a service of the US National Institutes of Health, administered by the National Library of Medicine). The former allocates a code number to trials in the format ISRCTNXXXXXXXX, the latter uses the format NCTXXXXXXXX – it is important that no other formatting is used (i.e. no space or punctuation between the prefix and the code number). For example: NCT00027300 is acceptable; NCT 00027300 or NCT:00027300 are not. When correctly formatted, the online journal will automatically create a hotlink to the trial's online registration details. **Proofreaders** should check that: (a) the registration code is correctly formatted; (b) the code number is correct (i.e. retrieves the correct trial registration information from the relevant database).
- To check the code number for ISRCTN registration, use the search box at: <http://www.controlled-trials.com/isrctn/>
- To check the code number for Clinicaltrials.gov registration, use the search box at: <http://www.clinicaltrials.gov/>

Section Three: Critical Appraisal

A critical review of the research process.

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The critical appraisal is a reflective account of the research process. The empirical paper is of primary focus, but some reflections upon the meta-synthesis are also provided. I first give a brief summary of the results from the research paper so they can be kept in mind whilst reading this appraisal. Next, I outline the development of my epistemological position and reflexive stance. The focus then shifts to some of the limitations I encountered when using grounded theory during the analytic process. Some of the issues encountered during the process of the research are also explored. I then consider the impact of the research and the essay concludes with some discussion on possible avenues for future research.

Summary of results

The results from the research paper indicate an initial conceptualisation of psychiatrists' understanding and use of psychological formulation. Four conceptual categories are named as 'conceptualising formulation', 'singing off the same hymn sheet', 'barriers to formulation' and 'making a Frankenstein's monster'. The findings suggest that psychiatrists view and use psychological formulation in a different way from that outlined by clinical psychologists. Findings also highlight the value psychiatrists place on collaborative formulation with psychologists. There are multiple contextual factors which may act as barriers to using formulation and lead to a disintegrated way of working.

Epistemology

This section offers some discussion of the development of my epistemological position during the research process. The majority of my initial learning about epistemology is took place during DCLinPsy teaching sessions on epistemology. Sessions focused on and contrasted a social constructionist perspective with a positivist position. Positivism considers that empirical evidence derived from logic and mathematics constitutes truth and that like the physical world, society operates according to this knowledge. In contrast, social

constructionism considers experience, knowledge and practice to be formed by historical, institutional and social processes. Burr (1995) defines social constructionism as anti-essentialist and anti-realist, denying the notion of an objective reality, as well as refuting the perspective that people have a definable, discoverable nature or 'personality' (Burr, 1995). Social constructionism also posits that knowledge may give power to some over others; Foucault (1967) argued that 'madness' was a label given by social institutions asserting social control over people who did not fit in with societal expectations (Foucault, 1967). This was in line with my beliefs about the power of language in shaping our society and the notion of 'mental illness' as a construct which incorporates the following cultural expectations as defined by Parsons (1951): i) you are not responsible for your disability; ii) you are exempt from certain social commitments; iii) being sick is seen as undesirable and the goal is always to be well; and iv) you need specific help which is available once you are categorised as a 'patient' (Parsons, 1951). Johnstone (2000) argues that once viewed in the sick role a person is presumed not to be responsible for their situation and therefore becomes a 'passive recipient of care' (Johnstone, 2000, p.40) and vulnerable to stigma from others and society as whole. I identified with these ideas and so aligned myself with a social constructionist epistemological perspective.

During the thesis process I encountered some issues with identifying with one particular epistemology over another. For example, using a constructivist epistemology when carrying out grounded theory analysis can conflict with the expectation of quality assessing research in order to conduct an effective systematic review. Moreover, in order to practice as a clinical psychologist one must draw upon a number of different theories, for example attachment theory (Bowlby, 1969) which subscribes to the notion that all human beings have innate personality traits rather than personality being exclusively socially constructed.

More recently I have learnt about critical realism which originates from Bhaskar's philosophies of science (Bhaskar, 1978). In opposition to empiricism and positivism where causal relationships are established, critical realism acknowledges an existent truth or reality, separate from our perception. Bergin, Wells, and Owen (2008) point out that critical realism is distinguishable from other metatheoretical positions as it is more concerned with ontology (what we know). For example, critical realism looks beyond what can be observed directly and considers what is *not* there, which offers more comprehensive explanations. Within a mental healthcare context this could be looking for causal mechanisms and how they become triggered (Sayer, 2000). This arguably makes critical realism an appropriate epistemological stance when researching and critically appraising mental health and social practices which are based on existing theories (Bergin, Wells, & Owen, 2008; Pilgrim, 2014).

Having reflected further on the development of my epistemological position I currently view the different epistemological positions on a spectrum and view critical realism as a midpoint between relativism (inclusive of social constructionism) and positivism. My own stance is between social constructionism and critical realism; however I am aware of the pragmatic need to move flexibly between points on the spectrum in order to satisfy course requirements.

Reflexive Stance

My interest in the research topic stems from my clinical experience of formulating in teams and advocating the benefits of multidisciplinary working. I hoped that focusing my research in the area of psychological formulation and psychiatry would allow me to: i) feel more comfortable working within an environment where using diagnosis was commonplace amongst the multidisciplinary team; ii) reflect and further understand the processes that psychiatrists, a profession steeped in medical understanding, may go through in trying to

understand their patients; iii) consider the impact of such conflict on psychiatrists' approach to psychological understandings; and iv) consider how mental health services can incorporate multiple models of understanding human distress in order to practice in a person-centred way.

Limitations: developing grounded theory in a time-limited fashion

This section first offers a brief overview of grounded theory, before some discussion of the time-limited nature of conducting the grounded theory analysis, which is considered to be a limitation to the research.

A grounded theory methodology is beneficial in developing theories and frameworks for understanding human processes (Glaser & Strauss, 1967). Traditional grounded theory is defined by its creators as 'the discovery of theory from data systematically obtained from social research' (Glaser & Strauss, 1967, p. 2). The traditional approach sits within a positivist paradigm and was developed in order to predict cause and effect relationships, bridging the gap between quantitative and qualitative research.

The development of grounded theory has been described as a "methodological spiral" (Mills, Bonner, & Francis, 2006, p. 2), illustrating how numerous grounded theory approaches have been proposed over time which differ to varying extents from the traditional theory. One such approach is Charmaz's (2006) constructionist grounded theory, which is rooted in a social constructionist epistemology, incorporating a relativist approach between researcher and data (Charmaz, 2006). The methodology acknowledges the contextual influence of the researcher on their data and the co-construction of meaning between researcher and participant (Charmaz, 2006; Pidgeon & Henwood, 1997).

I chose this approach for my empirical research as it was congruent with my own developing epistemological stance, an important factor in research design (Mills, Bonner, &

Francis, 2006), and because the methodology is widely used in mental health qualitative research to illuminate new theories and develop understandings (Tweed & Charmaz, 2012). Additionally the constructivist approach allowed a more flexible and non-prescribed methodology than classic grounded theory strategies (Charmaz, 2011).

Theoretical sampling is a distinctive feature of grounded theory (Glaser & Strauss, 1967). According to Charmaz (2006) theoretical sampling is defined as:

a type of grounded theory sampling in which the researcher aims to develop the properties of his or her developing categories... When engaging in theoretical sampling, the researcher seeks people, events, or information to illuminate and define the boundaries and relevance of the categories. Because the purpose of theoretical sampling is to sample to develop the theoretical categories, conducting it can take the researcher across substantive areas. (Charmaz, 2006, p. 189).

Through the process of theoretical sampling it is possible to create categories that are rich in narrative and have explanatory power. Theoretical sampling may be actualised in diverse ways, for example by adding new participants, observing new settings, or returning to participants who have already been interviewed and asking them new questions (Charmaz, 2006). Within my research I used theoretical sampling in two different ways; by adaption of the interview schedule and by adding new participants. After the initial interviews had been conducted and initial analyses had been carried out, the emerging codes from initial interviews were used to enhance and re-focus the interview schedule. For example, the first interview with Jack revealed that time was a barrier to using formulation. Therefore, the question was added to the interview schedule "Is there anything that makes it difficult to use formulation?" This helped to generate more codes in subsequent interviews which resulted in the category of 'barriers to formulation'. Theoretical sampling was again utilised once initial

categories had been developed, to test out the emergent theory. For example in earlier interviews a relationship was identified between the number of years participants had been qualified and the emphasis they placed on using formulations in teams. In order to seek clarification, the question “how your use of formulation changed as your career has progressed?” was added to the interview schedule and participants who had been qualified for a considerable number of years were selected from the participant pool. Other examples of theoretical sampling involved emailing potential participants in order to try and recruit participants that met the following criteria: i) do not use formulation within their practice; ii) use formulation when working with teams; and iii) use formulation to assess risk.

Despite the use of theoretical sampling to some extent, it is considered a limitation that due to the time restrictions involved in carrying out research as part of a doctoral course, which meant that some of the categories were not as developed as they could have been. For example, the case of “singing off the same hymn sheet” could have been further delineated and elaborated upon, had there been more time and resources to recruit participants who had experience of working closely with psychologists when engaging in team formulation. Similarly, the category “making a Frankenstein’s monster” could have been further developed had there been more time to interview more participants in order to implement the adapted interview schedule. Future qualitative research might seek to explore these areas further in order to develop an enhanced understanding. Evaluations of team formulation or case studies of successful joint work between psychologists and psychiatrists may offer further detail to the insights offered by this thesis.

Theoretical sampling allows for the development of properties of categories at which further data collection will offer no new information or theoretical insights about the emerging theory (Glaser & Strauss, 1967). This was termed by Glaser & Strauss (1967) as theoretical saturation. Similarly, within a constructivist framework, Charmaz proposes

“categories are ‘saturated’ when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of these core theoretical categories” (Charmaz, 2006, p.113).

It may therefore be considered a limitation to the research that data collection did not reach complete “saturation”. However, Dey (1999) has offered an alternative to saturation as ‘theoretical sufficiency’, as a better description of how researchers conduct grounded theory. This is because Dey (1999) asserts that saturation ‘stops short of coding all of the data’ (p.257) and that the process is subjective on the part of the researcher. From a social constructionist position, research is ongoing and its endpoint can never be objectively defined. Despite adopting the concept of theoretical sufficiency when carrying out my research it is evident that the time restrictions imposed on the research resulted in limited richness and depth in some of the categories.

Process issues

This section explores some of the issues encountered during the process of carrying out the research and includes: the interview-participant dyad, conducting ‘informed’ grounded theory and carrying out research within a medically dominated context. Some examples of how I overcame these challenges are also provided.

the interviewer-participant dyad. Acknowledging the dynamics in interaction between participants and researcher may promote reflexivity and rigour (Hall & Callery, 2001). The interview process provoked a sense of imbalance in power between myself and the participants, where at times I felt that perhaps some of my questions may be interpreted as ‘testing’ their knowledge rather than enquiring about their experiences. I was aware of my professional background within the context where diagnosis and psychiatry were challenged and in a place of threat (Craddock et al., 2008), which sometimes left me feeling that

participants were operating from a position of 'defence' or 'attack' during interviews. During one particular interview I was asked a lot of questions and noted feeling 'tested'. I wondered if this was perhaps due to interviewees perceiving my position as threatening and were projecting this onto me (Lemma, 2008). I responded to this in the moment, by empathising with their expressed difficulties, demonstrating that they were being heard by drawing on basic clinical skills I had learnt through clinical training.

During interviews it seemed to be challenging to get participants to reflect on the psychological processes involved in integrating biological and psychological understandings. I wondered whether the difficulty lay with me as a researcher not phrasing my questions well or whether this was something that they had not reflected on during their career, due to some of the reasons indicated in the empirical results, such as a lack of time and lack of resources for reflective practice. I found that asking the question 'how do you integrate the psychological with the biological?' also seemed 'testing'. This is something I discussed with JS in order to develop a better way of asking the question, which we worked out to be 'how do you integrate *your* psychological understanding into your day-to-day practice?' This highlighted how the nuances of language can have an impact on emotional response and again highlighted the need to have a psychiatrist as a supervisor in order to maintain a degree of neutrality.

conducting 'informed' grounded theory. Traditional grounded theorists maintain that the researcher should not approach existing literature around the topic until after data analysis, so that the 'discovery' of theory emerges solely from the data (Glaser & Strauss, 1967). This allows the researcher to remain faithful to the data, instead of imposing existing knowledge onto the emerging theory. In contrast, 'informed grounded theory' (Thornberg, 2012) describes an approach in which the researcher has an awareness of relevant literature. Appropriate steps to monitor any influences or bias are outlined, for

example maintaining constant reflexivity and using memo writing to record linking pre-existing knowledge to the data (Thornberg, 2012). When conducting a review of the area in order to develop the protocol and rationale for the research, the existing literature may be viewed as a source of inspiration and linking ideas together in novel ways, in line with principles of abduction (Thornberg, 2012). This approach seemed more suitable for that of a researcher fulfilling the requirements of a DClinPsy course. The pragmatic nature of the doctoral process demands detailed consultation of existing research in order to determine suitable area for further investigation, develop an appropriate research question and write a research protocol that includes a rationale for the research. Furthermore, trainees will come into contact with relevant research in the substantive area as part of teaching sessions, clinical experience and other assignments completed during training.

The research process allowed me to see how it was impossible to maintain a ‘tabula rasa’, particularly in the context of current technological paradigms, where information is available via a myriad of electronic domains such as social networking. The following excerpt from my reflective journal illustrates this point:

I witnessed a tweet on Twitter that Lucy had made about celebrities being non-critical and overly invested in a biomedical model of mental illness. Some psychiatrists, perhaps feeling threatened and defending their profession, called her attitude “shameful” and questioned her position as a leader of the DCP. I noticed that some psychiatrists were participating in the debate, stating Lucy to be showing “ideological narrow-mindedness”. It seemed like this forum continued to influence my thinking and engagement in the analytic process. This illustrates to me the idea that the researcher can be influenced in a myriad of ways in which may not be immediately apparent. Psychologists may also take a reductionist approach towards mental wellbeing if they assume that formulation is the best approach to take with

everyone, regardless of the person and their narrative. The relation between researcher and the data can never be objectively defined.

conducting a meta-synthesis within in a medically dominated context. The following challenge relates specifically to the process of conducting the metasynthesis on service user views of receiving a diagnosis of borderline personality disorder. Focusing the literature review proved challenging overall and took me through many avenues of uncertainty. I originally intended to carry out a literature review that would adopt a critical perspective on service users' experiences of receiving a psychiatric diagnosis within adult mental health services and the impact that it had upon their lives. However, due to the documented limitations of searching databases for qualitative studies (Pope, Mays & Popay, 2007), as well as pragmatic limitations outlined by the course in terms of time and the number of papers to be defined as 'acceptable', I eventually had to narrow the research focus to a specific diagnosis.

Systematic reviews adopt a rigorous search to incorporate all relevant studies. However, relevant bibliographical databases have arguably not been set up to facilitate searching for qualitative data (Dixon-Woods, Fitzpatrick, & Roberts, 2001). This highlighted a limitation in carrying out research within a context where evidence is hierarchical. Supervision enabled me to recognise such frustrations and acknowledge the documented challenges of qualitative researching in mental health (Dixon-Woods et al., 2001). I eventually chose to focus my literature review on the diagnosis of 'borderline personality disorder', due to its relevance in my clinical work during placement at the time of the research, and because I had witnessed high levels of stigma attached to this diagnosis within my clinical practice, which seemed to be more engrained and less challenged than stigma towards other diagnoses.

Overall I found that the exploration of an area of research that has a strong and dominant pre-existing framework was a challenge. Acknowledging the challenges during supervision and drawing on psychological models of emotions enabled me to manage my frustrations.

Considering the impact of my research

In this section I discuss some of the ways in which the research impacted upon me (as a clinical psychologist, researcher and student), as well as my perceptions of the impact upon my supervisors, and hopes for impact upon the wider audience.

My awareness of the differences between psychiatry training and psychology training has been amplified during the course of this research, as has the notion that training is vital in shaping the way I think as a clinician. During interviews I noted the different ways in which psychiatrists are trained to make decisions quickly, in order to be pragmatic and decisive. In contrast, I perceive psychologists to be trained to think in a much more tentative way. As one participant noted, time is a 'luxury' for psychologists. Some participants observed that the interviews had given them time to think in an unfamiliar way. Perhaps as an interviewer I facilitated a reflective space for them. This process allowed me to develop further appreciation for the time and space that clinical psychologists have for reflective practice as part of our ongoing professional development (Hughes & Youngson, 2009) and also the need for facilitating this space for others or perhaps 'burdening' ourselves with the uncertainty that they don't have capacity for.

This project has promoted my understanding of psychiatry which in turn has enhanced my clinical practice. I am more able to appreciate the context in which psychiatrists operate, which has increased my confidence in collaborative working. I am able to empathise with the

pressures they are placed under as well as the responsibility they hold in needing to make quick decisions as responsible clinician.

Overall I hope that this research has an impact on how the profession of clinical psychology think about other disciplines. Both field supervisors commented on their experiences of widened perspective after involvement in the research; for example PJ commented that during the psychosocial intervention training he delivered to medics, he was more able to identify with their position due to better understanding of their training and professional context. Similarly JS commented that, remaining mindful of the findings from this study that trainees do not have much opportunity outside of psychotherapy training to practise formulation, he had used a Cognitive Analytic Therapy (CAT; Ryle, 1995) formulation when working on the ward with some trainees to develop their understanding of a complex client.

Although the empirical paper has been formatted for publication in a psychiatric journal, it is hoped that findings will be disseminated across disciplines in order to promote integration. I am planning to disseminate findings at a northwest psychotherapy faculty for psychiatry trainees, in order to promote further thought about the way psychological formulation is incorporated into training.

Final Reflections

Upon re-consideration of my personal hopes for the research outlined at the start of this appraisal, I feel that I have furthered my understanding in all four areas.¹ My research has clarified some of the processes of psychiatrists' understanding and use of psychological

¹ My hopes for the research were: i) to help me feel more comfortable working within an environment where using diagnosis was commonplace; ii) to reflect and further understand the processes that psychiatrists may use in trying to understand their patients; iii) to consider the impact of conflict on psychiatrists' approach to psychological understandings and iv) to consider how mental health services can incorporate multiple models of understanding human distress in order to practice in a person-centred way.

formulation. It has raised for me the question of how, in my capacity as a clinical psychologist, I can influence organisations and challenge powerful discourses without creating a threat-based system. This is something that I would like to explore further in both research and clinical practice, drawing on attachment theory (Bowlby, 1969) and mentalisation (Bateman & Fonagy, 2011).

The experience of the service user is at the centre of our practice as both psychologists and psychiatrists. Previous research has demonstrated how service users experience integrated service provision and formulation-based approaches within services outside of the context of therapy (Cairns, 2013) but future research might act to clarify how service users perceive competing conceptualisations of their difficulties. It would also be interesting to carry out further qualitative research exploring clinical psychologists' use of psychiatric diagnosis in their clinical practice, as it has been contended that trainee clinical psychologists are poorly equipped during their training with contradictory explanations regarding the relationship between formulation and diagnosis (Carey & Pilgrim, 2010).

The experience of receiving teaching from both a psychiatrist and psychologist during training, as well as the interview process during research, highlighted to me that when there is a 'safe space' created between professions, honest and open debate can take place without feelings of threat arising. Upon reflection I consider the facilitating factors in such situations were remaining open to alternative paradigms and being able to express views without being judged. This draws parallels once again to attachment theory and the need for us all to have a 'safe base' (Bowlby, 1988), as well as to Rogers' (1961) outlined requisite for unconditional positive regard, in order for us to grow and develop as human beings (Rogers, 1961).

Finally, despite valuing the need to work in an integrated way, I recognise the importance of having strong voices within our profession who are not afraid to speak out against the dominant discourse. I hope to continue to develop my leadership skills in this

area during my career as a qualified clinical psychologist, while maintaining an awareness of the potential impact that this may have on others.

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Section Four: Ethics Section

An exploration of psychiatrists understanding and use of formulation

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The British Psychological Society state that the core purpose of the profession of clinical psychology is “to reduce psychological distress and to enhance and promote psychological well-being by the systematic application of knowledge derived from psychological theory and data” (BPS, 2011a, p.2). One of the ways in which clinical psychologists are expected to achieve this aim is through the application of psychological formulation. There is no universal definition of psychological formulation. However, the Division of Clinical Psychology describe psychological formulation as “the summation and integration of the knowledge that is acquired by the 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 (DCP, 2010, p.5). The BPS has produced guidelines on the use of psychological formulation, recommending an integrated collaborative approach which includes working across a multi-disciplinary team (MDT), (BPS, 2011b). This is in keeping with New Ways of Working (NWW, 2007), which advocates the need to “share knowledge , skills and competencies across professional and practitioner boundaries” as well as “to adopt a team approach to NWW, rather

than an individual practice or practitioner focus, thus making better, more effective use of existing resources” (p. 11). The process of formulating with a range of professionals within a team may facilitate shared goals, a shared philosophy and accepted roles and responsibilities which can enhance efficacy for service, service users and clinicians. Some research evaluating the process of MDT formulation shows that this process enhances psychological thinking within teams and improves relationships between staff and service users (Berry, Barrowclough & Wearden, 2009).

There has been limited research looking at how clinical psychologists work with formulation. One recent study focused on how clinical psychologists understand formulation as a process and as an event (Cole & Johnstone, in press). Another study featured clinical psychologist’s descriptions of their use of formulation in MDT working (Christofides, Johnstone & Musa, 2012). The authors found that participants reported “chipping in” (p. 424) and sharing formulations during informal discussions with the MDT rather than formally through training or team meetings. Participants also reported that the nature of the service and the previous experience of the staff also affected the way in which formulation was used. Overall findings indicated that the clinical psychologists who were interviewed in the study seemed to value the use of formulation within an MDT, despite its lack of formal recognition.

Two studies (Hood & Johnstone, 2013; Picken & Cogan, 2012) looking at clinicians’ views of formulation highlighted the theme of formulation as an alternative to diagnosis. Picken and Cogan (2012) used interpretative phenomenological analysis to analyze clinicians’ views of formulation and found four superordinate themes: ‘guiding assessment and intervention, telling one’s story, formulation as an intervention and the role of formulation in the wider mental health field’ (p.38). Within these themes, sub-themes regarding the relationship between diagnosis and

formulation were found, which included formulation as ‘adding meat on the bones of diagnosis’ (p.39). This indicated that formulation was viewed by clinicians as adding more depth and richness to the structure of diagnosis. In addition, Picken and Cogan (2012) found that participants questioned the possibility of formulation as an alternative to diagnosis given the current frameworks of service provision and the necessity for outcome measurements and evaluation. Hood and Johnstone (2013) used thematic analysis to demonstrate an MDT’s views that psychological formulation was valued highly and seen as part of a shift towards a more psychosocial understanding of distress. One of their themes highlighted staff members’ frustration with formulating in a biomedical context.

The findings from Hood and Johnstone (2013) and Picken and Coogan (2012) relate to current debates within clinical psychology and psychiatry, where diagnostic classification systems and the ‘disease’ model have been criticized by the Division of Clinical Psychology in favour of an approach that is “multifactorial, to contextualise distress and behaviour, and to acknowledge the complexity of the interactions involved, in keeping with the core principles of formulation in clinical psychology” (DCP, 2013, p.3). Some psychiatrists have also promoted the use of psychological formulation within a biopsychosocial framework (Bracken et al. 2012; Davenport, 2002; Mace & Binyon, 2005; Martindale, 2007).

The Royal College of Psychiatrists’ curriculum requires psychiatry trainees to be able to formulate using a biopsychosocial model (RCPsych, 2010). RCPsych state in their curriculum that trainees must “demonstrate the ability to construct formulations of patients’ problems that include appropriate differential diagnoses” (RCPsych, 2010, p.25). Additionally recent research has demonstrated that twelve psychiatry trainees receiving a recently developed teaching module within a UK-based university on integrated case formulation improved five times as much as a

control group of twelve psychiatry trainees receiving teaching as usual (Abbas, Walton, Johnston & Chikoore 2012). Trainees were assessed using The Case Formulation Scale; an 18-item clinician administered scale which assessed for the inclusion of relevant content and the integration of key information (Abbas et al., 2012).

Despite the requirement for trainee psychiatrists to incorporate biopsychosocial formulation into their practice, there is a lack of research focusing on psychiatrists' understanding and views of formulation within MDTs. Current research focusing on MDT views of formulation either features one psychiatrist as a participant in the study or none at all (Connelly & Williams, 2012; Wainwright & Bergin, 2010; Summers, 2006). Additionally, the research evidence so far has been based on service evaluations and descriptions of clinical practice which offers limited understanding. There is a need for further exploration of staff understanding and views of psychological formulation in order to ascertain how it can be used within the current service framework to benefit both service users and staff.

Aims

The aims of this study are to explore how psychiatrists understand psychological formulation and to explore how psychiatrists use psychological formulation. It is thought that an understanding of these processes may facilitate a cross-disciplinary understanding of mental distress within adult NHS services. Additionally, it is hoped that this understanding may also allow greater transparency between psychologists and psychiatrists, which may in turn enhance MDT-working. Findings also have the potential to inform the future development of the incorporation of psychological and multidisciplinary formulation into the RCPsych and DClinPsy teaching curriculum.

Research design

A qualitative methodology will be used due to the exploratory nature of the research question (Willig & Stainton-Rogers, 2008). Grounded theory (Charmaz, 2006) will be employed because it is widely recognized as an appropriate methodology for exploration and theoretical development into novel areas of research, where there is no pre-existing theory (Crooks, 2001). The researcher will adopt a social constructionist approach to grounded theory, where they will identify themselves as taking an active role and therefore influencing the interview process and findings (Charmaz, 2006).

Memos will be written during the initial coding process which be used as part of the initial analysis. Data will be coded and then codes will be synthesized into categories, which will be developed into an emerging theory through the process of theoretical sampling. Categories will be considered as ‘saturated’ when new data no longer gives rise to new categories and the emergent theory is considered ‘robust’ (Charmaz, 2006). Following recommendations outlined for sample sizes in the grounded theory literature (Birks & Mills, 2011; Charmaz, 2006) it is estimated that 10 – 15 participants will be required in order to develop a robust theory.

Participants

Participants will be qualified psychiatrists or psychiatrists in training, who have had some experience of working with a clinical psychologist in every day practice. Participants will be sought to cover a range of different levels of training (core trainees, higher specialist trainees, and consultants). Their level of experience and number of years practicing will be collected before interviews take place (appendix D). It is hoped that there will be a mixture of training

levels within the participant pool to ensure that the study reflects the different range of levels of experience and expertise. During recruitment, should there be an emerging “sample bias” (for example all participants think that formulation is useful) then recruitment will be focused to find participants who will address this (for example finding participants who are not in favour of formulation). Furthermore it is hoped that the variation within the participant pool will facilitate an indication of whether there is a relationship between factors such as the type of service worked in, level of experience and use of psychological formulation.

Recruitment

Recruitment will take place via email (appendix A), through the Royal College of Psychiatrists (RCPsych) Northwest Division. [REDACTED], manager of the North West Division, will send emails to all members residing in the counties of [REDACTED]. [REDACTED]. Emails will first be sent to all members residing in the counties of [REDACTED]. [REDACTED]. Should an insufficient number of participants be recruited from these counties then emails will be sent to members residing across the north-west counties not already included in the recruitment process. Should there be an insufficient number of participants following this process then other forums that are accessed by psychiatrists will be identified and approached in order to recruit further participants.

Additionally, emails will be sent out by the psychiatry field supervisor to psychiatrists and psychiatry trainees working within adult services at [REDACTED]. Additionally, the psychiatry field supervisor will email to the [REDACTED] and Northwest Deanery to (appendix A). All emails sent by the RCP and within [REDACTED] University will include an attached information sheet (appendix B), consent form (appendix C) and demographic form (appendix D). Should potential participants have any questions or concerns about taking

part in the study they will be able to contact the researcher using the telephone and email contact details provided. If potential participants would like to take part in the study they will then be advised by the researcher to return a completed consent form and demographic form by email. This is in order to allow the researcher to carry out interviews that are informed by theoretical sampling (Charmaz, 2006). The researcher will then liaise with the potential participants in order to arrange a convenient location and time for an interview.

Participants who work within [REDACTED] will be interviewed at their place of work. Approval will be sought from [REDACTED]. For other participants not working within [REDACTED], interviews will take place at appropriate local venues such as a local resource centre, meeting rooms in libraries, colleges or universities or in the participant's home. If these participants request to be interviewed on NHS premises then I will check with them whether or not there are any site protocols that need to be carried out before going ahead with interviewing.

Data Collection

Data collection will comprise of 1:1 semi-structured interviews using an interview schedule (appendix E), which was developed with the support of a LUPIN member (see 'service user/public involvement') and piloted with the psychiatrist supervising the project.

The interview schedule will be used flexibly with initial interviews and prompts and probes will be used where necessary. After the initial interviews have been conducted and initial analyses have been carried out, the interview schedule will be adapted. This is in keeping with a grounded theory approach which advocates the process of theoretical sampling (Glaser & Strauss, 1967; Charmaz, 1990). In this way emerging themes from initial interviews are used to enhance and re-focus the interview schedule.

Consent will also be gained from participants for a second interview to be carried out at a later date, should the analysis of the initial interview raise any themes that warrant further explanation in order to develop the emerging theory.

Should there be difficulties in the recruitment of a sufficient number of participants then the data collection process will be adapted to encompass not only 1:1 interviews but also telephone interviews. All interviews will be audio recorded.

Practical Issues

Risk Protocol

The researcher will accord with Lancaster University Lone Worker Guidelines and contact their field supervisor by telephone, both before and immediately after each interview.

Before carrying out the interviews the researcher will remind participants of the limits of confidentiality and outline that they will be able to withdraw their details up to two weeks after participating in the study. Participants will again be given the opportunity to ask any questions that they have about the study.

Ethical Issues

All audio recordings of interviews will be transferred from the audio recorder onto the researcher's laptop as audio files, which will be anonymised, password protected and encrypted. The audio recorder will then be deleted immediately afterwards. The recordings will then be transcribed by the researcher into a Word Document and password protected. Only the researcher will have access to these documents, although the research supervisor may also view some of the initial anonymised documents in order to advise on the process of analysis. All documentation with identifiable information on it (i.e the consent forms) will be kept in a locked filing cabinet at Lancaster University. Any email communication between researcher and

potential participants will be deleted once the thesis has been assessed. The information sheet will explain to participants that all data will be kept confidential, anonymised and stored securely and separately from other data. Participants will also be informed that audio recordings will be deleted after the thesis has been assessed and that any files on the computer will be encrypted and the computer itself password protected, and also deleted after assessment of the thesis. The information sheet will give contact details for researcher, research supervisor and external supportive services. The information sheet will also provide the necessary details should participants wish to make a formal complaint. At the end of the study, any hard copies of consent forms will be kept securely in a locked cabinet for ten years. At the end of this period, they will be destroyed by the DClinPsy Research Administrator.

Service User Involvement

In the initial stages of study design, a member from the reference group of Lancaster University Public Involvement Network (LUPIN) members gave feedback during a thesis proposal day. An additional LUPIN member, who had accessed both clinical psychology and psychiatry services was consulted and gave feedback and direction which was incorporated into the final design and methodology of the study.

Project Management

A contract for the project has been drawn up between the researcher, field supervisors and research supervisor. The researcher will receive twice weekly supervision from their research supervisor and monthly supervision from the psychology and psychiatry field supervisor.

Dissemination

The study will be written up for assessment as part of the researcher's Doctorate in Clinical Psychology. A summary of the general findings will be sent to all participants once the thesis is assessed. It is hoped that the research will be submitted for publication in a relevant academic journal.

Anticipated Timetable

Ethics submission	June 2013
Data collection	August – December 2013
Data analysis and write up	November 2013
Submit draft	December 2013
Submit final draft	March 2014

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Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research

Instructions

1. Apply to the committee by submitting
 - ✓ The University's Stage 1 Self-Assessment Form (standard form or student form) **and** the Project Information & Ethics questionnaire. These are available on the Research Support Office website: [LU Ethics](#)
 - ✓ The completed FHMREC application form
 - ✓ Your full research proposal (background, literature review, methodology/methods, ethical considerations)
 - ✓ All accompanying research materials such as, but not limited to,
 - 1) Advertising materials (posters, e-mails)
 - 2) Letters of invitation to participate
 - 3) Participant information sheets
 - 4) Consent forms
 - 5) Questionnaires, surveys, demographic sheets
 - 6) Interview schedules, interview question guides, focus group scripts
 - 7) Debriefing sheets, resource lists
2. Submit all the materials electronically as a **SINGLE** email attachment in PDF format. Instructions for creating such a document are available on the FHMREC website (<http://www.lancs.ac.uk/shm/research/ethics/>).
3. Submit one collated and signed paper copy of the full application materials. If the applicant is a student, the paper copy of the application form must be signed by the Academic Supervisor.
4. Committee meeting dates and application submission dates are listed on the research ethics committee website <http://www.lancs.ac.uk/shm/research/ethics>. Applications must be submitted by the deadline stated on the website, to:

Diane Hopkins
Faculty of Health & Medicine
B03, Furness College
Lancaster University, LA1 4YG
d.hopkins@lancaster.ac.uk
5. Attend the committee meeting on the day that the application is considered.

1. Title of Project: An Exploration of Psychiatrists' Understanding and Use of Psychological Formulation.

2. If this is a student project, please indicate what type of project by ticking the relevant box:
--

<input type="checkbox"/> PG Diploma <input type="checkbox"/> Masters dissertation <input type="checkbox"/> MRes <input type="checkbox"/> MSc <input type="checkbox"/> DClinPsy SRP
--

<input type="checkbox"/> PhD Thesis <input type="checkbox"/> PhD Pall. Care/Pub. Hlth/Org. Hlth & Well Being <input type="checkbox"/> MD <input checked="" type="checkbox"/> DClinPsy Thesis
<input type="checkbox"/> Special Study Module (3 rd year medical student)
3. Type of study
<input checked="" type="checkbox"/> Involves direct involvement by human subjects
<input type="checkbox"/> Involves existing documents/data only. Contact the Chair of FHMREC before continuing.

Applicant information
4. Name of applicant/researcher: Roxanna Mohtashemi
5. Appointment/position held by applicant and Division within FHM Trainee Clinical Psychologist
6. Contact information for applicant: [REDACTED] [REDACTED] _____
7. Project supervisor(s), if different from applicant: N [REDACTED] [REDACTED] [REDACTED] [REDACTED]
8. Appointment held by supervisor(s) and institution(s) where based (if applicable):

<p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p>
<p>9. Names and appointments of all members of the research team (including degree where applicable)</p> <p>Miss Roxanna Mohtashemi, Chief investigator, PG Dip Psychology</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p> <p>[REDACTED]</p>

<p>The Project</p> <p>NOTE: In addition to completing this form you must submit a detailed research protocol and all supporting materials.</p>
<p>10. Summary of research protocol in lay terms (maximum length 150 words).</p> <p>The aims of this study are to explore how psychiatrists understand psychological formulation and to explore how psychiatrists use psychological formulation. There is no universal definition of psychological formulation. However, the Division of Clinical Psychology describe psychological formulation as “the summation and integration of the knowledge that is acquired by the 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 (DCP, 2010, p.5). It is thought that an understanding of these processes may facilitate a cross-</p>

disciplinary understanding of mental distress within adult NHS services. It is hoped that this understanding may also allow greater transparency between psychologists and psychiatrists, which may in turn enhance multi-disciplinary team (MDT) -working.

11. Anticipated project dates

Start date: Sept 2013 End date: May 2014

12. Please describe the sample of participants to be studied (including number, age, gender):

Participants will be qualified psychiatrists or psychiatrists in training residing in the north west of England, who have had some experience of working with a clinical psychologist in an adult mental health setting. Participants will be sought to cover a range of different levels of training (core trainees, higher specialist trainees, and consultants). I aim to recruit between 10 - 15 participants.

13. How will participants be recruited and from where? Be as specific as possible.

Recruitment will take place via email, through the Royal College of Psychiatrists (RCPsych) Northwest Division. [REDACTED] manager of the North West Division and Northern & Yorkshire Division of The Royal College of Psychiatrists, will send emails to all members residing in the counties of [REDACTED]. Should an insufficient number of participants be recruited from these counties then emails will be sent to members residing across the north-west counties not already included in the recruitment process. Should there be an insufficient number of participants following this process then other forums that are accessed by psychiatrists will be identified and approached in order to recruit further participants.

Additionally, emails will be sent out by the psychiatry field supervisor to psychiatrists and psychiatry trainees working within adult services at [REDACTED]. Approval for this will be sought from [REDACTED]. Additionally, the psychiatry field supervisor will send an email to the [REDACTED] Deanery in order to recruit psychiatry trainees at local universities within the northwest.

14. What procedure is proposed for obtaining consent?

All emails sent will include an attached information sheet consent form and demographic form. Should potential participants have any questions or concerns about taking part in the study they will be able to contact me using the telephone and email contact details provided. If potential

participants would like to take part in the study they will then be advised by me to return a completed consent form and demographic form by email. This is in order to allow me to carry out interviews that are informed by theoretical sampling (Charmaz, 2006). I will then liaise with the potential participants in order to arrange a convenient location and time for an interview.

15. What discomfort (including psychological), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks.

There are no risks anticipated with participating in this study. However, participants will be advised to inform myself and contact the resources provided at the end of the information sheet should they experience any distress; for example, The Psychiatrist's Support Service.

16. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, details of a lone worker plan).

I will accord with Lancaster University Lone Worker Guidelines which advocate contacting a supervisor on the day, both before and immediately after each interview.

17. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

It is hoped that the findings from this study may facilitate a cross-disciplinary understanding of mental distress within adult NHS services. It is also hoped that this understanding may also allow greater transparency between psychologists and psychiatrists, which may in turn enhance multi-disciplinary team working.

18. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

There are no incentives or payments to participants. I will travel to the client's preferred base in order to carry out interviews.

19. Briefly describe your data collection and analysis methods, and the rationale for their use

Research design

A qualitative methodology will be used due to the exploratory nature of the research question (Willig & Stainton-Rogers, 2008). Grounded theory (Charmaz, 2006) will be employed because it is widely recognized as an appropriate methodology for exploration and theoretical development into novel areas of research where there is no pre-existing theory (Crooks, 2001). The researcher will adopt a social constructionist approach to grounded theory, where they will identify themselves as taking an active role and therefore influencing the interview process and findings (Charmaz, 2006). Memos will be written during the initial coding process which be

used as part of the initial analysis. Data will be coded and then codes will be synthesized into categories, which will be developed into an emerging theory through the process of theoretical sampling. Categories will be considered as 'saturated' when new data no longer gives rise to new categories and the emergent theory is considered 'robust' (Charmaz, 2006). Following recommendations outlined for sample sizes in the grounded theory literature (Birks & Mills, 2011; Charmaz, 2006) it is estimated that 10 - 15 participants will be required in order to develop a robust theory.

Participants who work within [REDACTED] NHS Trust will be interviewed at their place of work. Approval will be sought from [REDACTED] Research and Development. For other participants not working within [REDACTED] NHS Trust, interviews will take place at appropriate local venues such as a local resource centre, meeting rooms in libraries, colleges or universities or in the participant's home. If these participants request to be interviewed on NHS premises then I will check with them whether or not there are any site protocols that need to be carried out before going ahead with interviewing.

Data collection will comprise of 1:1 semi-structured interviews using an interview schedule.

The interview schedule will be used flexibly with initial interviews and prompts and probes will be used where necessary. After the initial interviews have been conducted and initial analyses have been carried out, the interview schedule will be adapted. This is in keeping with a grounded theory approach which advocates the process of theoretical sampling (Glaser & Strauss, 1967; Charmaz, 1990). In this way emerging themes from initial interviews are used to enhance and re-focus the interview schedule. Consent will also be gained from participants for a second interview to be carried out at a later date, should the analysis of the initial interview raise any themes that warrant further explanation in order to develop the emerging theory.

Should there be difficulties in the recruitment of a sufficient number of participants then the data collection process will be adapted to encompass not only 1:1 interviews but also telephone interviews. All interviews will be audio recorded.

20. Describe the involvement of users/service users in the design and conduct of your research. If you have not involved users/service users in developing your research protocol, please indicate this and provide a brief rationale/explanation.

In the initial stages of study design, a member from the reference group of Lancaster University Public Involvement Network (LUPIN) members gave feedback during a thesis proposal day. An additional LUPIN member, who had accessed both clinical psychology and psychiatry services was consulted and gave feedback and direction which was incorporated into the final design and methodology of the study.

21. What plan is in place for the storage of data (electronic, digital, paper, etc.)? Please ensure that your plans comply with the Data Protection Act 1998.

All audio recordings of interviews will be transferred onto the researcher's laptop as audio files, which will be anonymised, password protected and encrypted. The recordings will then be transcribed by the researcher into a Word Document and password protected. The audio recorder will then be deleted immediately afterwards. Only the researcher will have access to these documents, although the research supervisor may also view some of the initial anonymised documents in order to advise on the process of analysis. All documentation with identifiable information on it (i.e the consent forms) will be kept in a locked filing cabinet at Lancaster University. Any email communication between researcher and potential participants will be deleted once the thesis has been assessed. The information sheet will explain to participants that all data will be kept confidential, anonymised and stored securely and will be stored separately from other data. Participants will also be informed that audio recordings will be deleted once the thesis has been assessed, and checked and that any files on the computer will be encrypted and the computer itself password protected. The information sheet will give contact details for researcher, research supervisor and external supportive services. The information sheet will also provide the necessary details should participants wish to make a formal complaint.

22. Will audio or video recording take place? no audio video

If yes, what arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

All interviews will be recorded onto a portable audio device. Following the interview, the audio recording will be removed from the portable device, and saved onto a password protected computer. This is so that the audio file can be encrypted. Audio recordings will be transcribed after the interview and then destroyed once the thesis is assessed. Audio recordings and transcriptions as word documents will be deleted by the principal investigator from the password protected computer following examination of the thesis report. At the end of the study, any hard copies of consent forms or transcripts will be kept securely in a locked cabinet at Lancaster University for ten years. At the end of this period, they will be destroyed by the DClinPsy Research Administrator.

23. What are the plans for dissemination of findings from the research?

The study will be written up for assessment as part of my Doctorate in Clinical Psychology. A

**Appendix 4-A
Participant Information Sheet**



Participant Information Sheet

An Exploration of Psychiatrists' Understanding and Use of Psychological Formulation

My name is Roxanna Mohtashemi and I am conducting this research as a student in the Dclinpsy programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The purpose of this study is to develop an understanding of how psychiatrists working within adult mental health services understand and use psychological formulation. It is thought that an understanding of these processes may facilitate the effective use of psychological formulation within multi-disciplinary teams.

The study is being supervised by [REDACTED], a consultant psychiatrist at [REDACTED], [REDACTED], clinical psychologist and [REDACTED], a clinical psychologist and research tutor at Lancaster University.

Why have I been approached?

You have been approached because the study requires information from psychiatrists and psychiatry trainees. I am looking to recruit 10-15 psychiatrists and psychiatry trainees from the north-west of England.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part.

You are able to withdraw your participation before, during, or up to 2 weeks after your interview.

What will I be asked to do if I take part?

If you decide you would like to take part, you would complete a consent form and demographic information form, which you would return to me by email. It is hoped that there will be a mixture of training levels within the participant pool to ensure that the study reflects the different range of levels of experience and expertise. Therefore, not everyone who expresses interest in the study may be required to participate in an interview.

Should your level of experience be relevant for the study, I would then contact you to arrange a face-to-face interview with me. This could be at a time that is most convenient to you, at a quiet location of your choosing. I will ask you some questions about formulation during the interview, which is expected to last approximately 60 minutes. The interview will be recorded on a digital audio recorder and will later be transcribed by me onto a word document. Should further information be required after the first interview, I may contact you to arrange a second interview. This will be in keeping with the analytic approach I am using.

Will my data be confidential?

The information you provide is confidential. The data collected for this study will be stored securely and separately from other data and only the researcher and their academic supervisor (██████████) will have access to this data:

- Audio recordings will be deleted after the thesis has been assessed.
- Hard copies of consent forms will be kept in a locked cabinet for ten years. At the end of this period, they will be destroyed by the DClInPsy Research Administrator at Lancaster University.
- The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected. All files will be deleted once the thesis has been assessed.
- You will be asked to allocate a pseudonym during your interview. Only the researcher will know whose pseudonym is attached to whose interview. This chosen pseudonym will be attached to the typed version of your interview. Direct quotations from your interview may be used in the reports or publications from the study and will have the pseudonym attached to them, but your name or any other identifiable information will not be included.
- Any email communication between research and potential participants will be deleted.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and seek guidance from my supervisor about this, and discuss it further with you.

What will happen to the results?

The results will be summarised and reported as part of my thesis and may be submitted for publication in a relevant academic journal. A summary of the general findings will be sent to all participants once the thesis is assessed. All data will be anonymised before dissemination.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part

It is hoped that the findings from this study may facilitate a cross-disciplinary understanding of mental distress within adult NHS services. It is also hoped that this understanding may also allow greater transparency between psychologists and psychiatrists, which may in turn enhance multidisciplinary team-working.

Who has reviewed the project?

This study has been reviewed by the Faculty of Health and Medicine Research Ethics Committee, and approved by the University Research Ethics Committee at Lancaster University. Permission to recruit through [REDACTED] has also been granted from [REDACTED]

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher:

Researcher: Roxanna Mohtashemi

Tel: [REDACTED]

Email: [REDACTED]

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

[REDACTED]
Tel: [REDACTED]

Acting Research Director, Doctorate in Clinical Psychology Programme,

Email [REDACTED]

Faculty of Health and Medicine

Lancaster University

Lancaster

LA1 4YD

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

[REDACTED]
Associate Dean for Research Email [REDACTED]

Faculty of Health and Medicine

(Division of Biomedical and Life Sciences)

Lancaster University

Lancaster

LA1 4YD

Thank you for taking the time to read this information sheet.

Resources in the event of distress

Should you feel distressed either as a result of taking part in the study, then you may consider contacting your professional organisation supervisor or clinical tutor for support.

Additionally you may consider contacting the Psychiatrist's Support Service. Details can be found at this webpage:

www.rcpsych.ac.uk/workinpsychiatry/psychiatristssupportservice

or by calling: 020 7245 0412 or e-mailing: pss@rcpsych.ac.uk

Thank you for taking the time to read this information sheet.

Appendix 4-B Consent Form



Study Title: An Exploration of Psychiatrists' Understanding and Use of Psychological Formulation.

We are asking if you would like to take part in a research project aiming to facilitate a cross-disciplinary understanding of mental distress within adult NHS services.

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Roxanna Mohtashemi.

Please initial box after
each statement

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study
2. I confirm that I have had the opportunity to ask any questions and to have them answered.
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript.
4. I understand that audio recordings will be kept until the research project has been examined.
5. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. I understand that I can withdraw my data for up to 2 weeks following the first interview and 2 weeks following the second interview.
6. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication.
7. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published
8. I consent to information and quotations from my interview being used in reports, conferences and training events.
9. I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator may need to share this information with her research supervisor.
10. I consent to Lancaster University keeping written transcriptions of the interview for ten years after the study has finished.
11. I consent to take part in the above study.

Name of Participant _____ Signature _____ Date _____

Name of Researcher _____ Signature _____ Date _____

**Appendix 4-C
Recruitment Email**



Dear member/trainee/colleague,

Re. An Exploration of Psychiatrists' Understanding and Use of Psychological Formulation.

I am a trainee clinical psychologist at Lancaster University, and I am currently looking for psychiatrists who have **experience of working with clinical psychologists in adult mental health settings** to take part in my research, which will be exploring psychiatrists' understanding and use of psychological formulation. The aims of the study are to explore how psychiatrists understand and use psychological formulation, to facilitate a cross-disciplinary understanding and enhance working practices between the two disciplines, which may in turn enhance multidisciplinary team-working. Findings also have the potential to inform the future development of the incorporation of psychological and multidisciplinary formulation into the RCPsych and Clinical Psychology teaching curriculum.

Data collection will comprise of a one-to-one interview at a date and location most convenient for you. Depending on the findings from initial analyses of data, you may also be invited to a second interview, which would be approximately one month after the first interview.

It is hoped that there will be a mixture of training levels within the participant pool to ensure that the study reflects the different range of levels of experience and expertise. Therefore, not everyone who expresses interest in the study may be required to participate in an interview.

Please find attached an information sheet detailing the research.

If you have any queries or would like to take part in the study, please email me [REDACTED] or contact my research number [REDACTED]

Best wishes,

Roxanna Mohtashemi

Trainee Clinical Psychologist

Lancaster University

**Appendix 4-D
Demographic Form**



Assigned pseudonym	
Age	
Gender	
Ethnic background	
Job title	
Years since qualified	
Type of service currently working in	

Appendix 4-E
Interview Schedule



What is your understanding of formulation?

What is your experience of formulation?

What is your experience of psychological formulation?

How do you use formulation?

Who is it for?

How do you use psychological formulation?

How does formulation fit with diagnosis? How do you incorporate it with your medical understanding of mental health issues?

How can clinical psychologists and psychiatrists enable effective MDT working

Appendix 4-F
University ethical approval letter

LANCASTER
UNIVERSITY



Applicant: Roxanna Mohtashemi
Supervisor: [REDACTED]
Department: DHR

04 September 2013

Dear [REDACTED]

Re: An exploration of psychiatrists' understanding and use of psychological formulation

Thank you for submitting your research ethics application for the above project for review by the Faculty of Health and Medicine Research Ethics Committee (FHMREC). The application was recommended for approval by FHMREC, and on behalf of the Chair of the University Research Ethics Committee (UREC), I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact the Research Ethics Officer, [REDACTED]
[REDACTED] if you have any queries or require further information.

Yours sincerely,

[REDACTED]

Ethics Committee

[REDACTED]

[REDACTED]

tes

Appendix 4-G

R&D approval letter

[Redacted]

Ms Roxanna Mohtashemi
Doctorate in Clinical Psychology Student
Division of Health Research
Faculty of Health and Medicine
Lancaster University
Lancaster LA1 4YD

19th September, 2013

Dear Ms Mohtashemi

Formal Letter of Approval
Project 2013/24: An Exploration of Psychiatrists' Understanding and Use of Psychological Formulation.

Thank you for your research application which was reviewed by the Trust's Research Governance Committee at its July meeting.

The committee raised no major concerns and were happy to approve your study subject to ethical approval from the University and confirmation of support from the relevant R&D leads and service. There was no committee meeting scheduled for August.

You kindly forwarded evidence of University Research Ethics Committee approval (dated 4th September 2013) and the Research Governance Committee gave final approval at the meeting today.

The Committee have approved the study for [Redacted]

Please take this letter as confirmation of Trust R&D approval. Please read the attached 'Information for Researchers – Conditions of Research Governance Approval' leaflet, which provides information regarding research governance and R&D approval conditions.

Please contact the R&D Office should you require any further information, quoting the above reference number.

May I wish you every success with your research.

[Redacted signature]

[Redacted]

Appendix 4-H

NHS Letter of Access

[REDACTED]

Ms Roxanna Mohtashemi
Doctorate in Clinical Psychology Student
Division of Health Research
Faculty of Health and Medicine
Lancaster University
Lancaster LA1 4YD

19th September, 2013

Dear Ms Mohtashemi

NHS to NHS Letter of Access for Research

Project 2013/24: An Exploration of Psychiatrists' Understanding and Use of Psychological Formulation.

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research through [REDACTED] for the purpose and on the terms and conditions set out below. This right of access commences on the 19th September 2013 and ends on the 31st August 2014* unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to [REDACTED] premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

[REDACTED]



While undertaking research through [REDACTED] you will remain accountable to your employer Lancashire Care NHS Foundation Trust but you are required to follow the reasonable instructions of the R&D leads who provide a link to the services. The R&D leads for [REDACTED]

[REDACTED] The research will be carried out across the Trust involving staff within [REDACTED]

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with [REDACTED] policies and procedures, which are on the Trust website or available to you upon request, and the Research Governance Framework.

You are required to co-operate with [REDACTED] in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while [REDACTED] NHS Trust premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Trust's R&D department prior to commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

[REDACTED] will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

[REDACTED]

[REDACTED]

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

[Redacted signature]

[Redacted name]

* End date of substantive contract

cc: HR [Redacted]

[Redacted]

[Redacted]

