PSYCHOLOGICAL FORMULATION: A RADICAL PERSPECTIVE

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Middlesex University
A Joint Programme between the Institute of Work Based Learning, Middlesex University, and Metanoia Institute

Doctorate in Psychotherapy by Public Works

2011

CONTEXT STATEMENT FOR THE DOCTORATE IN PSYCHOTHERAPY BY PUBLIC WORKS

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VOLUME 1: INTRODUCTION

1.1 Abstract

The theme of this context statement is psychological formulation, which can be defined as a summary of a client's difficulties, based on psychological theory, and informing the intervention.

Within this context statement, I will demonstrate how I have contributed to the development of psychological formulation theoretically and clinically in the following areas:

- Co-editing the first book on psychological formulation to take a critical and reflective overview of formulation in different therapeutic traditions (Public Works 4.2.1 and 4.2.2).
- Developing an innovative model for teaching formulation to clinical psychology trainees (PW 4.1.1 and 4.1.2.)
- Developing and delivering workshops on integrative formulation, locally, nationally and for the Division of Clinical Psychology (PW 4.2.3).
- Developing the practice of team formulation in my own clinical work, in both inpatient and outpatient settings (PW 4.3.1.)
- Developing workshops and training in team formulation for teams and wards (PW 4.3.2.)
- Supervising research into formulation (PW 4.3.3.)
- Generally promoting the use of formulation for culture change among clinical psychologists, mental health professionals and service user groups by my writing and public speaking (PW 4.4.1, 4.4.2.).

Volume 1 Part 1 contains a summary of the Public Works, a timeline, and an introduction to the concept of formulation, with examples.

Volume 1 Part 2 outlines the personal and professional background to my interest in formulation, with reference to key publications, achievements, influences and challenges during my career.

Volume 1 Part 3 describes the Public Works, the knowledge and skills which underpin them, how I have applied them in the field of Adult Mental Health, and the impact they have had on theory and clinical practice. I will draw on four main areas of Public Works in more or less chronological sequence. The majority were produced over the time period 2006-2010, although some of the clinical work at Southmead Hospital, Bristol (2004-2006) precedes this, as does some of the work on the Formulation Theme of the Bristol Clinical Psychology Doctorate (2001 - 2010.) I will conclude with a critical reflection on the whole area of formulation and some plans for developing the work further.

Volume 1 Part 4 contains examples of the Public Works.

Throughout the context statement, I will demonstrate and provide evidence for advanced conceptual understanding, professional knowledge and collaboration, and critical evaluation of this leading edge area of clinical practice. Vol 1 parts 2 and 3 have been revised and extended to take account of feedback from the Registration Panel.

Supplementary information will be submitted in boxfiles, as follows:

Volume 2 boxfiles (unbound) will contain further examples of Public Works and evidence of impact.

Volume 3 boxfiles (unbound) will contain examples of general background work and additional evidence of impact.

1.2 **Timeline**

Timeline leading up to the Public Works 1956- 2010

<u>PROFESSIONALCONTEXT: ACADEMIC</u>	<u>PROFESSIONAL CONTEXT: CLINICAL</u>	<u>KEY PUBLICATIONS</u>
1960 – 1967 Welland House Junior School, Stamford, Lincs 1967 – 1973 Stamford High School for Girls 1975 – 1978 MA Hons in Psychology and Philosophy (P.P.P.) Class 2:1. St Hilda's College, Oxford 1979-1980 Postgraduate Certificate of Education, Brighton Polytechnic	1980-1983 Diploma in Clinical Psychology, NW Thames RHA Training Scheme 1983 – 1985 Basic Grade Psychologist at Faringdon Wing Unit, Luton and Dunstable General Hospital 1985 – 1988 Senior Clinical Psychologist based at Barrow Hospital, Bristol 1986-1990 Professional Adviser to National MIND	
1992 – 2000 Senior Lecturer in Clinical Psychology and Counselling, University of the West of England, Bristol	1988 – 1992 Principal Psychologist based at Ham Green Psychiatric Unit, Bristol 1992-1995Committee member, Psychotherapy Section of the BPS. Organiser and speaker at 1995 conference 'Meanings and madness: Psychotherapy and Psychosis, Bristol. 1993-1996 Professional Adviser to South West MIND	1989 *Users and abusers of psychiatry: a critical look at traditional psychiatric practice*, Routledge 1993b Family management in 'schizophrenia': its assumptions and contradictions. *Journal of Mental Health*, 14, 255-261 1993a Psychiatry: are we allowed to disagree? *Clinical Psychology Forum*, 56, 19-22

1993 Invited contributor to Dept of Health Scoping study on review of the 1993 Mental Health Act, in relation to ECT		
1995 Granted Statement of Equivalence as a Chartered Counselling Psychologist	1996-1997 Committee Member of ISPS (International Society for the Psychological Treatment of the Schizophrenias and other Psychoses) Co-organiser of and speaker at IPSP International Conference 1997	1997 Self-injury and the psychiatric response. *Feminism and Psychology*, 7, 3, 421-426
2000 Contributor to BPS report 'Recent advances in understanding mental illness and psychotic experiences'		1999a Adverse psychological effects of ECT. Journal of Mental Health, 8, 1, 69-85 1999b Do families cause 'schizophrenia'? in C Dunn, C Newnes and G Holmes (eds) *This is madness: a critical look at psychiatry and the future of mental health services*. Ross-on-Wye: PCCS Books
2001- 2008 Academic Tutor, then Director, on Bristol Clinical Psychology Doctorate	2001- 2004 One day a week in CMHT at Grove Road Day Centre, Bristol	2000 2nd edition of *Users and abusers of psychiatry*
2002 Member of reference group for Dept of Health/SURE review of user literature on ECT, Institute of Psychiatry		
2003 BPS representative for submission of evidence to the NICE technology appraisal on the use of ECT		2003 A shocking treatment? *The Psychologist*, 16 (5), 236-239.
2004 Author of BPS position statement on ECT		2007 'Can trauma cause "psychosis"?' Revisiting (another) taboo subject. *Journal of Critical Psychology, Counselling and Psychotherapy*, 7 (4), 211-220.

The Public Works 2006- 2010

ACADEMIC AND TEACHING	CLINICAL AND TRAINING	KEY PUBLICATIONS
2001-2008 Academic tutor, then Academic Director, on Bristol Clinical Psychology Doctorate 2001- 2010 Development and delivery of Formulation Theme on the Doctorate 17.10.06 Critique of psychiatric diagnosis. Hertfordshire Clinical Psychology Doctorate 20.10.06 Formulation: the role of the psychologist. Shropshire and Staffordshire Clinical Psychology Doctorate 7. 11.06 'Teaching formulation' (with Rudi Dallos): Group of Trainers in Clinical Psychology conference, Cardiff 4.12.06 'Formulation: a potential the way forward together?' in symposium on 'Working together in the critical mental health field', DCP conference, London. 21.1.07 Critique of psychiatric diagnosis. Cardiff Clinical Psychology Doctorate 24.05.07 'Using formulation in teams'. Psychosis Faculty of the BPS, BPS offices, London. 8.02.07 'Diagnosis or formulation?' at 'Beyond Diagnosis' conference, AWP Trust, Keynsham, Bristol 24.05.07 'Using formulation in teams.' Psychosis Faculty of the DCP conference 11.09.2007 'Beyond diagnosis' CASL inaugural conference, Liverpool. 17.09.07 Critique of psychiatric diagnosis. Plymouth Clinical Psychology Doctorate 24.10.2007 Opening speaker at 'Beyond Diagnosis', Weston super Mare.	(31.05.02 and 26.07.02 With Rudi Dallos and Willem Kuyken, Formulation Workshop, held at Exeter University May and University of the West of England.) 2004-2006 One day a week at in CMHT at Southmead Hospital, Bristol. Implementing team formulation meetings 25.05.07 'Integrated formulation: how to do it and how to use it.' DCP workshop, BPS offices, London 12.10.07 'Using formulation in supervision.' Cardiff Clinical Psychology Doctorate workshop 29.2.08 'Integrated formulation: how to do it and how to use it.' Trent Clinical Psychology dept, Mansfield	2006b L Johnstone and R Dallos (eds) *Formulation in psychology and psychotherapy: making sense of people's problems.* Routledge. Includes: Johnstone, L and Dallos, R Introduction to formulation; Dallos, R, Stedmon, J Wright, J and Johnstone, L Integrative formulations; Johnstone, L Controversies and debates in formulation 2006a 'The limits of biomedical models of mental distress.' In *Critical psychiatry*, ed D Double, Palgrave.

ACADEMIC AND TEACHING	CLINICAL AND TRAINING	KEY PUBLICATIONS
18.01.08 Critique of psychiatric diagnosis. Cardiff Clinical Psychology Doctorate 16.5.08 'Formulation as an alternative to diagnosis.' Leeds MIND conference 10.9.08 'Formulation as a radical alternative to diagnosis.' Asylum conference, Manchester 2008-2010 Programme Director on Bristol Clinical Psychology Doctorate	12.06.08 'Integrated formulation: how to do it and how to use it.' DCP workshop, BPS offices, London 19.06.08 'Integrated formulation: how to do it and how to use it.' Coventry and Warwick Psychology Dept, Stratford on Avon. 01.12.08 'Integrated formulation: how to do it and how to use it.' Leicester Clinical Psychology Dept, Leicester	2008b 'Psychiatric diagnosis.' In (eds) R Tummey and T Turner, *Critical issues in mental health*. London: Palgrave Macmillan
14.05.09 Psychiatric diagnosis: a critique. Seminar at Dept of Social Medicine, Bristol University 15.07.09 Keynote speaker: 'Challenges to psychiatric diagnosis: what can formulation offer?' Women in Psychology Annual Conference, Windsor	24.04.09 Using formulation in supervision. Bristol Clinical Psychology Doctorate CPD for supervisors 18.09.09 An introduction to integrative formulation. MSc in Applied Psychology Supervision Uni of Surrey	
20.10.09 Critique of psychiatric diagnosis. Hertfordshire Clinical Psychology Doctorate 6.11.09 Critique of psychiatric diagnosis. Plymouth Clinical Psychology Doctorate 12.11.09 Critique of psychiatric diagnosis. Cardiff Clinical Psychology Doctorate 18.11.09 Using formulation in teamwork: the F factor. Invited talk to Specialist Registrars' Jamboree, Bristol 8.03.10 'Research into formulation: what we know and what we don't.' Bristol Clinical Psychology Doctorate annual research conference	20.01.10 Using formulation in teamwork: part 1. Bristol Inner City Assessment and Intervention team 13.05.10 Using formulation in teamwork: Bristol Inner City Support and Recovery team. 9.06.10 Using formulation in teamwork: part 2. Bristol Inner City Assessment and Intervention team.	Johnstone, L (2010) Challenges to psychiatric diagnosis: What does formulation have to offer feminist psychologists? *Psychology of Women Section Review*, 12, 1. Johnstone, L (in press) People with problems, not patients with illnesses. In (eds) M Romme and S Escher *Making sense of psychosis,* ISPS series: Gaskell Johnstone, L Diagnosis and formulation (in press) In (eds) J Cromby, D Harper and P Reavey *Understanding mental health and distress: Beyond abnormal psychology* Palgrave Macmillan

ACADEMIC AND TEACHING	CLINICAL AND TRAINING	KEY PUBLICATIONS
4.10.10 'Borderline personality disorder: diagnosis or formulation? Keynote speech at 'Self harm and borderline personality disorder' conference, ORT conference centre, London.	8.09.10 Using formulation in teamwork: part 3. Bristol Inner City Assessment and Intervention team 9.9.2010 Integrated formulation and using formulation in teams. CPD formulation course, Leicester University 14.09.10 Using formulation in teams. CPD day for clinical psychologists, Bristol 15.09.10 Using formulation in teamwork. Speedwell Support and Recovery team, Bristol. 5.10.10 Using formulation in teams. Glos Assertive Outreach CPD day 8. 10.10 Using formulation in teams: Art Therapists CPD day, Bath 2009 –2010 One day a week on inpatient ward at Callington Road Hospital, Bristol. Promoting formulation, including teaching, and drawing up collaborative formulations , and establishing a formulation team on the ward.	Cole, S and Johnstone, L (in press) Formulation in psychology and psychotherapy: a review of its current status and future research directions. *Psychology and Psychotherapy: Theory, Research and Practice* Cole, S and Johnstone, L (in press) How clinical psychologists understand formulation as both a process and an event: An interpretative phenomenological analysis. *Psychology and Psychotherapy: Theory, Research and Practice* Christofides, S, Johnstone, L and Musa. M (in press) 'Chipping in': Clinical psychologists' descriptions of their use of formulation in multi-disciplinary team working. *Psychology and Psychotherapy: Theory, research and practice*. Hood, N and Johnstone, L (2010) The hidden solution. MDT members' experience of the use of formulation in teams. *Psychology and Psychotherapy: Theory, research and practice.*

1.3 **What is a formulation?**

A formulation can be described as a summary of a client's difficulties, based on psychological theory, and informing the intervention. Historically, formulation grew out of behaviour therapy in the 1950s. In an earlier form of 'functional analysis', it described problem behaviour in terms of environmental stimuli and response contingencies and was promoted by psychologists as a more useful guide to treatment than psychiatric diagnosis. Formulation played a crucial role in the development of clinical psychology from 1969 onwards, when the term first appeared in the professional regulations. To this day, it is a core training competency as mandated by the Division of Clinical Psychology (DCP, 2001.) Formulation is a key concept in most mainstream therapeutic approaches, including CBT, psychodynamic, systemic (where it is sometimes called the 'working hypothesis') and Cognitive Analytic Therapy. As such, it is part of the practice of other professionals as well as clinical psychologists. Psychiatrists also describe themselves as using formulation, although, as I will show, they tend to use the term in a rather different way. The context statement is based on formulation in its psychological, not psychiatric, sense. Despite its long history, remarkably little has been written about formulation until very recently. Except where otherwise indicated, therefore, the context statement describes my own original theoretical and clinical development of the concept, in conjunction and collaboration with colleagues.

In 2006, I and Rudi Dallos published the first critical overview of formulation from different theoretical perspectives ('Formulation in psychology and psychotherapy' 2006b, see PW 4.2.1 and 4.2.2.) In the first chapter I drew up this list of the core features of formulations from all therapeutic traditions:

- Summarises the client's core problems
- Shows how the client's difficulties may relate to one another, by drawing on psychological theories and principles
- Suggests, on the basis of psychological theory, why the client has developed these difficulties, at this time and in these situations
- Gives rise to a plan of intervention which is based in the psychological processes and principles already identified
- Is open to revision and re-formulation   (Johnstone and Dallos, 2006c, p.11)

In brief, a formulation is *a hypothesis about a person's difficulties*, which *draws from psychological theory.* It is thus a way of *integrating theory and practice.* In other works, it is 'the lynch pin that holds theory and practice together' (Butler, 1998, p.1), and a 'best guess' about what is going on for the client.

The main purpose of a formulation is to identify the most helpful interventions, but it can also serve to provide an overall map or picture, enhance the therapeutic alliance, predict difficulties in therapy, identify missing information, promote collaboration, help to think about 'stuckness' or lack of progress, counter messages about 'illness' and lack of agency, frame medical interventions, and emphasise strengths. There are additional benefits when it is used in teamwork, as will be discussed.

My clinical practice leads me to believe that all formulations should have the following characteristics:

- Constructed collaboratively
- Expressed tentatively (as a 'best guess')
- Shared with the client in manageable steps
- Written in ordinary language (avoiding professional jargon)
- Respectful of the client's view of what is accurate/helpful
- Reflexive about the therapist's own views and assumptions
- Emphasising strengths as well as difficulties
- Culturally sensitive
- Open to revision and re-formulation

A favourite quote of mine which describes the core assumption underpinning formulation is: '…..at some level it all makes sense' (Butler, 1998, p.2.) It seems to me that this conviction is absolutely central to our role as clinical psychologists and therapists. We have to start from the belief that no matter how unusual, eccentric, frightening, confusing, chaotic, challenging or upsetting someone's behaviour or experience, *there is a way of making sense of it*. This includes the presentations that come under the heading of 'psychosis.' The framework for co-constructing this sense is the formulation.

Another definition of formulation captures this well; it is 'a process of ongoing collaborative sense-making' (Harper and Moss, 2003, p. 8.) Or, in other words, it is 'a way of summarising meanings, and of negotiating for shared ways of understanding and communicating about them' (Butler, 1998, p.20.)

Formulation can also be an intervention in itself. Sometimes the act of clarifying someone's difficulties, and in the process helping them to feel listened to, understood and accepted, is enough to allow them to move forward again. Equally, constructing a team formulation of a complex client can itself be enough to facilitate change by enabling the staff to share and process their emotions, put their feelings and views about a service user in a theoretical context, and view a service user with new insight, compassion and hope. Team formulation is a rapidly-developing area of particular interest to me, and with great potential for changing cultures in mental health and other health care settings.

Although formulation is most often used by clinical psychologists, I have found that this simple and yet sophisticated framework for generating shared psychosocial understandings of people's difficulties is enormously valued by other mental health professionals once they have experienced how it can work in practice. My own background is in adult mental health, and it is within these settings and related teaching and training that I have developed and implemented the various strands of my work on formulation

1.4 **Examples of formulations**

To give a flavour of the use of formulation in Adult Mental Health settings, anonymised examples of two formulations appear below. Further examples of individual formulations developed with service users can be found in Vol 2.

This formulation was drawn up collaboratively with a service user whom I will call Sarah, as part of my work on an inpatient ward. She has given me permission to use it. The 'team' version can be found in Vol 2 (unbound.)

Sarah was in her mid-forties, and had a 25 year psychiatric history of 'bipolar disorder.' I met her during a very turbulent 15 month period of inpatient treatment, which included numerous incidences of sectioning, forced medication, transfer to a secure ward, and so on. Sarah had become deeply entangled in the mental patient role, which she both clung to and hated. In the process, she had alienated a series of ward teams, and came to me with a reputation of being a 'nightmare patient.' This is the formulation we had reached by the end of my contact with her, quoted with her permission.

It sounds as if you spent much of your early life longing for love, acceptance and approval from your parents and others. You particularly wanted to perform well academically to please your father. You did not always agree with your parents' values and lifestyle, but were perhaps not very sure about how you yourself wanted to live your life.

You had few friends at school, and felt that you did not fit in there either. You lacked confidence in your appearance but did well academically, and it was therefore a major blow to your self-confidence when you did not achieve your expected exam results.

Your craving for love and closeness meant that you looked for fulfilment in the form of a romance, and quickly developed strong feelings for boyfriends and partners, along with a wish to please, and fear of abandonment. The intense need for acceptance meant that you did not always choose partners who were right for you, and sometimes you were exploited by men. You also had some disturbing experiences with some men that you befriended, and this seems to have triggered your first breakdown at age 19. Receiving a psychiatric diagnosis and going into hospital was yet another serious blow to your self-image and confidence. While unwell, you had fantasies about unobtainable men, and about being famous and wealthy. This can perhaps be understood as a wish to compensate for your feelings of failure.

Your lengthy recent admission was partly the result of the very difficult decision to leave your second marriage. You feel that you had reached a crisis in your life, which boiled up in the form of extreme behaviour and 'high' moods. In your words, these moods were made up of a mixture of anger, defiance and despair. In retrospect, it seems as if you needed to go through this very difficult stage in order to find out who you were and how you wanted to live your life. You were full of fury, which was often expressed on the ward and in outbursts in the community. Some of this anger was fuelled by the belief that people were purposely frustrating you, or deliberately setting you tests. You found it difficult to reach a mid-ground between being a 'doormat', as you feel you have been all your life, and regaining a sense of power and control by being aggressive. Unfortunately, this often led to you being treated more restrictively, which gave you even more

reasons to feel trapped and angry. You hated being a 'mental patient' with all the stigma that this implied, but at the same time it seemed to the staff that you were quite scared about moving out of hospital and re-building your life. There was a period when you moved back and forward between the ward and the community, not quite able to leave the hospital behind, which was frustrating for everyone involved.

After we discussed and agreed the need for you to take back responsibility, you reached the point where you were ready to make the transition out of hospital, away from the 'mental patient' role, and into the start of your new life. You have marked this by changing your name. You are not on any medication and are having only limited contact with mental health services. This is a huge achievement.

You have done an enormous amount of reflecting over the last year, and feel rightly proud of yourself for being able to make your own decisions about your relationships and lifestyle. In doing this you have drawn on your many strengths – intelligence, perceptiveness, determination, creativity and so on. You acknowledge that you have a past history of mental health problems, but this is no longer a source of shame.

You know that there are certain risks ahead – for example, placing too many expectations on new relationships, feeling unable to settle for an 'ordinary' life rather than a fantasy one, allowing yourself to be provoked and lose your temper, and so on. It is a mark of the progress you have made that you are very aware of these, and are taking things slowly and realistically.

Comment and outcome: This was one of the rare cases in which, after a fairly long period of work with the ward and with Sarah, I managed to persuade the team to 'de-medicalise' her, rescind her section, accept that she would discontinue her medication, and treat her as responsible for her actions. This felt risky, but the effect was dramatic: Sarah left hospital, bought her own flat, started a healthy new relationship, and expressed enormous gratitude for being allowed to leave the patient role behind. She had a brief relapse and re-admission after 4 months, but together she and the team were able to identify triggers and draw up a joint plan to avoid them in the future.

Unfortunately, after a few setbacks on her home leave, Sarah lapsed back into her raging, angry self. She was admitted to a secure ward, where the team had strongly disagreed with our non-medical approach; they immediately re-instated large doses of compulsory medication for her 'bipolar disorder'. This illustrates a very typical split in treatment approaches between different parts of the service, in this case the ward and the secure unit. Currently there is a risk that the re-introduction of a narrow medical model intervention will once again set up the vicious circle of rebellion and fury from Sarah, which is seen as evidence of worsening 'illness' by the staff, which leads to more medication and restriction, and so on. My contract with the Trust ended at that point, but at our last meeting Sarah was still determined to resume her new life. She also

expressed enormous appreciation of the collaborative work we had done together and the hope it had given her.

Reflection on the formulation

I deliberately chose not to formulate one aspect of Sarah's presentation, the confused sexualised references that she made about her father and brother when she was 'high' in mood. Although aware of the possibility of sexual abuse, I felt that the aim of getting her out of hospital and into a safer place should take priority over unpacking potentially traumatic material. It would have been important to pursue this issue had I continued to work with her.

1.4.2 Mary

The second example illustrates a typical team formulation, developed at the request of a Community Mental Health Team in a series of meetings which I facilitated. The formulation was not shared in this form with the service user, and names and identifying details have been changed.

Mary's background:

- Aged 75
- Father died when she was 5
- Sent to live with cold, strict grandmother age 8
- Unhappy marriage
- 3 children, now adults and all refusing contact with her
- Worked in catering until 1995
- 45 year psychiatric history, with diagnoses of depression, bipolar disorder, personality disorder, anxiety. First breakdown after birth of eldest child ('post-natal depression')
- Low moods roughly twice a year ever since
- Many admissions plus different medications, 6 courses of ECT, day care, community   care, numerous groups and activities, etc.

Current problem:
- Experienced by staff as extremely difficult, controlling, demanding, complaining, insulting.

- Although she describes everything as useless, she still demands services, medication etc.
- Suicidal gestures.
- Professionals left with a sense of anger, stuckness, frustration and failure.
- Residential care staff cannot cope any more and have given her notice to leave, which may mean she ends up back on a psychiatric ward.

Tentative formulation drawn up with the team:

Mary suffered a major rejection when she was sent to live with her strict grandmother, and has been searching for care for herself ever since. She did not have the emotional resources to cope with her own children, hence the post natal depression, and indeed has spent much of her life trying to get them to look after her. Small events that are perceived as rejections (eg her daughters going on holiday) trigger her 'depression', which is perhaps better understood as a deep fear of being alone and abandoned.

Mary's early rejection left her not only needy but very angry. The only way she knows how to get care is by inducing guilt and making angry or threatening demands. This, of course, tends to alienate others, who then confirm her worst fears by rejecting her, which feeds further into her anger and neediness.

In relation to the psychiatric services, Mary has (probably not consciously or deliberately) found a solution to this situation by gaining care through her 'symptoms'. At some level she does not want to benefit from interventions since this would result in care being withdrawn – so she carries on demanding services even while declaring they are useless. Her identity as a patient enables her not to take (or be given) responsibility for her actions. The same pattern of neediness/demand/anger is now being played out in relation to the residential home.

Intervention:

- Share formulation with all staff, including new residential home
- Predict challenging behaviour until Mary feels accepted
- Draw up agreed boundaries of acceptable behaviour with Mary and staff
- Promote security and reward good behaviour by attention, time etc
- Anticipate rejection triggers
- Give regular support to staff
- Find valued non-patient roles for Mary
- Liaise with Mary's children
- Rationalise medication
- Review and re-formulate as necessary

Comment and outcome: This is a good example of how formulation can be useful even 45 years into someone's psychiatric career,. The staff at the new residential home needed a lot of support, but were able to tolerate Mary's initially very difficult behaviour by understanding it within the 'rejection' hypothesis. After a few months there was a sudden and dramatic change – presumably because Mary finally trusted that she had been accepted. She was able to show her lively and humorous side, and she became a genuinely accepted member of the home. Her children resumed contact with her, and at last update, she had not needed re-admission to hospital.

Reflection on the formulation
On reflection, the formulation may have fallen into the trap of seeing Mary primarily as a 'problem person', rather as the staff did, and thus underplaying her strengths. The inclusion of a social context – eg the very limited opportunities for a woman of her generation whose marriage had ended – would have minimised any implications of 'blame'.

VOLUME 1 PART 2

PERSONAL AND PROFESSIONAL BACKGROUND TO THE THEME OF FORMULATION

2.1 Overview of Part 2

In Volume 1 Part 2 of the context statement I will describe the personal and professional background to my interest in formulation, and my reflections arising out of the writing of this statement. It will be seen that my personal experiences both led to an interest in mental health (the 'wounded healer' syndrome, Rippere and Williams 1985), and to a profound scepticism about orthodox biomedical models of mental distress, which was fully borne out in my experience of clinical practice. My zeal for challenging and changing psychiatric practice led me to develop critiques in a number of areas including psychiatric diagnosis, the biomedical model, family work in psychosis, self-harm, the use of ECT and medication, the role of trauma and abuse in psychiatric presentations, and others. Through this work I came to realise that the artificial categorisation of human distress into 'diagnoses' is fundamental to every other damaging aspect of psychiatry. Without a reliable and valid categorisation system, psychiatry becomes 'something very hard to justify or defend – a medical specialty that does not treat medical illnesses' (Breggin,1993, p. 505.) With the illusion of such a system, psychiatry continues to turn 'people with problems' into 'patients with illnesses,' and in the process re-traumatises and re-abuses them. These critiques underpin and set the scene for my promotion of formulation over the last 4-5 years.

2.2 A note on reflexivity

During discussion and feedback at my Registration Panel, I was invited, among other suggestions, to be more explicit about the personal motivations and experiences underpinning my interest in formulation and in mental health work in general.

As a former Clinical Psychology Course Director, the requirement to be reflective is familiar to me. Section 2.9 in this volume describes how the Bristol Doctorate developed its own unique interpretation of the Reflective Rractitioner role. This context statement has some parallels with the trainees' final year Reflective Practice essay, in which they reviewed their personal and professional journey through the course. Criteria included 'Demonstrates awareness of own

beliefs, values, background and cultural context and its impact on practice'; 'Evidence of personal development over the last 3 years' and 'Ability to reflect on and learn from experience'. In other words, we asked trainees to be both reflexive and reflective. However, the boundaries of this were made very clear; for example, trainees were explicitly advised that it was not necessary to disclose personal details in order to demonstrate these competencies.

My understanding of the terms reflexive and reflective is as follows:

The term 'reflexivity' is most commonly applied to qualitative research, where it can be defined as '…..*reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research. It also involves thinking about how the research may have affected and possibly changed us, as people and as researchers'* (Willig, 2001, p.10.)

The concept of Reflective Practice was originally developed by Schon (1983) and is now widely applied in the fields of health and education. Reflective practice is a notoriously slippery concept, but can be summarised as 'the capacity to reflect on action so as to engage in a process of continuous learning' (Schon, 1983.) 'Reflection in action' refers to this process as it occurs during a particular experience or intervention; 'reflection on action' happens afterwards, as the practitioner engages in a critical review of the event(s) in the light of theory and values.

With this in mind, I have revisited the doctoral criteria. Neither reflexivity nor reflectiveness are mentioned in the doctoral standards listed on p. 33 of the Trainee Handbook. However, the section relating to the context statement says that candidates *'are…likely to need to take account of more personal factors, such as: motivation; what the major challenges have been in their work; what are the major influences upon the thinking of the candidate; main achievements over the course of their career; what skills and knowledge they have developed; how they have arrived at their current level of authority, influence, ability to be a change agent'* (p.34.) The Doctoral Descriptors include *'Self-appraisal and reflection on practice: …..Habitually reflects on own and others' practice so the self-appraisal and reflexive enquiry become intertwined, thereby facilitating positive changes'* (p 28.) The phrase 'reflection on practice' in the Descriptors echoes Schon's 'reflection on action.' This seems to indicate that candidates are

expected to be both reflexive and reflective about the production of their Public Works, although no precise definition of these terms is given in the handbook.

As we told the Bristol trainees, neither of these activities should be confused with has been termed by one qualititative researcher 'agonising confessional work' (Parker, 1999, p.31.) On reflection after the Registration Panel, it seems to me that there is a greater risk of blurring these boundaries when the qualification is in psychotherapy; hence this attempt at clarifying my understanding of the requirements and how I will meet them.

The principal subject and content of the context statement is, of course, psychological formulation and the Public Works that I have developed in this field. The revised context statement contextualises the Public Works within the various influences on my thinking and practice and the challenges I have faced in mental health services. It will also include reflexive awareness of the ways in which aspects of my social identity (white, female, middle class, well-educated, from a high-achieving family, and with some personal experience of mental distress) and the values and beliefs deriving from this background, have influenced my work. Towards the end, I will reflect on the personal development that has brought me to my current position, and the degree to which I have succeeded in my personal mission to bring about change in the psychiatric system. In this way, I hope to demonstrate both reflexivity and reflectiveness.

 2.3 Family background

I am the eldest child from an educated middle-class family. For complex reasons I was often unhappy during my childhood, adolescence and young adulthood. I was born in Dorset and brought up from the age of 4 in a small town in Lincolnshire; my parents were both schoolteachers. I found family relationships difficult at times and hated my rigid and rule-bound girls' grammar school. I was, however, close to my mother's parents, and particularly my grandfather, a very gifted Canon in the Church of England whose principled stance won him admirers and detractors in equal measure.

My identity as 'the clever one' of the siblings encouraged me to be a high achiever, but at the same time I was often socially isolated and confused. My main coping strategy was to hide away in my room and read, and from an early age I reacted not by outward rebellion, but by trying to

make sense of my feelings through books on psychology and psychotherapy. Thus my interest in mental health, psychotherapy and psychiatry dates back to my childhood.

When I eventually took up a place at Oxford University, the much longed-for escape turned out to be another trap. The hothouse atmosphere created by the presence of 10,000 other students who, like me, tended towards intellectual precocity coupled with emotional immaturity, was the opposite of what I needed. My subjects, philosophy and psychology, were taught in a way that in my arrogance I believed (and still believe) to be intellectually and morally barren. I could no more accept experimental psychology's perspective on human beings than I could go along with logical positivism as a philosophy of life. Then as now, I believe that human experience demands a more sophisticated explanation than one that was designed for pigeons in a cage (the positivist paradigm that 'has sought to apply to human problems a theory which barely fits the albino rat'; Ingleby, 1981, p. 39.) Equally, I have always believed that life has an intrinsic meaning above and beyond the purposes we bring to it, and to say that only empirically-verifiable statements are meaningful is more than mistaken; it is morally repugnant. I am well aware that I cannot 'prove' my views in terms that would satisfy a sceptic, but I completely reject the epistemological hierarchy that positions personal experiential knowledge as somehow inferior. Meanwhile at a personal level, my unresolved feelings and conflicts caught up with me in a way that took several years to resolve. While I have never been a service user myself, or claimed that identity, my own experience has given me an inside view of mental distress.

My need to understand emotional distress pointed me towards a career in clinical psychology. My reading (see below) had convinced me that the area of most need, and most intellectual and emotional challenge, was at the sharp end of psychiatry with people labelled as 'psychotic.' Clinical psychology (as opposed to counselling or psychotherapy) was a route into this world.

Unlike the trainees whom I subsequently taught on the Bristol Clinical Psychology Doctorate (see p.22), the critique of mainstream biomedical ideas about mental distress was never a revelation or a shock to me; it was my core assumption and starting point, based on my personal experiences and my immersion in books on psychotherapy and psychiatry since my early teens. Thus the hallmark of my career, my rejection of the biomedical model of mental distress which sees breakdown in terms of 'illnesses' whose primary causes will one day be located in faulty biochemistry or genetics, is deeply rooted in my own life experiences and the lessons I have

drawn from them. Exploring the tension between these two opposing perspectives, psychiatric and psychosocial, has characterised my whole career. Similarly, my alternation between academic and clinical posts is partly explained by the need to balance surviving within, versus seeking to change, traditional psychiatric practice. In the first 10 years of my career, I attempted the difficult task of challenging psychiatric practice from the inside. In the next 9 years in higher education, I took a step back from direct clinical work and critiqued psychiatric theory and practice in my teaching, writing, public speaking and research. In the 9 years up to 2010, I found the ideal compromise: teaching on a clinical psychology training course alongside part-time clinical work.

2.4 Clinical psychology training

When I took up my training place, my main intellectual influences had been Jung, whose work had a particular resonance due to his belief in the symbolic meaning of madness and his spirituality; Laing (eg Laing, 1960), whose books I had found too disturbing to read as an undergraduate, but whose ideas I became able to assimilate as I found my feet; Jan Foudraine, the 'Dutch RD Laing', and his powerful account of revolutionising a psychiatric ward by eradicating the 'illness' model (Foudraine, 1974); Susie Orbach, whose book 'Inside out, outside in' (Eichenbaum and Orbach, 1983) turned me into a feminist overnight by demonstrating that my relationship with my mother had simply followed the emotional template of all mother-daughter relationships; and the school of Transactional Analysis, especially Steiner's 'Scripts people live' (Steiner, 1990.) I should also mention the best single critique of the biomedical model of psychiatry that has ever been written, David Ingleby's 'Understanding mental illness' (Ingleby, 1981). An academic psychologist at Cambridge University, he demolished the positivist paradigm in psychiatry with such thoroughness and panache that he aroused the anger of Sir Martin Roth, the founding President of the Royal College of Psychiatrists, and was forced to leave his post.

I arrived on the clinical psychology course amazed at my luck in getting a place, full of passion and enthusiasm about mental health, and at the same time, still finding my feet after my breakdown at university. As a typical clinical psychology recruit, ie a bright, middle-class, young, white woman from a prestigious university, I am sure I was selected for all the wrong

reasons. Nevertheless I soaked up the experiences that the course offered, while finding ample evidence of the destructive aspects of the biomedical model of mental distress.

I was inspired by, among others, a supervisor who was particularly skilled in psychotherapy, and a psychiatrist who had worked with RD Laing and whose crisis intervention approach was based on a non-medical understanding of the reasons for psychiatric admissions. This man, Dennis Scott, was the author of a series of classic papers that have been a major influence on my thinking. In particular, I am indebted to him for the concept of the 'treatment barrier' (Scott, 1973a and 1973b.) This is his term for the irrevocable drawing of the line between the 'sick' and the 'well' by the process of diagnosis, or in his words 'the point at which inner disturbance in the family, which may have been present for years, or even generations, becomes officially located as being disturbance in one member' (Scott, 1975, p. 6). Scott points out the curious paradox that in effect the diagnosis is often made by lay people, who have selected one member of the family or group as 'the sick one.' These lay people then put the professionals under enormous pressure to rubber-stamp this decision with a label - any label - of mental illness, while denying that they are so doing '(You're the expert, doctor. He must be ill or he wouldn't be here.') The game will be exposed if the professional refuses to do this and instead tries to explore the dynamics that led up to the situation; the atmosphere can become very tense and threatening. However, if the professional gives in to pressure, an impenetrable barrier to working with the relationship issues, or in other words a 'treatment barrier', will be set up. The professionals are forced to take responsibility for the 'sick' person: 'mutual and unbearable pain between two or more family members is avoided, but the cost is frightful…...(this) may result in the permanent….crippling of one or more lives' (Scott, 1975, pp. 8-9 and see chapter 4 of 'Users and abusers of psychiatry', Johnstone, 2000.) In my clinical work I have found this to be profoundly and tragically true.

With my long-held views about the dangers of the biomedical model fully confirmed by my experiences in training, and equipped with new ways of thinking about mental distress, I was more than ready to go into battle in my first post.

2.5 First post in Adult Mental Health 1983-1985

For the first ten years after qualification, I threw myself into clinical work. My first job was in a District General Hospital psychiatric unit in Luton. I started with the naïve aim of overthrowing the psychiatric system, and my outspokenness created enemies as quickly as it recruited fans. The job was a bumpy ride at times, but I learned a huge amount, which formed the basis of the first edition of my book, 'Users and abusers of psychiatry' (Johnstone, 1989.)

2.6 'Users and abusers of psychiatry', first edition

'Users and abusers of psychiatry' was completed in 1987 when I was 31. My ambitious aim was to write a critical overview of every aspect of psychiatry, from theory to practice and from individual case histories to wider political interests, in a way that was accessible to service users and carers as well as professionals. I had long believed biomedical model psychiatry to be flawed in theory, and by now I had plenty of evidence of its profoundly damaging effects in practice. It was also a plea for a more psychologically sophisticated, socially aware and service-user-centred approach to mental distress. The central thesis, which I hope is more convincing in context than it may sound as an extract, is:

'…..that social and political factors are a crucial component of mental distress; that through being identified with the wider system of society, psychiatry shares its values and assumptions; that the psychiatric system in its turn passes on these values and assumptions by a process of identification on the part of its staff and mystification on the part of its patients; that as a result the overall effect of psychiatry, if not the conscious intent of its practitioners, is to reinforce social norms and political interests; and that since none of this is made explicit, dissent can only emerge in the form of continued symptoms on the part of the patients. My further contention is that social control, the maintaining of society's status quo by labelling dissent as illness, is actually the major function that wider society, consciously or unconsciously, expects and demands that psychiatry should fulfil; that while it is certainly not possible to explain all of an individual's distress in these terms, psychiatry as a whole will be able to offer genuine help to people struggling within their systems only to the extent that it is aware of and successful in challenging its own role in the wider system of society; and that where it fails most spectacularly (women's problems in general, 'schizophrenia', mental distress in ethic minorities) is also where such factors play the most important and ignored role in the problem. My final point is that the principal mechanism by which psychiatry performs its function of social control is the use of the medical model, that is, by propagating the myth that psychiatry is engaged in an objective, scientific enterprise to which medical science will one day produce the

solutions, which gives psychiatry powerful weapons for suppressing dissent (drugs, ECT) while enabling its true purpose to be concealed' (Johnstone, 1989, pp. 246-247.)

I wrote much of the book in my spare time after re-locating to Bristol. My research introduced me to other sources of inspiration. One was Richard Warner's epic overview of recovery rates from 'schizophrenia', and its radical conclusion that psychiatry ideology goes in cycles, according to the economy's need for recovered 'schizophrenics' in the workforce (Warner, 2004; summarised in chapter 10 of 'Users and abusers of psychiatry'.) In his words, 'Ideology and practice in psychiatry, to a significant extent are at the mercy of material conditions…Efforts to rehabilitate and reintegrate the chronically mentally ill will only be seen at times of extreme shortage of labour…At other times, the primary emphasis will be one of social control' (Warner, 2004, pp.134, 145.) He demonstrates that at such times, psychiatry will turn to theories about biological and hereditary factors, with sufferers being seen as untreatable. His work provides some of the missing evidence for the 'social control' allegations made by the anti-psychiatry movement of the 1960s. It will be interesting to see how his theories are borne out in the current recession. Although the reduction in hospital beds is unlikely to be reversed, there has already been a rise in prescriptions for psychiatric medication as more people become long-term patients in the community.

Around this time I started to make contacts with other people whose critical perspective on psychiatry was a great source of support and encouragement. This included members of the service user/survivor movement, in particular Viv Lindow, one of the very earliest activists (Lindow, 1992.) I have gained immensely from knowing and working with her and other survivor campaigners like Ron Coleman, Rufus May, Louise Pembroke, Jacqui Dillon, Jan Wallcraft, Jim Read, Ross Hughes and the late Linda Hart. I have also gained inspiration from other 'critical psychologists' such as Dorothy Rowe, David Smail, David Harper, John Read, Michele Roitt, David Winter, Craig Newnes and Mary Boyle, whose critique of psychiatric diagnosis has added rigour to my own (eg Boyle, 2002.) There is a small, courageous network of Critical Psychiatrists (www.critpsynet.freeuk.com), notably Phil Thomas, Pat Bracken, Duncan Double and Joanna Moncrieff, and I am pleased to have contributed to their conferences and their edited books.

'Users and abusers of psychiatry' received a number of very favourable reader responses and reviews, both in its first and second edition (see 'Reviews' in Vol 3.) For example:

'This book probably gives the best contemporary expression to the critique of the psychiatric system' (*Asylum* 2000, 12 (2), p. 29.)

'Users and abusers of psychiatry is a model of a sophisticated critique of the mainstream medical model, showing a good understanding of the complexities of psychiatric theory and an impressive knowledge of the way that treatment actually affects people….I recommend it highly' (www.mentalhelp.net/poc/view_doc)

'This is an immensely enjoyable book that can be described, with only slight exaggeration, as a saturation bombing raid over the drug company funded territory of biomedical psychiatry' (*Mental Health Care* 2000, 4 (2), pp. 72-73.)

'For brevity, clarity, and insightful honesty, this contemporary introduction of the ongoing struggle for a better future in our field is hard to beat' (*The Journal of Critical Psychology, Counselling and Psychotherapy* 2001, 1 (2), pp.130-131.)

'Her analysis is calm, thorough and persuasive…Read it, think about it, argue with it, use it.' (*Openmind* 2000, 105, p.26.)

 It also attracted some criticism that was so extreme that I was able to re-interpret it as a compliment, and a confirmation of my main thesis that psychiatrists cannot afford to admit to the shaky theoretical basis of their practice. For example, one reviewer advised the publishers, 'It is an immoderate, tendentious and sexist polemic. I cannot recommend its publication.' As if additional confirmation of the controversial nature of its arguments were needed, the book was put forward and then turned down for the MIND book of the year award in 1990. I was later told that the chair that year, Professor Anthony Clare, nominally a critic of psychiatry himself (see 'Psychiatry in dissent'1988), had blocked the committee's desire to select it. 1990 remains the only year in which the award was not made.

Writing the book in combination with a full-time job led to a long period of poor health, which was to become a familiar pattern.

2.7 Clinical work in Bristol 1985-1992

I had posts in two hospitals when I moved to Bristol. One, Barrow Hospital, had a ward run by a very psychologically-minded consultant along therapeutic community lines. He remains someone that I respect for his commitment to pursuing an alternative approach in the face of considerable opposition. It was my first experience of working within a compatible philosophy, and I was able to help implement some new approaches to service users (see the case of 'Jeanette' in 'Users and abusers of psychiatry', chapter 3.) Just across the pathway, in extreme contrast, another ward was run by an old-style consultant whose word – which usually consisted of prescribing ECT for any patient unfortunate enough to come his way - was law. When he was in a good mood he would regale the team with tales of administering 'aqua ad caput' (water to the head) in the early days of his career. Finding a role for myself on his ward, the first psychologist ever to do so, was not easy. Having learned a degree of tact, I wasn't rash enough to be explicit about my rejection of 'schizophrenia' as a diagnosis, or my total opposition to the use of ECT, but I recall one incident when politely declining to administer a psychological test in order to determine whether a patient had 'manic-depression' caused considerable upset. I was accused of rudeness and of reducing one of the junior psychiatrists to tears.

Subsequently, I was appointed to provide input to two newly-set-up wards on the outskirts of Bristol. It was a more liberal environment than Barrow, but still very medically-based. I felt accepted and respected by the ward teams and I look back on a number of achievements (setting up staff support groups, patient groups and so on) with satisfaction. The main consultant was someone I liked as a person but often disagreed with very openly (as described in the 1993a article quoted below.) Despite this, and I think he should take at least as much credit for this as me, we managed to maintain a working relationship and a personal friendship. Interestingly, he gradually became more radical later in his career, and his book 'Recovery beyond psychiatry' (Whitwell, 2005) talks a lot of sense about his gradual disillusionment with the biomedical model.

2.8 Reflection on clinical work 1983-1992

By now I had spent nearly 10 years wrestling with the dilemma of, as I put it in a recent chapter, 'challenge, compromise or avoidance as a response to traditional psychiatric practice. There are

no clear guidelines for indicating when compromise turns into collusion. It is impossible to work as a critical psychologist on, for example, an in-patient ward and not collude to some extent; if you object to every use of psychiatric labelling, your role will be impossible' (Johnstone, 2011, p. 102, Vol 3.)

There is no easy answer to this dilemma. I have come to believe that the best we can do is to hope that overall, in working within psychiatry, we are doing more good than harm. I also believe that:

'Clinical psychologists who accept these critiques are faced with unavoidable ethical dilemmas about their role and work. The key question becomes not 'How can we best use our scientific expertise to help the sick?' but 'How ought we to help the most disadvantaged members of our society when they are emotionally distressed?' This quickly leads on to other questions -'How do we understand the reasons for their distress? What role ought we to play in alleviating these causes? And what are our professional and moral obligations as members of a society in which this kind of suffering occurs? ……An overwhelming amount of evidence tells us that as clinical psychologists we cannot afford to ignore the context of social inequality and injustice in our work, for scientific as well as ethical reasons. This will inevitably also involve us in challenging, not colluding with, some of the core tenets of biomedical psychiatry. In this way we will be facing ethical dilemmas head on, wherever we work, and fulfilling our moral and professional responsibilities as clinical psychologists' (Johnstone, ibid, p 97.)

My frustration was expressed in a 1993 article titled 'Psychiatry: are we allowed to disagree?' in Clinical Psychology Forum, the monthly journal for clinical psychologists (Johnstone, 1993a, Vol 3.) It generated a large postbag of responses from similarly disillusioned psychologists and was re-printed as part of a special selection of 'Greatest Hits' articles for the 100th edition of Forum. An extract in which I summarised the tactics that are used to maintain the primacy of biomedical explanations gives the flavour:

'Attributing all improvement to medical intervention. Since medication is constantly being adjusted, any change for the better will be bound to coincide with a new dosage and can be attributed to it. Conversely, progress in counselling is ascribed to other factors. When I reported

a very successful outcome to a long period of therapy with one inpatient, the consultant commented, 'These conditions do go into remission sometimes.'

Belief in medical interventions is also maintained by *disqualifying the counter-evidence.* If ECT appears to 'work', then it will be used again. If it doesn't 'work', then it will be used again in case it 'works' next time. There are no circumstances which would count as indications against its use. This is in marked contrast to non-medical interventions, where a single failure (eg a family who did not respond to family therapy) will be quoted for years to come.

Quoting important-sounding research, for example, 'It's been proven that schizophrenics have lesions in their brains.' This frequently bamboozles non-medical staff, who may not realise that there is no proven correlation, that even if there were it would not necessarily indicate a causal link, and that any research based on a dubious concept like 'schizophrenia' is seriously compromised from the start.'

…..and so on (Johnstone, 1993a, p.32.)

I was invited to submit a follow-up article in 2001 ('Psychiatry: still disagreeing', Johnstone, 2001, Vol 3.)

On an ironic note, a psychiatrist who had read the article kindly confirmed its central thesis in a response titled 'The re-emergence of anti-psychiatry: psychiatry under threat' in which he lamented the fact that I would doubtless 'be teaching the next generation of clinical psychologists that mental illness does not exist. The only comfort from this paper is…that, where she previously worked, the nonmedical staff still consider psychiatrists to be "the most powerful professional group"'(Marks, 1994, p.188.)

I had become increasingly frustrated at having reached the age of some of the younger consultants, and yet knowing I would never be in a position to implement radical changes myself. As a psychologist, I could not run a ward, or make or unmake decisions about diagnosis, admission, medication or ECT. I had influence, but very little formal power. A lecturing post in clinical psychology and counselling at the University of the West of England offered an alternative career route, and I left the NHS for higher education.

2.9 Lecturing in higher education 1992 -2001

I remember the next 9 years as a very unhappy time workwise, although it also saw the births of my two children, Alissa in 1993 and Alex in 1996. On the one hand, I had freedom of speech as an academic, and used it to good effect in introducing a critical approach to mental health to psychology undergraduates, psychiatric nurses, counselling students and social workers, which was very well received. For the first time in my career I could openly question psychiatric diagnosis and biomedical theories, and far from attacking my views, my academic colleagues, who had no personal investment in any particular perspective, welcomed this novel and challenging approach. On the other hand, the bureaucracy and workload were overwhelming, particularly combined with two young children, two miscarriages, a termination of pregnancy under traumatic circumstances, and the general lack of sleep that goes with caring for babies and toddlers. I missed clinical work and never felt that I entirely fitted into the academic world.

I did, however, produce the 2nd edition of my book (Johnstone, 2000) which was essentially a complete re-write. The first edition now seems exceptionally naïve and dated to me, and although the re-write alongside a full-time job and family commitments was a vastly over-ambitious undertaking which again led to ill-health, I am pleased that I did it.

Another achievement while at UWE was the publication of a qualitative study into the experience of receiving ECT (Johnstone, 1999a, Vol 3.) I had long been concerned with the neglected psychological impact of this controversial intervention. My previous clients included a woman who made a very serious suicide attempt when she felt herself sliding into depression, because she could not bear the prospect of being forced to have ECT again, and a mute in-patient woman who one day managed to confide to me that she had miscarried her much-wanted baby as a result of ECT and had then been sterilised without her consent. I also got to know a furious, distrustful woman who had been gang-raped, a horrific experience which she re-lived under ECT when the anaesthetic failed to work and she lay paralysed but conscious on the bed. There were many other examples. I wanted to give these people a voice in the official literature so that their stories were accorded a higher status than 'anecdotal evidence.' I am proud that the publication formed the basis of recognition by the National Institute for Clinical Excellence (NICE) that some people experience 'feelings of terror, shame and distress, and found it

positively harmful and an abusive invasion of personal autonomy' (NICE, 2003, p.15). As far as I am aware, this is the first official acknowledgement of psychological trauma caused by ECT.

The study also led to an advisory role on the ECT subcommittee of the Department of Health scoping study on the 1993 Mental Health Act; a presentation to the All-Party Special Interest Group on Depression at the Houses of Parliament in 1999; and membership of the reference group for the Department of Health/Service Users in Research Enterprise review of user literature on ECT (SURE, 2002.) In addition, I was asked to produce the British Psychological Society's Position Statement on ECT (which formed the basis of an article in The Psychologist, Johnstone, 2003, Vol 3.) I was a little worried about my conclusion, which was that the evidence did not support the use of ECT in any clinical situation. When I rang the BPS to discuss this, I was assured that the committee that approved position statements did not include any clinical psychologists and would be unaware of the controversial nature of this recommendation, and so it proved. Although I doubt that many clinical psychologists are aware of it, their official body is now formally opposed to the use of ECT in any circumstances!

My time at UWE saw publications in another key area of interest, family work with 'schizophrenia'. This has been a highly controversial topic since the 1960s, when Laing was accused of blaming parents for their children's 'schizophrenia.' This is completely missing the point: Laing was very clear that 'we do not accept "schizophrenia" as being a biochemical, neurophysiological, psychological fact…Nor do we assume its existence. Nor do we adopt it as a hypothesis. We propose no model of it' (Laing and Esterson 1964, p.12.) The accusations have, however, been a convenient and effective way of dismissing the psychodynamic perspective on so-called 'schizophrenia' in favour of a biomedical one, which is absolutely crucial if the status of 'schizophrenia' as 'the prototypical psychiatric disease' (Boyle 2002) and 'the heartland of psychiatry' (Goodwin and Geddes, 2007, p.189) is to be maintained. In fact, to deny that people go mad for *reasons* – or, to put it more bluntly, crazy people often come from crazy families – is unsustainable in theory or practice. A version of CBT-based family work has become very popular by basing itself on the careful concession that the quality of family relationships can *inhibit or promote recovery* from psychosis, although family dynamics have *nothing to do with breaking down in the first place.* I deconstructed this contradictory position in an article (Johnstone, 1993b, Vol 3) which led to a somewhat acrimonious debate in two journals (Lam and Kuipers, 1993; Leff and Vaughn, 1994.) Although two eminent family work

researchers asserted that my article 'impugns our integrity as scientists' (Leff and Vaughn, 1994, p.115), it has been widely cited. I presented my version of the research findings in relation to family dynamics in 'schizophrenia' at the 1997 international conference of the International Society for the Psychological Treatments of the Schizophrenias and other Psychoses (ISPS) and subsequently wrote the talk up as a book chapter (Johnstone, 1999b, Vol 3.)

Thanks to my time at UWE I became an experienced and confident teacher and public speaker, but I missed the direct contact with clients. I loved my time with the future mental health professionals (psychiatric nurses and social workers), but as a high achiever myself, I became increasingly discouraged by what I saw as the erosion of academic standards and the impossibility of allowing any undergraduate to fail. I also felt too distant from my roots as a clinician. It was time to move on.

2.10 Lecturing on the Bristol Clinical Psychology Doctorate 2001 - 2010

An exciting opportunity arrived on my doorstep in the form of the newly-set-up Bristol Doctorate in Clinical Psychology, which was initially based at the University of the West of England and subsequently moved into premises at Bristol University. In 2001 I was accepted for the job of academic tutor, and was promoted to Academic Director in 2004 and Programme Director in 2008. I also returned to clinical work part-time and with renewed enthusiasm, although feeling a little rusty after the long gap. I was influential in shaping the direction of the doctorate course and developing its unique version of the reflective scientist-practitioner philosophy, which we described as follows in the course handbook (Bristol Trainee Handbook 2007, pp. 9-10, Vol 3):

'While emphasising the importance of evidence-based practice, we also recognise some of the limitations of a pure scientist-practitioner model. In acknowledging this, we seek to encourage trainees to:
a) Develop and draw on a broad range of evidence and skills in their work. This particularly applies to clinical practice, where empirical evidence may be lacking and practitioners need to respond creatively and flexibly in complex, uncertain or unique real life situations. Effective skills are likely to be based on tacit knowledge gained from clinical experience, as well as on academic theory. These skills will be refined via a continual process of reflection.
b) Develop an awareness of their own feelings and processes, and the part that they as a person, with their individual history, background, experiences and values, play in all aspects of the work of a psychologist. This implies a continuing process of personal development occurring in parallel with, and contributing to, the acquisition of clinical, academic and research skills.

c) Consider the widest possible perspective and range of evidence in order to take a constructively questioning approach to all aspects of theory and practice. This will include an awareness of the influence of social, historical and cultural factors in constructing the role and knowledge-base of clinical psychologists and related professions.'

In partnership with colleagues, I devised and delivered much of the reflective practice theme (Johnstone and Staite, 2010, in Clinical Psychology Forum 213, Vol 3) and the critical approach to theory and practice (Johnstone, 2010, in Clinical Psychology Forum 213, Vol 3; AMH teaching block outline and feedback, Vol 3) which, along with Health Psychology, were the core characteristics of the course.

Teaching a 'critical' perspective brings its own risks. For reasons of both intellectual transparency and political pragmatism, we explicitly decided not to promote a particular view on mental health or anything else. Instead, the Trainee Handbook (Vol 2) advised:

'We provide opportunities for trainees to, for example, hear from speakers who argue both for and against biological, psychodynamic, CBT, systemic and social perspectives; both for and against formulation, diagnosis and evidence-based practice; and many other issues…...Similarly, guest speakers will include psychiatrists, psychologists, academics, carers, advocates and service users, and trainees will be encourages to understand and debate all of these viewpoints as a way of coming to their own conclusions and developing their own very individual synthesis of the views they are exposed to. Our concern is not to produce trainees of any specific orientation, but to ensure that all graduates base their eventual perspective and personal style on a thorough and thoughtful consideration of all aspects of the areas in question.'

This explicit stance shielded us from most, though not all, accusations of bias, brain-washing and so on. Introducing trainees to a critical perspective on mental health was very challenging but ultimately rewarding for them: ' Regarding my experience of the critical perspective of the course, I can only compare it to psychology boot camp: it broke us down and built us back up! ..Within months….I was questioning ideas and "facts" that hadn't even occurred to me to question at all. Honestly, I can't say that was a nice place to be…..I feel very privileged to have been on a course where teaching from a critical perspective has been strong since the start….I am incredibly proud to be associated with a course which values the critical consumption of research, ideas and "truth"' (Johnstone, 2010, Clinical Psychology Forum 213, p.17, Vol 3.) The course quickly gained a good reputation and attracted a very high number of applicants.

It was a delight to update my mental health teaching for successive cohorts of bright, motivated trainees. I had never really considered a career in clinical psychology training, but when the opportunity came up, I found that in combination with part-time clinical work it was the perfect

solution to the dilemma of whether to work inside or outside the psychiatric system. It was also the ideal way to utilise all my abilities to the full in order to help develop a course that reflected my own beliefs and values. It was hugely rewarding to see the course develop in philosophy, content and reputation, and to see its values embodied by successive cohorts of enthusiastic young graduates, setting out on their careers, as I had done, full of drive and idealism.

Trainees were also able to benefit from my reflections on my own early immaturity, and adopt a more sophisticated approach to any challenges that they might wish to make (we did not assume that this was inevitable.) The principles that emerged over many discussions with trainees were:

- take your time
- gain credibility by willingness to take on the most challenging service users
- build respectful relationships with teams before attempting to change anything
- choose your battles
- find your allies
- challenge ideas not people
- remember that even in the most entrenched hospital system, the vehicle of change is the personal relationship you have with the service user.

Each cohort was set the task of drawing up their own list of strategies for surviving in and/or introducing change into the psychiatric system (Trainee list of coping strategies: Vol 3.)

The course also allowed me to develop my thinking, teaching and writing on my critiques of psychiatry, focusing on psychiatric diagnosis (in which I drew on important earlier work by Boyle, 2002) as the foundation of the biomedical model in psychiatry. In the words of Kovel (1981, p. 86), 'Diagnosis is the Holy Grail of psychiatry and the key to its legitimation.' While these themes had been strongly present in 'Users and abusers of psychiatry', I was able to elaborate on them in three book chapters (Johnstone, 2006a, Vol 2; Johnstone, 2008b; Johnstone, in press c) and in teaching sessions delivered on the Bristol course and also by invitation at clinical psychology courses across the country (Plymouth, Exeter, Cardiff, Oxford, University of East London, Hertfordshire, Salomons, Shropshire and Staffordshire.) These have been consistently well-received (see Vol 3 for teaching sessions on Psychiatric Diagnosis and Biomedical Models and feedback.)

An extract from a chapter (Johnstone, 2006a, p. 84, Vol 2) gives the essence of my critique of diagnosis:

'Psychiatry needs to be able to claim that it has a valid and reliable classification system, because this is absolutely crucial to its status as a legitimate branch of science – in this case, medical science. As psychiatrist Michael Shepherd puts it, "To discard classification is to discard scientific thinking" (1976). If there is no agreement on basic classification, then there is no basis for drawing up the general laws that constitute a body of scientific knowledge. The implications are profound: if classification can be shown to be neither reliable nor valid, then everything that follows from the biomedical assumptions outlined above, our current interventions, settings, professionals, up to and including the language we use, would need fundamental revision. Hence the statement, 'The critique of diagnosis *is* the critique of psychiatry' (Brown,1990).'

I then argue that psychiatric diagnosis cannot be shown to be either reliable or valid, because in the absence of confirming 'signs' such as blood cell counts, genetic abnormalities etc it has to rely on 'symptoms' that are not bodily complaints, but examples of problematic thoughts, feelings and behaviours. Since there can in principle be no objective way of drawing a line between 'normal' and 'abnormal' experiences of this kind, any pretence of doing so must in fact be based solely on implicit personal and cultural values. In other words, to give someone a psychiatric diagnosis is to make a social, not medical, judgement. While the people to whom diagnoses are applied may indeed be distressed and in need of some kind of help, there is no medical justification for inviting them into a psychiatric career by turning 'people with problems' into 'patients with illnesses.' Both the chapters and the workshops argue that formulation is a viable and valid alternative to diagnosis, and that by using formulation as a starting point, the whole destructive cycle of re-abuse within a psychiatric career can be avoided.

Another recent area of interest, a logical step on from my critiques of family work and 'schizophrenia', is the increasingly widely-recognised role of trauma in the development of psychosis (as well as in other mental health conditions.) I have been inspired by the work of John Read, a New Zealand-based clinical psychologist whose life's mission is to raise awareness of the shockingly high prevalence of trauma and abuse in psychosis. He has assembled a range of evidence which demonstrates beyond reasonable doubt that the relationship between trauma and psychosis is a causal one. I summarised this in a forthcoming book chapter (Johnstone, in press a, Vol 3):

'Trauma, in this body of work, refers mainly but not exclusively to events in childhood, and includes physical and sexual abuse and general neglect; and 'psychosis' includes 'schizophrenia' and 'bipolar disorder' (eg Garno et al, 2005; Hammersley et al, 2003) as well as specific 'symptoms' such as delusions and hallucinations. Some surveys have also included the role of experiences such as war, torture and natural disasters (eg Scott et al, 2007.)

- There is a general relationship between child abuse and adult pathology of all types, but this has typically been ignored or downplayed in relation to psychosis.
- Childhood abuse and neglect is as least as strongly linked to psychosis as to other psychiatric conditions, and the link appears to be a causal one.
- There is also evidence for a link between psychosis and trauma in adult life (see Fowler et al, 2006 for a summary.)
- There is some evidence linking particular kinds of abuse experience with particular 'symptoms' (eg CSA seems to be a stronger causal factor than CPA for auditory hallucinations; see summary in Read et al, 2006.).
- The content of 'delusions' is often closely related to actual experiences of CA.
- Cognitive theories suggest that unintegrated memories of abuse may lead to cognitive misattributions (eg about where voices come from.) 'Delusions' may be a defence against overwhelming feeling.

'……..(E)vidence for a causal role for trauma in the development of psychosis includes the finding of a dose-dependent relationship between the severity (Janssen et al, 2004, Spauwen et al, 2006), number (Whitfield et al, 2005), and number of types (Scott et al 2007) of traumatic episodes, and the probability of subsequent symptoms. The relationship between trauma and abuse has been found to hold in prospective studies (Janssen et al 2004; Spauwen et al, 2006) and after controlling for factors such as substance abuse, ethnicity, gender and education (Bebbington et al, 2004; Whitfield et al, 2005.) People who are abused as children are 9.3 times more likely to develop psychosis, while for those suffering the severest kinds of abuse the risk rises to 48 times (Janssen et al, 2004.)'

It is curious, and humbling, to reflect that for the first 10 years or so of my training and career, I had never knowingly met any victims of sexual abuse. Obviously there must have been many of them, and indeed I have been able to follow up some early clients who have since revealed such histories. My self-imposed penance is to do all I can to raise awareness of the issue with trainees and clinical teams. I vividly recall one highly disturbed young woman with a diagnosis of 'schizophrenia' –defined as such by the family, as per Scott's work, a label which was eagerly confirmed by the psychiatrist – whose 'delusion' was that men were coming through her bedroom walls at night and raping her. This was too obvious a clue for me to miss, even back in 1990, and I raised my suspicions with the consultant only to have them completely discounted. 15 years later I bumped into her at a conference. She told me that she had finally escaped from both her family and the psychiatric system with the support of a voluntary mental health

organisation. She also told me, 'It wasn't just my father who was sexually abusing me. It was my mother as well.'

John Read is optimistic about the impact of the evidence about trauma: '….the entire construct of schizophrenia receives arguably its largest challenge since its inception' (Read, 1997, p. 449). I am more cautious. My chapter welcomes this body of work, but at the same time warns of the various manoeuvres that are likely to strip it of its radical implications – for example, creating a sub-category of 'traumatic psychosis' but retaining a biomedical model for other 'schizophrenics'; and indeed the use of the term 'psychosis' itself, a category error which reifies a set of experiences that are perhaps best understood, quite simply, as reactions to extreme trauma. As I put it in another article, 'There is the abuse, and there are the effects of the abuse. There is no additional 'psychosis' that needs explaining' (Johnstone, 2008a, p.8.)

There are clear links between the evidence that many, perhaps nearly all, cases of 'psychosis' can be understood as the consequence of trauma, and the need for a formulation-led rather than a diagnostic approach in psychiatry. In the words of Jacqui Dillon, Chair of the Hearing Voices Network England and herself a survivor of psychiatry and of abuse: 'Instead of asking "What is wrong with you?" we need to ask "What has happened to you?"'

The Bristol Clinical Psychology Doctorate was the main impetus for my increased interest in the concept of formulation, which had always been a central part of my work with service users but had not previously been the subject of my teaching, training, writing or research. I devised and helped to deliver the teaching on formulation, including assignments, marking criteria, teaching, workshops, and essays. I was granted a short sabbatical to edit 'Formulation in psychology and psychotherapy: making sense of people's problems (Johnstone and Dallos, 2006b, PW 4.2.1. and 4.2.2.) All of this is described in more detail in Part 3.

2.10.1 Closure of the Bristol Clinical Psychology Doctorate

The context in which I am reflecting on my work in formulation as a possible way forward in my career, is the closure of the Bristol Doctorate. While I do not want to make this loss my main focus, some background might be helpful.

In 2005 the host university of the Bristol Doctorate, Plymouth, decided to seek a local home for the course. After a selection process that was widely felt to be unsatisfactory, several candidates were rejected in favour of Bath University. It quickly became clear that Bath had very different plans for the course in terms of philosophy and content, and that our jobs could not be guaranteed for long. For two and a half years, Bath held the legal status of 'preferred bidder' while breaking numerous deadlines for signing the contract. Given complete uncertainty about the future, 14 staff including the then course director resigned over this period. Official complaints to the British Psychological Society resulted in a formal investigation into Bath's plans, which in turn led to accreditation problems and the cancellation of their projected first intake of trainees. Eventually Bath University withdrew at the end of 2008, and I stepped into the role of course director.

At this point, we hoped that an alternative host university would be sought. However, Plymouth University immediately announced that they would not be seeking to transfer the course again but would be closing it and making all staff redundant in September 2010. The SHA then commissioned a new course, rather than a transfer of the existing one. There was widespread astonishment when Bath won the contract for the second time. Bath is currently in the process of setting up their very different course, while the Bristol course closed in September 2010.

It would not be fair to see the events outlined above solely as a response to the course's reflective and critical perspective, although that was part of the picture. We were caught up in wider political factors, many of which remain obscure to us. However, it is not a coincidence that our course is being replaced by one that is a model of clinical psychology orthodoxy – strongly CBT-focused, heavily research-oriented, sceptical about the role of personal development and drawing only from a narrow range of 'evidence-based' theories and practices. This fits with wider Government agendas and with the preferences of influential local clinicians. The 6-year disaster has resulted in much 'victim-blaming', and I and other senior colleagues have been made aware that a number of local job options (including Bath) are now closed to us. In the process, some of the few critical voices within clinical psychology training have been silenced.

As part of the closure process, we decided to describe the unique features of the Bristol course in a special edition of the monthly journal for clinical psychologists, Clinical Psychology

Forum, which I edited (see Clinical Psychology Forum 213, 2010 in Vol 3.) Our intention was to ensure that our learning, ideas and expertise were not lost to the wider training community. The journal editor notes that 'Bristol….had earned great respect and support within the training community in the UK. I am particularly pleased, therefore, that we have been able to produce this issue as a celebration of the achievements and good practice promoted at Bristol. Bristol's ethos will hopefully live on….through the cohorts of trainees who have graduated in the last decade' (Turpin, 2010, p.6.) Despite the closure of the course, I am proud to have contributed to these achievements. I believe that I and my team managed to bring the course to as successful a closure as was possible, retaining our dignity and our commitment to the trainees to the end.

VOLUME 1 PART 3

THE PUBLIC WORKS

3.1 Overview of Part 3

In Part 2, I described the personal, intellectual and professional context within which my interest in formulation has arisen. My critiques of biomedical psychiatry in general, and of psychiatric diagnosis in particular, underpin and set the scene for this development. As I have argued in a series of articles, chapters and presentations, diagnosis is both the foundation on which psychiatric theory is built, and from the service user's perspective, the starting point of the profoundly damaging process of turning 'people with problems' into 'patients with illnesses.' If diagnosis were to be replaced by a credible alternative, then everything else in psychiatry would have to change too. Over the last 4-5 years I have come to believe that formulation has the potential to be that alternative. Formulation has thus become the main focus of my work.

In Part 3 of the context statement, I will describe four main areas in which I have sought to develop the theory and practice of formulation and to promote its wider acceptance as a way forward for mental health services. These areas, and the Public Works that link to them, are:

The Formulation Theme on the Bristol Clinical Psychology Doctorate

(see Public Works in Volume 1, 4.1.1 and 4.1.2.)

 'Formulation in psychology and psychotherapy: making sense of people's problems' (Johnstone and Dallos, 2006b) including:

• Further work on Integrated Formulation

(see Public Works in Volume 1, 4.2.1, 4.2.2, 4.2.3.)

Using formulation in teams, including:

- My own clinical practice, using individual and team formulations

- Trainee research projects on team formulation

- Workshops and training on team formulation

 (see Public Works in Volume 1, 4.3.1, 4.3.2, 4.3.3.)

Promoting formulation for culture change, including:

- Using team formulations to raise awareness of trauma and abuse

- Formulation as an alternative to diagnosis

- Formulation as a radical act

(See Public Works in Volume 1, 4.3.2, 4.4.1, 4.4.2.)

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3.2 Formulation Theme on the Bristol Clinical Psychology Doctorate (links to PW 4.1.1 and 4.1.2.)

As co-ordinator of the Formulation Theme (a 'theme' being our version of a module), I took the lead on devising the structure, content and marking criteria, on organising and delivering the teaching and on marking the assignments, but was well supported by clinical psychology colleagues both on the course and in local services. At the time there was little to draw on in the literature, and the guidelines that I gave to the trainees were based mainly on my clinical experience. Across the 3 years, the theme was built up as follows:

Year 1.
 - Introduction to the core therapeutic models of the course, and their approaches to formulation.
 - Session on introduction to formulation (see Year 1 formulation teaching, Vol 2.)
 - The Formulation Day. 4 clinicians (staff and local psychologists) presented a formulation of an actual AMH client, from one of 4 therapeutic perspectives, which was used as a basis for drawing up an integrated version, debating issues and controversies about formulation, and

participating in. a role-play about a team discussion of the client, in which trainees were invited to role-play a formulation-based perspective on the client's difficulties (see Formulation Day handbook including extra material, Vol 2.)

 - A task-based learning assignment. Groups of trainees had 6 weeks to produce a presentation of an integrated formulation of an actual client case which was described by a local clinician, drawing on the course teaching and resources and their knowledge (PW 4.1.1). Trainees wrote a short reflective essay on their experience of the group work

Year 2

 - Trainees were required to produce a 3,000 word formulation of a Child and an Older Adult client, presented by a local clinician, under similar headings to the TBL task (PW 4.1.2). The clinician returned at a later date in order to share their own formulation of the client and his/her subsequent progress.

 - Trainees were also asked to write up 4 case studies during the course, each of which had to contain a formulation (see criteria in Trainee Handbook, Vol 3.).

 - Some cohorts were asked to write an essay on a topic of their choice related to formulation.

Year 3

 - I gave teaching sessions on Integrated Formulation and Using Formulation in Teams (see Vol 2.)

 - Throughout the 3 years, drawing up formulations under supervision was a key aspect of placement experience.

The theme developed into a coherent progression from single-model to integrated formulations, and from using formulation with individuals to using it with teams and to create culture change. Throughout, close links were maintained with local practitioners, who presented actual examples of their client work as material for the trainees, and who co-facilitated the day workshops. All the teaching, but particularly the formulation day, was evaluated extremely positively. I and Rudi Dallos presented this work in 2006 at the conference for clinical psychology trainers (see Vol 2.)

 The course's emphasis on formulation inspired some of our trainees to choose this as the topic for their doctoral research project under my supervision, and several of these studies are about to

be published (Cole and Johnstone, in press; Cole and Johnstone, in press; Christofides, Johnstone and Musa, in press, abstract in 4.3.3, full version in Vol 2; Hood and Johnstone, 2010, unpublished, abstract in 4.3.3, full version in Vol 2; Ray and Johnstone, 2008, unpublished; Redhead and Johnstone, 2010, unpublished.)

3.3 'Formulation in psychology and psychotherapy: making sense of people's problems' (eds L Johnstone and R Dallos, 2006b) (links to PW 4.2.1 and 4.2.2.)

As described in chapter one of 'Formulation in psychology and psychotherapy', the concept of formulation is not new, and it is a central feature of most, though not all, therapeutic approaches. However, at the start of the Doctorate in 2001 remarkably little had been written about the subject. The main existing text was based only on CBT (Bruch and Bond, 1998) and there was nothing at all from the reflective and critical perspective that we adopted. This inspired me and colleagues from the Exeter and Plymouth courses to put on some workshops for psychologists in the area in 2002. From this it became clear that we had tapped into an under-explored area of considerable interest. Rudi Dallos and I went on to edit our book, using the same AMH client case as the basis for the chapters. Our collaborator from the Exeter course, the then course director Willem Kuyken, has taken the theme in a slightly different direction and is now the co-author of a book and various articles on formulation in CBT (Kuyken, Padesky and Dudley, 2009.)

Rudi's and my book is now a recommended text on many clinical psychology courses, and a second edition has been commissioned. Reviewers have commented (see 'Reviews' in Vol 2):

'Buy this book! It is a clear and well-articulated approach to formulation in the psychological psychotherapies….It will take its place as required reading on training courses.' *Clinical Psychology Forum*, 2007 (175).

'A lot of thought-provoking material and practical guidance is packed into this excellent text and it is likely to become an accessible classic of its kind.' *Therapy Today*, 2008 (Sept).

'I see this book as a boon to both trainees and qualified therapists, whichever theoretical perspective they work in.' *Journal of Critical Psychology, Counselling and Psychotherapy.*

'The book will be invaluable to people entering training, and to specialists who want to update their knowledge of other approaches….Most important, the book provides a refreshingly critical perspective on various claims made about clinical psychology, without undermining clinicians' concern to do something useful.' *Journal of Community and Applied Social Psychology,* 2007 (17.)

'The final chapter is quite brilliant, and is the best account I have seen of the whole question of categorising clients…This is a very worthwhile book, and could be a revelation to anyone reading it.' John Rowan on amazon.co.uk, 23.11.2008

The first chapter (PW 4.2.1) introduces the subject of formulation, and the last one, 'Controversies and debates in formulation' (PW 4.2.2), is as far as I am aware the only published literature to examine the subject from a critical angle. This is in keeping with my commitment to maintaining a critical perspective even in those areas (psychotherapy, formulation, social inequalities approaches, the service user movement) which are closest to my own principles and values.

3.3.1 Further work on Integrative Formulation

The chapter that is perhaps in most need of updating is the one on Integrative Formulation. Since the book came out in 2006, I have devised a one-day workshop on this subject, which has twice been delivered as a Division of Clinical Psychology CPD event, and repeated by invitation at various other locations round the country (PW 4.2.3; feedback in Vol 2.) When I started to explore this aspect of formulation, I was surprised to find that although clinical psychologists are supposed to be trained to 'derive a formulation…..which incorporates interpersonal, societal, cultural and biological factors' (DCP, 2010), virtually nothing at all has been written about *how* to create this kind of integrated summary.

One of the very few exceptions is the Weereskera framework in 'Multiperspective case formulation' (1996.) However, close inspection reveals the rather serious limitation that Weerasekera's grid does not, in fact, result in an integrated formulation. Rather, it is a way of collecting together the various factors that might be included in such a formulation, with little

regard for whether or not they might be theoretically compatible. In other words, it is an example of what one of the participants in a trainee project described as 'a diagnostic style of formulation which is just a list of problems….an inflexible and concrete bunch of ideas' (Ray and Johnstone, 2008.) ' I would see this as an example of eclecticism, defined as 'an empirical, atheoretical mixing of various methods from different therapies' rather than integrationism, defined as 'drawing from a variety of models to create a new integrated and conceptually superior model' (Weerasekera, 1996.)

One of the dimensions of the grid is 'Biological' – which, unless carefully defined, invites the formulator to add in a psychiatric diagnosis, or a phrase such as 'genetic vulnerability to schizophrenia.' As I argue in my workshop (PW 4.2.3), this kind of eclecticism, where biomedical and psychosocial factors are simply added together, does not make sense. The two models are based on different, indeed contradictory assumptions: 'You have a medical illness with primarily biological causes' versus 'Your problems are an understandable emotional response to your life circumstances.' This leads to all the contradictions of psychiatric practice, and the mixed messages to service users that I have summarised as 'You have an illness which is not your fault, BUT you retain responsibility for it and must make an effort to get better BUT you must do it our way because we are the experts in your illness.' This kind of muddled thinking, and the muddled practice that flows from it, is routine in psychiatric settings.

While some successful examples of integrated therapy do exist (eg Cognitive Analytic Therapy, Ryle and Kerr 2002), I have yet to find a satisfactory set of integration principles or guidelines for achieving integration, either in therapy as a whole or in formulation as a central aspect. This is curious, given that most clinical psychologists and therapists say that they work integratively (McLeod, 2009.) I suspect that in practice this is more likely to be eclecticism.

A slide from the Integrated Formulation workshop (PW 4.2.3) illustrates some of the unresolved issues:

Some therapeutic models may be incompatible. In this case they would only open to eclectism, not integrationism, and would be internally contradictory. These incompatibilities indicate different philosophical assumptions about human beings
For eg:
 - Agency. Are we in control of our lives and actions (humanistic therapies), or simply responding to our environments (strict behaviourism) or our internal drives (psychoanalysis) or biochemical imbalances (psychiatry)?

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- Are we essentially loving and well-intentioned (humanistic) or in a constant battle to keep instinctual drives under control (psychoanalysis) or do we react to our environment in a morally neutral way (behaviourism)?
- Is the 'problem' in mental distress within our minds (cognitive therapy; psychology in general) or our bodies (psychiatry) or in society (community psychology)?

At the same time, I agree with Fear and Woolfe 2000, p. 331 (in Palmer and Woolfe, 2000) that integration must be attempted: 'The counsellor's journey towards integration mirrors the client's central if unconscious task in therapy: to join up the discontinuities of one's life so that…..''cut off'' parts (are) reintegrated and accepted….It is the task of the counsellor to….achieve a personal integration.'

As a first step towards a conceptual framework, I have drawn up a checklist of principles for integrated formulations:

- Awareness of other models
- Inclusion of key strengths of other models
- Awareness of own values
- Culturally sensitive
- Collaborative
- Provisional
- Expressed in everyday language
- Alternative to, not addition to, psychiatric diagnosis

I have also suggested that integrative formulations should seek a balance between:

- Inner and outer worlds
- Thinking, feeling and behaving
- Past, present and future
- Introspection and action
- Strengths and difficulties
- Symbolic meanings and real life facts
- Transference and collaboration
- Individual agency and social pressures
- Individual and family/systemic perspectives

(see PW 4.2.3)

In addition, I suggest four main formats for constructing a written formulation (PW 4.2.3.) These are: Inner world to outer world; past to present; core theme, such as separation difficulties, or unresolved trauma; or selecting a primary model and adding to it. Some psychologists and psychiatrists like the PPPP (pre-disposing, precipitating, perpetuating and protective factors) format. I dislike it because, like the Weerasekera equivalent, it does not actually integrate. It is also frequently used to add 'genetic vulnerability to schizophrenia', or similar, into the 'predisposing' heading.

Despite the challenges it presents, integration is, in my view, one of the essential characteristics of team formulations, as I will discuss below.

3.4 Using formulation in teams (links to PW 4.3.1, 4.3.2, 4.3.3.)

3.4.1 My own clinical practice, using individual and team formulations

I have always seen formulations as a central aspect of my work with individual service users (see 'Sarah' in Vol 1 Part 1, and further examples in Vol 2.) In the last three years I have become very interested in one particular application of formulation: using formulation within teamwork. By this I mean the process of facilitating a whole team to come up with agreed and shared formulations for the kind of complex and challenging clients who constitute an increasing amount of mental health services' work.

My interest and indeed awareness of this as a specific area of clinical practice stems from my time in an AMH community mental health team where I worked one day a week for a period of two years from 2004-2006. It occurred to me that offering to co-construct formulations for complex and challenging service users with the team, and using this a basis for the team's interventions, would be a useful way of making the most of my limited time. I hoped to enhance the team's understanding and care planning without necessarily taking on every service user for individual work. It was also a good way of involving trainees on placement with the kind of

service user that they would not usually be expected to take on while still in training. The approach I developed was:

- Ask the team if there are any service users who are experienced as challenging, frustrating or 'stuck.' (This is a risky strategy since it instantly results in a long list of the most complex service users in the service!)
- Read through the notes and summarise the psychiatric history plus key facts, events, and interventions
- Meet the staff who knew the service user best and ask them about the aspects that don't appear in the notes: what they feel about the service user, and their hunches about the problem
- Draw up a very tentative formulation
- Convene a meeting for key staff, in order to share and get feedback on the formulation and collectively decide on the best way forward
- Share the formulation with the service user as appropriate; follow up as needed (PW 4.3.2.)

An example of this work is 'Mary', Vol 1 Part 1. Further examples can be seen in Vol 2`. The approach was felt to be very useful by the team, as evidenced by a steady stream of requests for team formulations, although I did not formally evaluate it. I subsequently used it with some success on an in-patient ward, from 2009 to 2010 (see handout of a ward teaching session, Vol 2.)

3.4.2 Trainee research projects on formulation

One of the trainees who had helped me while on placement decided to carry out her research, under my supervision, in the area of using formulations in teams. She interviewed a number of local team-based psychologists with interesting results (Christofides, Johnstone and Musa, in press; Vol 2 and PW 4.3.3.) This first alerted me to the fact that there is a whole hidden body of work being carried out by psychologists and others in team settings, unacknowledged in the statistics, mostly unshared with the profession as a whole, and largely unresearched. This is surprising given that the psychologists in Christofides et al's study described this work in such terms as 'I think it's one of the most powerful tools we have'; 'It should be central to all the stuff we do, whether it be working individually, working systemically, working organisationally.'

Another trainee subsequently did her doctoral research, also under my supervision, into a parallel exploration of the views of the non-psychologist MDT members who had experienced this kind of work in their teams (Hood and Johnstone, 2010, Vol 2 and PW 4.3.3.) The participants were universally enthusiastic, using such phrases as, 'Formulation is really really useful and I think just to have the head space really to think about what was happening'. Indeed, they seemed to have a rather idealised view of formulation as a possible solution to the demoralising struggle with biomedical models and interventions in mental distress. In the words of one of them, 'That is potentially where mental health has gone wrong because we try to manage things, we don't try to resolve things, whereas if you went more towards formulations and therapy you would be looking at resolution. Not just treatment.' Of course, these were small-scale studies of self-selected participants, but the results are consistent with other findings (see summary in 'Using formulation in teams' presentation, PW 4.3.2) and were enough to confirm my clinical experience of this as a highly effective and valued use of formulation.

3.4.3 Workshops and training on team formulation

In my experience, additional benefits arising from the use of formulation with teams, as opposed to with individuals, are:

• Consistency of approach to intervention
• Generating new ways of thinking
• Dealing with core issues (not just crisis management)
• Improved morale
• Supporting each other with complex clients
• Increasing team understanding and empathy
• Meta-messages about hope and responsibility
• Promoting more psychological thinking in teams

In summary, formulating adds in the bit that routinely gets squeezed out in busy teams: providing a space for thinking, and for processing feelings. Formulation itself can be defined as a way of integrating thinking (our thoughts and theories about a service user) and feelings (theirs, and ours about them.) It can also serve as a process for integrating thinking and feeling

within teams. Workshop participants have almost all used comments like 'excellent, inspiring,stimulating, brilliant, thought-provoking, challenging, extremely useful' in their feedback (Vol 2.)

Facilitating a team formulation meeting can be challenging. The facilitator needs to keep an eye on the large amount of information and the need to reduce it to a concise form, but also on the feelings and processes within the room, which often parallel the service user's dilemmas. For example, the team may experience intense sadness, or frustration, or anger, as part of the discussion. 'Splitting' or Rescuing/Persecuting dynamics may also be present. All of this needs noticing and using as further information about the service user and the formulation.

In parallel with this new area of interest, I have developed a workshop on the subject, which I was invited to present to a group of 40 local psychiatrists on 18.11.2009 (Vol 2.) I did so, tactfully and strategically omitting the anti-diagnosis angle and including a number of flattering references to the pioneering work of psychiatrists in this exciting field, and the response was very positive. I was immediately invited to give the presentation to several local teams, including a series of workshops to an inner city mental health assessment team (see handouts in PW 4.3.2, and feedback in Vol 2.) So far, every team has evaluated the workshop extremely positively and each event has led to requests for a repeat performance from other teams. I have now taken this roadshow to eight local teams with more engagements pending. I have also supported a number of our clinical psychologist graduates in devising teaching on formulation for their teams (see examples in Vol 2) and on 14.09.2010 gave a very well-received training day on 'Using formulation in teams' to 46 local psychologists (handout and feedback in Vol 2.)

Using formulation in teams raises the tricky question of how far to disseminate the resulting document. A team formulation almost inevitably centres around the staff's counter-transference; the powerful feelings of anger, frustration and pity that reflect service users' own dilemmas. It has become clear to me that formulations are bound to take a slightly different form when the client is, in effect, the team (it is their struggles that are the presenting problem). In the same way that therapists would not share the entire content of supervision with a client, team formulations may also need to be kept within the team. However, good practice suggests that as far as is possible, a parallel formulation should also be developed with the service user (see example in Vol 2.)

As outlined above, I believe that the best formulation is always an integrative one, and nowhere is this more true than in work with highly complex service users who have long psychiatric histories. My experience of using formulation in teams has led me to believe that the following factors must always be included in an integrative team formulation:

• Transference and counter-transference
• A systemic perspective on the interaction between service user and the services as a whole
• Social factors, including the identity of a 'mental patient'
• Psychological framing of medical interventions such as medication, diagnosis and admission
• The role of trauma and abuse

(see PW 4.3.2)

In my experience, clinical psychologists often omit the fourth factor from their formulations, as though matters like medication and admission are none of their professional business. On the contrary, these aspects of care need formulating like everything else. Medication, for example, can have all kinds of meanings, from 'The doctors are trying to control me just as my parents did' (see Sarah, Vol 1 Part 1) to 'I want to be cared for but I am too angry and fearful to accept it' (see Mary, Vol 1 Part 1.) 'Helpful' responses like compliance may indicate a desire to hand over all responsibility to the team, while 'uncooperative' responses like refusing medication may represent a healthy desire to reject the patient role.

The last factor, the role of trauma and abuse, is discussed under the next heading, 'Promoting formulation for culture change.'

3.5 Promoting formulation for culture change (links to PW 4.4.1, 4.4.2.)

3.5.1 Using team formulations to raise awareness of trauma and abuse

It will be apparent from the previous section that using formulation in teams has benefits, and sometimes aims, beyond increasing the effectiveness of interventions with a series of challenging clients. It can also be a powerful way of changing team thinking. As a recent Division of Clinical Psychology document 'Working psychologically in teams' (DCP, 2007, p.

23) notes, 'Taking formulation into a wider setting can be a powerful way of shifting cultures towards more psychosocial perspectives.'

One of the most urgently-needed shifts is towards acceptance of the major role of trauma and abuse in psychiatric breakdown (as discussed earlier.) I make these factors very explicit in my presentations (PW 4.3.2.) The slides on the shockingly high prevalence of trauma and abuse in 'psychosis' always induce a stunned silence in my audiences. I tell them that the default formulation in any long-term case should always be trauma and abuse. A quote from Judith Herman's classic book 'Trauma and recovery' (2001, pp.1-2) makes this point very powerfully:

'People who have survived atrocities often tell their stories in a highly emotional, contradictory, and fragmented manner which undermines their credibility and thereby serves the twin imperatives of truth-telling and secrecy.....Witnesses as well as victims are subject to the dialectic of trauma. It is difficult for an observer to remain clearheaded and calm, to see more than a few fragments of the picture at one time, to retain all the pieces, and to fit them together. It is even more difficult to find a language that conveys fully and persuasively what one has seen.'

This quote vividly describes the pain, confusion and chaos that service users present to us. It is understandable, and yet not excusable, for professionals to try and avoid this pain and the horrific truths that lie behind the labels. In Scott's words, 'When the presenting "madness" is penetrated and the anguish and desperation is laid bare, it takes a strong stomach to continue with one's endeavour' (Scott and Seccombe, 1976, p.6). One way of beginning this task, and of starting to 'fit all the pieces together', is to construct a formulation. By doing this, of course, we enter the immensely painful position of witness to the atrocities.

A more lighthearted way of making the same point is the 'free gift' that I include in my presentations to teams (PW 4.3.2):

Lucy's FREE one-size-fits-all formulation for long-term service users

Service user X has unmet attachment needs and unresolved trauma from their early life. X tries to meet these through the psychiatric services, but fails, since services are not set up to do this. Still needy, but unable to achieve enough emotional security to move on, X ends up trading 'symptoms' for whatever psychiatric care is on offer. Staff are initially sympathetic but become increasingly frustrated at X's lack of progress. The resulting dynamic may end up repeating X's early experiences of neglect, rejection or abuse. Both parties become stuck, frustrated and demoralised in this vicious circle.

Interestingly, no individual or team has ever disagreed with this analysis of the way that services replicate people's damaged early attachment relationships and in effect re-abuse them – and of course, the fault rarely lies at an individual level. It is a consequence of a mismatch between service user needs and the model we use to understand distress. By offering a formulation instead, ideally at first contact with the psychiatric services, there is a good chance that the whole destructive cycle can be interrupted, as follows:

Service user X has unmet attachment needs and unresolved trauma from their early life. X tries to meet these through the psychiatric services…….

<div align="center">

FORMULATE HERE!!!!

</div>

The scene would then be set for offering the kind of help that the service user actually needed, whether that was therapy for the effects of abuse, social support, different housing, or whatever. Of course, a formulation does not guarantee an easy way forward or a happy final outcome. However, it does at least ensure that we are working collaboratively on appropriate responses to people's actual problems.

3.5.2 Formulation as an alternative to diagnosis

Formulation is not just a vehicle for introducing awareness of trauma and abuse. Implicit in the one-size-fits-all formulation is the message that service users are best understood as 'people with problems' not 'patients with illnesses.' In other words, the biomedical model of mental distress is not only completely inappropriate; it actually compounds service users' difficulties. (This was true of both Sarah and Mary, Vol 1 Part 1.) Again, this can be a tricky aspect of facilitating team formulation meetings. The staff in the room are rarely to blame as individuals; in fact, they tend to be a self-selected group of people who are willing to adopt new perspectives. At the same time, as team formulations accumulate, the uncomfortable message that we are all part of a system that creates rather than reduces distress is hard to ignore.

As I have argued in several textbook chapters, formulation can be an antidote to the toxic effects of psychiatric diagnosis and everything that follows from that act. My table summarises this:

Diagnosis   Formulation

Removes meaning	Creates meaning
Removes agency ('sick role')	Promotes agency
Removes social contexts	Includes social contexts
Individualises	Includes relationships
Keeps relationships stuck	Promotes relationship change
Expert-derived	Collaborative
Stigmatising	Non-stigmatising
Emphasis on pathology	Includes strengths
Culture and value blind	Culture and value aware
Medical consequences	No medical consequences
Social consequences	No social consequences

(see PW 4.4.1 and 4.4.2.)

In other words, formulation can put back what psychiatry takes out – it restores meaning and restores agency. It reminds us that we are not *treating medical illnesses*, which can be divided into neat parcels along the lines expected in medicine and the natural sciences, but *working with human suffering*, which manifestly cannot be categorised in this way.

It is only to be expected that psychiatrists are reluctant to give up diagnosis, and prefer to see formulation as an addition to, not a replacement for, medical classification. However, it is disappointing that the profession of clinical psychology is deeply divided on this issue. While all clinical psychologists are familiar with formulation, many are reluctant to leave diagnosis behind. This was apparent when The Psychologist published a collection of scholarly articles arguing against the use of psychiatric diagnosis in May 2007. Responses to the supporting letters (of which mine was one) varied from moderate wishes 'not to abandon a procedure which has served us well' to the accusation that critics are 'the new totalitarians' who use 'defensive rhetoric, ad hominem argument and sneer quotes' to advance their case ('Who criticises the critics?'Vol 3.).

David Pilgrim, a senior member of the profession, has asked, 'Do we not have a professional responsibility to challenge and expose the shortcomings of a diagnostic approach?…Surely our main duty is …not to shore up medical reifications' (Pilgrim, 2000, p. 304.) It appears that the majority of clinical psychologists see it differently.

3.5.3 Formulation as a radical act

There is a curious paradox in psychiatry, which I explored in a recent overview of '25 years of disagreeing with psychiatry' (Johnstone, 2009): everything changes and nothing changes. The diagnoses, medications, management structures, types of intervention and so on are in a constant state of flux, but at the same time, this can be read as a desperate attempt to maintain the appearance of progress and to ward off despair in the face of the fact that nothing changes; the new icing on the cake conceals the same old biomedical model underneath, and the recovery rates are no better than before. The explanation I gave for this extraordinary state of affairs in 'Users and abusers of psychiatry' is: '…..psychiatry is required to be the agent of society while purporting to be the agent of the individual; and its main function is not treatment but social control' (2000, p. 219.) I further contended that 'the principal mechanism by which psychiatry performs its function of social control is the use of the medical model….. which gives psychiatry powerful weapons for suppressing dissent (drugs, ECT) while enabling its true purpose to be concealed' (2000, p. 223.) Many others have made the same point.

The implications for the use of formulation are crucial. Introducing formulation as an alternative to the cornerstone of psychiatry, psychiatric diagnosis, is not simply a case of replacing poor practice with more effective methods. Giving service users back their voices, and ensuring that their stories are heard, is a fundamental challenge to the whole purpose of psychiatry and the vested interests therein. We can expect to meet resistance, as illustrated by the response from some clinical psychologists and by the example below.

In 2009 Ross Hughes, an ex-service user who was employed as an advocate within my local Trust, started a campaign to have diagnosis replaced by formulation. He produced some eye-catching posters ('Help cure the terrifying mental health condition Delusional Diagnosing Disorder! Very, very silly labels damage lives!') After various tactics such as threatening to hold a demonstration outside Trust headquarters, Ross and his co-workers were successful in getting a box marked 'Formulation' added to the CPA (Care Plan Approach) documents, but not in eliminating the compulsory 'Diagnosis' box. The medical director insisted that the word 'Biopsychosocial' appeared before 'Formulation', thus allowing retention of essentially medical elements such as 'Schizophrenia, triggered by stress.' Ross also invited me to speak at a local conference titled 'Beyond diagnosis' (Vol 2.) Evidently I went too far beyond diagnosis, because the head of psychology (my former NHS manager) subsequently refused my offer to

provide formulation training for the Trust on the grounds that 'it would give the wrong message.' The 'wrong' message, I assume, was one that caused controversy by critiquing diagnosis. Without training, staff were unclear what to put in the 'Formulation' box, and it either remained blank or was simply used to record the diagnosis, as a service evaluation by one of our trainees found (Thomas, 2009.) Ross became disillusioned with his role, and moved on. New paperwork was introduced, and the 'Formulation' box disappeared.

This gives a flavour of the resistance that can be anticipated. Nevertheless, I have continued to champion the use of formulation as an alternative to, not an addition to, diagnosis, in several book chapters (eg Johnstone, 2006a, Vol 2; Johnstone, 2008b ; Johnstone, in press b, 4.4.1; Johnstone, in press c.) I have also presented my views at a number of training events and conferences, including the inaugural conference of the Campaign to Abolish the Schizophrenia Label (www.asylumonline.net), where I was a keynote speaker (PW 4.4.2) and at a number of similar events (see Vol 2 for other examples of promoting formulation as an alternative to psychiatric diagnosis.) I wholeheartedly agree with CASL's statement that 'a single word can ruin a life as surely as any bullet, and schizophrenia is such a word' (Hammersley and McLaughlin, 2007.) The same applies to every psychiatric diagnosis.

3.6 Reflection on formulation: the wider picture, and future directions

In this final section, I will summarise some of the reflections that have arisen from immersing myself in the theory and practice of formulation.

3.6.1 Formulation: part of a long-standing tradition

I have always maintained that there is nothing new under the sun in psychiatry or psychotherapy, and I have no wish to claim that formulation is an exception to this rule. Instead, I have come to see it as a contemporary rephrasing of an idea that has been part of the subjugated discourse in psychiatry since its inception, that *madness has meaning.* As such, it appears in slightly different forms in many other places. Although Freud did not use the term,

psychodynamic formulations are based on his ideas about the personal meaning of symbolic communications, defences, and the unconscious. Systemic therapists talk about a 'working hypothesis', which is simply a synonym for a formulation. The Hearing Voices Movement encourages voice-hearers to develop a *construct* about their voices, which is based on 'at least 3 different ways of formulating the link between the voices and someone's life history: as a historical relationship, as a psychodynamic relationship, and as a metaphorical relationship' (Romme and Escher, 2000, p.28.) Research into attachment theory shows that the outcome of damaging early relationships can most clearly be predicted from an adult's ability to form a *narrative* about their childhood; if this can be done, their difficulties need not be passed on to their own children. Narrative therapy, as the name suggests, encourages clients to create alternative and more hopeful stories, or narratives, about their lives (Harper and Spellman, 2006.) The Tidal Model of mental health nursing, which is a version of the Recovery Model, emphasises reclaiming the service user's personal story of their distress (Barker and Buchanan-Barker, 2006.) Looking further afield, some innovative approaches to psychosis in Finland are moving away from diagnosis and towards what might be called broad-level formulations, such as 'identity crisis' or 'separation crisis' in place of 'schizophrenia' (Alanen et al., 2000.) I believe that the theory and practice of formulation will be strengthened if we distance ourselves from claims about unique professional skills, and instead seek to build on the solid foundation created by many other clinicians and researchers.

3.6.2 Formulation and its epistemological roots

We should be aware that formulation remains firmly located within Western psychological theory. This epistemology is based on assumptions about individualism, selfhood, values, the role of spirituality and religion, mind-body relationships, family structures and the boundaries between 'normality' and 'abnormality which are not givens in all cultures. Equally, other cultures may frame their explanations in mystical, metaphysical or paranormal terms that are alien to most Westerners. This raises various questions. At a theoretical level, do we simply regard personal or culturally-sanctioned explanations of this type as wrong? If so, how does this fit with our commitment to respect service user perspectives? And does it mean, essentially, that formulation as commonly understood can only be practised within a Western culture? At a pragmatic level, how do we work with someone whose explanations for their distress seem to us

manifestly 'untrue'? Is it possible to have a shared formulation in such cases, or do we privately retain our own version of the psychiatrists' verdict of 'lack of insight' and regard them as mistaken?

I do not have a full answer to these questions, but in reflecting on them it occurred to me that they arise within as well as between cultures. As we know, 'psychotic' service users frequently, in fact routinely, present us with explanations that clinicians do not believe to be true in a literal sense. For example, they may believe that devils have invaded their bodies. This does not prevent us from attempting to co-construct a formulation which assumes that such experiences are *personally and symbolically meaningful* even if not factually accurate. As always with formulation, we are looking for meanings not 'facts', whatever the service user's cultural background. Of course we may need to inform ourselves about the cultural meanings of certain beliefs in order to do this effectively, and there may be quite a bit of 'negotiating for shared meanings' (Butler 1998) before we are able to develop a formulation that both parties can provisionally agree upon.

Perhaps this also involves an appropriate degree of humility about our own constructs. I am currently working with a woman who believes that she has been taken over by evil spirits. I have suggested to her that a dissociative response to early sexual trauma may be a better explanation. At the same time, and I am aware how odd this may sound, I do not want to commit myself completely to the view that there are no such things as evil spirits. I am also open-minded about ghosts, reincarnation, life after death, telepathy, psychic predictions and many other phenomena. If my extremely elementary understanding of modern physics is correct, there may yet be a way of accommodating such experiences within a scientific viewpoint.

I think we can also reasonably assume that certain psychological processes and responses are common to all human beings; indeed the psychiatrist and anthropologist Roland Littlewood has suggested that themes of powerlessness, role strain, social rejection and so on underpin the more unusual cross-cultural manifestations of distress (Lipsedge and Littlewood, 1997.) Building on this kind of evidence may give us confidence that our Western formulations are well-grounded and not just applicable within Western psychology.

The Hearing Voices Network's 'construct' takes an interesting perspective on these issues. . It is willing to step right outside conventional psychiatric and psychological explanations and acknowledge entirely different frameworks that may be held by voice-hearers such as mystical, religious, metaphysical and paranormal beliefs. A conviction that voices are, for example, due to telepathy or reincarnation or gods or ghosts is treated with as much respect as any other belief system, and valued for its importance and usefulness to the voice-hearer.. Similarly, recent work on unusual beliefs suggests that it may be helpful to accept the reality of the person's account and work with it (Knight 2007.) For example, carrying iron objects is said to ward off aliens, and may be reassuring to someone who is afraid of alien abduction. Ministers or shamans may be useful to people who report invasion by ghosts or spirits. Knight points out that 'delusional' beliefs are widespread in the 'normal' population, and as with hearing voices, do not need to be seen as problematic unless they are causing distress. In such cases it may not be possible to reach a shared formulation. At a pragmatic level, though, we can respect the person's belief system and work with them to reduce distress.

The strong self-help tradition of the Hearing Voices movement means that the creating of constructs is not seen as something that necessarily involves a professional; it can also be facilitated by a friend, partner or another voice-hearer. Within psychology, on the other hand, formulating is generally seen as an advanced skill that can only be carried out by professionals. . This brief consideration of epistemological issues reminds us that all of us can help to create meaning and offer ways of coping with distress; that our own culturally-sanctioned explanatory constructs are not necessarily more 'true' or more 'useful'; and that we need to respect a variety of ways of understanding and coping with distress even if we do not fully share them.

3.6.3 Formulation: limitations and traps

As I have reflected on formulation throughout this doctoral process, it has become very apparent to me that it has limitations as well as strengths. Despite the list of ways in which formulation can be an antidote to diagnosis, nothing necessarily prevents it from being expert-driven, individualising, pathologising and so on, as discussed in Johnstone 2006d (PW 4.2.2.) I concluded that 'Perhaps the best that can be said is that such tendencies are not intrinsic to the process of formulation…..whereas they are, arguably, an almost unavoidable consequence of psychiatric diagnosis' (p. 224.)

We should also, in my view, beware of an emerging tradition within CBT formulation which sees it as 'a central process in the role of the scientist-practitioner' (Tarrier and Calam, 2002, p.311.) As such, it is argued that formulation should be open to assessment of reliability and validity. To this end a number of studies have been carried out, with the general conclusion that reliability of formulations is weak at best, while validity has hardly been addressed at all.

It seems to me that this kind of approach rests on very questionable assumptions. For a start, it necessarily assumes that formulation is a kind of 'event' or 'object' rather than a process. From the latter perspective, formulation is an intrinsic part of a therapeutic encounter and has no clear start or end point, and indeed no clear guidelines as to what to include and what to leave out. A complete formulation would, presumably, take a lifetime to construct and could potentially include every thought, feeling and experience within that lifetime. Some of the clinical psychologists who were interviewed for trainee projects expressed this elegantly; one used the phrase 'broad snapshot summaries of complex evolving stories' (Cole and Johnstone, in press.)

Secondly, this approach seems to rest on the positivist assumption that personal narratives or meanings can be described as either 'true' or 'false'. This seems self-evidently nonsensical. Even if such a judgement were possible, who would make it? In fact this kind of research has largely ignored the service user perspective; assessments of validity and reliability have been based only on the clinicians' views. In my opinion, it makes much more sense to acknowledge that 'there is no one version of the truth because we largely construct our own realities, which inevitably leads to multiple perspectives on that reality' (Messer, 1996, p.136), and that because of this, a formulation can only be assessed in terms of usefulness, not truth. Of course, 'usefulness' also has to be defined (and Butler provides a list of criteria such as whether a formulation accounts for all the important factors, identifies risks and so on, Butler, 1998, p. 21.) 'Usefulness' as a criterion also raises the question of 'Useful to whom?' These are important debates which raise questions of values and power, and cannot be answered within a positivist framework (see Johnstone, 2006d, PW 4.2.2.)

3.6.4 Formulation and research

With all the caveats outlined above, it is an unavoidable fact that critics of psychiatry increasingly need to be able to 'market' and 'sell' their products in a highly sophisticated way. I have come to the conclusion that if we want to take forward formulation for culture change, using 'formulation' as a brand or marketing device which has some credibility, then in today's evidence-based climate we need to show that it is effective – that it produces better outcomes, more satisfied 'customers', fewer admissions, reduced costs, and so on. So far, this evidence is lacking. This is particularly embarrassing for clinical psychologists, whose claim to be implementing evidence-based practice is undermined by the fact that their core skill, formulation, is itself unevidenced.

I have summarised the existing research findings in my presentation 'Research into formulation' (given on 8.03.2010, see Vol 2.) In brief, there is little support for improved outcomes in therapy and mixed evidence about perceived helpfulness by clients (although formulation does seem to make the therapist feel better, Chadwick et al, 2003.) As above, reliability is moderate at best, while validity in formulations has hardly been defined, let alone assessed. Audits and qualitative research suggest that staff find team formulations very helpful (PW 4.3.2), although whether and how this translates into improved client outcomes is unknown.

Researching the use of formulation in individual therapy presents numerous problems. How do you disentangle the formulation from the therapy, and what would it mean to carry out therapy without a formulation, or in other words, without a hypothesis about what is going on? This touches on the 'formulation-as-event' vs 'formulation-as-process' debate; the former may be easier to research, but the latter may be a better reflection of clinical reality.

One way of separating formulation from therapy is to look at its use in teams. In such a case, the formulation can be separated out from the new intervention plan, which does not necessarily include therapy anyway. It would be relatively simple to compare a team formulation approach to service users with treatment-as-usual in a different team, and to take measures such as service user and staff satisfaction, length of treatment, number of admissions, and so on. I and a research colleague are hoping to be able to carry out such an evaluation in the near future.

3.6.5 Formulation - part of being human?

In Johnstone (2006d, p. 229, PW 4.2.2) I asked: 'Is formulation a special skill?…The answer is both yes and no. We are all constantly engaged in a process of creating theories about the world and the people in it, and a great many non-professionals (as well as novelists, poets, philosophers, priests and others whose subject matter is human nature and human suffering) are extremely good at this.' This, of course, is why formulation is so appealing to staff and service users; without necessarily being trained in formulating, they can instantly see its relevance and importance.

On the other hand, I also know that creating shared understandings with highly distressed service users, doing so sensitively and reflectively, while drawing on a large basis of theory and clinical experience and framing it in a way that is useful to them and to the professionals who support them, is one of the most challenging aspects of my work. It is certainly not a skill that trainees acquire overnight. In this respect, formulation is worthy of at least some of the rather grandiose claims that have been made for it by members of the clinical psychology profession.

I am continuing my formulation work as follows:

- Preparing a 2nd edition of 'Formulation in psychology and psychotherapy', to include, among other aspects, a chapter on using formulation in teams.
- Leading a working party to draw up Good Practice Guidelines on Psychological Formulation on behalf of the Division of Clinical Psychology. This will be a resource for clinical psychologists, trainees and training programmes, and is due to be launched at the December 2011 DCP Annual Conference.
- Membership of a working party to draw up a Division of Clinical Psychology position statement on psychiatric diagnosis. This is an opportunity for the profession to develop a coherent position on the issues, and, I hope, be willing to promote formulation as an alternative to diagnosis.
- Planning the first conference on 'Using formulation in teams' to be held in October 2011 under the auspices of the Division of Clinical Psychology. Co-organisers and speakers will include several of the Bristol graduates who have taken the team formulation approach into their first jobs.
- Delivering a training package to embed formulation into a major service re-design in the Adult Mental Health services in Sussex Partnership Trust.

- Continuing to promote formulation through clinical practice, training, writing and conference speaking.

3.7 Final personal reflection

The Registration Panel invited me to reflect on 'the adversarial nature of…your current approaches to change.' Such questions need to be posed with caution. There is a risk of implying that opposition and dissent are simply a matter of personal pathology. We would not ask Nelson Mandela to reflect on his antagonism towards apartheid, because we entirely accept that apartheid is wrong. I am in no way comparing myself to such a towering figure, but the principle is the same. From my perspective, biomedical psychiatry is every bit as reprehensible (and indeed it has some parallels with apartheid in that black and minority ethnic service users are treated particularly harshly.) In my experience, anger, frustration and disillusionment with biomedical psychiatry are almost universal among mental health professionals. The more relevant question then becomes, 'Why do others accept the status quo?' Some of the answers lie in lack of intellectual confidence and knowledge about the alternatives. Even if this doesn't apply, anyone who takes a remotely dissenting position, however respectfully, is likely to find themselves in an 'adversarial' situation very quickly. Merely holding certain views is treated as a threat ('Psychiatry: are we allowed to disagree?' Johnstone, 1993a, Vol 3.) This is nothing to do with personal issues, and everything to do with a powerful system needing to defend itself.

Having said that, there is of course a personal context to whatever positions we find ourselves in. From my family, I am indebted to my grandfather for permission, in Transactional Analysis terms, to think critically and act on my beliefs. As I have shown, clinical psychology as a platform for my values is the logical consequence of my personal experiences, and the perfect opportunity to use my abilities in teaching, training, writing, research, public speaking and clinical work. I wrote in 2006, 'Questions about how we respond to human suffering are not simply ones of science or evidence, though that may be a part of it. They are ultimately moral, ethical and political issues on which we all need to take a stand' (Johnstone 2006a, p 98; Vol 2.) This doctoral thesis has been an opportunity for me to reflect on my stand and the reasons behind it. It has also served as a way of processing some of the more difficult events of recent years.

In relation to the request to 'say more about your strategy as a change agent', I have described how this has developed from naïve confrontation in my first post, to a far more sophisticated multi-level engagement with psychiatric theory and practice as taught to trainees on the Bristol Doctorate. Although the early years of my career were characterised by fights with the system, for the last 10 years I have been mainly engaged in promoting positive alternatives – training others, and of course developing formulation as a tool for radical change.

This brings me onto the question of impact, and how much change I have achieved, either on my own or in conjunction with like-minded allies. The bigger answer is clear: very little. Despite constant reincarnations, the juggernaut of biomedical psychiatry rolls on in much the same way (see 3.5.3.) It serves important political and business interests, and would-be reformers only have limited room for manouevre within this wider picture (Warner, 2004.) Nevertheless, history tells us that even the most oppressive regime cannot ultimately withstand a grassroots movement. If real change comes from anywhere, I believe it will be from the growing strength of the service user/survivor movement, of which I am proud to be a supporter.

Within the contextual limitations described above, I am fortunate enough to have had the opportunity to influence others, including the 200 graduates from the Bristol Doctorate, through the various stages of my career and many of these people have taken the critical perspective forward into their own settings. As I used to tell trainees, you never know what seeds you are sowing by your words and actions (see 'Additional evidence of impact' Vol 3 for some examples.) Equally importantly, I have had the enormous privilege of helping at least some service users to leave psychiatry behind. As I also used to tell trainees, a single one of these lives saved justifies an entire career.

The world of mental health is currently being swept by a wave of Mindfulness (Kabat-Zinn, 2004.) Despite my instinctive cynicism about some of the ways it is being packaged, I have personally found it helpful to try very hard to adopt an attitude of 'doing what is right' without aim or ego. What follows from that, will follow; and the things that change must be accepted along with those that do not change. Mindfulness doesn't prevent conflict, but it provides a vantage point above the battlefield, so to speak, which offers some protection against burn-out and despair. It has been particularly painful coming to terms with the loss of the course I loved, and with what feels like exile to my current clinical post in a highly medicalised service in South

Wales - not unlike my first post nearly 30 years ago. It is not how I envisaged my future. I am working towards accepting this too.

3.7.1 **Final final personal reflection**

In my work I describe formulation as a framework for integrating *thinking* and *feeling.* I also emphasise that formulation is centrally about *personal meaning*. The core assumption of a formulation is that 'at some level, it all makes sense.' Formulation should also form a bridge between professional and service user, a way of creating an agreed way forward together.

This context statement can perhaps be understood as a way of integrating my own thinking and feeling, my own theory and practice, and the bridge between the professional part of me and the part that identifies with service user experience. It illustrates the personal meaning behind my own journey, and the plans (or in formulation terms, interventions) that I may develop for the future.

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