Portfolio Volume 1: Major Research Project

Young People's Experiences and Views of Formulation, and its Clinical Implications for Mental Health Professionals.

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Abstract

The experiences and opinions of adult clients, professionals and teams regarding clinical formulation have been researched, with mixed findings. Formulation helps some clients understand their problems, and feel accepted (Redhead, Johnstone & Nightingale, 2015; Burchardt, 2004). However, some can find it upsetting and worrying (Chadwick, Williams & Mackenzie, 2003). Professionals reported that formulation increases understanding of clients and gives direction (Pain, Chadwick & Abba, 2008), but can limit care plans (Summers, 2006).

A systematic literature review with a critical analysis is presented in this research. The review found no published research regarding young people's (< 18 years) experiences of formulation. Thus, the current study aimed to explore young people's views, opinions and experiences of formulation in Child and Adolescent Mental Health Services (CAMHS).

A qualitative study is outlined, in which semi-structured interviews were conducted with nine 13-17-year olds currently accessing therapy in CAMHS across one county in the UK. The data were analysed using Thematic Analysis. Findings included three key themes: Shared Sense Making; Formulation Process as a Therapeutic Intervention; and The Purposes and Uses of Formulation.

These findings were shared with 13 Multi-disciplinary professionals within the CAMHS' teams which the young people were recruited from. Two focus groups were conducted, again analysed using Thematic Analysis, and aimed to explore clinicians' reactions to the findings, and what impact the findings might have on clinical practice. Findings included three key themes: The impact of young people's experiences of formulation on clinical practice; clinician's reflections on their role and their reactions to the young people's findings; and wider network and societies' expectations of CAMHS and knowledge of formulation.

Clinical implications are discussed which include a need for clinicians to check understanding with clients; increasing familiarity of formulation outside of mental health services; ensuring inclusion of client's strengths in formulations; and ensuring collaboration.

Chapter 1: Introduction

"No decision about me without me" (Department of Health [DoH], 2010) – but where are we with this really?

In 2010 the white paper "Equity and Excellence: Liberating the NHS" (DoH, 2010) set out proposals to give everyone more say over their care and treatment. Within this, a new NHS Outcomes Framework was developed which provided national outcome goals which the NHS Commissioning Board had to align with, alongside goals for overall improvements. These outcomes crossed over three domains: The effectiveness, safety and broader experiences of patient treatment/care, measured by both clinical and client-reported outcomes. Whilst it is arguable that this legislation is mostly applicable to physical health, the initial white paper did state that this should include key services such as those for children, older people and mental health. However, a government response paper (DoH, 2012) noted that some respondents, such as the National Children's Bureau and the Council for Disabled Children, believed that the original consultation document did not appropriately recognise the involvement of children and young people in decisions about their care and treatment.

The author is interested in increasing client engagement and improving mental health services for children and young people through their involvement. This includes improving effectiveness of interventions and patient experiences, as outlined by the DoH. The current research aims to explore young people's (11-18 years) thoughts and experiences of accessing Child and Adolescent Mental Health Services (CAMHS): Specifically, what young people say about the usefulness (or otherwise) and their experiences of clinical/case formulations when accessing therapy.

This is a qualitative research project, employing semi-structured interviews with young people, followed by a focus group with NHS CAMHS multi-disciplinary professionals. Both the interviews and the focus group will be transcribed and analysed using Thematic Analysis.

In this first chapter the author's personal and epistemological positions to the topic will be outlined and the terms and language used throughout will be defined. Furthermore, what formulation is, how it is used and where it sits in mental health services in the early 21st century will be considered. A systematic review of the literature regarding formulation, and clients experiences of it, will then be critically outlined and evaluated followed by highlighting gaps in knowledge/research and the rationale for the current research. In the subsequent chapter the methodology of this research will be outlined, the third chapter will report the results, and the final chapter will be the discussion.

Statement of Researcher's Epistemological Position

Throughout, the researcher was aware of their epistemological viewpoint: a tendency towards a contextualist/critical realist (Willig, 1999) approach. This is said to be between the poles of realism and constructionism and explores the ways individuals make meaning of their experiences as well as the social context. Indeed, the researcher acknowledges that there may be a reality, but that this reality will be influenced by social context, including 'Social Graces' (Burnham, Alvis Palma, & Whitehouse, 2008; Burnham, 2012), intergenerational beliefs (e.g. Dallos & Vetere, 2009), and wider social and political influences. For instance, this research was conducted in NHS CAMHS in a time of recent austerity, funding cuts and subsequent changes to such services (Williams & Hazell, 2011; Mattheys, 2015). Therefore, services are currently managing large waiting lists and aiming to increase cost-effectiveness and efficacy

of psychological therapies for young people. Further, this research was undertaken at the University of Hertfordshire; a training course which values and teaches a Social Constructionism and Constructivism approach (Gergen, 2009; Burr, 2015), which may also impact the approach to the research.

Introducing Key Terminology

There are many terms used to refer to people who access services such as CAMHS, including 'clients', 'patients', 'service users', 'survivors' and, in reference to people who have accessed services and now engage with them such as for service improvement, 'experts by experience'. Research has reported that people accessing services prefer the term 'patient' when meeting with a Psychiatrist or Nurse, but 'client' is equally preferable when talking to another professional such as therapists or Social Workers (Simmons, Hawley, Gale & Sivakumaran, 2010). Recent research suggests that the use of phrase 'patient' has been reported to identify a person solely as one with mental health difficulties due to its collective noun and is a term which people do not like but is imposed upon them, thus increasing stigma and power imbalances (Christmas & Sweeney, 2016). The author does not subscribe to any one term as there are advantages and disadvantages to them all and uses them interchangeably; adopting the preferred term of the individual or family in therapeutic settings. However, for the purposes of consistency and in relation to the above-named research, throughout this research young people will be referred to as 'clients.'

The term formulation can also vary, with labels such as 'case conceptualisation' often used in Cognitive Behavioural Therapy (CBT; Beck, 1997), 'dynamic formulation' in psychodynamic

therapy (Malan, 1995) or 'reformulation' used in Cognitive Analytic Therapy (CAT; Ryle, 1995). No type of formulation was consciously excluded throughout this research.

Child and Adolescent Mental Health Services

CAMHS in the UK provide NHS funded mental health services for children up to the age of 18 years. Generally, CAMHS community teams are split into Tier Two services, in which young people are offered support in primary care settings such as schools, and Tier Three services, in which multidisciplinary professionals offer secondary care services for young people with more severe, complex and persistent difficulties. There are also Tier Four services for young people referred into inpatient services or more intensive community services such as specialist eating disorders teams. The current research was conducted within Tier Three community CAMHS in the south of England.

The Choice and Partnership Approach (CAPA, 2017) is implemented in many CAMHS (and more recently other services) in the UK, Australia and New Zealand, Belgium and Canada. It is a service transformation model which aims to: Increase collaboration with clients; enhance effectiveness of services; reduce wait lists; set clear goals with clients; use of outcome measures; and increase transparency about commissioning, care options and capacity. The CAPA approach is used in the CAMHS teams with which this research was conducted.

What is Psychological Formulation?

Formulation is a key competency for Clinical Psychologists (Division of Clinical Psychology, 2010; DCP), and the Health and Care Professions Council outline it as a skill that each school

of psychologists should have (Health and Professions Council, 2009). It may be defined as, "…a hypothesis about the causes, precipitants and maintaining influences of a person's psychological, interpersonal and behavioural problems" (Eells, 2011). Furthermore, formulation has a range of purposes including to facilitate a shared understanding of a client's difficulties; prioritise issues and problems; plan specific interventions; and trouble-shoot lack of progress (Johnstone & Dallos, 2013). Further they can provide an overview and explanation for a client's difficulties, which is hypothetical and collaborative (Tarrier & Calam, 2002). Finally, formulation may help the client feel understood, help the clinician feel contained and strengthen the therapeutic alliance (DCP, 2011).

Formulation has arguably been used in different forms over many decades, including Freud's case studies encompassing details of the client's unconscious processes, transferences and defence mechanisms (Bateman & Holmes, 1995). Today, there are many different styles of formulation including systemic formulations which may include exploring problem-maintaining patterns in the family and wider cultural and contextual factors (Carr, 2006). Furthermore, cognitive-behavioural approaches often use 'case formulation' which tend to look at a client's presenting issues and precipitating, perpetuating, predisposing and protective factors, and the link between thoughts, feelings and behaviours.

Formulation may also act as an alternative to clinical diagnoses (Dudley & Kuyken, cited in Johnstone & Dallos, 2013). Likewise, formulation can also be disorder specific. Disorder specific formulations include Clark's (1986) cognitive formulation model for panic, which uses a diagram to explore what triggers an individual's panic, and their perception or appraisal of threat, followed by a circular explanation of the anxiety, physical and cognitive symptoms, catastrophic misinterpretation, and avoidance or safety seeking behaviours. Similarly, Ehlers

and Clark (2000) developed a formulation model for post-traumatic stress disorder (PTSD) in which relationships are explored between the characteristics of the trauma and the individuals pre-existing beliefs and experiences, cognitive processing during the trauma, the trauma memory, negative appraisals of the trauma, current threat and arousal, and control or coping strategies used. Other disorder-specific formulation models include Beck's (1967) depression model, Wells' (1999) model of generalised anxiety disorder, Salkovskis' (1999) model of obsessional compulsive disorder (OCD), and Clark and Wells' (1995) cognitive model of social phobia. umma, Marshall, & Mauer, 2018). Further, people may be referred to mental health services without a specific mental health condition, such as for support with difficult everyday experiences or early distress which has the potential to worsen. This may particularly be the case in early intervention or first episode of mental health services (Dudley, Kuyken, & Padesky, 2011).

As such, formulation can often be person-specific, integrative or transdiagnostic. In the transdiagnostic approach, the specific content or concern is thought to differ between disorders or individuals, though the underlying processes are thought to be similar. In turn, common factors or presenting difficulties are formulated, alongside the individuals' maintaining factors and strengths for example; rather than using disorder specific models (Dudley, Kuyken, & Padesky, 2011). Similarly, integrative formulations combine various concepts or techniques from different therapeutic models, to meet the unique needs of the client. This approach can also be more tailored to an individuals' personality factors and socio-cultural context. However, when using this approach, care needs to be taken to ensure that techniques are selected in a systematic way with a clear rationale, to avoid inconsistent or contradictory practice (Lampropoulos, 2001). Person-specific models can overcome the difficulties of

formulating co-morbid difficulties and may also help socialise clients to the therapy (Grant & Townend, 2008).

Guidelines and Policies Regarding Formulation

The British Psychological Society (BPS) Division of Clinical Psychology published good practice guidelines on the use of psychological formulation (BPS, 2011). These guidelines outline that formulation is a core competency for Clinical Psychologists. Further, formulation is included in UK psychiatry training (Royal College of Psychiatrists, 2010), though is likely to have differences compared to psychology training.

The BPS guidelines outline that formulation should include an integration of interpersonal, biological, social and cultural factors. It should not just be a list of factors though, and should integrate possible causes of the presenting difficulty, cultural understanding of the difficulty, and critical awareness of the wider societal context. Further, it should be "constructed rather than discovered" in a collaborative manner (Harper & Spellman, 2006), using accessible language. Each one should be unique to the individual and concerned with the 'personal meaning' to the clients and should be assessed on their usefulness rather than as a 'truth' (Butler, 1998; Johnstone, 2006). That said, it should also draw on relevant psychological theory and evidence-based practice as well as publications such as NICE guidelines and Cochrane reviews. Overall, a formulation should include reflective practice, and should be offered as a tentative explanation (Christofides et al., 2011) which is not imposed on a client or team. Further, it should be carefully constructed to acknowledge real difficulties whilst avoiding diminishing hope or agency.

There may be some discrepancies regarding what is considered a formulation. For instance, some may consider 'formulation-as-a-process', utilised throughout assessment, therapy and feedback in a recursive manner. Others might consider 'formulation-as-an-event', such as a written summary and formulation in case notes, or a letter to client or GP (Ingram, 2006). Further, formulations can differ in their amount of detail. Some may contain a detailed summary of large amounts of a person's history, and people may re-formulate as more information is discussed. In contrast some may consist of simple diagrammatic formulations. There are various templates available to aid summarising a formulation, such as biological, social, interpersonal factors (Weerasekera, 1996), or 'the five P's' (presenting difficulties, predisposing, precipitating, perpetuating and protective factors). It is reported that the five P's format is used in psychiatric training (Royal College of Psychiatrists, 2010). Additional information that may be useful in formulations yet more rarely integrated can include factors such as transference and countertransference; client experiences of diagnosis or medication; stigma; social factors such as class and power relations; and ethnic and cultural factors (Johnstone & Dallos, 2006).

It is important to note that whilst aiming to reduce power imbalances between therapist/services and clients, people may struggle to disagree with their formulation (Johnstone & Dallos, 2006), just as they might struggle to disagree with a diagnosis. This may be particularly prominent in more 'vulnerable' groups such as young people, or people with learning disabilities. Further, as will be seen in the following systematic review of formulation literature, clients can experience formulations as saddening, upsetting, overwhelming or worrying (Chadwick, Williams & Mackenzie, 2003; Pain, Chadwick & Abba, 2008), at least in the short term. To help reduce such difficulties the good practice guidelines suggest that consent and involvement of caregivers of more vulnerable people could be considered. Further, use of supervision and

reflection can help ensure that formulations are psychologically informed accounts of the client's circumstances. Formulations should also use everyday language, emphasise client's strengths, and include awareness of organisational and societal factors to reduce 'blame' of the client for their presenting difficulties. Formulation should also be able to outline a client's difficulties, needs and presentation, highlighting the severity of the difficulties, so that appropriate individualised intervention goals can be established (Winston, Rosenthal, & Pinsker, 2011).

Formulation in Current Context

Diagnosis or Formulation?

Formulation is a contentious issue in current UK Psychology training courses and NHS services. It has been suggested as an alternative to psychiatric diagnosis, as concerns have been raised about the validity, utility and power imbalance of diagnostic labels. For example, Macneil, Hasty, Conus and Berk (2012) suggest that diagnoses tell us little about the causation of a mental health difficulty, may not readily inform which intervention to try, and does not tell us about the person's experience of their difficulty. Further, diagnoses in the DSM-V (American Psychiatric Association, 2013) and the International Classification of Diseases (ICD-11; World Health Organisation, 2018) rely on confirming the presence or absence of a certain number and type of symptoms often over a suggested duration. Whilst this may help to differentiate between possible diagnoses in some cases, it is possible for two people to be given the same diagnosis with few or even no symptoms in common (Tarrier & Calam, 2002). Similarly, concerns have been raised about the lack of biomarkers of conditions, which might

otherwise validate diagnostic categories (Boyle & Johnstone, 2014), and diagnostic categories are often poor predictors of outcomes (Bentall, 2004).

A diagnosis might also suggest to clients that they have some individual 'deficit'. When difficulties are seen as individual, the solutions offered are also often individual, such as medication or individual therapy, over social or political interventions (Harper, 2002). It has been suggested that psychiatric diagnoses can cause loss of meaning and loss of stories of trauma, abuse, discrimination or deprivation for example (Johnstone, 2018).

There may also be negative effects of a diagnosis such as developing a learned hopelessness mindset, or spiritual experiences can be described as a 'delusion' (May, 2007). Indeed, symptoms such as hearing voices are often discussed as a negative experience by clinicians, but people often report that their voices can be positive or even supportive (Miller, O'Connor & Di Pasquale, 1993). For example, Horn, Johnstone and Brooke (2007) explored clients experiences of a diagnosis of Borderline Personality Disorder, using semi-structured interviews analysed using Interpretative Phenomenological Analysis (IPA). Five superordinate themes were outlined: Knowledge as power (held by the practitioner who has more knowledge and control); uncertainty about what the diagnosis meant; diagnosis as rejection (feeling like a 'burden' or 'freak' and feeling withdrawal by services); diagnosis is about not fitting (into other categories such as depression); and hope and the possibility of change (e.g. feeling that the illness can be 'controlled' and you can get 'better', or being able to challenge your diagnosis).

Further, it should be acknowledged that people's experiences can be understood as normal and adaptive responses to difficult or traumatic experiences or social circumstances. For example, evolutionary adaptations such as vigilance, fear and avoidance adapted to protect against threat,

shame in response to humiliation; and withdrawal or low mood in response to loss (Sitko, Bentall, Shevlin, O'Sullivan, Sellwood, 2014).

A report by the BPS (2010) recommended that services should not insist that all clients see their difficulties as an 'illness' and take medication. Further, some people who have previously accessed services, such as those who work within the Hearing Voices Network, have commented that they start to recover after moving away from their diagnosis (Hearing Voices Network, 2003). It has been suggested that formulation can offer an alternative to diagnosis which can overcome some of these limitations. For example, when done sensitively formulation can provide a shared understanding of a person's difficulties and answer questions such as why this person, why these difficulties and why now? (Macneil et al., 2012).

However, if not done sensitively, formulation could also be individualizing, exclude social contexts, or impose ideas which the client disagrees with (Johnstone, 2013a). Further, it is important to take a critical and balanced view. Indeed, diagnoses can serve important functions. For example, they can aid communication in multidisciplinary team meetings. A diagnosis can also facilitate access to services in some instances. In Australia, diagnoses are reported to facilitate funded treatment, and in the UK, diagnoses could be used to prioritise people for treatment (Carey & Pilgrim, 2010). Further, some diagnoses can assist access to additional help, such as extra support in schools for individual young people with neurodevelopmental difficulties. That said, it is arguable that access to services should be based on individual need, thus provided based on one's presenting difficulties or indeed a summarised formulation. Diagnoses might also be useful in research, since they may be used as inclusion or exclusion criteria for participants (Carey & Pilgrim, 2010).

It is also possible and sometimes useful to use both diagnosis and formulation together. For example, a diagnostic interview often enables clients to provide a lot of information about their history and their current difficulties, which can inform a formulation as well. Additionally, a formulation can help clients, families and services to understand how the diagnosed difficulty developed and is being maintained. Further, a diagnosis can be used to develop and test formulation hypotheses, or a formulation can help to understand a person or family's perspective and reaction to the diagnosis. Finally, the formulation and diagnosis together might also help decide intervention plans. For example, the diagnosis can help decide which part of the formulation to focus on and 'anchor' the work (Persons & Tompkins, 1997).

The Power-Threat Meaning Framework

In 2018 the BPS published 'The Power Threat Meaning Framework' (Johnstone & Boyle, 2018) which aims to identify patterns in emotional distress and behaviours as an alternative to psychiatric diagnosis. The framework incorporates theories from a range of theoretical orientations and includes explanations for the emergence, maintenance and expression of distress from a variety of sources including cultural, relational, biological, social and other important factors. Further, it highlights the need to think about the personal meaning of experiences, personal agency, and how difficulties or 'symptoms' may be functional and adaptive survival mechanisms to past and present adversities. Distress is also put into context such as what counts as 'mental health' politically and socially. Likewise, the framework suggests alternative language to diagnostic categories and discusses implications for how wider communities and social and political bodies should respond to human distress. The framework encourages people to consider 'Power', such as economic, social, cultural imbalances including possible re-traumatisation by mental health services; 'Threat' including negative uses of this power on individuals or groups; and 'Meaning' developed through social and cultural

discourses which shapes the experiences and expressions of this power and threat. In turn, it encourages the reframing of questions such as, “What is wrong with you?” to “What has happened to you?” “How did it affect you?” “What sense did you make of it?” and “What did you have to do to survive?” Further, it is important to ask people, “What are your strengths?” Overall, this framework claims to ask, “What is your story?”

The authors acknowledged that psychiatric diagnoses can give some recipients relief, and validation of their suffering (Johnstone, 2014). Further, diagnoses currently give people access to some services and benefits, and this right should be protected. However, they argue that people also have the right to describe experiences in a way that makes most sense to them, and so the framework hopes to help services to let go of diagnostic labels whilst maintaining access and support, by offering an evidence-based alternative.

The framework suggests a pattern which is universal: Economic/social inequalities lead to negative use of power, which increases insecurity, fear, violence or discrimination for example. Added to this, disrupted attachment relationships can lead to increased risk of adversities, such as multiple kinds of danger, inescapability, lack of predictability and control over threats, or sense of betrayal. These adversities are mediated by biology and threat-systems. Together, this leads to adversities being cumulative, synergistic, transmitted down generations, and possible re-traumatisation by services.

The development of the framework included consultation with eight clients, survivors and carers. They highlighted some potential limitations of the framework such as: Complex language and concepts; further possible threat responses; risk of imposing another professional model; and the need for large cultural change for it to have an impact. In turn, they suggested

using visual materials and concrete examples of power to make it more accessible; creating a simpler document for services and including a clearer opening statement about the purpose of the framework; and emphasising the framework as a guide to be used flexibly, sensitively and collaboratively.

The Power-Threat Meaning Framework (Johnstone & Boyle, 2018) was important to hold in mind during this research for several reasons. Each of the factors outlined in the Framework, such as cultural, relational, biological, and social factors should arguably be used in the most detailed and holistic formulations. Further, the Framework may have social and political implications, such as the potential to change the way clinicians use formulation and/or diagnosis, and the potential to change what clients expect from services. Finally, the Power-Threat Meaning Framework (Johnstone & Boyle, 2018) was in its infancy during this research and so it may not yet be highlighted in the following semi-structured interviews by clients. However, it is arguable that findings related to client's experiences or views of formulation may be transferable to the Framework.

Summary

The following research was conducted at a time when there was much debate between the use of psychiatric diagnosis or formulation in services. Amongst this debate between professionals we risk losing sight of the client's views regarding what they prefer and find most useful. How then do we ensure, "No decision about me without me"? This research aimed to extend client involvement in mental health care by exploring young people's experiences and opinions of formulation through semi-structured interviews. Following this, their views were taken to a

selection of professionals working with this client group to explore potential impact of client's views on clinical practice.

In the next section, a systematic review of literature regarding clients and professionals' experiences of formulation is presented.

Systematic Literature Review

Literature Search Strategy

There are a number of articles regarding formulation. However, few explore client's thoughts and experiences of it. Therefore, the following literature review focused on finding articles which focus on client's experiences or opinions specifically. Initial searches revealed that such articles are extremely limited. In turn, and due to the second half of this research including a staff focus group, articles regarding professionals and teams' experiences of formulation were included.

Six databases were searched: Scopus, Pubmed, APA PsychNet, CINAHL (Ebsco), ProQuest and Google Scholar. The inclusion and exclusion criteria for the literature search are displayed in Table 1. Throughout the searches, many articles were found regarding the validity, utility and reliability of formulation. Whilst important they were not directly relevant to *experiences* of formulation, so these were therefore discarded.

Inclusion and Exclusion Criteria

Table 1: Inclusion and Exclusion Criteria for the Systematic Literature Review

Inclusion Criteria	Exclusion Criteria
Relating to Psychology, Family Therapy, Psychiatry, Mental Health Nursing or mental health. Inpatient or community care. Relating to diagnosis AND formulation, or formulation only Any type of formulation, e.g. Case, CBT, Systemic, team formulation. Aim to gather information particularly regarding the experience of formulation from client's perspective. Can include articles regarding relatives or professionals' experiences Can include advantages and disadvantages of formulation. Regarding child or adult mental health (as initial review found few to no articles regarding young people's experiences of formulation). May include articles regarding effectiveness/efficacy/validity of formulation. Any type of mental health difficulty. Can include physical or chronic pain/illnesses if in mental health context. Both qualitative and quantitative research.	Not mental health related. Not available in English language. Provides general overview or definitions of formulation only. Provides only specific case examples using formulation, e.g. formulation of eating disorders. Uses the terms formulation or client* or experience* in a different context, e.g. experience of pharmacist prescribing *(or related synonyms) Training materials or textbooks for teaching formulation only. Regarding diagnosis only. Regarding medication/drugs only. Physical health only (without 'formulation') Articles regarding people's experiences of ONLY therapy, mental health services in general, service waiting lists, transitions between services, their mental health difficulties etc. Not peer reviewed.

Search Terms

Two search terms were used on each database. Firstly, a Boolean search method was used with the terms ‘psychological formulation’, AND ‘experience OR evaluation OR perspective OR perception’ AND ‘mental health’. The term mental health was added due to the nature of the word ‘formulation’ which is used in multiple contexts, to reduce the number of irrelevant search results. The second search terms used on each database were ‘case formulation’ AND ‘experience OR evaluation OR perspective OR perception’. The following flow chart demonstrates the number of articles screened and selected at each stage of the search.

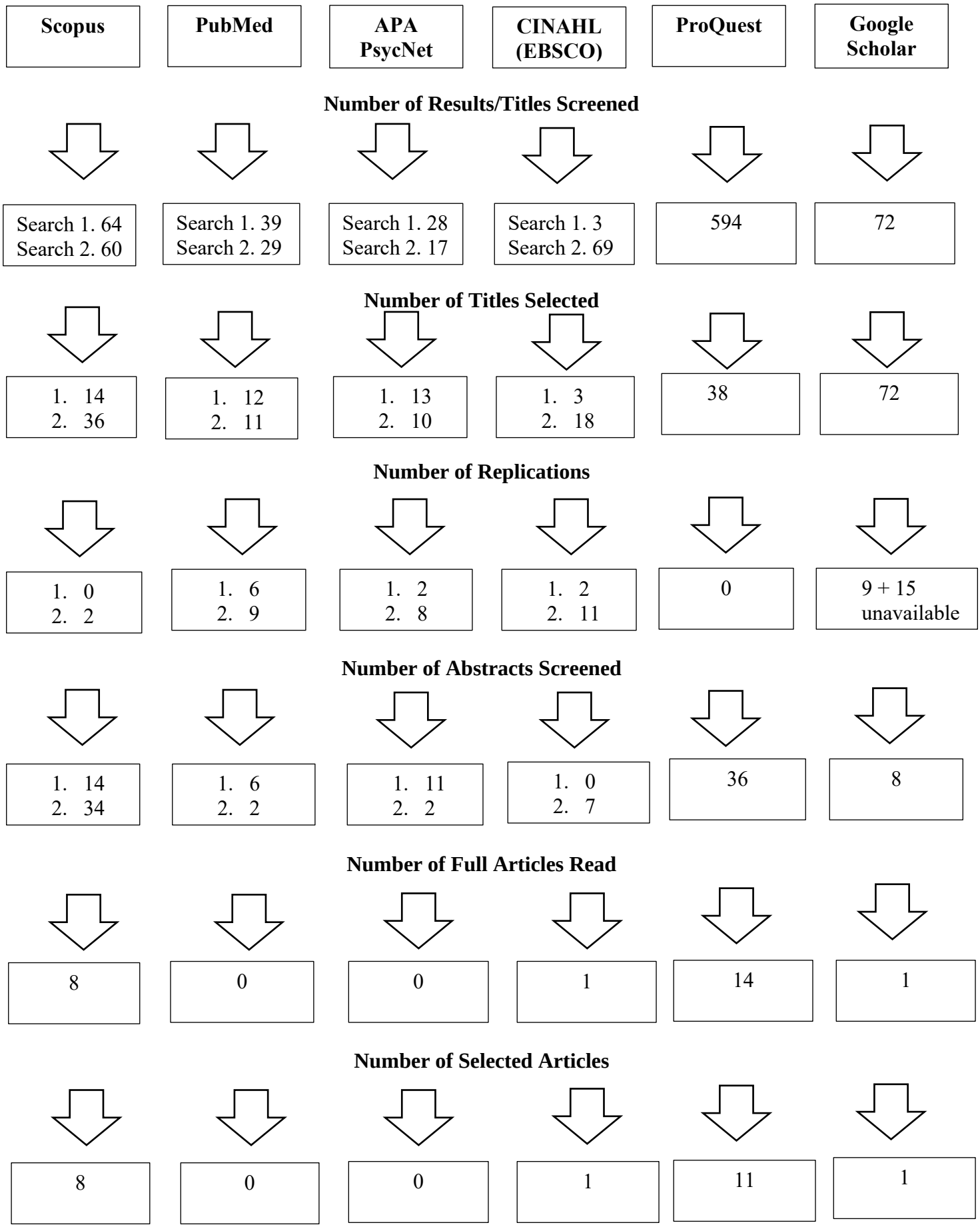


Figure 1. Flow Chart Demonstrating the Number of Articles Selected in Each Stage of the Systematic Literature Review.

A number of additional articles (n = 3) were also obtained from the reference lists of the above articles or were highlighted in the 'similar articles' section of the databases. Therefore, 24 articles were included in the final literature review (Table 2, Appendix 1).

Summary of Findings from the Systematic Review

Twenty-four studies were included in the literature review: 16 used qualitative designs, six used quantitative, and two used mixed methods.

Twenty of the studies were conducted in the United Kingdom, one in Canada, one in Australia and two in the United States of America. International research was considered appropriate due to the use of guidelines such as by the American Psychological Association (APA) by clinicians and services across many countries. Further, there are many similarities regarding the training of clinicians such as Clinical Psychologists across different countries. Thus, there are likely to be important similarities regarding how formulation is conducted internationally.

Many of the following studies are included in peer-reviewed journals. Of note, nine of the studies were dissertations conducted for partial fulfilment of the Doctorate in Clinical Psychology or the Doctorate of Philosophy. In turn, whilst not included in peer reviewed journals, these nine articles were robustly reviewed by independent examiners and viva voce processes, thus demonstrating a mark of quality. Doctoral theses were included due to the research in this area being relatively limited and in its infancy.

Overall, the quality of the following studies was high, with many utilising strategies such as independent coders and reflecting on their epistemological standpoint which both increase the

reliability of research. Further, though some had small sample sizes, the nature of the topic meant that many of the studies were qualitative where the sample size was appropriate. Even so, some of the studies used large sample sizes. Importantly, the research provides a somewhat balanced summary of clients and professionals opinions and experiences of formulation, as some describe both the advantages and disadvantages or negative aspects of formulation.

The systematic literature review includes details of the sample, study design and key findings. A critical review of the synthesised literature was also conducted thereafter.

Clients Experiences of Formulation

Six studies were conducted with people who have accessed mental health support. All involved adult participants and explored their experiences of formulation. Four of the studies used qualitative methods and data analysis, whilst one used quantitative and one used mixed method.

Redhead, Johnstone and Nightingale (2015) conducted semi-structured interviews with ten adult clients (aged 24 – 67 years, male to female ratio 2:8) approaching the end of CBT for anxiety or depression in an IAPT service. Four key themes were outlined: Formulation helped clients understand their problems, feel understood and accepted, leads to an emotional shift, and enables them to move forward. Themes were compared to those of an independent researcher, thus reducing researcher bias. Further, the authors attempted to put some of the findings in context – for example, two participants were distressed by their formulations because they were inaccurate. However, in these two cases, the clinicians had formulated independently and then shared the written formulations with the clients later. In turn, it was proposed that therapists should write formulations collaboratively with clients' present.

Similarly, Kahlon, Neal and Patterson (2014) utilised semi-structured interviews and reported that seven adults (aged 19 – 54 years) who engaged in therapy for depression described the development of the formulation as 'coming to my own conclusions to something the therapist developed'. Further, they moved from negative towards mixed feelings in reactions to the formulation during the therapeutic process, and it helped them work towards making a new sense of their selves. Importantly, the researchers were transparent about their relationship to the topic throughout and provided a summary of the data to enable readers to differentiate between the participants voice and the researchers' interpretations. Of note however, participants sometimes talked about their experiences of therapy in general, so it is difficult to tease apart the impact of therapy or formulation on the participants' experiences. In another similar study, Burchardt (2004) conducted semi-structured interviews analysed using IPA with eight adults (seven females, aged 28 – 63 years) engaged in psychotherapy in an NHS adult mental health service. Five 'master' themes were developed. Participants described formulation as giving them somebody that listened and understood, therefore increasing trust in the therapist. Further, it helped clients understand what happens, and gave them and their therapist a foundation and direction from which to work on and a plan, and increased effectiveness and self-efficacy. Participants of this study were self-selecting, so the findings may be biased towards people who have had positive experiences of formulation and their therapists. However, the use of IPA enables reflections on such processes, as well as the researcher's preconceptions and influences on the research.

Stewart (2016) utilised semi-structured interviews with three males engaged with Clinical Psychologists in a community mental health service, analysed using grounded theory. A core category was developed called, "Formulation-sharing develops a sense of self-in-the-world" and contains three stages of formulation sharing: Formulation needs to occur in an emotionally and physically safe environment; it helps clients recognise a potential for change, and a more

expansive view of the world; and it gives an opportunity to rehearse these new understandings of themselves and the world, leading to feeling more engaged in the world. The authors included in their conclusions a discussion about the importance of clinicians attending to social, political and wider systemic factors during formulation. The small sample size and use of only Clinical Psychologists from a multi-disciplinary team may limit the generalisability of findings, thus the above theory may benefit from further evidence-based practice or practice-based evidence.

Similarly, Hess (2000) explored the effects of formulation for seven clients (aged 18 – 33 years) engaged in counselling for depression in a service in Texas, America. They used quantitative measures, such as the Beck Depression Inventory, the Stages of Change Scale, and the Working Alliance Inventory, pre and post counselling. Findings included that the use of the 'core issue' in a formulation did not impact therapeutic alliance, symptoms, readiness for change or perceived impact of the session significantly. However, participants' engagement with and acceptance of the formulation was positively associated with measures of therapeutic alliance, session depth and arousal and symptom reduction. The measures used in this study are highly validated. Further, the findings suggest an alternative view to the positive aspects and advantages of formulation. This is despite the researcher being one of the therapists providing the counselling.

Finally, Thew and Krohnert (2015) used mixed methods with one case study (a 32-year-old female with low mood, suicidal ideation and a recent inpatient admission). Pre and post formulation, she completed measures such as the Rosenberg Self-Esteem Scale (Rosenberg, 1986) and the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM), and

then she was interviewed to explore whether her formulation offered the benefits that the BPS DCP (2011) guidelines suggest. Scores on all measures were below clinical cut-off level prior to the formulation. The participant described formulation as a helpful experience overall, allowing her to make sense of the difficulties. However, there remained unanswered questions, particularly around the onset of the difficulties. Further, she described formulation as difficult at times as she did not want to blame others, but it had been helpful to recognise and contain patterns, cycles, and consequences. She was not sure that formulation had normalised her difficulties but did give her a sense of hope for the future. Further, there were no changes in the measures of depression, anxiety and stress or self-esteem post formulation, though there were some small improvements on the CORE-OM. It may have been more beneficial to conduct this study with someone who met clinical thresholds, to enable exploration of the impact of formulation on clinical presentation.

Professionals' Experiences of Formulation

Six studies were conducted with multi-disciplinary professionals working in mental health services. One was quantitative, and the remainder were qualitative. The majority involved multi-disciplinary participants, whilst one utilised just Psychologists, and one interviewed just Psychiatrists.

Firstly, Berry, Barrowclough and Wearden (2009) asked 30 multi-disciplinary professionals to complete quantitative measures pre and post the development of formulations with seven male clients with diagnoses of 'Schizophrenia'. After conducting a formulation, professionals reported more helpful attitudes towards working with clients; rated clients as putting more effort into getting well; and regarded clients as being less likely to have caused their problems

and were less likely to blame them. Further, ratings for the likely duration of problems decreased; ratings for treatment efficacy increased; staff reported a better understanding of clients' problems; rated their feelings towards clients as being less negative; reported greater confidence in working with clients; and viewed both staff and clients as having greater control over problems. Similarly, Summers (2006) conducted semi-structured interviews with 25 multi-disciplinary professionals working in a ward in a high-dependency rehabilitation service. Findings included that inpatient multi-disciplinary team members reported that formulation helps relationships, such as increasing empathy and patience, and improves team working. Further, formulation brings together different perspectives, staff knowledge and understanding of clients, and provides a space to think creatively. However, there were four mentions that formulation can limit care plans, some can be incomplete or excessively speculative, and too much information about a new client can lead to inaccurate perspectives.

Moreover, Huisman and Kangas (2018) surveyed 79 Psychologists in Australia about what they thought was most important in formulation. This included seeking contextual information to plan treatment, checking the formulation, and describing and hypothesising about the client's presenting problems. Psychologists rated external factors as significantly less important and less frequently implemented in formulations, compared to the other aforementioned factors. Interestingly, 'General Psychologists' reported less frequent implementation or evaluation of their hypotheses about causal and maintaining factors in the therapeutic work following formulation. Further, they reported that they less frequently consulted psychological theory or evidence relevant to the client's presenting problems when developing formulations, compared to Clinical Psychologists. The psychometric properties of the items in the survey developed for this study had adequate significance (alpha > 0.7) but requires further validation. That said, this

study highlighted the use of formulation to improve professionals' perceptions of clients, and the authors highlighted how these findings link to previous research.

Adams (2015) also explored the views of 12 non-psychology multi-disciplinary professionals (Social Workers and Nurses) in CAMHS. Firstly, staff did not fully understand what formulation involved, whether they were integral to their assessments and reported a lack of confidence using it. Further, they described needing to address immediate medical issues first, lack of training, and some resistance to engaging with it. However, they were utilising it, particularly in supervision, and working collaboratively with clients. Some reported that the benefits of using formulation included providing tangible reasons for presenting difficulties and building a rapport with clients. They saw Psychologists as more senior and able to supervise on formulation. Participants noted a 'rivalry' between Psychologists and Psychiatrists and expressed concern about future 'imbalance' of multi-disciplinary working through increased recruitment of Psychologists and use of formulation. This study was conducted for partial fulfilment of the author's Doctorate in Clinical Psychology and is not yet peer reviewed. However, it would have been reviewed by robust examination processes. Similarly, Mohtashemi, Stevens, Jackson and Weatherhead (2016), explored the understanding and use of formulation by 12 Psychiatrists working in an adult mental health service. The findings were analysed using constructivist Grounded Theory. It was reported that the use of formulation and seeking Psychologists to help formulate was low when Psychiatrists start off in the profession but increased with clinical experience and training. Use of formulation or Psychological input also increased when risk or complexity increased. Barriers to formulating included limited time in Psychiatric appointments, perceived pressure to conform to a medical model, and a perception that Psychologists could be a 'threat' or 'anti-psychiatry'. It was identified that there needs to be a good working alliance between Psychiatrists and

Psychologists to enable formulating together, and this was sought-after. Finally, lack of reflection or formulation was reported to lead Psychiatrists to try 'alternative approaches' which included trying to treat complexity with multiple medications. This lack of holistic understanding led to some clients repeatedly returning. The authors of this study reflected on their impact on the research and the potential biased sample of people who were particularly interested in the topic. However, they reported that their Grounded Theory model had good 'internal consistency', which may increase its generalisability.

Finally, Glader (2009) conducted content analysis of archival data regarding case studies of psychodynamic clinicians working with children. The analysis explored how clinicians develop formulations, which included receiving information from other people in a child's environment, such as parents or schools, and developing hypotheses that they acted on, whether they shared them with the child or not. Glader (2009) reported that children said that they want summaries in different forms, including play and questions. Therefore, to find out what children want formulations should start "where the client is." The reliability of this study was strengthened by using an independent coder who also analysed the texts, with a minimum agreement rate of 80%.

Clients and Professionals

Authors of a further five studies, similar to the above, met with both clients and professionals concurrently. Two were qualitative, two were quantitative, and one used mixed methods.

Firstly, Pain, Chadwick and Abba (2008) explored 13 clients' (five females, eight males, aged 21 – 64 years) experiences of developing a formulation within CBT for psychosis and coded their responses. 40.5% of coding units contained negative emotions and 22.5% contained positive emotions regarding client's reactions to formulation. Regarding therapeutic value, 34% of coding units outlined anticipated clinical improvement, 29% described general helpfulness, and 18% suggested no benefit. Furthermore, 20% of coding units suggested that formulation made the therapeutic relationship worse, but 90% described positive reaction to the therapist or the relationship. The authors discussed that negative responses may be because negative schemata is reactivated; negative reactions are healthy and understandable reactions to the content of formulations; or clients may be drawing unintended conclusions such as the difficulties are too embedded to change. Secondly two therapists, who provided therapy to the participants, ranked the top three benefits of formulation as: Increased understanding of client, clearer sense of direction, and enhanced therapeutic relationship. This study had good reliability due to two researchers conducting the coding (inter-rater reliability Cohen's k = 0.79), and a further 'blind' coder (Cohen's k = 0.89).

Moreover, Herhaus (2014) conducted a grounded theory study exploring staff and client experiences of formulation and care. Participants were five Clinical Psychologists, four non-Psychologist professionals, and six clients in an early intervention for psychosis service. Formulation was reported to create a 'shared understanding', including establishing and maintaining working relationships, and sharing understanding and perspectives. Further, formulation was considered to aid therapists' emotional responses to clients; and increase flexibility, consistency and empathy in responses to clients. Secondly, 'processes' were discussed, including formulation being involved in negotiating professional roles, tolerating uncertainty, and creating a safe space to share thoughts.

Similarly, using quantitative measures such as the much-validated Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983) and The Helping Alliance Questionnaire (Alexander & Luborsky, 1986), Chadwick, Williams and Mackenzie (2003) explored the impact of formulation for 13 (seven males, six females, mean age 31.5 years) clients engaged in CBT for psychosis. The authors concluded that formulation did not have a significant impact on alliance for clients. However, there was a significant increase in alliance ratings from the perspective of therapists. Further, formulation did not have a significant impact on strength of delusions, or negative self-evaluations. In semi-structured interviews with 11 of the above clients, it was reported that formulation enhanced their understanding of their problems, and reported positive emotions—feeling reassured, encouraged, and more optimistic. However, some clients reported a negative emotional response, such as finding the formulation saddening, upsetting and worrying. Therapists reported that formulation helped them feel more hopeful about therapy; increased a sense of alliance and collaboration; and maintained adherence to the CBT model. More information about how the semi-structured interviews were conducted and analysed would have been helpful to increase the transparency and the replicability of the research. That said, this study was one of the first of its kind in this area, and so arguably may have stimulated further research regarding client's experiences of formulation.

Finally, Shaw, Higgins and Quartey (2017) conducted research within The UK Offender Personality Disorder (OPD) service, which is a joint initiative between the National Offender Management Service and the National Health Service (NHS) and uses a formulation-based approach to increase understanding of an offender's difficulties to determine the treatment pathway and the required response from staff. They recruited 77 Offending Managers (probation officers working in the National Probation Service) who completed the Dual Role

Relationships Inventory – Revised (Skeem et al., 2007) and the Perceived Benefits Rating Scale. The findings outlined that those in a formulation group reported significantly higher overall relationship quality, a stronger working alliance and greater confidence, compared with a non-formulation control group. Further, 39 offenders/clients in the formulation group similarly reported significantly higher degrees of trust in their Offending Managers. Whilst this study would have benefitted from a larger sample (a power analysis revealed 84 participants were needed for a medium effect size and 80% power) and more validated measures, it did suggest that formulation increases trust in professionals working with high risk offenders. Similarly, Berry, Haddock, Kellett, Roberts, Drake and Barrowclough (2015) compared the impact of formulation-informed interventions to Treatment as Usual (TAU), using pre and post measures such as the Working Alliance Inventory (Tracey & Kokotovic, 1989), with 36 patients and 74 professionals across 10 adult inpatient wards. Findings suggested that the formulation-based interventions can be more effective than TAU regarding improving patients' perceptions of therapeutic relationships, as well as ward atmosphere and some aspects of burnout for professionals. However, the formulation-based intervention group did not significantly improve professionals' perceptions of relationships, staff stress or patient outcomes such as length of stay, change in treatment or relapse. A strength of this study is that it was a single blind cluster randomised design. However, there was a relatively large amount of drop-out (15 patients and 11 professionals).

Team Formulation

The remaining seven studies explored team use, experiences and perceived impact of formulation. Five used qualitative methodology including semi-structured interviews and analysis of speech, and two used quantitative methodology (questionnaire designs).

Firstly, Christofides, Johnstone and Musa (2012) conducted semi-structured interviews with 10 Clinical Psychologists in one NHS adult mental health service covering both community and inpatient services. They reported that team formulation provides a space and framework to help make sense of client's difficulties together and Psychologists 'chip in' with psychological ideas as an ongoing process. Further, formulation helps other professionals such as nurses to practice more effectively or psychologically; gives professionals space to reflect on their work; is beneficial when discussing clients who are described as challenging; helps understand emotional reactions to clients; and helps staff work consistently. Of the 78 Psychologists invited only 10 participated. This could mean that those particularly keen on formulation volunteered, though may also represent the busy workloads of clinicians in the NHS. Similarly, Blee (2015) conducted semi-structured interviews with three Clinical Psychologists and focus groups with 12 multi-disciplinary professionals in an adult community mental health service. It was reported that formulation can help to manage overwhelming ideas. However, they were reported to be added to care plans which can have a short 'life expectancy' and may not be revisited. Psychologists reported not knowing if care plans are utilised but 'hoped' that they were, otherwise, formulation is a 'waste of time'. Secondly, formulation can help one to stop and think about clinical practice, but this can be difficult to implement in teams where 'work' is seen as action focused. Further, staff outlined that there needs to be a safe environment in which to formulate to reduce anxiety regarding sense of competence. Formulation was said to help shared decision making, with professionals feeling less 'stuck' in clinical work, though this was described as a 'luxury'. This study was conducted for partial fulfilment of the Doctorate in Clinical Psychology, with a limited sample size. However, the author was transparent about their contextualist, critical realist standpoint, and considered clear clinical implications of the findings such as the need for teams to encourage colleagues to participate in formulation and to value multiple perspectives.

Three of the studies focused on formulation/team meetings. Weedon (2017) conducted semi-structured interviews, analysed using Thematic Analysis, with 11 multi-disciplinary professionals from two early intervention for psychosis services. Findings outlined three key themes in which participants described that team formulation offers a different perspective. For example, the structure of formulation meetings is more flexible than other meetings. Further, diagnosis was discussed as being helpful at times, though formulation was considered to offer something more comprehensive, less stigmatising and useful. They described that this 'different type' of meeting is valuable. For instance, team formulation helps people think about cases differently; find appropriate interventions, but may not be as action focused as staff would like; staff felt more confident sharing their ideas in these meetings compared to others; it offered a place to discuss and contain their own anxieties; and help staff feel less alone such as in managing risk, and they help staff learn from their peers. Again, there may be a bias in the sample as participants were self-selecting. That said, the interviews did enable participants to talk openly about the benefits of diagnosis as an alternative to formulation. Similarly, Manuel (2016) conducted semi-structured interviews analysed using constructivist grounded theory with 10 non-Psychologist multi-disciplinary professionals, who had attended an average of 9.4 team formulation meetings over the prior 12 months. Findings outlined that professionals say that team meetings needed to have "the right chefs" to facilitate the meeting, such as creating a safe space and helping attendees to feel valued and able to contribute their ideas. Resulting meetings were said to be a "unique environment", where unlike in other team meetings the output is not fixed, there was shared ownership and there is acceptance of ambiguity. This led to positive changes for the staff such as feeling validated, understanding the client, feeling less stuck and enjoying the meetings.

Moreover, Whitton, Small, Lyon, Barker and Akiboh (2016) conducted a service evaluation using a questionnaire with 89 multi-disciplinary professionals in a secure forensic learning disability and Autism service. Participants completed the questionnaire pre and post a formulation meeting. It was reported that staff found the meeting insightful and said that it helped bring staff together, helped individuals to stop and think about their own feelings, and they found it enjoyable and helpful. Staff reported an increase in their psychological understanding and empathy towards the client and their difficulties and strengthened their belief in their thoughts and plans as a team. However, several professionals still reported that they were "undecided" if the formulation meeting would help them to work better as a team. This study utilised a large sample size, which may increase the generalisability of findings to other services; particularly those which have been using formulation for many years like in this service. Similarly, Wilcox (2013) set up case formulation meetings in a community intellectual disability service. They obtained feedback from and information about the experiences of multi-disciplinary professionals who attended the formulation meetings. They asked attendees to complete a questionnaire after four out of the 15 meetings. This generated 29 responses in total. Findings suggested that the professionals found the meetings useful, including that they felt like they achieved something and felt less alone in their work. Further, some reported that the meetings increased their confidence in working with the discussed client and their system and increased their understanding of and ability to manage risks. However, it was noted that attendance dropped in the meetings from 13 professionals in the first three meetings to two-four professionals in the remaining 12 meetings. This study included vast reflections on the researchers experience of setting up the meetings, and considerations regarding why people stopped attending for example. This meant that there was little information about the attendees' experiences of the formulation meeting. Further the questionnaire used was not a validated

measure. Nonetheless, data add to knowledge regarding the perceived benefits of formulating as a team.

Dinh, Groleau, Kirmayer, Rodriguez and Bibeau (2012) transcribed and analysed speech by mental health clinicians attending 12 out of 177 'Cultural Consultation Service' meetings in which cases are outlined and formulated, in an outpatient Psychiatry department of a hospital in Canada. They reported that team formulation helped move from an emphasis on biomedical diagnostic issues toward a broader interdisciplinary discussion. Further, formulation helped facilitate sharing of knowledge; construct new types of meaning (other than a disease/disorder focus); and facilitates power sharing, giving space for non-medical speakers (including clients by proxy) to share alternative views. Perhaps future research could go beyond using conversational analysis as a method and make links or interpretations of the data as well.

Critical Evaluation of Formulation Evidence Base

Tracy's (2010) eight 'big-tent' criteria for qualitative research were utilised to evaluate the research from the systematic literature review (summary in Table 3, Appendix 2). Some of the 'big-tent' criteria are also relevant to quantitative research, such as resonance, worthy topic, rich rigor, contribution, and ethical practice. Therefore, the quantitative studies were also assessed using these criteria. However, specifically for mixed and quantitative studies aspects such as reliability and validity were also assessed. Further, the Quality Assessment Tool for Quantitative Studies (Thomas, 2003) was used to evaluate only the quantitative and mixed methods studies from the literature review (summary in Table 4, Appendix 3). It measures six constructs such as selection bias, the study design, and dropout rate, then gives an overall ('global') rating of the paper. It asks questions such as "Are the individuals selected to

participate in the study likely to be representative of the target population? 1 - Very likely, 2 - somewhat likely, 3 - not likely, 4 - can't tell". Each construct is then rated on a scale of 1-3 (1 = strong, 2 = moderate, 3 = weak).

This literature review identified several studies with small sample sizes. This may limit the generalisability of the findings. There was one single case report (Thew and Krohnert, 2015) and one exploring archival case examples (Glader, 2009). Further, seven studies involved 10 or less participants (Redhead, Johnstone & Nightingale, 2015; Kahlon, Neal & Patterson, 2014; Christofides, Johnstone & Musa, 2012; Burchardt, 2004; Hess, 2000; Manuel, 2016; and Stewart, 2016). Likewise, Chadwick, Williams and Mackenzie (2003) had just four participants in one of their two experiments, which utilised quantitative measures. Moreover, most of the studies participants were self-selecting. This may have biased the findings as only those who were particularly positive or negative about formulation may have volunteered.

Nine studies reflected on the researcher's epistemological position and/or the impact they may have had on the study (Redhead, Johnstone & Nightingale, 2015; Kahlon, Neal & Patterson, 2014; Christofides, Johnstone & Musa, 2012; Adams, 2015; Blee, 2015; Herhaus, 2014; Manuel, 2016; Mohtashemi, Stevens, Jackson & Weatherhead (2016); and Summers, 2006). This increases the trustworthiness of the resulting research. Further, two of the studies supported reliability/quality of their data analysis by including independent researchers to code themes (Kahlon, Neal & Patterson, 2014; Glader, 2009; and Pain, Chadwick & Abba, 2008). This can reduce researcher bias. However, none of the other 19 studies utilised inter-rater methods.

The majority of the studies were conducted in the UK. However, one was conducted in Canada (Dinh et al., 2012), one in Australia (Huisman & Kangas, 2018), and two in America (Glader,

2009, and Hess, 2000). In turn, there may be important differences in how formulation is used in different countries, which may mean differences in people's experiences. However, it may be that these countries use similar ways of formulating, given the use of American Psychological Association (APA) guidelines.

Five of the quantitative studies (Chadwick, Williams & Mackenzie, 2003; Shaw, Higgins & Quartey, 2017; Berry, Barrowclough & Wearden, 2009; Hess, 2000; and Thew and Krohnert, 2015) utilised validated and/or reliable measures. Such measures included, though not exclusively, the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983), the Beliefs About Voices Questionnaire (Chadwick, Lees & Birchwood, 2000), or the Dual Role Relationships Inventory-Revised (Skeem et al., 2007). However, some used non-validated or newly created measures such as a measure of 'personality disorder' in Shaw, Higgins and Quartey (2017), and measures of attitudes towards clients and such like in Whitton et al., (2016). Further, Huisman and Kangas (2018) developed a measure regarding the importance and utility of formulation, though did calculate that the psychometric properties of the survey items were adequate (alpha > 0.7).

The quantitative studies may have benefitted from power calculations to assess required sample size. Shaw, Higgins and Quartey (2017) did conduct and report a power analysis, which reported that 84 participants were required for a medium effect size and 80%, though they had 77 participants in one group and 39 in another, due to participant drop-out.

Research regarding client's experiences of formulation is limited. In turn, studies which directly targeted this (Pain, Chadwick & Abba, 2008; Chadwick, Williams & Mackenzie, 2003;

Redhead, Johnstone & Nightingale, 2015; Kahlon, Neal & Patterson, 2014; Burchardt, 2004; Stewart, 2016; and Thew and Krohnert, 2015) could be considered a worthy topic and makes a significant contribution to our knowledge base.

That said, none of the studies explored young people's (under 18 years) experiences or opinions of formulation. Glader (2009) conducted a content analysis of case studies of work with young people, but such texts were written by professionals. It cannot be assumed that findings from research with adult participants is automatically generalisable to young people.

Synthesis of Findings

Available research regarding the experiences of formulation is divided into at least three key areas: Adult client's experiences of formulation; professionals' opinions and perceived impact of formulation for factors such as the therapeutic relationship; and team experiences/benefits of formulation in meetings.

Overall, the literature suggests that there are many advantages of formulation. For instance, clients described that formulation helped them understand their problems, feel understood and accepted (Redhead, Johnstone & Nightingale, 2015; Burchardt, 2004), and make sense of difficulties (Thew and Krohnert, 2015). Further, it gives a direction from which to work on and helps them recognise a potential for change (Burchardt, 2004; Stewart, 2016).

However, formulation did not appear to impact therapeutic alliance from client's perspective (Hess, 2000; Chadwick, Williams & Mackenzie, 2003), though it did appear to help develop a shared understanding (Herhaus, 2014). Further, clients reported both positive and negative

reactions to formulation (Pain, Chadwick & Abba, 2008) and could find it saddening, upsetting and worrying, at least in the short-term (Chadwick, Williams & Mackenzie, 2003).

For professionals, formulation did appear to increase alliance from their perspective (Chadwick, Williams & Mackenzie, 2003; Shaw, Higgins & Quartey, 2017; Pain, Chadwick & Abba, 2008). Further, professionals reported that formulation appears to increase understanding of clients and gave a clearer sense of direction (Pain, Chadwick & Abba, 2008). Moreover, developing formulations can increase more helpful attitudes and empathy towards their clients, and reduced feelings of the client being to blame or causing their difficulties (Berry, Barrowclough & Wearden, 2009; Summers, 2006).

However, some professionals described that formulation can limit care plans, or be excessively speculative (Summers, 2006); some multi-disciplinary professionals did not fully understand what formulation involves and described needing to prioritise addressing medical needs first (Adams, 2015); and some Psychiatrists at the start of their careers may be less likely to seek formulation or psychological input, impacted by pressure to work medically, lack of time, and perceived 'rivalry' with Psychologists (Mohtashemi, Stevens, Jackson & Weatherhead (2016).

Finally, explorations of team formulation outlined that formulation meetings can give space and a framework to help make sense of client's difficulties together, practice more effectively (Christofides, Johnstone & Musa, 2012) manage overwhelming ideas (Blee, 2015) and contain their own anxieties and feelings (Weedon, 2017; Whitton, Small, Lyon, Barker & Akiboh, 2016). Further, team formulation can enable sharing of knowledge, understanding and risk (Weedon, 2017; Dinh et al., 2012). Interestingly, team formulation meetings were seen as a different environment to other meetings such as being more flexible and offer, or should offer,

a safe space to share ideas (Weedon, 2017; Manuel, 2016; Blee, 2015; Dinh et al., 2012). However, concerns were raised that team formulations may be added to care plans which can have a short 'life expectancy' and may not be revisited and are difficult to implement in teams where 'work' is seen as action-focused (Blee 2015; Weedon, 2017).

Rationale for the Current Research

Overall then, whilst our knowledge of formulation is widespread academically and central to many psychological interventions, our research knowledge regarding the opinions, experiences and impact of formulation is limited, particularly from the perspective of clients. Likewise, Johnstone and Dallos (2014) outlined that the conceptual and empirical basis of formulation has yet to be firmly established. Furthermore, the findings we do have can be complex and somewhat contradictory at times, though research is in its infancy and would benefit from further exploration and more in-depth qualitative analysis. Additionally, research in this area has so far been disorder specific, conducted with adult clients and professionals, and have used relatively small, mostly female samples. Moreover, there are gaps in our knowledge. For instance, there appears to be no research into young people's or carers/families' experiences of formulation.

Understanding formulation may also help clinicians to be more willing to engage with it. This has clinical relevance as it is important to provide evidence of clinical and cost effectiveness, particularly currently when services such as CAMHS are going through large changes and re-commissioning. There is also limited knowledge of clients' perceptions and experiences of formulation and so exploring their opinions may help aid ethical clinical practice and hear the opinions of this client group.

Research Aims & Questions

The first key aim of this study was to explore young people's experiences and opinions of formulation when accessing CAMHS. The second key aim was to explore CAMHS professionals' responses to the young people's views. Due to the conflicting and complex findings from the limited research available it is difficult to make directional hypotheses. Therefore, the research aimed to elicit participants' own experiences of the topic. The main research questions of the study were:

- What are young peoples' understandings, opinions and experiences of formulation?
- What are CAMHS clinicians' reactions to this, and what impact might the findings have on clinical practice?

Chapter 2: Method

Design

This project utilised a qualitative, exploratory design, using semi-structured interviews to find out about participants' understanding, opinions and experiences of formulation. Data from interviews was analysed using Thematic Analysis (TA).

Subsequently, a focus group was held with CAMHS clinicians in the same service(s) to share the main themes. Multi-disciplinary professionals were asked to discuss their responses to the

young people's ideas as well as any potential implications for clinical practice. Again, TA was utilised to analyse data.

The researcher is aware that studies of this nature are likely to be influenced by self and other pre-assumptions and biases. Therefore, to increase the transparency, trustworthiness and rigor of this study, the researcher aimed to be reflective and reflexive throughout the research. This included keeping a reflective journal throughout the project from design to final analysis and discussion, extracts of which can be seen in Appendix 4.

Why Thematic Analysis

A qualitative TA design was decided upon because the research aimed to find out young peoples' views. A quantitative method such as a survey could have missed out rich or meaningful, data from the client group. TA was chosen over other qualitative methods for two main reasons: Firstly, because it was the approach that appeared to be best for the research question at this time, and secondly because of the researcher's epistemological position (Priebe & Slade, 2006).

As previously outlined, the researcher leans towards a contextualist/critical realist (Willig, 1999) approach. In research, critical realists (post-positivists: Guba & Lincoln, 1994) are said to assume that data can tell us about reality but not as a direct mirror. In turn, when interviewing someone for example, participants may not be fully aware of all the factors that influence their experience, such as their early life, family beliefs, cultural expectations, or the history of the concept itself. TA appeared a good fit since it allows data to be presented in a hypothetical way

and considers data in its context. For example, it could be hypothesised that some of the clients' responses are influenced by factors such as expectations, including about what 'should' happen in NHS services and what their parents expect to happen.

Strengths and Weakness of Thematic Analysis

Thematic Analysis (TA) when done well can offer rich and meaningful data analysis. It can sometimes be described as not as robust as quantitative methods or not as reflective as other qualitative methods. However, one strength of TA is its flexibility, such as being accessible to researchers coming from a range of theoretical orientations (Braun & Clarke, 2006). TA can also summarise key features of large data, offer 'thick descriptions' of data, generate unanticipated insights, and highlight similarities and differences across the data set.

Furthermore, due to its relative simplicity, the results are more readily accessible for a range of audiences (Braun & Clarke, 2006). In turn, this could increase client engagement in research and service development. Similarly, TA can be used to inform policy development.

However, some argue that there is an absence of clear and concise guidelines regarding TA and how to do it, and TA can sometimes relate to poorly conducted analysis or inappropriate research questions. Nonetheless, criteria for good qualitative research do exist. For example, Elliott, Fischer, and Rennie (1999) outlined that publishable qualitative research should evidence the researcher owning their position, grounding results in examples, showing respect to participants, and contributing to knowledge.

Finally, a simple TA does not allow researchers to analyse or make claims about language use, as in Discourse Analysis, nor does it offer the depth of reflectivity and reflexivity as Interpretative Phenomenological Analysis. IPA was considered for the current research. However, it is often used for research which explores participants' meaningful and detailed life events or experiences. In contrast, formulation is arguably a small event in one's life. In turn, the interviews are unlikely to provide the depth of information needed for IPA.

Participants

Nine young people participated in the semi-structured interviews. There were two males and seven females, aged 13 to 17 (average age = 15.44 years). All were White British (the latest national census from 2011 reported that 87.58% of the population of the county in which this research was conducted were White, Office for National Statistics, 2011). Whilst a diagnostic category was not sought for this research, two of the participants reported neurodevelopmental difficulties (Autism Spectrum Condition), one reported an eating disorder not specified, one reported diabetes and associated adjustment difficulties and low mood, one described anxiety difficulties, and the remaining four described low mood/depression and anxiety. Five participants developed their formulations with Clinical Psychologists, three with CBT Therapists/Mental Health Nurses, and one with a Clinical Social Worker. Formulations included longitudinal CBT, Systemic and Interpersonal Therapy. All the participants were currently in therapy at CAMHS at the time of the semi-structured interview.

In the professionals' focus groups, there were 13 participants (two males, 11 females). There were three Clinical Psychologists, two Assistant Psychologists, one Trainee Clinical

Psychologist (not the researcher), two Child Psychotherapists, one student Mental Health Nurse, two CAMHS Practitioners, one Social Worker and one Family Therapist.

Recruitment

Participants were recruited through local NHS CAMHS. A field supervisor (a qualified Clinical Psychologist) supported the project, particularly recruitment. A purposive sampling approach was used in which participants were selected from within the population (Guarte & Barrios, 2006) of four CAMHS teams in the same county. Clinicians referred young people, and participants volunteered themselves from an advert (Appendix 5). The researcher presented the research (Appendix 6) to each of the CAMHS teams across the county. Clinicians and CAMHS waiting rooms were also provided with recruitment leaflets (Appendix 7) for young people, to help them understand what the researcher meant by 'formulation' and to decide if they wished to participate. Despite best efforts, including regular reminder emails to CAMHS professionals and administrative teams, visiting team away days, and contacting individual clinicians directly, recruitment was difficult. The number of participants stagnated at three for a couple of months. It was reflected amongst the supervisory team that some professionals were wary of volunteering the young people they were working with as they were unsure of their formulation abilities. The researcher also wondered if they were concerned about the research being upsetting for the young people. When it was explained that the interviews would not ask young people about their history, difficulties, or personal details about the therapy, more young people were recruited.

There are no set guidelines for how many participants a thematic analysis study needs, though for a 'small' project it has been suggested that 6-10 participants are needed for interviews, and

2-4 are needed for focus groups (Fugard & Potts, 2015). It has also been suggested that recruitment should stop after 'theoretical saturation', which has ranged from six participants (Isman, Ekéus, & Berggren, 2013) to 17 (Francis et al., 2010) in studies of similar design.

Inclusion and Exclusion Criteria

Inclusion and exclusion criteria for the young people's semi-structured interviews were developed by the researcher and the main research supervisor throughout the proposal, design and ethical approval stages of the research.

Criteria were as follows:

- Aged between 11 - 18 years
- Currently open to or recently discharged from an NHS CAMHS service
- Worked with a clinician during assessment and/or therapy who used formulation
- Able to provide informed consent to participate
- Sufficient verbal communication and cognitive ability to participate in an interview about conceptually abstract matters.

For the focus group, any multi-disciplinary professionals (not just Clinical Psychologists) were invited.

Ethics

This project obtained NHS (IRAS ID: 240816; REC reference number: 18/NW/0363; Appendix 8), Health Research Authority (HRA, Appendix 9) and University of Hertfordshire ethical approval (Appendix 10) prior to recruitment and data collection. It took 12 months to receive confirmation of ethical approval from each of the associated bodies. This also delayed the ability to recruit participants.

Participants were involved in the research in three ways: Firstly, the researcher consulted with a council of young people who have accessed CAMHS for feedback regarding the study, recruitment methods and interview questions. This did not require ethical approval; nonetheless the following ethical considerations were still applicable. Secondly, participants for the semi-structured interviews and professionals focus group were required to meet with the researcher once for approximately one hour and give consent for the interview to be audio recorded. The audio recordings were kept confidential between the researcher and research supervisors on an encrypted device and deleted following (anonymised) transcription. Further, identifying and contact information was kept in a secure locked cabinet on the University premises, and separate from other information such as transcripts. Recent GDPR protocols were followed (see Participant Information Sheet; Appendix 11).

Participants were involved in the project on a voluntary basis, though a £10 Amazon gift voucher was given to the young people as a thank you for participating, and to cover their time and expenses. This was not advertised to potential participants at recruitment stage, to reduce impact of inducement or bias. It was also hypothesised that participants could feel

accomplishment, helpfulness or so forth by participating in clinically relevant research which could make positive changes to services.

Participants were made aware of the purpose of the study and the intended use of the findings. An information sheet (Appendix 11) and consent form (Appendix 12) were given to all participants (the young people). As discussed with the NHS Ethics committee, for participants under the age of 16 years their parents/legal carers also had to consent for their young person to participate (Appendix 13) and assent was sought from the young person (Appendix 14). For the professionals focus group, another participant information sheet (Appendix 15) and consent form (Appendix 16) were provided.

Participants were made aware that they could withdraw from the research during the interview or up to one month after. This limit was put in place because individual interview transcripts were combined with other's responses, and so it was no longer possible to remove their responses. They were made aware that withdrawal would not affect their care given by the researcher or the CAMHS team.

Potential risk was managed throughout by making participants aware that if they told the researcher anything during the interview which made them believe that they or someone else is at risk the researcher would tell a senior clinician, such as their Care Coordinator. It was considered that participants may become mildly distressed or anxious during the interviews. However, the research covered a relatively neutral topic. Any instances of distress were to be reported to their Care Coordinator. Further, as a Trainee Clinical Psychologist with therapeutic competence and experience both with young people and other client groups, the researcher was able to deal with this type of presentation and respond accordingly.

Finally, all participants were given a debrief sheet including contact details for the researcher following completion of the study (Appendix 17).

Client Consultation

Before commencing the research, the local Youth Council were consulted - with consent - about the proposed study, and the advertising leaflet and poster created to aid recruitment.

The council had general questions and concerns about formulation itself. They had not heard the term before and said it sounds like "something scientific". When the researcher described what it was, they said it sounds like their initial "getting to know you" sessions with their clinician following initial assessment. Some of the council were concerned that if young people are aware that therapists are using a 'technique' to understand their difficulties, then people might speak less in the first few sessions. Furthermore, some expressed concern about formulation replacing clinical diagnosis entirely because they found when they were in services that a diagnosis helped them, and their parents/carers understand what is happening and it helps services talk to each other. Some of the young people also did not like the idea of formulations being shared in letters as this could breach confidentiality if their parents/carers got a copy, and some were concerned about inconsistencies: For example, are some people getting formulations and others not?

As previously outlined, the advertising leaflet and poster were also shown to the Youth Council for consultation. Some of the council had questions about the formatting of the leaflet, such as asking what "bodily sensations" means on the Cognitive Behavioural Therapy (CBT) maintenance cycle, and wondered if it would be better to move some of the information around

– e.g. the suggestion that formulation might be a verbal summary shared by therapist could be moved to the start of the leaflet as this is more common in practice. Regarding the poster advert, they suggested phrasing the advert in a way which demonstrates that participants can help improve services.

The Youth Council were also consulted on our recruitment ideas. The council strongly disliked the idea of the researcher being in CAMHS waiting rooms to recruit. They explained that often young people are anxious at that time and just want time alone to think and process. Instead, they suggested that the researcher could give receptionists the recruitment leaflets to hand out to all new clients who attend, and/or leave leaflets on the reception desk. They also explained that young people are unlikely to email the researcher. They suggested recruiting through a range of options to access all kinds of young people. E.g. a confidential box in the CAMHS waiting room that they could write their contact details on for the researcher to contact them. Finally, they suggested that the researcher conducted the interviews in CAMHS, once they are settled in, rather than at home or school.

Following consultation with the client group, changes were made to the leaflet, poster, and recruitment avenues. The researcher sent the Youth Council details of the changes made to the project following their feedback (Appendix 18).

Measures

A draft interview schedule was developed in the proposal stage of the research, and peer consultation was sought to develop the proposed interview schedule. This was then shared with the Youth Council to develop it further. After the first interview, the transcript was reviewed,

and some further questions were added or expanded, creating the final semi-structured interview schedule (Appendix 19).

The professionals' focus groups were kept as unstructured as possible. A written summary of the themes from the young people were provided to the focus groups before the meeting, and again in the meeting, and participants were asked to discuss their thoughts and reactions to this. The researcher was also present in the focus groups to prompt participants to check each theme presented to them to ensure the discussions stayed focused on the topic. Following this, they were asked if the young people's responses might have any clinical implications (interview guide in Appendix 20).

Procedure and Data Collection

Following completion of ethical approval, client consultation and developing the interview schedule, recruitment began. Participants were then involved in the following procedure:

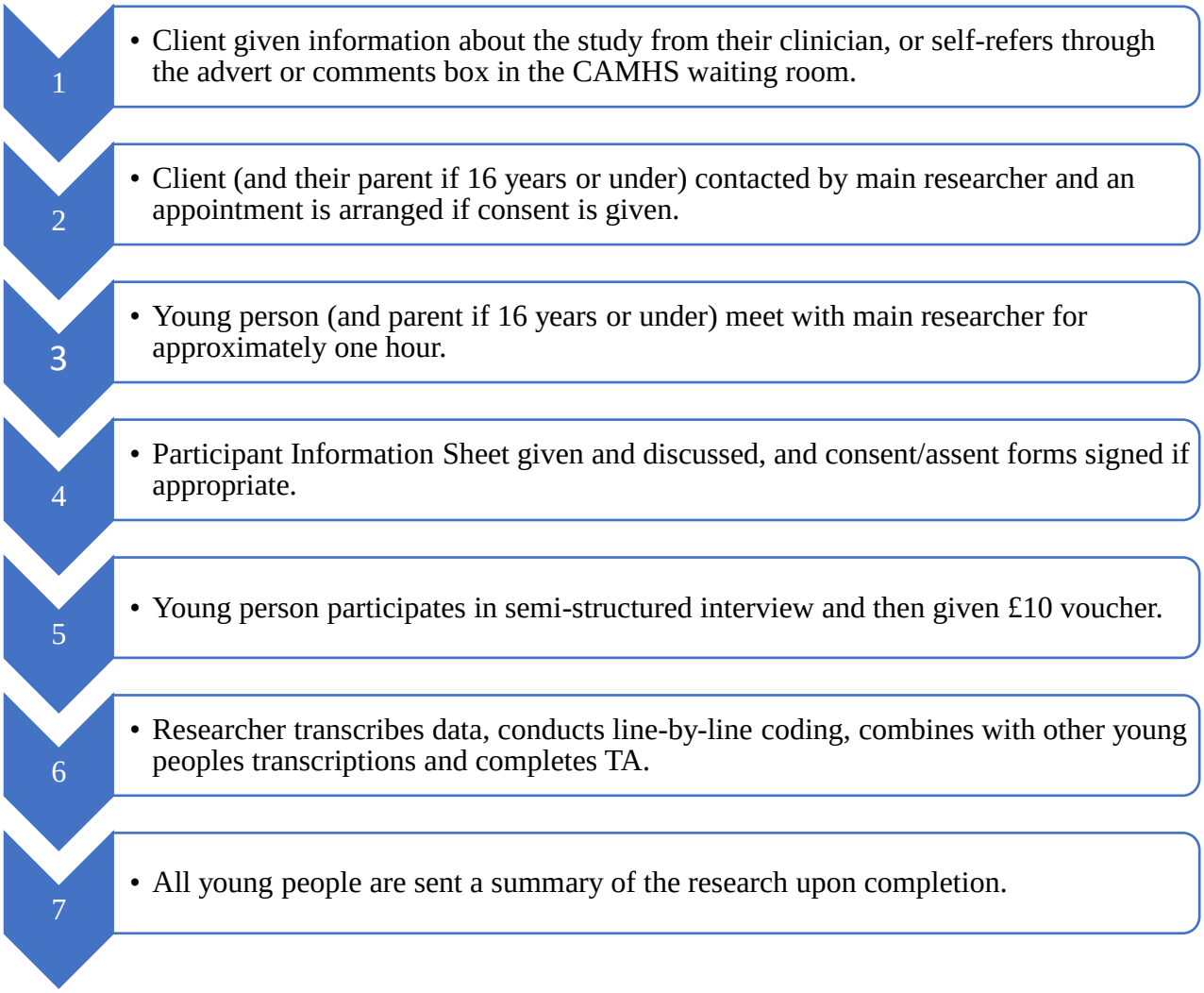


Figure 2. Flow Chart Summarising Recruitment and Data Collection Method for Semi-Structured Interviews with Young People

Then, each of the CAMHS teams which were visited during the recruitment phase were emailed to ask for participants for a focus group. Once participants volunteered, they were involved in a similar procedure to the young people as follows:

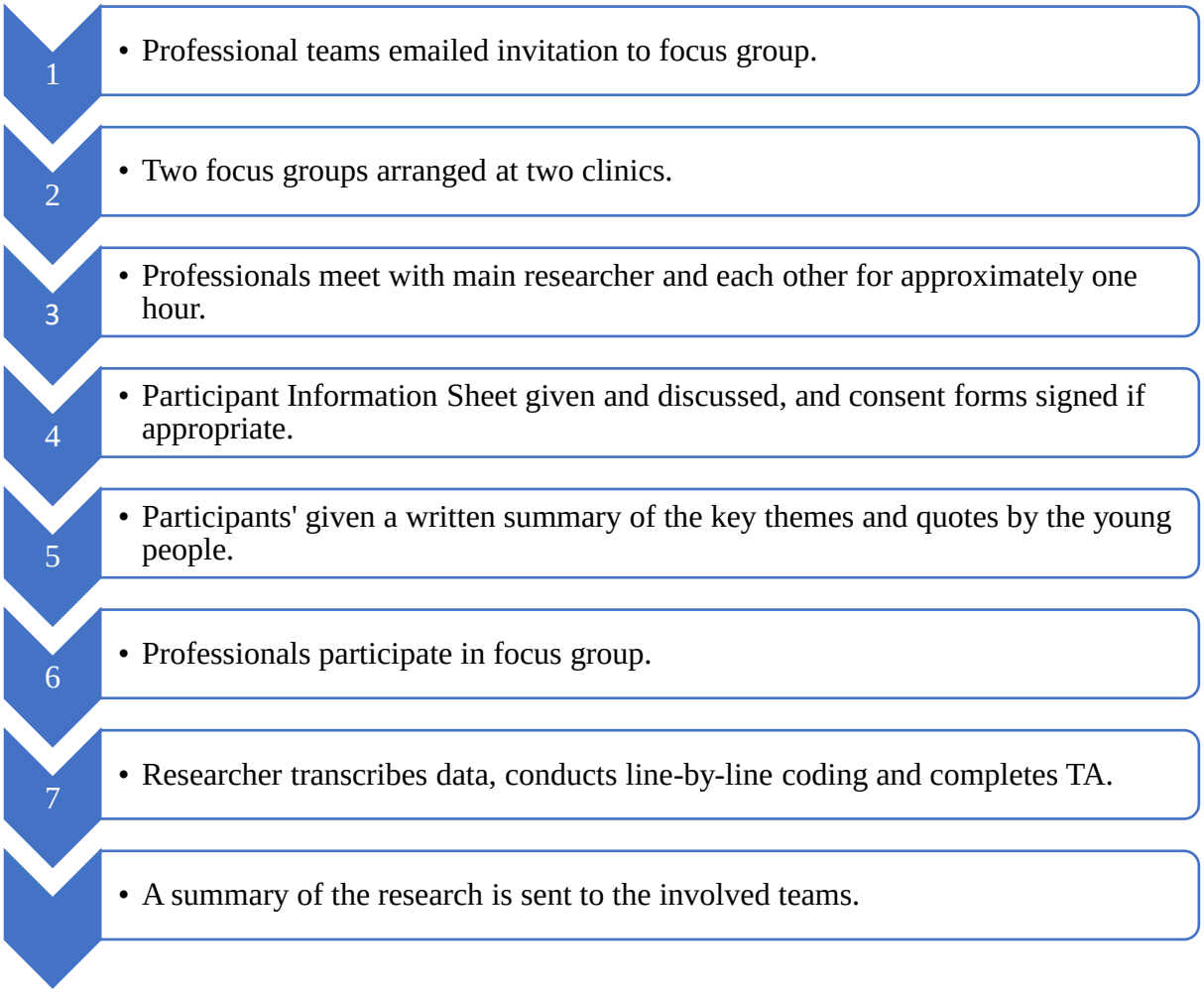


Figure 3. Flow Chart Summarising Recruitment and Data Collection Method for Focus Groups with CAMHS professionals

Upon completion of the study, a summary was sent to the host NHS Trust (Appendix 21). Finally, the research will be written in an appropriate format and sent to an academic journal for potential publication.

Data Analysis

Transcribed interviews were uploaded onto data analysis software (QSR NVivo 11 for Windows) (an extract of a transcribed semi-structured interview with a young person is

available in Appendix 22 and an extract the transcription from one of the professionals' focus groups is available in Appendix 23). Thematic Analysis was selected to analyse the data from both the semi-structured interviews and the focus group. In turn, line-by-line coding was utilised to summarise key ideas from each line of data. Then, themes were developed and grouped into main themes and subthemes. (Evidence of the data analysis process is available in Appendix 24). Of note, the findings could be analysed and reported in infinite different ways and inevitably interpreted differently by different researchers. Reviewing codes and themes with peer and supervisory researchers, and reflexive practice aimed to manage this bias as far as possible.

Data analysis involved the following process (Braun & Clarke, 2006):

- Transcribing and familiarisation with the data
- Generating initial codes
- Sharing an example transcript with a peer researcher for them to develop initial codes to aid reliability and validity of researcher's data analysis.
- Developing themes and subthemes using deductive reasoning
- Developing themes and subthemes using inductive reasoning
    - Themes were developed based on how meaningful the themes are for answering the research question - What are young peoples' understanding and experiences of formulation?
- Reviewing line codes, themes and subthemes with supervisory researcher
- Further developing themes
- Defining and naming themes, based on what is meaningful to the research question, and what the central organising concept is
- Producing the report, including illustrative quotes from participants

- ‘Cleaning up’ the data – e.g. removing hesitation or repetition without changing the meaning
- Analysing the data/reporting latent meanings
- Sharing the key themes with the professionals in the focus group
- Completing each of the above stages of analysis again with the data from the focus group.

Quality, Validity and Self-Reflexivity

To ensure this research was of high quality, the same standards (Tracy’s 2010, ‘8-big tent criteria’) used to assess the quality of the literature outlined in the systematic review were also used during this research.

This research was a worthy topic since it was conducted at a time when there was a lot of debate regarding the use of formulation or diagnosis. Further, it adds a significant contribution as there was no available literature at the time of young people’s (under 18 years) understanding and experiences of formulation. Likewise, the results contribute practically as clinicians were encouraged to reflect on how the young person’s responses may affect clinical practice. Sincerity was actively aimed for throughout the design, interviews and analysis of the research by reflecting on and outlining the researchers’ epistemological position, reflective accounts and considerations of researcher bias. To ensure credibility of the data, thick descriptions, including quotes, were outlined alongside the summary of themes, so that readers can draw their own conclusions about the findings. It is difficult to ensure full generalisability due to time and recruitment constraints. However, generalisability was attempted by recruiting from more than one CAMHS across the county, and the county in which the study was conducted offers some

diversity in terms of factors such as socioeconomic status. This may increase the transferability of findings to other CAMHS.

Chapter 3: Results

Summary of Findings with Young People

Three main themes were developed from the semi-structured interviews with young people.

Theme 1: Shared Sense Making

- Subtheme 1.1: Method of Formulation and Accessibility for Clients
- Subtheme 1.2: Collaboration, Power and Openness to Formulation
- Subtheme 1.3: Perceived Usefulness and Meaningfulness of the Formulation for Clients

Theme 2: Formulation Process as a Therapeutic Intervention

- Subtheme 2.1: Shared Decision Making and Impact of Formulation on Professionals and Wider Network
- Subtheme 2.2: Therapeutic, Affective and Cognitive Effects of Formulation on Clients

Theme 3: The Purposes and Uses of Formulation

- Subtheme 3.1: Formulation Explains Causes and Maintenance of Difficulties
- Subtheme 3.2: Formulation Steers Direction of Interventions

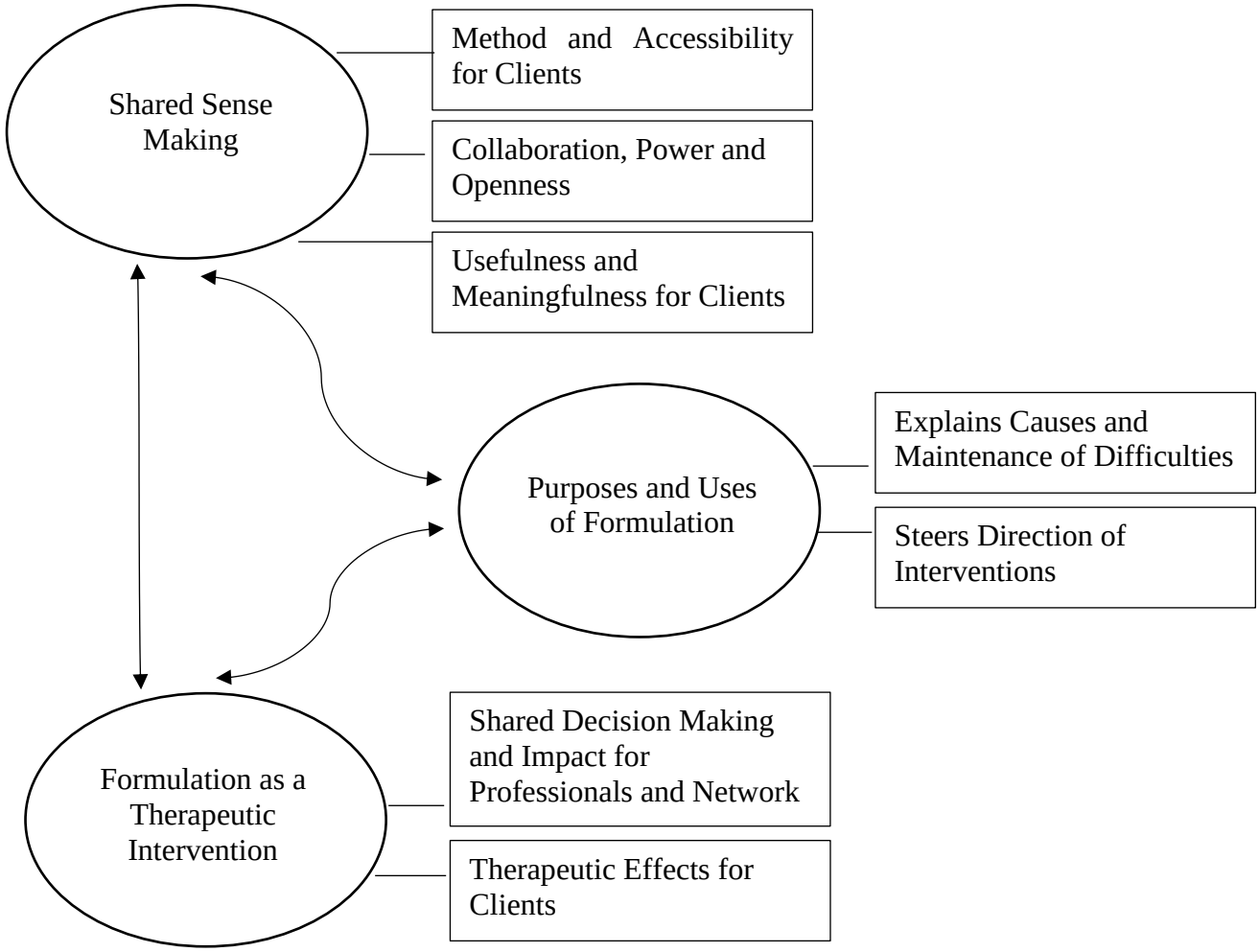
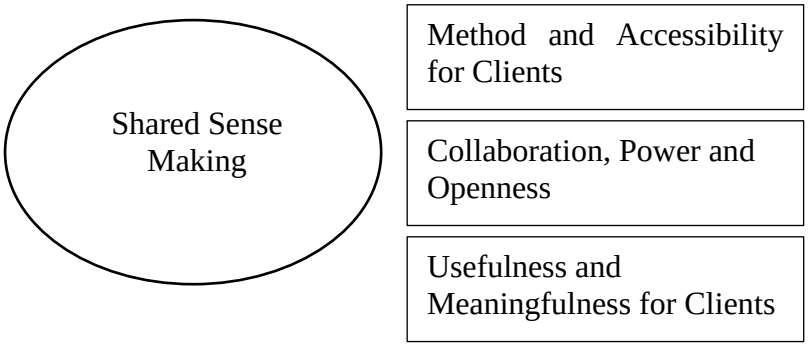


Figure 4. Thematic Map summarising the three main themes and seven subthemes developed from the data with young people

Thematic Analysis: Semi-Structured Interviews with Young People

Theme 1: Shared Sense Making



The theme 'Shared Sense Making' draws together ideas regarding the mode of and details in formulations, how it was conducted and the user-friendliness for clients; collaboration and power between clients and clinicians during formulation or diagnosis; and whether the formulations meaningfully matched client's experiences and needs. These subthemes were tied together because, for example, it may be hypothesised that for a formulation to be meaningful it must also be user-friendly for the client, and presumably created collaboratively to accurately describe their experiences. Further, the mode of and details in formulation would have arguably differed greatly between clients depending on the clinician's approach and client's needs.

Subtheme 1.1: Method of Formulation and Accessibility for Clients

Subtheme one includes participants' descriptions of how their formulations were developed, including the mode of formulation and factors that were included in it, and people's familiarity with formulation.

Some participants found formulation to be accessible and understandable.

> *'I think formulation is done at the pace of the patient no matter what, because we discuss things and then we kind of write it down in the style of formulation.'* (Participant 1).

Clients who had used a longitudinal CBT formulation template found the approach particularly easy to grasp.

> *'It follows a really general formula. So you get really used to it. I think it's really efficient'* (Participant 9).

However, some clients found formulation confusing or difficult to make sense of.

> *'It took me a few times to try and understand it. But then it made sense. Because I kind of I can't focus that well.'.* (Participant 4).

> *'It's quite hard to tie in everything really clearly. And because factors usually have their own causes you, you end up like, kind of going into a spiral.'* (Participant 9).

The data may suggest a difference in the complexity of formulations: For example, if following a template or dealing with fewer difficulties the formulation may be more accessible to young people. However, when difficulties or factors surrounding difficulties increase, formulations may become more complicated.

Some participants described their formulation as an ongoing process that was developed over multiple therapy sessions and returned to later.

> *'It's been (developed) over I think three (sessions) now, so we go back keep going back.'* (Participant 3).

However, some described formulation as more of a one-off process.

> *'...Looking at it, reading it, I take it in, I can see why we did it in session. But not, I can't do anything with it now.'* (Participant 2).

Some participants explained that other people or systems were incorporated in the formulation.

> *'It's mainly like things that have happened to me and the way that I'm feeling but then also taking into consideration the way that other people act and like the external pressures.'* (Participant 3).

However, some described that their formulations focused more on the here-and-now.

> '*We don't really do much about my background. Um is mostly just kind of what happens now.'* (Participant 9).

Participants described various different types of formulation, such as diagrams or letters, and that they contained useful amounts of detail.

'She had the template … and when we first started doing it she was like "this is how you lay it out."' (Participant 4).

'We sort of like, talk about things and then they start drawing it down and yea, and sometimes (the clinician) says, oh I'm making a formulation!' (Participant 5).

'It was kind of like a letter you get from your grandma! It was like a Dear (client's name) sort of thing.' (Participant 7).

Some described their formulations in a creative way, seeming to describe that the formulation had one main idea with other ideas branching off that.

'It's almost like a tree branching off in different directions and going back to the same trunk.' (Participant 1).

'Some things that's happened can cause the other stuff; it also comes off each other.' (Participant 3).

Of note, some young people described a preference for diagnosis, both for their own benefit and for others.

'Sometimes I feel that myself and other people need that name to it.' (Participant 1).

Some participants discussed that diagnosis is more familiar than formulation, and so a diagnosis can help others to understand their difficulties. Perhaps this familiarity increases accessibility and is why some showed a preference for diagnosis.

> *'Formulation isn't as well known. So if you want people to understand and you say I have depression or have anxiety specifically about schoolwork. They'll know that they shouldn't like, push it too far.'* (Participant 3).

Some participants shared an idea of how to increase awareness of formulation.

> *'If like mental health charities spoke about it more, then maybe it could help like spread the word because then if someone say if they did, like even just the social media posts explaining what it is .'* (Participant 3).

> *'Do it more. 'Cause this is the first time I've heard of it.'* (Participant 7).

Moreover, some participants described that a formulation gives a deep understanding.

> *'Diagnosis doesn't really help you understand everything; that's more formulation. Formulation can help you understand why you are the way that you are. But I think you do need to diagnosis to know that like, isn't all in your head.'* (Participant 3).

This suggests that some young people identified that a combination of formulation and diagnosis is useful to them as they got both an understanding and validation of their difficulties,

and a ‘name’ which is easily understood by others and may accelerate support in other networks such as school.

Subtheme 1.2: Collaboration, Power and Openness to Formulation

This subtheme describes the ability for clients to challenge the formulation or disagree with the clinician’s ideas. The impact of a good working alliance and collaborative decision-making is also discussed.

Most of the participants reported that their formulation was accurate. However, one expressed that their clinician focused heavily on an idea that the client did not agree with.

> *‘She sort of put everything on to my parents’ divorce … I was like four so I can't remember it, it never had an impact on me and she repeatedly asked me about it.’* (Participant 2).

At times, the ability or desire to challenge the clinician was impacted by the trust that clients put into ‘the professional’.

> *‘Well I kind of feel like, you know, you’re the professionals… I trust their opinion on this more than I trust my own.’* (Participant 1).

That said, some other participants felt that the divide between client and professional was less, and so they could freely challenge them.

'Oh, she's just so quite a nice person, like laid back … I don't see her as someone that has like a teacher relationship' (Participant 3).

Overall, there was a mix of opinions and experiences regarding whether a formulation could be challenged. Some felt able to challenge which was impacted by both intrapersonal factors such as confidence and interpersonal factors such as whether the clinician was viewed in an authoritative position. Further, there was a suggestion that clinicians are trusted to make the right decisions on behalf of the young person, as in a traditional 'Dr-patient' relationship. This may be embedded in participants' context. This research was conducted in one of the home counties in which there is a diverse community of rural and urban areas, where there is a range of poverty and affluent areas. People's socio-economic status, gender, and abilities for example (Burnham, 2012) may impact what they 'expect' from a relationship with a clinician.

Some participants highlighted the benefits, or perhaps the need, to collaborate on and check accuracy of formulations.

'(If) it goes into your notes and then they've got the wrong end of the story, when your next clinician looks at it everyone's got like a different version of what you're saying and I'd rather like just have it from me .' (Participant 2).

Collaboration during formulation appeared to benefit the client.

'…It was quite nice to see that someone had given their opinions on what I'd said, and they'd been able to contribute.' (Participant 7).

Further, an ‘accurate’ formulation appeared to help clients feel understood and listened to by their clinician.

> *‘It makes me feel quite relieved that they know what I'm actually like thinking. Because sometimes I think that they don't know what I'm saying. But then when they did that, I’m like “oh they do”’* (Participant 5).

This in turn appears to benefit the working alliance. Vice versa, a good working alliance benefitted the formulation.

> *‘I felt more comfortable around (my clinician) because I knew that she was actually like paying attention’* (Participant 7).

> *‘Formulation works a lot better if someone gets along with their therapist. ’* (Participant 6).

Moreover, some participants identified that for a formulation to be most helpful therapeutically, the client needed to be actively involved.

> *‘People have got be open to help themselves as well because otherwise it won't work.’* (Participant 6).

Overall, participants appeared to want to be involved in their formulation. They appear aware of the structure of NHS services, such as an awareness that what happens in sessions stays on their patient records. Therefore, they wanted and expected accuracy in their notes otherwise it

can distort the story they wanted to tell. Moreover, an accurate formulation increased their trust in their therapist which also seemed to give feelings of validation from being accurately heard. This may impact the direction and experience of therapy overall. Interestingly, some participants identified that for formulations to be accurate and for the working alliance to be good, there needed to be commitment and openness from the clients too.

Also in reference to collaboration, some participants were told overtly when the clinician was developing a formulation with them.

> *'… It was mostly "we're going to use this theory, this helps you to find–… like, we only use this, this is how it works," and just kind of explained it.'* (Participant 9).

However, many were not clear, until their clinician invited them to this study, of the difference between formulation and therapy.

> *'That's the thing it's quite hard to identify like what is formulation what isn't because it's never made clear.'* (Participant 2).

> *'Say it is a formulation. Or maybe even if they just say, well, this is the process, and this is what we do. This is a formulation, and this is why it helps. '* (Participant 5).

Similar to the above, some participants expressed a desire to be assessed for a diagnosis, though this appeared not to be followed up on. At times, this may be because clients did not feel that they could or wanted to challenge people.

'I have brought it up occasionally um saying, I would prefer to at least be checked out if I do have this um if this condition/disorder because but um … I just generally don't like confrontation.' (Participant 1).

Additionally, some participants were not sure whether they had a diagnosis and if they did, how that decision was made. At times, this appeared to be due to lack of communication.

'If it's a case of um "I know, you don't have this disorder, this diagnosis" then that's okay by me, because I trust um your professional expertise in this, but I at least want to know why, instead of just being told no, or just not being told anything at all.' (Participant 1).

'They never said, "we're diagnosing you with this." It just is on my… so like when they sent a letter to my school it has my diagnosis.' (Participant 2).

'Well, that was a bit, grey. Well, I mean, it was a bit because we went through a lot of different services… I think they just didn't know.' (Participant 5).

These findings suggested that diagnosis is not certain in services. This could represent a reduction in the use of diagnoses, a hesitancy to give young people a label, uncertainty about which would be the best diagnosis, or an increase in formulation instead.

Subtheme 1.3: Perceived Usefulness and Meaningfulness of the Formulation for Clients

The final subtheme within the main theme 'Shared Sense Making' outlines whether formulation was individualised, meaningful and a good representation of participants' experiences and difficulties.

Most participants reported that they felt at the centre of their formulation and that it was individualised and tailored to them.

> *'It does feel individual because you kind of go into your personal experiences and what you personally feel so it's not really like, kind of a template that's applied to you.'* (Participant 9).

Furthermore, participants outlined various things that they like about formulation.

> *'I think the advantages are, if someone feels lost, and don't know why they feel the way they do it gives them a reason.'* (Participant 6).

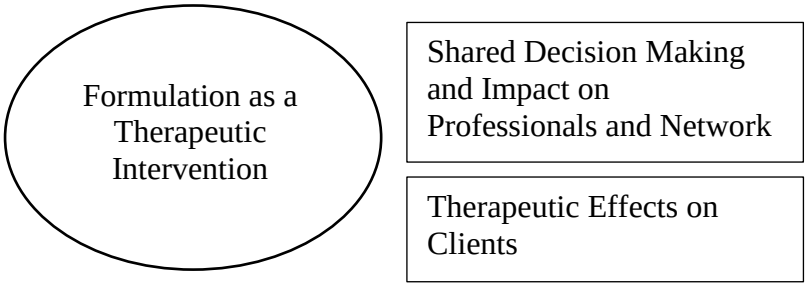
> *'It was really good to get a succinct version, of how (my clinician) was perceiving what I was going through.'* (Participant 7).

That said, some described that the formulation did not create meaningful narrative.

> *'It kind of told a the story, it kind of didn't. You could see what was doing it, but it wasn't. It didn't flow as such.'* (Participant 6).

Overall, the young people felt at the centre of their formulations. This suggests that even if formulations are collaborative or not, one-off or ongoing processes, or based on the here-and-now or wider factors, most were client centred. However, there was a difference in whether formulations told a succinct and meaningful narrative. Perhaps this could be impacted by age/development of the client, the complexity of the situation, or how the formulation was presented.

Theme 2: Formulation Process as a Therapeutic Intervention



Theme two outlines the therapeutic impact that formulation had for both clients and professionals or other systems. This includes a look at some of the therapeutic effects of diagnosis, and limitations of both formulation and diagnosis.

Subtheme 2.1: Shared Decision Making and Impact of Formulation on Professionals and Wider Network

The first subtheme outlines the impact and usefulness of formulation for clinicians and other systems such as schools and families. Some clients identified that sharing a formulation with other systems could be useful.

'If I had CAMHS at the time I would've definitely wanted them to inform the school.' (Participant 2).

Participants also identified that formulation helped clinicians, such as to help them remember details and to plan, even where the formulation was less helpful to the client directly.

'She (the clinician) can refer back to it, if she forgets anything, or if there's, you know, one other theory that she has, then you can kind of like, compare the formulation with whatever she's thinking.' (Participant 7).

'So it's not, it's equally as much as it is for me as it is for (the clinician) to use… because I was making sense of it with her help it makes sense to her.' (Participant 8).

This may suggest an acceptance of formulation as it helped those involved in their care but does not necessarily suggest that the clients themselves found the formulation helpful or meaningful. Further, it could mean that young people see formulation as a procedural rather than a therapeutic experience.

Some participants identified some disadvantages of formulation for them, for example, it can 'slow things down'. Further, rather than viewing formulation as a way of conceptualising difficulties or even a diagnosis, it was viewed by one participant as getting in the way of a diagnosis.

'I feel that the process is a lot slower when you're also doing um a lot of work around formulation.' ... 'Before I started formulation, um the diagnoses they came they came a lot quicker and they were more certain.' (Participant 1).

Interestingly, some young people liked to share their formulations such as with their friends because it helped them to process their difficulties or give others a better understanding. Those that did not share their formulations seemed to be those who saw formulation as a one-off process.

'I will talk about my formulation. I've spoken about it to my mates because I know that it helps me.' (Participant 3).

'No (we didn't share the formulation). Just, we did it in a session and I took home the worksheets to look at, I never looked at them, but yeah, it'd just stay between me and my clinician.' (Participant 2).

When it was shared, it appeared to have some benefits such as reducing the need to repeat themselves to clinicians.

'Well it's good that I didn't have to completely introduce myself, go through my entire life story habits, likes, dislikes.' (Participant 1).

However, some participants explained that they would prefer their formulation not to be shared, for example because it contained quite personal or sensitive information.

'I'm not sure about parents, because I don't know how they would take it, reading some of the stuff.' (Participant 3).

'I like having everything private and internal. I prefer it not to be written up.' (Participant 9).

Even when formulations were shared, this had its own limitations at times.

'Well I've had multiple psychiatrists at the moment because they keep leaving, and then each time I get a new one it's like repeating myself all the time.' (Participant 4).

'... that they will start treating me a little bit different, and I kind of always get nervous about that because I don't want to be treated different.' (Participant 4).

'But you have to send it to the right person. 'Cause like things might seem normal to a counsellor but others might not be able to handle the information that they read.' (Participant 7).

When young people shared their history and concerns, they appeared to hope that it would be passed on to necessary others, such as when they were given a new clinician. At times, there is also a suggestion of mistrust in what would happen with the formulation, which may also be associated with some people's preference not to share their formulation with others.

Subtheme 2.2: Therapeutic, Affective and Cognitive Effects of Formulation on Clients

The second subtheme of theme two summarises some of the effects that formulation had on clients therapeutically. This includes suggestions that formulation helps people to feel like their difficulties were valid, and it can prevent things getting worse.

For example, developing the formulation helped some to understand their difficulties and feel like their difficulties were 'valid'.

> *'"Oh I'm sad, why am I sad?" And then when you look back on it, like all of this sh*t has happened in your life…so having it written down I think it'd be quite helpful.'* (Participant 3).

> *'It made me understand why I thought like that, why I did the actions I do.'* (Participant 4).

Similarly, though, some said that getting a diagnosis 'validated' or normalised their difficulties.

> *'It's like, "yeah you're struggling with depression." ... I feel understood. It's not like people are just going "oh, you're just a bit sad, or just having a rough day."'* (Participant 8).

> *'I mean, it might make it feel a bit more normal. There are lots of stats like that one in four teenage girls have this, you know stuff like that.'* (Participant 7).

Regardless of the method used, what was important to young people appeared to be the 'validation' that they are 'allowed' to feel sad or have the difficulties.

Whilst it increased understanding, one participant described that the process of developing the formulation to get to that understanding can be upsetting, at least in the short-term.

> *'It was helpful, but I got very emotional. It was upsetting because obviously of bringing it all up, but then it kind of showed me a little bit of understanding as well.'* (Participant 4).

> *'Um like disadvantages they kind of can be quite upsetting, and stressful to like, listen to it and understand. It kind of makes you feel like you're not doing things right in a way. But then you have the understanding, and then you work towards that.'* (Participant 4).

Despite some finding the formulation upsetting temporarily, one identified that it was necessary to include even upsetting ideas in a formulation in order to be factual.

> *'I mean not all of it was nice to read. But you know, you've got to be factual in it. So you can't really do a lot about that.'* (Participant 7).

This was similar to one of the findings from subtheme 1.2 in which a young person identified that the client needs to be actively involved in their formulation and be honest for the formulation to be meaningful.

Further, formulation broke things down or made them seem more manageable.

> *'It helped me to sort of map everything out. And it makes, when you break it down, it makes everything seem a lot more manageable.'* (Participant 3).

> *'Mum said dad and her found that quite useful. Just having all of it there, like, without me, you know, me dropping things in, yeah, it made it easier to follow.'* (Participant 7).

Formulation seemed to help make things more manageable by making difficulties and experiences seem more succinct, and summarising narratives. Further, this process of making things more succinct appeared to have a therapeutic effect in that it helped clients to feel less overwhelmed by their difficulties and dealing with them.

Similarly, having a formulation written out was said to help some people to process emotions.

> *'Reading it. Now it was, like, kind of desensitized it a little bit. It's like it is about you but at the same time, it's a bit like you've distanced yourself from it.'* (Participant 7).

Some described that formulation can offer alternative perspectives or help to think about their difficulties in a new way.

> *'Well, it did help explain some things, things that I didn't think that were relevant that actually had quite a big impact 'cause I didn't see it as that.'* (Participant 3).

> *'It's quite interesting 'cause I really thought about it like that before.'* (Participant 5).

The process of the formulation helped some participants to talk to their clinician and others such as their parents.

> *'I think I prefer like, say, if I was meant to draw or write down something. I think I prefer that because I didn't really like talking. So it was less awkward.'* (Participant 5).

> *'Because I never told my mum how I felt and working on the formulation together and then doing certain kind of like homework tasks that I had to do, I'm by myself actually coming out of my shell talking to mum about how I felt.'* (Participant 4).

The impact of formulation was also discussed by participants, and there was some disparity with some saying that it had a big impact, whereas others were unsure or felt there was limited impact.

> *'End result of the formulation, yes (has an impact). Yet the formulation itself for me personally not.' (Participant 1).*

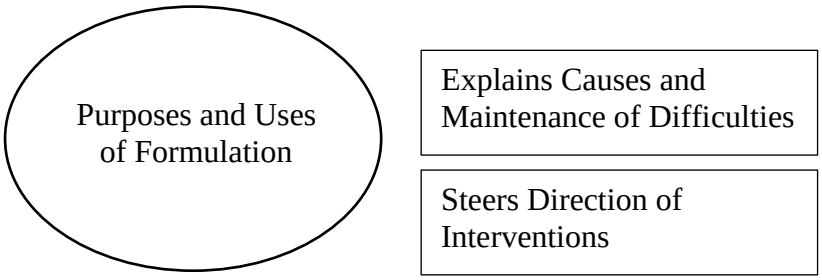
> *'I think overall, it's pretty helpful. You don't really realize how helpful it is until after. I'm not quite sure how, but it definitely has.'* (Participant 5).

Participants suggested that formulation may take a while to have an impact. This may be because it is a method which clients gradually reflect on and make use of.

Some participants suggested that formulation can have further therapeutic effects such as preventing things getting worse and preventing relapse.

'I think formulation as much as it I think it is like a coping technique as well, because it does help you figure things out. ...I feel like it'd reduce the amount of relapses' (Participant 3).

Theme 3: The Purposes and Uses of Formulation



The final theme outlines participants' ideas regarding the purposes of formulation, such as to explain causes of difficulties, and identify solutions and goals for interventions.

Subtheme 3.1: Formulation Explains Causes and Maintenance of Difficulties

Firstly, this subtheme summarises participants' views on the purpose of formulation to summarise ideas, explain the causal and maintenance factors of difficulties, and exclude alternative possible causes.

Participants described that formulation can help to draw information and ideas together.

'It was kind of like um, I had all the pieces of the puzzle I just didn't I just didn't have the picture to put it together.' (Participant 1).

'I found that quite helpful as well cause it's not she wasn't putting words in my mouth it was everything I was saying just put into like a system.' (Participant 2).

Another purpose of formulation identified by participants was that it can help explain which factors contribute to difficulties and behaviours and exclude factors which may not fit.

'It's just like, how things that have happened in the past, like, affect your future relationships and whether you deal with things.' (Participant 3).

'Well, from my understanding, it's identifying the root or the source of what has made me feel the way I feel and like all the causes instead of just one.' (Participant 6).

Another purpose of formulation identified by participants was that it can explain factors that maintain their difficulties or behaviours. This appeared to help clients identify changes that either they or others can make to reduce the repetition of difficulties. Young people may not be consciously aware of this benefit of formulation at first, given in subtheme 2.1 some described that formulation has not had an impact yet, or that it may be more useful for the clinicians.

'That helps you understand like behaviour that you do now which can contribute and like keep the problem going.' (Participant 3).

'They talked to my parents about like what motivates me and like, what would kind of be a barrier to getting better, and like things that they perhaps shouldn't do!' (Participant 5).

Finally, formulation was reported to help identify protective factors and strengths, like the following example that a participant discussed with her clinician.

> *'Kind of like the horse riding, and what I want to do in future.'* (Participant 8).

This was not discussed by many of the young people, suggesting that either strengths and protective factors are not discussed or highlighted in formulations, or that young people do not see it as a significant part of the process. Participant eight talked a lot about the support and impact her outside network and hobby has for her mental wellbeing, suggesting that inclusion of protective factors may have therapeutic benefits.

Subtheme 3.2: Formulation Steers Direction of Interventions

The second and final subtheme of the theme 'The Purposes and Uses of Formulation' describes that formulation can help to identify a person's key difficulties and then identify solutions, goals, and intervention plans. Similarly, some participants discussed the use of diagnosis to plan intervention. Limitations of both are discussed throughout.

Some concluded that formulation was used to identify key difficulties.

> *'So formulation is sort of identifying the difficulties I'm facing, and what CAMHS are trying to help you. That's my understanding of it.'* (Participant 8).

That said, formulation was identified on one occasion as being more suited to complex problems.

> *'Maybe formulation isn't necessary, because it could be like one of your parents has died so you feel sad while you're grieving. And that said, maybe that doesn't need a formulation.'* (Participant 3).

Following identification of difficulties, participants reported that formulation can be used to plan intervention.

> *'We were making decisions about discharging or offering future appointments, and as a result of (the formulation) they've kind of increased the frequency of appointments for a bit.'* (Participant 5).

In line with planning intervention, some participants reported that formulation can identify strategies.

> *'I think the only thing is you have to bring in strategies, because the whole point in doing it.'* (Participant 1).

> *'With the other counsellors, (who didn't do formulation) they didn't know what they were dealing with, so she just kept taking shots in the dark and like trying different techniques that might work out for other people but didn't help me.'* (Participant 7).

Similarly, some believed that a diagnosis can be, or is, used to plan intervention.

> *'For almost like reoccurring problems, if there could potentially be something then I think will be more useful to um to get it diagnosed first, and then go off what the recommended treatment for the diagnosis is rather than just winging it as such.'* (Participant 1).

> *'If you don't fit the criteria, then you're not diagnosed so you can't get any treatment. But you can't be diagnosed if you like, aren't getting any treatment!'* (Participant 5).

There was a suggestion here that a formulation is less 'valid' or structured than a diagnosis as it is referred to as 'winging it', whereas a diagnosis is believed to lead to a 'recommended treatment.' This may be associated with subtheme 1.1 in which some participants described diagnosis as more well-known than formulation. Alternatively, it may suggest a misunderstanding amongst some clients, or clinicians, that formulation is not evidence or theory based. That said, other participants appeared to identify a vicious cycle or a gap which can occur in mental health services where one is either considered either 'too ill' or 'not ill enough' to gain access to a service.

Furthermore, some described that a diagnosis helps explain things to others, and progress intervention or give access to medication for example.

> *'I feel like a diagnosis would be very beneficial to me, because it would help me explain to other people that may not know me so well.'* (Participant 8).

'I think sometimes it can be a negative but then also can be positive because like it makes it more clear about what it is, and what you're going to do.' (Participant 5).

'Well they gave me tablets for depression. Um but it didn't really change about how I have more of an understanding of like why I've been feeling like this.' (Participant 4).

Again, as in subtheme 1.1, one participant appeared to suggest that a combination of diagnosis and formulation is most helpful. Whilst the participant did not state that the formulation would give this understanding, they did identify that a diagnosis and medication are not able to provide it.

Moreover, some participants outlined limitations of diagnosis.

'You can't just in one hour, "right, this is your problem" when you don't know everything.' (Participant 2).

'Obviously they can't have like a diagnosis for everyone because it might not be that clear what it is.' (Participant 5).

'So I was referred in, had the assessment, and they'd say "Oh, there's nothing wrong" because it was SAD so it doesn't affect me all the time.' (Participant 8).

Whilst some participants felt positive or neutral about getting a diagnosis, this finding highlights that young people are able to consider the limitations of diagnoses, and moreover

would appreciate professionals to be hesitant about it since presenting difficulties may be less prominent at the time of the appointment.

Finally, some participants outlined that using both a formulation and a diagnosis together can be most explanatory.

> *'I feel like you could have like, "this person has anxiety" and then go into the formulation. I feel like it does need to be both.'* (Participant 3).

> *'I mean it's good to have both because obviously when you do your formulation you can kind of understand where they're coming from with the diagnosis.'* (Participant 4).

Summary of Findings with CAMHS Clinicians

Three main themes were developed following the focus groups with CAMHS' multi-disciplinary clinicians.

Theme 4: The impact of young people's experiences of formulation on clinical practice.

- Subtheme 4.1: Reflecting on the therapeutic impact of formulation
- Subtheme 4.2: Clinical practice in the context of young people's experiences of formulation
- Subtheme 4.3: Importance of good working alliance and communication

Theme 5: Clinicians' reflections on their role and their reactions to the young people's findings

- Subtheme 5.1: Clinicians' reflections on their skills, preferences and limitations

- Subtheme 5.2: Clinicians' reactions to young people's experiences

Theme 6: Wider network and society's expectations of CAMHS and knowledge of formulation

- Subtheme 6.1: The network's expectations of CAMHS
- Subtheme 6.2: Need for education regarding formulation and diagnosis in services and wider society

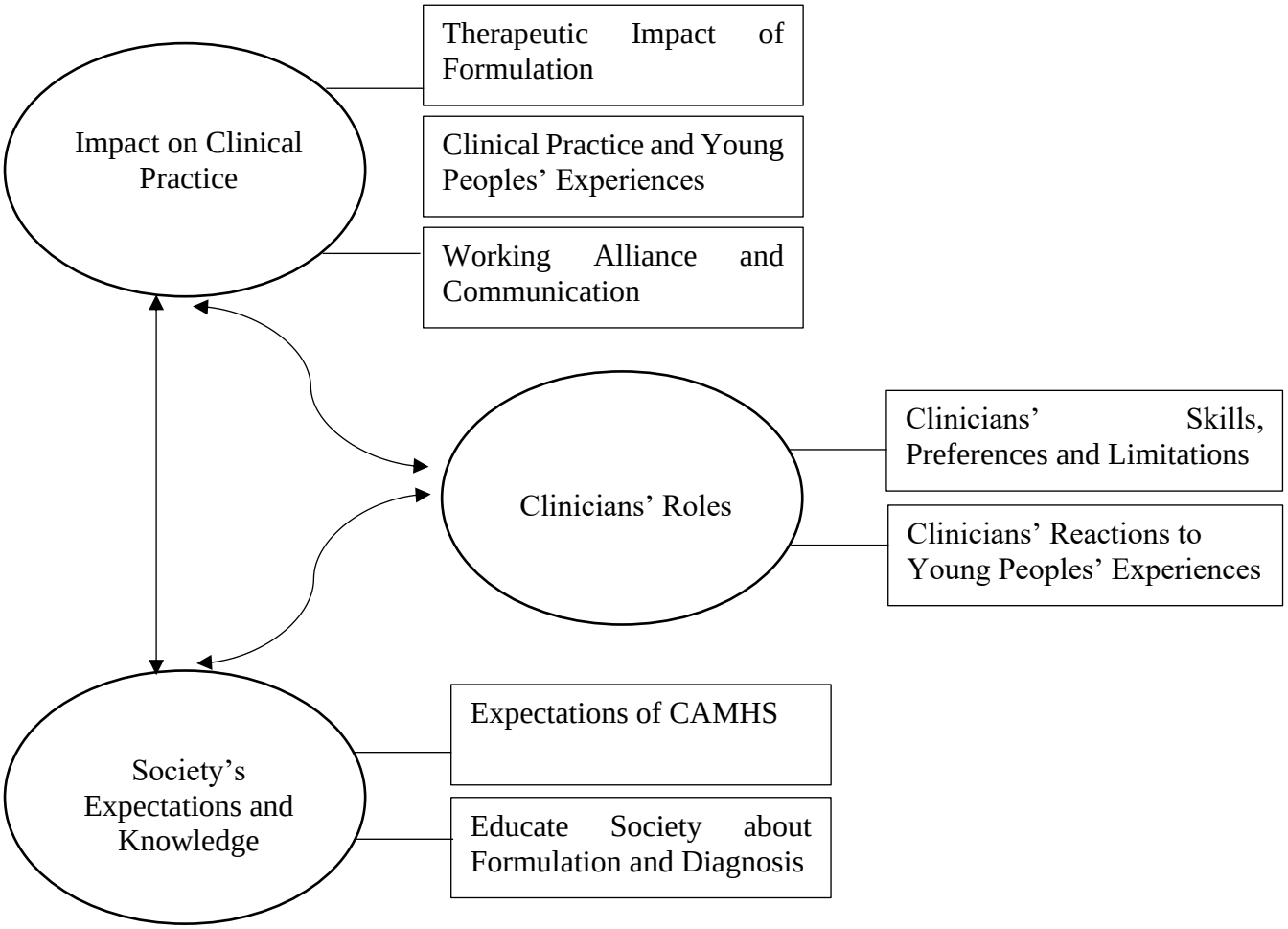
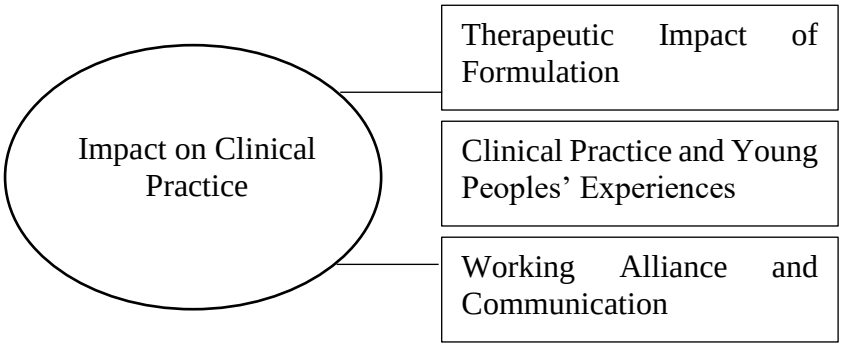


Figure 5. Thematic Map summarising the three main themes and seven subthemes developed from the data with CAMHS Clinicians

Thematic Analysis: Focus Group with CAMHS Clinicians

Theme 4: The impact of young people's experiences of formulation on clinical practice



The first theme draws together clinicians' reflections on the impact that the young people's findings and formulation itself might have on clinical practice. This includes the therapeutic benefits of formulation that young people appeared to describe; other things that clinicians would like to see happen in clinical practice; and the felt importance of a good working alliance and communication between clinicians and clients.

Subtheme 4.1: Reflecting on the therapeutic impact of formulation

Some of the clinicians reflected on the apparent therapeutic impact of conducting formulations with their clients. For example, they noted that some of the young people appeared to find their formulation containing.

> *'It's synthesising the data, isn't it? And then leave it behind. It is therapy, isn't it? Sometimes the formulation is the intervention. Other times it is just the start.'* (Participant 10, Clinical Psychologist).

> *'A lot of young people want to be held together by a word, the word like diagnosis, a word like formulation.'* (Participant 1, Child Psychotherapist).

Similarly, one clinician reflected that a formulation can have another therapeutic impact in that it helped reduce symptoms and encourage change.

> *'There is a link there to behaviour change. That is what we want. That is why the formulation exists, isn't it, to create a change.'* (Participant 10, Clinical Psychologist).

Likewise, a clinician reflected on a young person's descriptions of using their formulation outside of sessions to understand themselves or their emotions in certain situations.

> *'If you self-formulate, you start to do it outside of the room, it is a learning, it is your emotional intelligence, isn't it?'* (Participant 12, Social Worker).

Clinicians reflected on young people's descriptions regarding feeling validated by an accurate and non-judgemental formulation.

> *'The formulation can play a really important role in helping, well acknowledging the discussions that you've had and helping them to feel sort of understood, and, and their difficulties made sense of and given meaning to.'* (Participant 1, Child Psychotherapist).

> *'And then it is like, "OK, I feel like this because this has happened".'* (Participant 11, Assistant Psychologist).

Going further than validating difficulties, some clinicians reflected that during formulation they could almost give clients 'permission' to feel low for example.

'We should be encouraging adolescents to feel low content, a range of emotional things, not this striving for perfection or depression.' (Participant 10, Clinical Psychologist).

It was also acknowledged that young people appear to want something 'useful' from their formulation, therefore suggesting that it was not just used for information gathering and summarising.

***'**It seems some are not just commenting on what we understood it to mean, but also on its usefulness. Whether it's useful for them as an individual or other people, whether it tells them they know what the clinician is thinking.'* (Participant 3, Child Psychotherapist).

Subtheme 4.2: Clinical practice in the context of young people's experiences of formulation

Going forward, some clinicians reflected on changes they would like to see in their own or whole teams' clinical practice. For example, one clinician commented that they would like to use supervision and leadership skills more to share information to increase good practice for young people:

'I wanted supervisors to be more linked in and more accountable, but, ultimately, more accountable to the young person.' (Participant 10, Clinical Psychologist).

Further, some clinicians discussed that reflecting on how formulations are experienced by clients can be done in supervision.

'I was thinking about how we tell the formulation and understanding of difficulties, and then also thinking about how upsetting it can be. One time I didn't realise until I talked about it in supervision. The young person didn't want to go there.' (Participant 8, CAMHS Practitioner).

There were also suggestions that formulation could be a place in which to encourage young people to think more widely about changes they would like to make, or to encourage changes at a societal level.

'Sometimes I think, 'Where is the social activism?' or, 'Where are the young people wanting to get involved with political things?' It is making me think a little bit more about how can I start incorporating those conversations, if they are appropriate, into formulations.' (Participant 13, Clinical Psychologist).

Additionally, some clinicians noticed that there was little discussion by the young people interviewed about strengths being included in formulations. They discussed that there may be benefits of discussing strengths during formulations.

'A strong formulation should help to identify strengths, ways to go on, rather than just a problem definition…If we could do that sooner, that would become empowering, wouldn't it?' (Participant 12, Social Worker).

'Is that something to do with low self-esteem when people can't generate that, maybe? Or maybe it is something to do with the high-risk group that we see. I will take that

away and think is my formulation strength's focused as well.' (Participant 10, Clinical Psychologist).

Similarly, there was a discussion about the time-limits that services have, and the nature of therapy being offered in this context when there is a 'problem' or a risk; meaning that referrals, assessments and thus formulations can readily become problem-saturated.

'It kind of feels like it is problem-focused from before they come to CAMHS, which is for a reason, because I suppose the GP might not have time to write lots of information.' (Participant 13, Clinical Psychologist).

'I guess the nature of therapy is that you are problem-solving, and it is like, 'Oh, what's wrong?' or, 'What difficulties do I have?'(Participant 11, Assistant Psychologist).

With regards to clinicians' reflections on changes they would like to see in clinical practice, there were also lots of discussions about how to work collaboratively with young people. Some clinicians discussed how letters including formulations could be written, to keep the young person at the centre.

'When we're doing an assessment report back to the GPyou word it very differently if you're addressing the family and the young person. But I think either way, I always have the young person as a reader and in mind.' (Participant 1, Child Psychotherapist).

Some of the clinicians discussed the young people's comments that formulation can be useful for the clinicians, such as to help them remember things. In turn, the clinicians reflected on whether they were collaborative in their work.

> *'It made me think about times when perhaps I am not so confident or I feel quite confused and where I will try and use formulation, perhaps, more to put myself at ease. Then I am not sure how collaborative it becomes or how therapeutic it is.'* (Participant 13, Clinical Psychologist).

Moreover, clinicians considered how they might increase collaboration during formulation, which included asking clients what to discuss in clinical supervision and giving them the opportunity to 'correct' information such as in letters.

> *'The supervisee asking young people what questions they want taken to supervision. Those kinds of ideas that can drive inclusiveness but also facilitate the formulation.'* (Participant 10, Clinical Psychologist).

> *'Ask what they thought of it, just there may be some corrections that they may not have expressed.'* (Participant 3, Child Psychotherapist).

It was also discussed that being collaborative was a balance between clinicians giving enough of their professional ideas to be helpful versus not 'taking over'.

> *'They actually appreciated knowing what we thought and how we put things together. And I suppose you have to be careful with that, because you don't want to, you know,*

put words people's mouths or make links that they then think, "Oh, she doesn't understand."' (Participant 5, Clinical Psychologist).

Similarly, it was discussed that collaboration was a highly important, if not a key part, of the process, regardless of the type of method used.

'Be transparent and collaborative, that whatever you do, whether you're giving a diagnosis, or just formulating or hypothesizing or whatever you want to call it.' (Participant 6, Family Therapist).

It was also suggested that the amount of collaboration varied amongst clinicians.

'Isn't it about how transparent you are about what you're doing and why. And I guess there's probably a variation between clinicians of that.' (Participant 6, Family Therapist).

Collaboration in the formulation may also inevitably be impacted by the nature of making sense of people's difficulties and stories. That is, clinicians continued to formulate and make sense of things after the client had left the session.

'There may be some things we might add that we thought of afterwards. Because I think we continue to work it through don't we.' (Participant 3, Child Psychotherapist).

Furthermore, clinicians suggested that services could increase collaboration and team working amongst multi-disciplinary professionals. Additionally, services could increase opportunities for team training or sharing knowledge.

> *'Increase communication and working collaboratively with psychiatry or just within the MDT, because, to me, it feels like they (formulation and diagnosis) are both helpful.'* (Participant 13, Clinical Psychologist).

Subtheme 4.3: Importance of good working alliance and communication

Clinicians discussed that the young people appeared to suggest that the working alliance was an imperative part of the assessment or therapy, regardless of the formulation.

> *'It sounded like the relationship was quite important in the formulation. So, it wasn't necessarily about the formulation or the outcome of it, but more about the process.'* (Participant 13, Clinical Psychologist).

Clinicians also reflected on the unintended power dynamic that exists between the client and professional. This power dynamic could be useful for the client, such as using it to aid change. However, it could perhaps make clients feel vulnerable. In turn, one clinician commented on being careful about how she shares her formulations to different audiences.

> *'It is clear that they do feel a power dynamic there, don't they? That we have the power to change their story, in a way.'* (Participant 10, Clinical Psychologist).

'I am having to be very mindful of how I might share my understanding and, I guess, what parts you might say and what parts you might not share explicitly or in the same way that you would discuss it in MDT.' (Participant 13, Clinical Psychologist).

To manage this power dynamic, clinicians discussed the need to give clients choice.

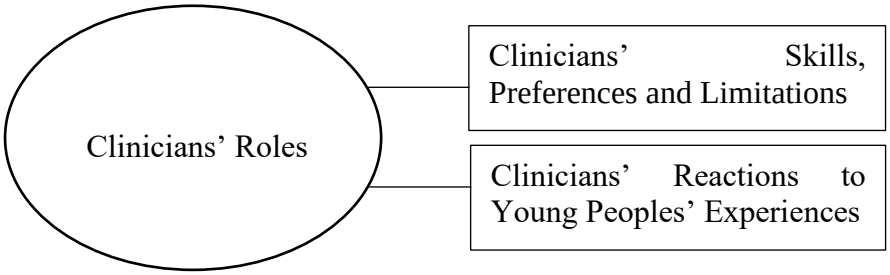
'What do you want as a young person within this? We can sit here and reel loads of different things off but give options.' (Participant 12, Social Worker).

'I think they should be given the choice shouldn't they. And that seems to be taken away from them. I don't know how either by the system or their parents or a professional.' (Participant 7, Student Mental Health Nurse).

Finally, within a positive working alliance, clinicians reflected on the impact and importance of good communication on both the formulation and therapy.

'There's a statement here, "with the other counsellors who didn't do formulation, they didn't know what they were dealing with……" So, you'd have to question that whole communication between those people.' (Participant 6, Family Therapist).

Theme 5: Clinicians' reflections on their role and their reactions to the young people's findings



Theme five summarises clinicians' views of their role in the development of formulations, and their preferred ways of working regarding formulation or diagnosis. Further, their responses to the young people's views are outlined, including some of the views that the clinicians were happy to hear, and some differences of opinion they had with the young people.

Subtheme 5.1: Clinicians' reflections on their skills, preferences and limitations

Some clinicians outlined what might get in the way of developing a formulation or including wider and more complex factors in a formulation, including the ability of the client, the understanding of the clinician and time-limits.

> *'Maybe when the child is younger, it may not be appropriate for them to read and try and take in any kind of formulation.'* (Participant 1, Child Psychotherapist).

> *'There is only so much you can think about when you formulate and there is only so much time we have.'* (Participant 13, Clinical Psychologist).

Moreover, some of the clinicians reflected on what else might get in the way of formulating, including their own lack of confidence.

> *'We have very high expectations of ourselves in CAMHS. Do you remember what (a manager) said this morning? Clinical Psychologists rate themselves as being 65% competent in working with trauma.'* (Participant 10, Clinical Psychologist).

However, it was also suggested that it can be okay not to have all the answers as clinicians, and that it can help to be transparent about that. The limitation in clinician's knowledge was impacted by multiple factors such as the time it takes to process and understand clients' stories, or the complexity of difficulties.

> *'I think sometimes people have to be honest, and say, "We don't know what's the best way to pull this together. But I mean, these things look important at the moment.'* (Participant 3, Child Psychotherapist).

Clinicians discussed the impact of risk and service changes on formulation. The Tier 3 CAMHS services in the area in which this research was conducted tend to be referred high-risk or complex cases, with the young people with lower risk levels being referred to Tier 2 or primary care services. This increase in the number of clients presenting with risk can lead to a reduction in the ability or time to formulate well.

> *'We have become more crisis-led as a service over the last five years… It is really interesting what happens to formulation in that: It disappears.'* (Participant 10, Clinical Psychologist).

Despite the difficulties and limitations of conducting formulations, clinicians reflected on the skills that they bring to the development of the formulation.

> *'You do have lots of things going around in your mind, lots of thoughts, you are trying to understand the people in the room, within a relatively short space of time.'* (Participant 12, Social Worker).

'That is a clinician skill, isn't it? Matching what it is and in what media to share it, the formulation.' (Participant 10, Clinical Psychologist).

There was also a discussion about the use of diagnosis in services, and clinicians noted that some of the young people wanted a diagnosis or discussed its utility. This was an impassioned discussion point, as many clinicians have their own views regarding whether diagnosis is useful, or something that they are comfortable using, which was at times in contrast to some of the young people's current views.

'I don't do diagnosis, it's not something that fits with the way I think. .' (Participant 6, Family Therapist).

'Often parents are wanting a diagnosis as a ticket to a service. Whereas I sometimes feel that a diagnosis will actually do a person or family no good, whatever.' (Participant 1, Child Psychotherapist).

Clinicians discussed that even if a diagnosis was not sought by the clinician or the client, restrictions placed by services or systems can mean that a diagnosis or medicalised framework was imposed.

'In a previous Trust that I worked in, as part of the electronic system when you assess somebody you had to give them a diagnosis. I just gave everybody adjustment disorder, because I wasn't going to give them anything else.' (Participant 6, Family Therapist).

One described an experience of offering a service to clients without the need for this diagnostic system.

> *'I just worked with a new ASD service and the young people who are referred to their service, they do not have a diagnosis. No matter if they get a diagnosis at the end or not, they still can work on something related to psychological support, counselling or financial support.'* (Participant 4, Trainee Clinical Psychologist).

As can be seen, there were differing views regarding the use of diagnosis in young people's mental health service. However, one participant highlighted the impact diagnoses can have on accessing treatment.

> *'A diagnosis that I don't agree with which is borderline personality disorder, for example, is inheritably so stigmatizing, but people won't get access to Dialectical Behaviour Therapy or mentalisation based therapy or other treatment, if they don't sometimes have those diagnoses.*' (Participant 9, CAMHS Practitioner).

Subtheme 5.2: Clinicians' reflections on young people's experiences and understanding of formulation, and clinicians' level of agreement with their views

This subtheme draws together some of the clinicians' responses and feelings to reading the quotes by the young people interviewed. For example, some felt hopeful about the young people's views.

> *'I love this participant: "Diagnosis doesn't help you understand everything. That is more formulation." Yes. That is what we need the world to understand.'* (Participant 10, Clinical Psychologist).

Further, some shared general positive comments regarding the ability of the young people to express their views, and to process formulation and therapy.

> *'I'm sort of impressed that the young people are giving thought and are able to express themselves well. Not saying I'm surprised, I'm just saying it's impressive.'* (Participant 3, Child Psychotherapist).

Similarly, one reflected on the ability of the young people to understand therapy, and themselves following formulation, and the long-term benefits this can have for help-seeking behaviours for instance.

> *'What is so heartening to hear is that these young people get it; they understand therapy. ...So they are more likely to do it again when they run into trouble.'* (Participant 10, Clinical Psychologist).

> *'It seems like they grasp the ideas about the process. ... How they like that is a process for me to understand myself.'* (Participant 4, Trainee Clinical Psychologist).

However, there were some slight disparities with some of the young people's ideas. For example, many of the young people suggested that formulation is beneficial as it helps to

develop interventions and suggest strategies though some clinicians suggested it is for more than that.

> *'People can often tell us that "we need some strategies, we need some strategies," you could get caught in the trap of just giving a strategy.'* (Participant 5, Clinical Psychologist).

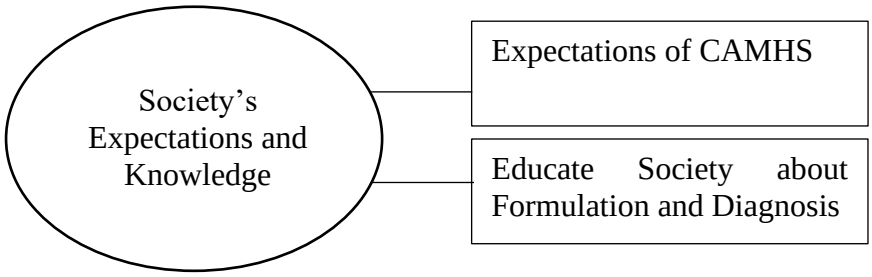
'But putting together a formulation is completely different to the task of deciding what we're doing. That comes next.' (Participant 1, Child Psychotherapist).

Similarly, the clinicians developed their own sense making of young people's understanding of diagnosis.

> *'I was thinking about diagnosis and wondering what their understanding of this is. Maybe they're thinking it's something that's been looked at by a Dr.'* (Participant 8, CAMHS Practitioner).

> *'I don't think diagnosis in mental health is equivalent to diagnosis in some physical sciences. So the same word might be used and people could misinterpret it.'* (Participant 3, Child Psychotherapist).

Theme 6: Wider network and society's expectations of CAMHS and knowledge of formulation



The final theme describes clinicians' experiences of the expectations that other networks such as schools have regarding how CAMHS might work with young people, and reflections on the knowledge and use of methods like formulation and diagnosis by such networks and wider society in general.

Subtheme 6.1: The network's expectations of CAMHS

In this subtheme, the clinicians reflected on the young people's quotes in the context of service delivery in CAMHS, and the expectations of CAMHS by other services and networks, such as schools.

> *'There is so much anxiety, I think, in other professionals, projecting onto CAMHS being this thing that is going to sort everything out. (Participant 12, Social Worker).*

One wondered if formulation was not of interest to the young person's network as their key interest was in quick recovery.

'Cynically, I think the young person cares about formulation. I don't think their network does. I think their network cares about them being well or happy or fitting in or something selfish.' (Participant 10, Clinical Psychologist).

Similarly, there were discussions regarding the network's anxieties about risk or even mental health itself. There was a suggestion that this anxiety, along with expectations of what CAMHS will do, shuts down creativity and thinking in other networks, who may be able to formulate with the young people earlier.

'The anxiety coming up from the system through schools and doctors and referrers, there is no formulating that comes into us.' (Participant 13, Clinical Psychologist).

One implication for practice might be that networks involved with young people could start to develop their own formulations, which may provide enough containment for the young person, or may reduce networks anxieties about risk.

'They might have self-harmed or they might have done this impulsively or whatever, but, if there was a formulation around that, you might realise, actually, maybe it is not as risky as it seems.' (Participant 11, Assistant Psychologist).

However, some benefits of sharing formulations with the young people's networks or families were considered.

'Sharing formulation with families can be helpful. So, I had someone where mum wasn't really aware of how much everything in the past was affecting her now. So, mum came

into one of the sessions and we shared the formulation together.' (Participant 11, Assistant Psychologist).

The impact of diagnosis for clients and their network was also reflected on. It may be that a concrete 'answer' helps to reduce some of this anxiety in the system. Further, it may also offer a language which is understood more easily across contexts. There did not appear to be a suggestion that this was the preferred way of working, but more of a pattern of communication that has been noticed.

'... a language that, you know, wider institutions like schools would understand and it fits in with the education system; diagnosis.' (Participant 6, Family Therapist).

'It's a way that they communicate.' (Participant 4, Trainee Clinical Psychologist).

'I wonder if the diagnosis, because it's shorter, it's easier. I don't think people ever have the time to actually read things.' (Participant 5, Clinical Psychologist).

Subtheme 6.2: Need for education regarding formulation and diagnosis in services and wider society

In this final subtheme, clinicians discussed some of the current wider research and academic knowledge which they draw on in their understanding of their clients, and the factors that need to be considered for understanding and supporting young people. For example, they showed awareness of the impact of social deprivation on mental wellbeing. However, not all clinicians were aware of new publications about this, leading to a suggestion of the need for continued sharing of knowledge within teams.

'We have the Power Threat Meaning Framework, which is very useful, isn't it? But we wouldn't necessarily share that with the young person. (*… we need some kind of CPD to think about the wider social context, don't we and how that links to formulation.'* (Participant 10, Clinical Psychologist).

The focus group also reflected on clients' and the general public's knowledge of current ideas and clinical practice regarding both diagnosis and formulation. They also reflected that there was a degree of mismatch between what the clients understood about the difference between diagnosis and formulation versus what people around them understood.

'It seemed like the young people were making the distinction between diagnosis and formulation, and they were describing it as two very different things' (Participant 13, Clinical Psychologist).

'Whether people like diagnosis or not, in terms of explaining to school etc they're saying it feels easier. But doesn't necessarily give an understanding.' (Participant 5, Clinical Psychologist).

There were also some questions regarding the young people's knowledge of formulation and specifically, reformulation. It was noted that the young people did not speak about formulation as a flexible and changing entity. This could be because the participants were currently engaged with CAMHS and so had not experienced it yet, some clinicians do not do it, or that the participants had not noticed or reflected on it.

'I am wondering if that is also something that they feel is something that might change or can change, or if it feels like, "This is the diagram I take away with me," and then it is fixed. I guess formulation, it comes with the word 'reformulation', doesn't it?' (Participant 13, Clinical Psychologist).

Consequently, it was discussed that there was a need to educate society about diagnosis and formulation.

'It's not only mental health service settings that set up the diagnosis, but it's the world that we live in.…Ask your mum and dad about formulation, they can't tell you, but if you ask them about diagnosis, they can definitely tell you something.. .' (Participant 4, Trainee Clinical Psychologist).

'I wonder if there is a way of trying to make it easier to understand or is it more of a cultural change in terms of the understanding of what mental health might be?' (Participant 2, Assistant Psychologist).

Ideas regarding how to increase this awareness within networks which work with young people were suggested. Similarly, some clinicians reflected on ways in which they were trying to change others' ways of thinking about the need for a diagnosis, such as by changing the way they communicate with them.

'If you said to people and to schools that someone has anxiety and low mood, and that needs to be taken into account of when they're angry. And it's not as it were, a 'conduct problem'.' (Participant 3, Child Psychotherapist).

> *'We're often asked for letters and it's "oh we need a diagnosis." I rarely write, a diagnosis in a letter. But usually the letters are enough.'* (Participant 5, Clinical Psychologist).

Likewise, some reflected on how their practice might inadvertently reinforce the reduced frequency of other networks using or understanding formulation. Further, perhaps there could be a combination of formulation and diagnosis, particularly if a young person expressed a preference.

> *'Working in NHS I noticed that there are just two kinds of letters. One, it's really, really short with a diagnosis, without explanations. And the other one is really lengthy, lots of formulations without diagnosis. So I just wonder why can't they just blend it together.'* (Participant 4, Trainee Clinical Psychologist).

> *'One of them said, "I feel like you could have both the diagnosis and the formulation". Maybe that's what some of the young people would like; a bit of both.'* (Participant 2, Assistant Psychologist).

Finally, there were discussions about the use of language, and how certain terms or jargon can alienate clients and their networks from fully understanding what is happening, or even cause a power imbalance between client and clinician.

> *'We live in a world of acronyms, and we just say them as though everyone is supposed to understand what we are talking about. Then they might feel silly for saying, "I don't know what that is".'* (Participant 12, Social Worker).

'That's why people don't know what formulation is; because we don't use the word. And it's interesting isn't it, because diagnosis gets used as a word. And it's the thing that everybody wants. And you try and do these formulations. And they're like, "yes, but what's wrong with me?!"' (Participant 5, Clinical Psychologist).

Chapter 4: Discussion

Overview of Results in Relation to Research Questions

This research had two main questions:

1. What are young peoples' understandings, opinions and experiences of formulation?
2. What are CAMHS clinicians' reactions to this, and what impact might the findings have on clinical practice?

Question 1

Regarding young people's understanding of formulation, many of the young people were not aware of the term until they were invited to this study. That said, they understood it to have specific purposes including to identify key difficulties, causes of difficulties, and solutions, or to prevent behaviours which maintain their difficulties. Further, some understood it as a tool which helps clinicians to plan, make sense of and remember client's difficulties and the intervention.

Regarding their opinions and experiences of formulation, there was variation. Some described it as a one-off process, whereas others used it throughout therapy. All described their formulations as collaborative and felt at the centre of it. Most felt that could challenge their formulation, which was impacted by both interpersonal factors such as not seeing their clinician in an authoritative role, and intrapersonal factors such as confidence. Further, formulation impacted the working alliance positively. Some commented that the formulation also helped their parents to understand their difficulties. However, one participant described finding her formulation confusing. Following the formulation, there were therapeutic effects such as believing that their difficulties were valid and seeing their difficulties as more manageable. One participant described developing the formulation as temporarily upsetting, whilst some reported that formulation helped to process their emotions.

Question 2

Regarding CAMHS clinicians' reactions to the young people's experiences of formulation, findings included hopeful surprise that the young people were articulate and curious about formulation and therapy. Further, clinicians reflected on what seems to work well, such as a good working alliance, and the apparent therapeutic effects of formulation. The findings also aided clinicians to reflect on their own skills, and at times lack of confidence, regarding doing formulation. There were some discussions and at times discrepancies regarding young people's understanding and preferences for formulation or diagnosis. For example, some did not agree that formulation is to help identify strategies. This could perhaps be because the process of developing an understanding is seen as therapeutic itself. Alternatively, it could be that clinicians felt somewhat criticised, associated with burn-out or pressures from higher

management. Further, some described that whilst some young people wanted a diagnosis, there may be negative effects of one.

Finally, regarding what impact the young people's responses might have on clinical practice, there were many implications identified for services. This included a need to check accuracy of formulations and written correspondence, a want for more sharing of knowledge amongst the team, and inclusion of more societal level factors in formulations. There were also implications discussed for other services and networks, including a hope to educate wider society about formulation and the limitations of diagnosis, and possible changes in communication such as how letters are written to schools or GPs.

Relevance of the Findings to Past Literature

Many of the findings were in line with previous research. For example, much like in Redhead, Johnstone and Nightingale's (2015) and in Burchardt's (2004) research, young people described that formulation helped them to understand problems (e.g. "Formulation can help you understand why you are the way that you are"; "why am I sad?" And then when you look back on it, like all of this sh*t has happened in your life"; subtheme 2.2). Further, both of those previous studies as well as Pain, Chadwick and Abba (2008) and Shaw, Higgins and Quartey (2017) reported that formulation helped participants feel understood by their clinicians. Further, Burchardt (2004) outlined that formulation helped develop trust in therapists, which was also reported in this study. Likewise, many of the young people in the current research described that they had felt heard when an accurate formulation was presented back to them ("they know what I'm actually like thinking"; subtheme 1.2), which in turn helped them feel more comfortable around and confident in their clinician.

In addition, Kahlon, Neal and Patterson (2014), Redhead, Johnstone and Nightingale (2015), and Burchardt (2004) outlined that formulation enabled participants to move forward, such as processing their emotions. Indeed, some young people in the current research described that the formulation helped to desensitise or give distance from their difficulties. Similarly, in those previous studies and some of the young people in this research both reported that formulation helped plan strategies and get support from others; in this case parents and schools. Moreover, participants in both the current research and research by Thew and Krohnert (2015) described that formulation can help to recognise and contain patterns, cycles and consequences. Indeed, some of the young people in this research described that formulation can help recognise the actions and thoughts that affect their emotions, and what keeps difficulties going, and one even suggested that formulation could be used as a relapse prevention tool when known patterns start re-occurring.

Some difficulties with formulation were also noted in previous research and by the current participants. For example, Redhead, Johnstone and Nightingale (2015), Thew and Krohnert (2015), Pain, Chadwick and Abba (2008), and Chadwick, Williams and Mackenzie (2003) reported that some participants experience negative emotions or blame with regards their formulation. Likewise, in the current study, some of the young people reported that the formulation can be upsetting, though one reflected that it needed to be factual and therefore needs to contain potentially upsetting information. Similarly, one described that it made them feel like they had not been doing things in the ‘right way’ when they read their formulation. Furthermore, as in Redhead, Johnstone and Nightingale (2015), one of the participants in the current research reported that her formulation with a past clinician had been inaccurate, which in turn negatively impacted the therapeutic alliance and emotions.

There were some differences compared to the research by Thew and Krohnert (2015). For example, in the previous research the participant described having remaining unanswered questions, particularly around the onset of the difficulties, and did not feel it normalised her difficulties. Whereas, in the current research participants described that formulation helped to identify causes and normalised and validated difficulties.

Formulation was not necessarily experienced by participants in the current study in a similar way to Stewart (2016)'s research. Stewart (2016) reported that formulation-sharing develops a sense of self-in-the-world; helped them recognise potential for change; and gave an opportunity to rehearse these new understandings. This may be because participants in the current study were still at the beginning of understanding and utilising their formulation. Alternatively, young people may not have been developmentally ready to consider formulation in an aspect as wide as giving 'a sense of self-in-the-world'.

Similarities were also evident in the responses by professionals in the focus groups in this research, compared to previous research with professionals and teams. For example, like Herhaus' (2014) research, participants in the current research discussed the use of formulation in negotiating professional roles, and the use of sharing formulations in supervision to share difficulties in the working alliance or when the clinician was not feeling confident on a case. Moreover, participants in both the current research and Herhaus' (2014) research, discussed the use of formulation to help tolerate uncertainty. Indeed, some of the current participants discussed that it was ok for a clinician to not fully know or understand a case at first, and that formulations can change, or re-formulation can occur. Participants in the current research also discussed that they would like to see more social and contextual information in formulations,

as well as discussions about social activism with clients. Similarly, participants in Huisman and Kangas (2018) research described that contextual information was important in formulations.

However, much like the findings from Blee's (2015) research in which formulation was described as a 'luxury', it was discussed in the current research that as risk increases and the amount of time to work with clients decreased, formulation 'disappeared' and in particular inclusion of things like client's strengths decreased. Furthermore, similarly to Mohtashemi, Stevens, Jackson and Weatherhead's (2016) research, some of the participants in the current research suggested that psychiatry, and multi-disciplinary professionals in general, should work together as both a formulation and diagnosis approach can be helpful. Similarly, participants in both the current research and research by Weedon (2017) discussed that formulation can be less stigmatising than diagnosis; though current participants acknowledged that some diagnoses are more stigmatising than others, and that clients should be given chances to make informed choices. Finally, in contrast to the research by Adams (2015) who reported that professionals described needing to address medical issues before formulating and some resistance to doing it, participants in the current research appeared to describe that formulation was important in getting an understanding of clients.

Novel Findings

Some novel findings were also drawn from the young people in the current study. For example, different responses by different participants highlighted the range of ways in which a formulation is developed and shared, such as verbally, in diagrams or through seemingly narrative style letters ("It was kind of like a letter you get from your grandma!"; subtheme 1.1). Moreover, it was described by some of the participants that developing the formulation in a

way which drew their focus to a diagram, drawing or letter made the first few meetings with their clinician feel less 'awkward'. It was also suggested that the information drawn together in a formulation could be shared with other professionals, to help reduce the need for clients to repeat their stories to each professional they meet, which may be particularly important when a client has appointments with various members of a multi-disciplinary team. Further, participants reflected on the benefits of formulating for the clinicians, such as helping them to understand, remember and plan, and discussed this in a way which suggested that they respect and understand the need for clinicians to use the formulation to help themselves as well as the client. The young people also reflected on the varying levels of complexity which may impact formulation. Firstly, a suggestion that formulation is not needed for 'straightforward' difficulties like a single bereavement, and secondly a suggestion that formulation has lots of ideas 'branching off' one and other.

Whilst many of the participants in both this and past research (e.g. Hess, 2000; Kahlon, Neal & Patterson, 2014; Pain, Chadwick & Abba, 2008; and Chadwick, Williams & Mackenzie, 2003) have explored the impact of formulation on the therapeutic alliance, the current research additionally highlighted that sometimes clients would not challenge a clinician because they trusted their view as a professional, whereas others did challenge because they did not see clinicians in an authoritative way. The efficacy of a formulation was also highlighted to be impacted by the client's own level of engagement to the process and impacted by whether the therapeutic alliance was present when it was conducted. Furthermore, some of the participants called for a formulation to be accurate, as this impacted trust in the current therapeutic alliance, as well as the story that is told to other professionals in future. Similarly, some of the participants wanted to be told what was happening (e.g. "say it is a formulation… and this is why it helps."; subtheme 1.2).

Much of the previous research with professionals regarding formulation focused on their views of it first-hand. In contrast, the focus of the current research was giving professionals the opportunity to reflect on their clients' experiences of formulation. In turn, novel findings were developed from the professionals focus groups too. For example, participants reflected on the impact that formulation appeared to have for clients, such as synthesising data, 'holding' together the client, encouraging behaviour change, and developing emotional intelligence. Participants also discussed the skills that clinicians bring which can aid these processes. For instance, being able to understand lots of different people and thoughts in a short amount of time and matching the style of a formulation to the client. Furthermore, participants discussed a desire to make their formulations more collaborative, such as asking clients what they want discussed in supervision, giving opportunities for letters to be edited by clients, and giving clients choice; such as which therapist they want to work with or whether they want a formulation and/or a diagnosis. Finally, participants discussed the wider network around a client. For example, some described that referrals are often problem-saturated and systems such as schools can expect services like CAMHS to 'fix' everything. In turn, they wondered if such systems could formulate too, to put the difficulties into context or perspective. Furthermore, participants discussed that it may be important to educate the general public on the differences between formulation and diagnosis for example.

Relevance to Academic Literature

The findings from the current study were also relevant to academic literature. For instance, many participants identified one of the purposes of formulation was to explain the causes of difficulties. This was in line with theories and academic guidelines regarding formulation (e.g. Johnstone & Dallos, 2013). Additionally, some participants described formulation as a one-off process whilst others were used throughout therapy. Perhaps this suggests a difference in

clinicians' views regarding the purposes of formulation: If doing it once at the start of therapy perhaps it is used to prioritise issues or plan treatment (Johnstone & Dallos, 2013). Whereas if using it throughout, the purpose of formulation may be used to help the client feel understood, and strengthen the therapeutic alliance (DCP, 2011).

Furthermore, there were a range of experiences; for example, some of the young people were informed when a formulation or diagnosis was being made, whereas some of the young people were not. This could relate to a power imbalance between clinician and client, in a traditional 'Dr-patient relationship'. The Power-Threat Meaning Framework (Johnstone & Boyle, 2018) encourages people to consider 'Power'. Could this not include professionals' awareness and attention to explaining what is happening in assessments, formulation and interventions?

Who is Formulation For?

The findings also highlighted areas for further evaluation and reflection. For example, there were comments by some of the young people regarding the usefulness of formulation for clinicians, such as to help them remember and understand the young person's difficulties and plan the intervention. In addition, none of the young people had heard of the term formulation. Who then is formulation for? Clinicians or clients? Formulation is taught to various mental health professionals as a way of making sense of people's difficulties (e.g. Johnstone & Dallos, 2013). Further, some clinicians in the current study reflected on the use of formulation to support them when they are struggling to understand a case, or the use of formulation in supervision. In turn, the temptation or pattern of use of formulation in services may be to use it as a clinician's tool. However, given that the findings highlighted that formulation can have therapeutic gains in and of itself, and that some young people valued being told what clinicians are doing and why they believe it to help, perhaps the use of formulation could be widened out.

Perhaps it extends beyond the scope of making sense of people's difficulties and planning interventions, to having open conversations with clients about what formulation is, why it is thought to be helpful, and how it is used in services. As well as increasing the use of formulation as a therapeutic tool for clients, this may further even-out power imbalance between clinician and client.

Uses and Limitations of Diagnosis and Formulation

Finally, the aim of this research was not to enter a diagnosis versus formulation debate; instead it was to explore young people's experiences and opinions from their perspective. Moreover, in general there does not always need to be a diagnosis or formulation debate. Instead, the focus could be on what the client believes to be most useful for them. Indeed, not all the young people in the current research found formulation helpful, even when they understood it and its use, and explained that they would not go back to their formulation after it had been written out for example. Moreover, many of the young people discussed the benefits and functions of diagnosis to them and their networks. For them, this included feeling that the difficulties they were experiencing were validated by the diagnosis, believing that they could get better because there was a known 'illness' or difficulty which could be treated, and feeling like they had been listened to by the professionals. For their network, the diagnosis served functions, such as explaining quickly and easily to people, like teachers, how they were feeling and what support they might need; helping their parents to understand what is going on for them; and encouraging them to be able to talk to friends about how they are feeling. Further, some participants suggested that formulation and diagnosis can work well together, and, at times, both were needed. In turn, one of the key findings and implications from the current research was the importance of giving clients opportunities to make informed choices, good communication and information giving, and collaborative working. This could at times mean

clinicians working in a different way to their preferred method: Adopting diagnostic conversations alongside formulation conversations alongside diagnostic, depending on the client.

Meeting the Functions of a Diagnosis

Recent literature has highlighted some ways in which the functions of diagnosis might also be met in a different way, such as in formulations. For example, the Power-Threat Meaning Framework (PTMF; Johnstone & Boyle, 2018) acknowledged that diagnosis has multiple functions in and out of mental health services, including assessing eligibility for services; benefits assessments; risk assessments; judgements about criminal responsibility for actions; psychiatric research and grant applications; textbooks and training courses; record keeping; and use of diagnostic language in public health policies, mental health charities and campaigns and media coverage. The PTMF then attempted to outline potential alternative ways of meeting the functions of a diagnosis. This could include using personal narratives at the individual level, and a 'problem list' in ordinary terms for research or welfare claims (Kinderman, 2014). Similarly, the PTMF suggested that for research or eligibility for specific interventions, non-medical problem descriptions such as 'very low mood' or 'hearing hostile voices' could be used (Johnstone & Boyle, 2018). Likewise, it was proposed that service design and commissioning could also be based on problem categories or clusters; for instance, some existing services have pathways such as 'complex trauma' (Sweeney, Clement, Filson, & Kennedy, 2016). The authors reflected on the limitations of this, such as some descriptions or formulations may not be readily understood or accepted by lay people such as family or employers. However, given that people often readily take-up narratives such as "I am grieving", there may be space to alter narratives so that people are understood to be

experiencing certain difficulties because of some context, rather than they 'are' a disorder (Johnstone & Boyle, 2018).

Formulation and Diagnosis; Not Either/Or

Conversations regarding acknowledging the utility of both ways of working, rather than a polarised diagnosis or formulation debate, are evident in the general media. For example, Watts (2018) wrote in The Guardian that a tense dynamic between professionals with polarised views of diagnosis or formulation, discussed publicly on social media for example, can cause distress as well as lead to increased attention to negative stories of diagnosis only. Furthermore, similarly to the current research, it was noted that a review by The Lancet Psychiatry highlighted that for some people a diagnosis was helpful and sometimes not given soon enough from the client's perspective (Perkins, Ridler, Browes, Peryer, Notley, & Hackmann, 2018). Moreover, Watts (2018) discussed that some diagnoses are more helpful than others. For example, she discussed that diagnoses such as Obsessive-Compulsive Disorder or Depression can be experienced positively, validate difficulties, and encourage people to speak about their distress and access support. In contrast, a diagnosis such as Borderline Personality Disorder (BPD) may be experienced as a judge of the persons character, and the stigma and narratives around BPD can lead to some professionals not taking seriously communications from people with this diagnosis. Finally, it was discussed that the way in which a diagnosis is shared impacts whether it is useful or experienced positively, such as whether it is shared carefully, with clear information, and time is given for discussion. Indeed, in the current research some young people were not told their diagnosis but saw it on letters to their school for example. Vice versa, some asked for a diagnosis but were not given it but reported not being clearly explained why. In turn, Watts (2018) likewise encouraged people to give clients choice, increase discussions

regarding the impact of trauma and the socio-political context on distress, enable access to services even without a diagnosis, and encourages open dialogue over polarised debates.

Hart (2018) described that these debates occur because they matter. However, she suggested that the debates are also about power and expertise and searching for one truth. In doing so, people on both sides of the polarised debate risk silencing or not representing some people's views, thus leading to oppression; the very thing some people are trying to reduce through these debates. Further, Hart (2018) also discussed the function of diagnosis for some, such as helping people feel validated. Going even further, diagnosis can be necessary for survival in terms of accessing benefits or some services. By discussing formulation and diagnosis in polarised ways, Hart (2018) argued that an alternative single-story may emerge, in which trauma is seen as the cause of all distress and so should be formulated not diagnosed. This single story could in turn oppress other stories or understanding of distress such as spiritual, neurodiversity, or illness, which many people find useful. Instead, Hart (2018) suggested that it is possible to have an 'imperfect' system which allows all these different views and similarly argued for giving people choice.

The findings and discussions were complex. There is no one route to helping people feel understood or contained. Formulation will be helpful to some clients not all, likewise with diagnosis. Further, it can difficult to disentangle whether clients prefer either way of working because one feels more comfortable for them, or because one is more well-known and expected. Further, not all clinicians will have the confidence or training to move between formulaic and diagnostic ways of working with ease, despite good intentions. Together, this could re-iterate an implication from this research which was, whichever way one is working,

make it collaborative, share information and the advantages and disadvantages of different ways of understanding difficulties, and give choice.

Strengths of the Study

A major strength of this study was that it was (to the researcher's knowledge) the first of its kind to explore views and experiences of formulation from the perspective of people under 18 years old. Given that formulation is routinely used with young people accessing mental health services, it is important to ensure that it is accessible, useful and acceptable to them.

Another strength of the study was the involvement of young people in the design of the research materials. This may increase the accessibility and relevance of recruitment materials and interview questions. Further, it increased the involvement of and perhaps power to young people in another aspect of their care.

Furthermore, this study utilised the findings from the young people to explore clinical implications they might have for professionals. This may increase the usefulness of the findings for services, and it gives more in-depth information as it is gathered from two different sources.

Limitations of the Study

One limitation of this research was the small sample size in the young people's semi-structured interviews. Moreover, all participants accessed formulation/therapy within one NHS Trust. Together, this may limit the generalisability of findings to other young people, and services. That said, guidelines for formulation are national. Further, there is likely to be some variation

regarding how formulation is presented by all clinicians. Thus, the findings may represent natural differences in formulations.

There were a wide range of therapeutic models used across the formulations the young people in this research experienced, and the professionals in the focus group utilised, including IPT, CBT and psychotherapy. These all have somewhat different epistemological standpoints. Whilst this means the findings may be more generalisable, there is little distinction between people's experiences of the different models, which could be explored further in future research.

Another limitation of the current research was that the questions asked and then the codes and themes developed will have been influenced by the researcher's epistemological positioning. Further, as the researcher tends to use formulation over diagnosis, it is possible that the conclusions and implications reported may be impacted by researcher bias. To limit such biases, reflective journaling and checking data with a peer researcher and a research supervisor were conducted.

Similarly, bias may have been present in both the young people and the clinicians who participated. Firstly, only professionals who were confident with the quality of their formulations may have told their clients about the research or volunteered in the focus group. Secondly, only young people and clinicians who were particularly interested in the topic or had positive or negative (not neutral) experiences of formulation may have volunteered. That said, one of the focus groups was held in a regular monthly "visitors' slot" after the CAMHS team's standard team meeting, which may have increased the likelihood that a more balanced representation stayed for the research group.

Clinical Implications

Findings from young people suggested various clinical implications. Firstly, there was a difference in their experiences of how accessible and understandable they found their formulation. However, they valued thinking about many factors that may have caused and maintained their difficulties. In turn, when working with young people it may be difficult to make sense of a complex situation whilst not making it too simplified. These different experiences might suggest a need for clinicians to check understanding with the clients when developing a formulation. Moreover, in the current CAMHS climate, clinicians often write Choice and Partnership letters summarising the initial assessment and formulation. This letter tries to serve various functions, such as summarising needs and intervention plans for caregivers and other professionals, as well as for clients. This may make the letters less accessible for clients but more useful for professional networks. A balance regularly needs to be explored to increase the ability for the clients to make use of the initial written formulation in a meaningful or therapeutic way.

Similarly, an accurate formulation increased young people's trust in their therapist, which also gave feelings of validation from being accurately heard. This may impact the direction and experience of therapy overall. Therefore, ensuring collaboration, shared meaning-making and checking one's understanding is important for supporting a good working alliance both in the short and long-term.

Secondly, some participants discussed that diagnosis was more familiar than formulation, and so a diagnosis can help others to understand their difficulties. If formulation were more familiar outside of mental health services perhaps others would not need 'a name' to their difficulties

to feel understood or to get support. This is in line with some of the ideas from 'The Power Threat Meaning Framework' (Johnstone & Boyle, 2018) which suggests alternative language to diagnostic categories and discusses implications for how wider communities and social and political bodies should respond to human distress. One implication then could be that services and professionals need to be proactive at making wider systems more aware of formulation.

Moreover, some of the findings suggested a need for wider information sharing regarding mental health more generally. For example, some of the professionals in the focus group highlighted that networks such as schools can expect services such as CAMHS or a diagnosis itself to 'fix' a young person's difficulties. Additionally, it was reflected that there may be a misconception that mental health care follows the same route as physical health care, such as diagnosis – treatment - outcome. This may be impacted by individuals and groups expectations of a traditional 'Dr-patient' relationship in which the Dr is the 'expert' who 'treats' the patients. Such narratives may have been further ingrained by dialogues used by large systems such as mental health charities. For example, Mind and Rethink Mental Illness previously partnered on campaigns such as Time to Change, in which statistics highlighting how common mental health difficulties are were published (e.g. 'approximately one in four people in the UK will experience a mental health difficulty each year', McManus, Meltzer, Brugha, Bebbington & Jenkins, 2009). Such campaigns arguably made huge waves in encouraging people to open-up about mental health difficulties and reducing stigma. Indeed, the impact of Time to Change was analysed, and statistically significant differences (improvements) were reported in knowledge, attitudes, desired social distance from and contact with people with mental health difficulties in England in 2015 compared to 2009; during the time of the Time to Change programme (Henderson, Robinson, Evans-Lacko, Corker, Rebollo-Mesa, Rose, & Thornicroft, 2016). However, to do so, there appeared to a be a reliance on increasing knowledge of

diagnoses, and seeking help was somewhat simplified to the diagnosis – treatment – outcome framework. In contrast, mental health may be more complex than physical health, requiring several or a combination of interventions, support and change may be required at the familial, wider systems or societal level, and symptoms may cut across several diagnostic categories.

Furthermore, such dialogues and help-seeking behaviours do little to increase individuals, families or networks knowledge regarding why people have problems. Seeking diagnosis – treatment – outcome may suggest that mental health problems are purely biological for example, which leaves little space to reflect on the impact of wider social-cultural factors on mental health. How we can facilitate dialogues regarding knowledge of mental health, and expectations of services and treatment requires careful thought and action. Increasing discussions of the impact of social-cultural factors on mental health may increase feelings of shame or blame in families for example (Thew & Krohnert, 2015). Further, shutting down campaigns like Time to Change would disrupt the huge benefits observed. However, additional dialogues which highlight the multiple factors that often work together to increase mental health problems could increase knowledge of why people experience mental health difficulties. For example, increasing the general public's knowledge of the Adverse Childhood Experiences studies (e.g. Chapman, Whitfield, Felitti, Dube, Edwards, & Anda, 2004; Dube, Anda, Felitti, Chapman, Williamson, & Giles, 2001) - sharing the information outside of systems such as mental health professionals or teachers - may further increase understanding of the causes of mental health difficulties. Such dialogues could be facilitated by mental health charities, and through local mental health Trusts. This could be facilitated through charity and Trust websites, social media accounts and information leaflets, and through mental health professionals publishing research, dialogue articles, or social media comments. To increase accessibility and interest in such dialogues, such as for young people, parents or teachers, these conversations

may benefit from moving outside of mental health training courses and lengthy publications to things like posters or short videos, which encourage people to reflect on recent changes in the traditional Dr-patient relationship and the differences between treatment for mental health compared to physical health.

Finally, the PTMF (Johnstone & Boyle, 2018) suggested that questions that are asked by mental health services should include questions about what people did to 'survive' and their strengths, to gather a full story of the person. However, only one of the participants in the current study mentioned strengths being a factor in their formulation. Perhaps this is the aspect of formulation which is most readily lost when working with complexities or in time-limited interventions. However, ensuring inclusion of strengths can both gather the full story of a person and provide some catalysts for change.

Future Research

As previous research suggested that some professionals do not feel confident in constructing and sharing formulations, future research may benefit from exploring the barriers to clinicians' confidence. This may have important clinical implications because if professionals do not feel confident constructing formulations then the process may not be as beneficial for clients or teams. Moreover, lack of confidence could mean that professionals could avoid doing it.

Many of the young people discussed that they found both a diagnosis and a formulation helpful. Some young people described that the diagnosis helped them to feel that their difficulties were valid, but the formulation helped them to understand where their difficulties/diagnosis came from and made it more manageable. Therefore, future research could further explore how to

link formulations and diagnoses together in a way that is meaningful and useful to clients and professionals.

Interestingly, people with neurodevelopmental difficulties such as Autism Spectrum Conditions (ASC) seemed to find written and drawn formulations particularly helpful in understanding and breaking down their difficulties. Further research into the experiences of people with neurodevelopmental conditions may be useful. Moreover, given that research with people with ASC, particularly females, is limited this may add to our knowledge of the usefulness (or otherwise) of formulation for people with such conditions.

Of note, as this was the first study to explore the experiences and opinions of young people specifically regarding formulation, future research could replicate and extend this research to explore whether the findings are the same in other young people's services, and to add to our knowledge base.

Reflections

Throughout this research the author reflected on their interests and relationship to all aspects of it, to increase transparency and consider the potential impact of the researcher on the outcomes.

When designing this research, the author was aware that services for children and young people are complex and research is needed in many areas. For example, other research ideas considered included exploring young people's choice of type of therapy, or their experiences of CAMHS overall. However, many UK CAMHS teams, including those local to this research,

were going through recommissioning and/or restructuring at the time of designing the research. Thus, now might not have been the right time to research such issues. Clinical formulation however is a current and contentious issue. Therefore, it was considered that exploring young people's first-hand views of formulation (and diagnosis to some extent) could impact this narrative, services and young people. Further, this was in line with the researcher's aim to increase engagement of young people in their care.

Defining what is considered a formulation was important for this research. The CAMHS teams in which this research was conducted follow a process of a 'Choice appointment' in which the young person has an assessment of their needs and an initial formulation is developed. This was followed by 'Partnership appointments' – the therapy sessions, often with a different clinician, where formulation is developed further. It was important to clarify when the researcher should conduct the semi-structured interviews with the young people. It was aimed to explore experiences of formulation-as-a-process; therefore, it was agreed that young people should have completed both their choice appointment and some partnership appointments and have developed a more detailed formulation.

Also, during the design stage feedback was sought from the local Youth Council. Some of their feedback regarding formulation in general was somewhat surprising. For example, they raised concerns about formulation replacing diagnosis and any possible negative impact this may have on intervention. Given the feedback from the Youth Council, it was considered possible that participants of the research would give similar feedback, which may have important ethical and clinical implications. Questions regarding diagnosis were added to the interview schedule to clarify young people's views on this. It was believed to be vital that the researcher gave

young people an opportunity to express both positive and negative views on formulation as the researcher prefers formulation and did not want to overly bias the research.

Recruiting young people for this study was very difficult. It was delayed by a lengthy ethical approval process, and then for a couple of months the number of participants stagnated at three people. Various methods were tried to encourage professionals to tell their clients about the research. This included: Presentations to teams, weekly reminder emails, connecting with clinicians the researcher knew well, and informing people of what had gone well in the study so far. After a while there was a burst in recruitment. This may have been due to providing further information, including that the semi-structured interviews did not ask personal questions about client's history, presenting difficulties or experiences of therapy in general, which may have reduced professionals' concerns.

Finally, completing this research gave the researcher the opportunity to reflect on their own clinical work. As a Trainee Clinical Psychologist, the researcher aims to work collaboratively with clients, and uses formulation as they believe it to be helpful. However, given the mixed findings which suggests that people do not know of or understand this term, the researcher is becoming more explanatory and open about what formulation is and why it's thought to be helpful for example, to increase its therapeutic usefulness for clients.

Likewise, some of the young people's opinions regarding diagnosis were important to reflect on. For example, some discussed its usefulness for them and their network (parents, schools) to explain, contain and validate difficulties. The researcher leaned towards formulation over diagnosis and trained on a social-constructionist Doctorate in Clinical Psychology in which diagnostic categories are critically evaluated. This way of working is common amongst some

Clinical Psychologists. In turn, the findings from this research offered the researcher and other mental health professionals' space to reflect on the importance of at least discussing with clients the advantages and disadvantages of formulation and diagnosis. This could both increase client choice and reduce a power imbalance between professional and client; and increase clients and wider networks' knowledge of the different ways of working.

Conclusions

This research aimed to investigate young people's understandings, experiences and opinions of formulation. A systematic literature review was conducted which found a range of good quality research regarding adult client and teams' experiences of formulation. The current research appears to be the first to extend this research to people under 18 years old. Semi-structured interviews were conducted with nine 13-17 year olds currently accessing CAMHS, and demonstrated that they experience formulation as collaborative; it can have therapeutic effects such as making difficulties seem more manageable and helping them to talk to others; and they believed that formulation has key purposes, such as to identify strategies and to help the clinician to remember things. These findings were shared with 13 multi-disciplinary professionals within CAMHS to explore their reactions to the findings and impact the findings might have on clinical practice. This included a need to increase familiarity of formulation in wider society; ensuring inclusion of client's strengths in formulations; and ensuring collaboration.

References

Adams, A. D. (2015). *Formulation: An investigation into perspectives of non-psychologists within a Child and Adolescent Mental Health Service* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database.

Alexander, L. B., & Luborsky, L. (1986). The Penn Helping Alliance Scales. In L. S. Greenberg, & W. Pinsof (Eds.), *The Psychotherapeutic Process: A Research Handbook.* London: Guildford Press.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, Virginia: American Psychiatric Publishing.

Anda, R. F., Whitfield, C. L., Felitti, V. J., Chapman, D., Edwards, V. J., Dube, S. R., & Williamson, D. F. (2002). Adverse childhood experiences, alcoholic parents, and later risk of alcoholism and depression. *Psychiatric Services, 53*(8), 1001-1009.

Bateman, A., & Holmes, J. (1995). *Introduction to Psychoanalysis: Contemporary Theory and Practice*. Hove: Psychology Press.

Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects*. Philadelphia: University of Pennsylvania Press.

Beck, A. T. (1997). The past and future of cognitive therapy. *The Journal of Psychotherapy Practice and Research*, *6*(4), 276-284.

Bentall, R. P. (2004). *Madness Explained: Psychosis and Human Nature*. London: Penguin Books.

Berry, K., Barrowclough, C., & Wearden, A. (2009). A pilot study investigating the use of psychological formulations to modify psychiatric staff perceptions of service users with psychosis. *Behavioural and Cognitive Psychotherapy, 37*(1), 39-48.

Berry, K., Haddock, G., Kellett, S., Roberts, C., Drake, R., & Barrowclough, C. (2016). Feasibility of a ward-based psychological intervention to improve staff and patient relationships in psychiatric rehabilitation settings. *British Journal of Clinical Psychology*, *55*(3), 236-252.

Blee, T. A. (2015). *Community mental health team members' perceptions of team formulation in practice* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database.

Boyatzis, R.E. (1998). *Transforming qualitative information: Thematic analysis and code development.* California: Sage.

Boyle, M., & Johnstone, L. (2014). Alternatives to psychiatric diagnosis. *The Lancet Psychiatry*, *1*(6), 409-411.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.

Brown, T. A., Campbell, L. A., Lehman, C. L., Grisham, J. R., & Mancill, R. B. (2001). Current and lifetime comorbidity of the DSM-IV anxiety and mood disorders in a large clinical sample. *Journal of Abnormal Psychology, 110(4)*, 585−599.

Burchardt, F. (2004). *Client experience of the formulation within cognitive behavioural therapy* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database.

Burnham, J. (2012) Developments in the social GRRRAAACCEEESSS: visible - invisible and voiced-unvoiced. In I.-B. Krause (ed.) *Culture and Reflexivity in Systemic Psychotherapy. Mutual Perspectives* (pp. 139–160). London: Karnac.

Burnham, J., Alvis Palma, D., & Whitehouse, L. (2008). Learning as a context for differences and differences as a context for learning. *Journal of Family Therapy*, *30*(4), 529-542.

Burr, V. (2015). *Social Constructionism*. London: Routledge.

Butler, G. (1998). Clinical formulation. In A.S. Bellack & M. Hersen (Eds.), *Comprehensive Clinical Psychology.* Oxford: Pergamon.

CAPA (2017). *What is CAPA?* Retrieved November, 29, 2018 from http://capa.co.uk/what-is-capa/

Carey, T. A., & Pilgrim, D. (2010). Diagnosis and formulation: what should we tell the students? *Clinical Psychology & Psychotherapy*, *17*(6), 447-454.

Carr, A. (2006). *Family Therapy: Concepts, Process and Practice, Second Edition*. Chichester: John Wiley & Sons.

Cecchin, G. (1987). Hypothesizing, circularity, and neutrality revisited: An invitation to curiosity. *Family Process*, *26*(4), 405-413.

Chadwick, P., Williams, C., & Mackenzie, J. (2003). Impact of case formulation in cognitive behaviour therapy for psychosis. *Behaviour Research and Therapy*, *41*(6), 671-680.

Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders*, *82*(2), 217-225.

Christmas, D. M., & Sweeney, A. (2016). Client, patient, survivor or client… has the time come to return to 'patient'? *The British Journal of Psychiatry*, *209*(1), 9-13.

Christofides, S., Johnstone, L., & Musa, M. (2012). 'Chipping in': clinical psychologists' descriptions of their use of formulation in multidisciplinary team working. *Psychology and Psychotherapy: Theory, Research and Practice*, *85*(4), 424-435.

Clark, D. M. (1986). A cognitive approach to panic. *Behaviour research and therapy*, *24*(4), 461-470.

Clark, D. M., & Wells, A. (1995). A cognitive model of social phobia, pp. 69-93. In Heimberg, R. G. (Ed.). (1995). *Social phobia: Diagnosis, assessment, and treatment*. Surrey: Guilford Press.

Dallos, R., & Vetere, A. (2009). *Systemic therapy and attachment narratives: Applications in a range of clinical settings*. London: Routledge.

Department of Health (2010). *Equity and Excellence: Liberating the NHS.* Retrieved, July, 25, 2019 from https://www.gov.uk/government/publications/liberating-the-nhs-white-paper.

Department of Health (2012). *Liberating the NHS: No decision about me without me – Government response*. Retrieved September, 2, 2018 from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216980/Liberating-the-NHS-No-decision-about-me-without-me-Government-response.pdf.

Dinh, N. M., Groleau, D., Kirmayer, L. J., Rodriguez, C., & Bibeau, G. (2012). Influence of the DSM-IV outline for cultural formulation on multidisciplinary case conferences in mental health. *Anthropology & Medicine*, *19*(3), 261-276.

Division of Clinical Psychology (2010). *The Core Purpose and Philosophy of the Profession.* Leicester: The British Psychological Society.

Division of Clinical Psychology (2010). *Understanding Bipolar Disorder*. Leicester: The British Psychological Society.

Division of Clinical Psychology (2011). *Good Practice Guidelines on the Use of Psychological Formulation*. Leicester: The British Psychological Society.

Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: findings from the Adverse Childhood Experiences Study. *Jama*, *286*(24), 3089-3096.

Dudley, R., Kuyken, W., & Padesky, C. A. (2011). Disorder specific and trans-diagnostic case conceptualisation. *Clinical Psychology Review*, *31*(2), 213-224.

Edwards, V. J., Holden, G. W., Felitti, V. J., & Anda, R. F. (2003). Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: results from the adverse childhood experiences study. *American Journal of Psychiatry*, *160*(8), 1453-1460.

Eells, T. D. (Ed.). (2011). *Handbook of Psychotherapy Case Formulation*. New York: Guilford Press.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour research and therapy*, *38*(4), 319-345.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, *38*(3), 215-229.

Francis, J. J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. P., & Grimshaw, J. M. (2010). What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology and Health*, *25(10)*, 1229–1245.

Fugard, A. J., & Potts, H. W. (2015). Supporting thinking on sample sizes for thematic analyses: a quantitative tool. *International Journal of Social Research Methodology*, *18*(6), 669-684.

Gergen, K. J. (2009). *Realities and Relationships: Soundings in Social Construction*. Cambridge, Massachusetts: Harvard University Press.

Glader, G. W. (2009). *Understanding children's communications in the diagnostic formulation of treatment: How do we hear what children want?* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database.

Grant, A., & Townend, M. (2008). The fundamentals of case formulation. Assessment and formulation in cognitive behavioural therapy, pp. 45-61. In Grant, A., Townend, M., Mills, J., & Cockx, A. (2008). *Assessment and case formulation in cognitive behavioural therapy*. California: Sage.

Guarte, J. M., & Barrios, E. B. (2006). Estimation under purposive sampling. *Communications in Statistics—Simulation and Computation*, *35*(2), 277-284.

Guba, E.G., & Lincoln, Y.S. (1994). Competing paradigms in qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 105-117). Thousand Oaks, California: Sage.

Halpin, E., Kugathasan, V., Hulbert, C., Alvarez-Jimenez, M., & Bendall, S. (2016). Case Formulation in Young People with Post-Traumatic Stress Disorder and First-Episode Psychosis. *Journal of Clinical Medicine*, *5*(11), 106-117.

Harper, D. & Spellman, D. (2006). Social constructionist formulation: Telling a different story. In L. Johnstone & R. Dallos (Eds.), *Formulation in Psychology and Psychotherapy: Making Sense of People's Problems* (pp.98–125). London: Routledge.

Harper, D. (2002). The tyranny of expert language. *Open Mind, 113*, 8–9.

Hart, A. (2018). *Pursuing Choice, Not Truth: Debates Around Diagnosis in Mental Health.* Asylum. Retrieved August, 22, 2019 from https://asylummagazine.org/2018/06/pursuing-choice-not-truth-debates-around-diagnosis-in-mental-health-by-akiko-hart/.

Health and Professions Council (2009). *Standards of Proficiency: Practitioner Psychologists.* London: Health Professions Council.

Hearing Voices Network (2013). *Position Statement on DSM-5 & Psychiatric Diagnosis.* Retrieved July, 10, 2018 from http://www.hearing-voices.org/wp-content/uploads/2013/05/HVN-Position-Statement-on-DSM5-and-Diagnoses.pdf

Henderson, C., Robinson, E., Evans-Lacko, S., Corker, E., Rebollo-Mesa, I., Rose, D., & Thornicroft, G. (2016). Public knowledge, attitudes, social distance and reported contact regarding people with mental illness 2009–2015. *Acta Psychiatrica Scandinavica, 134(446),* 23-33.

Herhaus, J. (2014). *Constructing shared understanding-A grounded theory exploration of team case formulation from multiple perspectives* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database.

Hess, S. M. (2001). *The effects of a case formulation approach on process and outcome in the treatment of depression.* Unpublished article. Retrieved August, 21, 2018 from https://elibrary.ru/item.asp?id=5328130.

Horn, N., Johnstone, L., & Brooke, S. (2007) Some service user perspectives on the diagnosis of Borderline Personality Disorder, *Journal of Mental Health, 16(2),* 255-269.

Huisman, P., & Kangas, M. (2018). Evidence-Based Practices in Cognitive Behaviour Therapy (CBT) Case Formulation: What Do Practitioners Believe is Important, and What Do They Do?. *Behaviour Change, 35*(1), 1-21.

Ingram, B.L. (2006). *Clinical Case Formulations: Matching the Integrative Treatment Plan to the Client.* Hoboken, New Jersey: Wiley.

Isman, E., Ekéus, C., & Berggren, V. (2013). Perceptions and experiences of female genital mutilation after immigration to Sweden: An explorative study. *Sexual & Reproductive Healthcare, 4(3),* 93–98.

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.* Leicester: British Psychological Society.

Johnstone, L. & Dallos, R. (2006). Introduction to formulation. In L. Johnstone & R. Dallos (Eds.), *Formulation in psychology and psychotherapy: Making sense of people's problems* (pp.1–16). London: Routledge.

Johnstone, L. (2013a). Controversies and debates about formulation. In L. Johnstone & R. Dallos (Eds.), *Formulation in psychology and psychotherapy: Making sense of people's problems* (2nd ed., pp. 260-289). London, England: Routledge.

Johnstone, L. (2018). Psychological formulation as an alternative to psychiatric diagnosis. *Journal of Humanistic Psychology, 58*(1), 30-46.

Johnstone, L., & Dallos, R. (2013). *Formulation in Psychology and Psychotherapy: Making Sense of People's Problems*. London: Routledge.

Kahlon, S. (2011). *Formulation in psychology: A review of child formulation use and an exploration of formulation experiences of clients with depression.* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database.

Kahlon, S., Neal, A., & Patterson, T. G. (2014). Experiences of cognitive behavioural therapy formulation in clients with depression. *The Cognitive Behaviour Therapist*, *7, 1-15*.

Kinderman, P. (2014). *A prescription for psychiatry: Why we need a whole new approach to mental health and wellbeing*. Basingstoke: Palgrave Macmillan.

Lampropoulos, G. K. (2001). Bridging technical eclecticism and theoretical integration: Assimilative integration. *Journal of Psychotherapy Integration*, *11*(1), 5-19.

Leeming, D., Boyle, M., & MacDonald, J. (2009). Accounting for psychological problems: How user-friendly is formulation? *Clinical Psychology Forum, 200,* 12-15). Leicester: The British Psychological Society.

Legislation.gov.uk (2014). *Children and Families Act (2014)*, Retrieved April, 24, 2019 from http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted.

Macneil, C. A., Hasty, M. K., Conus, P., & Berk, M. (2012). Is diagnosis enough to guide interventions in mental health? Using case formulation in clinical practice. *BMC Medicine, 10*(1), 111-114.

Malan, D. (1995). *Individual Psychotherapy and the Science of Psychodynamics*. London: CRC Press.

Manuel, N. P. (2016). *A grounded theory study of multidisciplinary staff views on participating in team formulation* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database.

Mattheys, K. (2015). The coalition, austerity and mental health. *Disability & Society*, *30*(3), 475-478.

May, R. (2007). Working outside the diagnostic frame. *The Psychologist, 20(5),* 290-292.

McManus, S., Meltzer, H., Brugha, T. S., Bebbington, P. E., & Jenkins, R. (2009). Adult psychiatric morbidity in England, 2007: Results of a household survey. The NHS Information Centre for health and social care. Retrieved August, 19, 2019 from https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-in-england-2007-results-of-a-household-survey

Miller, L. J., O'Connor, E., & DiPasquale, T. (1993). Patients' attitudes toward hallucinations. *American Journal of Psychiatry, 150(4),* 584-584.

Mind (2013). *Mental health facts and statistics.* Retrieved April, 25, 2019 from https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/#one.

Mind (2017). Mental Health Facts and Statistics. Retrieved August, 19, 2019 from https://www.mind.org.uk/media/34727125/facts-statistics-2017-pdf-version.pdf.

Mohtashemi, R., Stevens, J., Jackson, P. G., & Weatherhead, S. (2016). Psychiatrists' understanding and use of psychological formulation: a qualitative exploration. *BJPsych Bulletin*, *40*(4), 212-216.

NHS England (2018). *Children and Young People's Improving Access to Psychological Therapies Programme.* Retrieved December, 4, 2019 from https://www.england.nhs.uk/mental-health/cyp/iapt/.

Office for National Statistics (2011). *2011 Census.* Retrieved May, 22, 2019 from https://www.ons.gov.uk/census/2011census.

Pain, C. M., Chadwick, P., & Abba, N. (2008). Clients' experience of case formulation in cognitive behaviour therapy for psychosis. *British Journal of Clinical Psychology*, *47*(2), 127-138.

Perkins, A., Ridler, J., Browes, D., Peryer, G., Notley, C., & Hackmann, C. (2018). Experiencing mental health diagnosis: a systematic review of service user, clinician, and carer perspectives across clinical settings. *The Lancet Psychiatry*, *5*(9), 747-764.

Persons, J. B. and Tompkins, M. A. (1997). Cognitive-behavioral case formulation. In T. D. Eells. (Ed.), *Handbook of Psychotherapy Case Formulation* (pp. 314–339). New York: Guilford Press.

Redhead, S., Johnstone, L., & Nightingale, J. (2015). Clients' experiences of formulation in cognitive behaviour therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, *88*(4), 453-467.

Royal College of Psychiatrists. (2010). *A competency-based curriculum for specialist core training in psychiatry.* Retrieved September, 20, 2018, from https://www.rcpsych.ac.uk/pdf/CORE_CURRICULUM_2010_Mar_2012_update.pdf.

Ryle, A. E. (1995). *Cognitive Analytic Therapy: Developments in Theory and Practice*. New Jersey: John Wiley & Sons.

Salkovskis, P. M. (1999). Understanding and treating obsessive—compulsive disorder. *Behaviour Research and Therapy, 37(1),* S29-S52.

Shaw, J., Higgins, C., & Quartey, C. (2017). The impact of collaborative case formulation with high risk offenders with personality disorder. *The Journal of Forensic Psychiatry & Psychology*, *28*(6), 777-789.

Simmons, P., Hawley, C. J., Gale, T. M., & Sivakumaran, T. (2010). Client, patient, client, user or survivor: describing recipients of mental health services. *The Psychiatrist, 34*(1), 20-23.

Sitko, K, Bentall, R.P., Shevlin, M., O'Sullivan, M., Sellwood, W. (2014). Associations between specific psychotic symptoms and specific childhood adversities are mediated by attachment styles: An analysis of the National Comorbidity Survey. *Psychiatry Research, 217(3),* 202–209.

Stewart, M. (2016). *A grounded theory analysis of patients' experience of formulation-sharing with clinical psychologists* (Doctoral dissertation, School of Psychology).

Summers, A. (2006). Psychological formulations in psychiatric care: staff views on their impact. *The Psychiatrist, 30*(9), 341-343.

Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: What is it and how can we further its development? *Mental Health Review, 21*(3), 174–192.

Tarrier, N., & Calam, R. (2002). New developments in cognitive-behavioural case formulation. Epidemiological, systemic and social context: An integrative approach. *Behavioural and Cognitive Psychotherapy, 30*(3), 311-328.

Thew, G. R., & Krohnert, N. (2015). Formulation as intervention: case report and client experience of formulating in therapy. *The Cognitive Behaviour Therapist, 8,* 1-14.

Thomas, H. (2003). *Quality assessment tool for quantitative studies.* Toronto: Effective Public Health Practice Project McMaster University.

Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry, 16*(10), 837-851.

Wagstaff, C., & Williams, B. (2014). Specific design features of an interpretative phenomenological analysis study. *Nurse Researcher, 21*(3), 8-12.

Watts, J. (2018). *Mental health labels can save lives. But they can also destroy them.* The Gaurdian. Retrieved August 22, 2019 from https://www.theguardian.com/commentisfree/2018/apr/24/mental-health-labels-diagnosis-study-psychiatrists.

Weedon, J. L. (2017). *Multidisciplinary team members' experiences of team formulation: A thematic analysis* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database.

Wells, A. (1999). A cognitive model of generalized anxiety disorder. *Behaviour modification, 23*(4), 526-555.

Weerasekeera, P. (1996). *Multiperspective Case Formulation: A Step Towards Treatment Integration.* Malabar, Florida: Krieger.

Whitton, C., Small, M., Lyon, H., Barker, L., & Akiboh, M. (2016). The impact of case formulation meetings for teams. *Advances in Mental Health and Intellectual Disabilities*, *10*(2), 145-157.

Wilcox, E. (2013). Biscuits and perseverance: Reflections on supporting a community intellectual disability team to reflect. *Advances in Mental Health and Intellectual Disabilities*, *7*(4), 211-219.

Williams, R., & Hazell, P. (2011). Austerity, poverty, resilience, and the future of mental health services for children and adolescents. *Current Opinion in Psychiatry*, *24*(4), 263-266.

Willig, C. (1999). Beyond appearances: a critical realist approach to social constructionism. In Nightingale, D.J. and Cromby J (eds.). *Social Constructionist Psychology: A Critical Analysis of Theory and Practice.* London: Open University Press.

Winston, A., Rosenthal, R. N., & Pinsker, H. (2011). *Learning Supportive Psychotherapy: An Illustrated Guide*. Washington: American Psychiatric Association Publishing.

World Health Organization. (2018). *International statistical classification of diseases and related health problems, 11th Revision (ICD-11).* Geneva: WHO.

Zigmond, A. S., & Snaith, R. P. (1983). The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scandinavica*, *67*, 361–370.

Appendices

Appendix 1: Table 2. Summary of Articles in Final Systematic Review

Author, Title, Setting	Participants	Methodology	Summary of Study and Key Findings	Strengths and Limitations
Pain, Chadwick & Abba (2008). Clients' experience of case formulation in cognitive behaviour therapy for psychosis. United Kingdom (Southampton)	13 people recently assessed and starting cognitive behaviour therapy (CBT) for psychosis. Five women, eight men aged 21 – 64 years. Additionally, their respective therapists (2 Clinical Psychologists) participated.	Qualitative. A collaborative case formulation (CF) was developed over two sessions. Semi structured interview with clients: Asked questions such as "At the time the CF was shared, how did you feel?" Analysed using Content Analysis. Therapists ranked in order the benefits of CF (1 = most applicable, 7 = least applicable), e.g. "The CF process increased my understanding of the client".	This study explored adult clients' experiences of developing a formulation within CBT, in an NHS mental health service. After coding responses into seven themes, percentages of coding units within each theme are reported. E.g. 72 (40.5%) of coding units contained negative emotions and 40 (22.5%) contained positive emotions regarding client's reactions to CF. Regarding therapeutic value, 32 (34%) coding units outlined	In the discussion the authors ask good questions about why negative responses were found, such as are negative schemata being reactivated; are negative reactions understandable and healthy responses to the content; or are clients drawing unintended conclusions (e.g. that difficulties may be too strong to change if they go back to formative experience)? The authors acknowledge that the codes extracted will be influenced by the research

			anticipated clinical improvement; 28 (29%) described general helpfulness; and 17 (18%) suggested no benefit. Additionally, regarding the therapeutic relationship 5 (20%) of coding units suggested CF made the relationship worse, but 21 (90%) described a positive reaction to the therapist or the relationship. The therapists ranked the top three benefits of CF as increased understanding of client, clearer sense of direction, and enhanced therapeutic relationship.	question. However, they did not outline their relationship to the topic. They assessed the reliability of their coding: They reported that the inter-rater reliability between the first two coders was 'acceptable' (Cohen's k = 0.79). Further, they had a third 'blind' author code the transcripts and reported a 'high' inter-rater reliability (Cohen's k = 0.89). The sample size was relatively small, and the CF's were conducted by two clinicians. This limits generalisability of findings.
Chadwick, Williams & Mackenzie (2003).	***Experiment 1:*** 13 participants referred to CBT for Psychosis.	***Experiment 1:*** Within subject, repeated measures	***Experiment 1:*** Explored the hypotheses that CF enhances	This study used reliable and valid measures.

Impact of case formulation in cognitive behaviour therapy for psychosis. United Kingdom (Southampton)	Seven men, six women, mean age 31.5 years. 11 participated in the semi-structured interviews. ***Experiment 2:*** Four people with auditory hallucinations, two women, two men, aged 20 – 56 years.	design. Two measures were completed at four time points. The Helping Alliance Questionnaire (HAq, Alexander & Luborsky, 1986) is an 11 item selfreport measure of the therapeutic alliance. Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) was used to measure symptoms of anxiety and depression. Brief, semi-structured interviews were conducted shortly after formulation to gather subjective information about participants' experiences of formulation. ***Experiment 2:*** Distress was measures using the HADS,	therapeutic alliance and eases distress. A Friedman 2-way ANOVA reported a significant interaction between time and total scores on the HAq-P. Wilcoxon Signed Ranks Test reported a significant increase in ratings between times 1 and 3 and times 1 and 4. The authors concluded that this is consistent with a general improvement in scores over time but does not conclude that CF has a significant impact on alliance for clients. However, there was a significant increase in alliance ratings from therapists' perspectives.	This research is one of the first of its kind and may have stimulated future research. It may have benefited from a power calculation to assess the sample size needed for the quantitative aspects of the study. There is no information about how the semi-structured interviews were analysed. Further information about the qualitative aspect of the study would be useful, such as for it to be replicable and for the robustness of the data to be assessed.

		Socratic questioning was used to assess delusions and negative beliefs about the self. Beliefs About Voices Questionnaire was also used (BAVQ-R: Chadwick, Lees, & Birchwood, 2000)	There were no significant differences on the HADS at any time point. Semi-structured interviews: Nine clients said they found formulation enhanced their understanding of their problems. Six reported positive emotions—feeling reassured, encouraged, and more optimistic. Six clients reported a negative emotional response. Some described their experiences as saddening, upsetting and worrying, e.g. "there are so many factors, I can't see how the patterns can be stopped". Therapists reported that CF helped them feel more hopeful about therapy; increased a sense of	

			alliance and collaboration; and maintained adherence to the CBT model. ***Experiment 2:*** Explored impact of CF over four sessions in CBT on distress, delusions and views of the self. Findings reported that CF did not have a significant impact on strength of delusions, or negative self-evaluations. However, delusion conviction ratings did reduce by time three in five participants.	
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**
Redhead, Johnstone & Nightingale (2015).	Ten clients at the end of CBT for anxiety and depression. Aged 24 – 67 years. Male: female ratio was 2:8.	Qualitative. Semi-structured interviews analysed using Inductive Thematic Analysis.	This study explored adult client's experiences of developing a formulation	Themes were compared to those of an independent researcher. The main researcher discussed themes in

Clients' experience of formulation in cognitive behaviour therapy United Kingdom (3 IAPT services in England)			during therapy in an IAPT service. There were four themes and ten subthemes identified. The key themes were: formulation helps client understand problems; it leads to feeling understood and accepted; it leads to an emotional shift; and enables them to move forward.	supervision throughout and reflexivity regarding the researcher's ideas about the topic were considered during analysis. However, it would have been useful to see evidence of this reflexivity and information about the researcher's standpoints. The authors considered the results in context – i.e. they noted that two participants felt distressed by their formulations because they were inaccurate, but these were developed by the therapist outside of therapy. In turn, the authors made suggestions about reducing the

				therapist power dynamic by increasing collaboration.
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**
Kahlon, Neal & Patterson (2014). Experiences of cognitive behavioural therapy formulation in clients with depression. United Kingdom.	Seven adults aged 19 – 54 years, referred for psychological therapy for depression.	Qualitative. Semi-structured interviews analysed using Thematic Analysis.	Four superordinate themes were outlined: 'Feeling trapped or restricted by depression', 'the development of the formulation – from coming to my own conclusions to something the therapist developed', 'from negative towards mixed feelings: emotional reactions to the formulation during the therapeutic process' and 'a new journey: towards making a new sense of oneself'.	The author was transparent about their relationship to the project (e.g. interest in CBT formulation). They have provided a descriptive summary of the data which they claim enable the reader to differentiate between the participants' and the researcher's voice and make their own interpretations. The results are detailed, and long quotes are provided. Data analysis was quality controlled by having an independent researcher

				conduct line by line coding and themes on extracts of transcripts. It is difficult to tease apart the impact of the formulation from the therapy. Participants were currently receiving psychological therapy at the time, from Clinical Psychologists who may have used an integrative approach. Comments are made throughout regarding the impact of therapy, formulation and the therapeutic relationship on depression symptoms. There is not information about how it was assured that participants were

				talking about their experiences of formulation.
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**
Shaw, Higgins and Quartey (2017). The impact of collaborative case formulation with high risk offenders with personality disorder. United Kingdom (London).	77 Offending Managers (Oms; 62 females, 15 males). 39 offenders - 13 from the formulation group and 26 from a control group (33 males, 6 females).	Randomised, controlled post-test only design. OMs and offenders were randomly allocated to a formulation or control group (probation as usual). The formulation group were given formulation training by the researchers. OM's and offenders completed the following measures: Dual Role Relationships Inventory – Revised (DRI-R; Skeem et al., 2007)	This study was conducted in the context of The UK Offender Personality Disorder (OPD) strategy. This is a joint initiative between the National Offender Management Service and the National Health Service (NHS) to provide psychologically informed services for offenders with personality difficulties and risk to the public. OM's and other non-psychology staff now develop formulations. OM's and offenders completed the measures after	The researchers conducted a power analysis which indicated a total sample size of 84 was required to reliably detect a medium effect with 80% power. However, they had 77 and 39 participants. Data were skewed, and the assumption of normal distribution was not met. Seven participants from the 84 originally selected dropped out. There may be some bias in who completed the study, such as differences in relationship and/or OM competence.

		Perceived Benefits Rating Scale (PBRS) - A four-item Likert scale developed by the researchers for the OMs to evaluate factors such as improved client engagement and improved staff confidence	either developing a formulation and risk management plan, or probation as usual (no formulation). OMs in the formulation group reported significantly higher overall relationship quality, a stronger working alliance and greater confidence. Offenders in the formulation group reported significantly higher degrees of trust in their OMs.	A non-validated measure of 'Personality Disorder' was used. However, the findings provide an initial suggestion that completing collaborative formulations may have a beneficial impact on trust towards OMs by high risk offenders.
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**
Christofides, Johnstone & Musa (2012). 'Chipping in': Clinical psychologists' descriptions of their use of formulation in	10 Clinical Psychologists (six females, four male) from one NHS Trust adult mental health services.	Qualitative. Semi-structured interview analysed using Thematic Analysis.	Clinical Psychologists' use of formulation in teams was explored. Two key themes were described: "The need for a	78 Psychologists were invited to participate but only 10 completed the research. It is possible that there was a self-selection bias in which only

multidisciplinary team working. United Kingdom			space and framework to help make sense of client's difficulties together" and "'Chipping in' with psychological ideas as an ongoing process". Example findings include reports that formulation helps other professionals such as nurses to practice more effectively or psychologically; gives professionals space to reflect on their work; is beneficial when discussing clients who are described as challenging; helps understand emotional reactions to clients; and helps staff work consistently. Further, participants described using formulation informally in	Psychologists who were advocates of formulation volunteered. All participants worked in adult mental health services, so it is not known whether their experiences are generalisable to other mental health services, such as those for children and young people. However, participants were from across inpatient and community settings and so may represent views across these types of services. A larger sample size from each context may be useful to increase generalisability. The authors of the study reflected on their stance

			teams, smaller teams are more accepting, capacity for formulation reduces when there are time constraints, and psychologists should not adopt an expert position.	towards the topic and were transparent about their own positive views of formulation. This study is one of the first to explore this topic and calls for future research, which would strengthen our knowledge.
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**
Dinh, Groleau, Kirmayer, Rodriguez & Bibeau (2012). Influence of the DSM-IV Outline for Cultural Formulation on multidisciplinary case conferences in mental health.	Mental health clinicians attending a Cultural Consultation Service (CCS) in an outpatient Psychiatry department of a hospital. Data for this study was collected from ongoing research. 12 taped and transcribed conferences were selected	Transcription followed standards for the representation of spoken action, for discursive and conversation analysis (Mishler, 1984). Styles of talk (tone, style, rhythm); conversational turn-	This study explored the use and impact of cultural formulation in multidisciplinary consultation meetings, via conversation analysis. Findings and conclusions included that formulation in	This study drew from a pool of 177 meetings, conducted as standard practice, which may reduce the possible impact of bias in how the formulations were presented. The 12 selected meetings were chosen specifically by the

Canada (Montreal).	from 177 meetings held over four years.	taking, interruptions, simultaneous speech, and hesitations, and their effect on group interactions; and paralinguistic/nonverbal elements (sighs, laughter, silence) were analysed.	meetings helps teams to move from an emphasis on biomedical diagnostic issue toward a broader interdisciplinary discussion. Further, the authors concluded that formulation helps facilitate sharing of knowledge; construct new types of meaning (other than disease/disorder focused); and facilitates power sharing, giving space for non-medical speakers (including clients by proxy) to share alternative views.	researcher. This was done to reduce variation in the quality of the case history and formulation. However, it may increase selection bias, such as selecting formulations which had a positive impact. It may have been useful for the data analysis to go beyond conversational analysis to make interpretations or links between the data, such as using Thematic Analysis or Interpretative Phenomenological Analysis. Information about the researcher's stance, as well as why the chosen extracts of the transcripts were published would have been useful.

Author, Title, Setting	Participants	Methodology	Summary of Study and Key Findings	Strengths and Limitations
Berry, Barrowclough & Wearden (2009). A Pilot Study Investigating the Use of Psychological Formulations to Modify Psychiatric Staff Perceptions of Clients with Psychosis. United Kingdom (Manchester).	30 staff from three psychiatric rehabilitation units (15 males, 15 females, mean age 39.87 years). Formulations were developed for seven clients (all male) who had diagnoses of 'Schizophrenia'.	Quantitative repeated measures design. Staff perceptions of clients' mental health difficulties were measured before and after a pilot formulation intervention (formulation meetings in which longitudinal formulations were developed based on Beck's (1976) cognitive model). Perceptions of factors such as negative feelings towards clients and confidence in their work were measured using Likert scales, based on the Brief Illness Perception Questionnaire (IPQ; Broadbent, Petrie, Main and Weinman, 2006) and the	A pilot intervention in which multidisciplinary staff in a psychiatric hospital were supported to develop formulations about their clients was analysed using pre and post Likert measures of staff perceptions. Post intervention, staff reportedly had more helpful attitudes towards working with clients; rated clients as putting more effort into getting well; regarded clients as being less likely to have caused their problems and were less likely to blame them for their problem; ratings for the likely	Participants completed the questionnaire twice in a short space of time. Changes in participants perceptions may therefore have been affected by demand characteristics, which the authors reflected on. Further, there was no control group, so findings may have been attributable to non-specific factors. However, this study provides initial evidence that formulation may improve staff perceptions of clients. Further, the authors link the findings to previous research and suggest possible explanations for their

		Illness Perception Questionnaire for Schizophrenia (Lobban, Barrowclough and Jones, 2005).	duration of problems decreased; ratings for treatment efficacy increased; staff reported a better understanding of clients' problems; rated their feelings towards clients as being less negative; reported greater confidence in working with clients; and viewed both staff and clients as having greater control over problems.	findings, as well as suggest ideas for future research.
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**
Huisman & Kangas (2018) Evidence-Based Practices in Cognitive Behaviour Therapy (CBT) Case Formulation: What Do Practitioners Believe	79 Psychologists. 68 (86%) female, aged 26 – 69 years (average 40 years). 9% did not complete all sections of the survey.	The authors developed an online survey. 13 statements were developed regarding participants' belief in the importance of formulation activities rated on a 5-point	79 qualified 'general' and 'Clinical' Psychologists completed a newly developed online survey regarding their opinions of the importance, frequency and implementation	The psychometric properties of the survey items were adequate alpha > 0.7). However, this new measure requires further validation in future research.

is Important, and What Do They Do? Sydney, Australia		scale (1 = not important, 5 = very important). Participants also rated how frequently they implement these activities in their current practice, using a 5-point scale (1 = I never do this as part of case formulation, 5 = I always do this as part of case formulation). For example, "identifying the client's goals in seeking treatment". Three of the statements assessed how participants used formulation currently, e.g. "I use assessments such as self-report questionnaires to identify thoughts, emotion and behaviours."	of different aspects of case formulation in CBT. A factor analysis developed a three factor model: Factor 1, consisted of four items regarding activities in which the clinician seeks contextual information to plan treatment; factor 2 included three items, related to activities used by clinicians to structure or check the formulation; and factor 3 included five items regarding activities related to the clinician describing and hypothesising about the client's presenting problems. T-test comparisons reported that participants rated items related to use of external evidence as significantly less	There were relatively small differences in responses to both belief and practice items. The authors hypothesised that this may reflect that the scales used to capture differences did not do so adequately, or there may be relatively little variation in perceived importance and implementation of formulation activities. In turn, future research with a larger and more varied sample is needed. This study was the first to investigate clinicians' beliefs and practices related to CBT formulation. Further, it encourages future research into barriers to clinicians using

			important and less frequently implemented compared to other activities. General Psychologists reported less frequent implementation of evaluation of their hypotheses about causal and maintaining factors, and less frequently consulting theory or evidence relevant to the client's presenting problems, compared to Clinical Psychologists.	external evidence and evaluation methods, to in turn increase the evidence base for formulation.
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**
Whitton, Small, Lyon, Barker & Akiboh (2016). The impact of case formulation meetings for teams.	89 multi-disciplinary staff in a secure forensic learning disability and autism service.	A service evaluation was conducted using a within group self-report questionnaire, completed before and after a formulation meeting regarding one client.	Multi-disciplinary staff completed a questionnaire before and after attending an in-depth formulation meeting, and some offered qualitative	This study included a large sample of multi-disciplinary staff, which may help to increase the generalisability of findings.

Middlesbrough, UK		The pre-questionnaire consisted of 10 questions, rated on a five-point Likert scale (strongly agree to strongly disagree), regarding professional, personal and practical issues, and items measuring negative attitudes towards the patient, how psychological information influences care plans, and consistency amongst the MDT. The post-questionnaire had a further five questions evaluating participant's experience of that team formulation, and an open-ended question regarding their experience of the formulation.	information about their experience of the meeting. The data did not meet the assumption of normality, so Wilcoxon signed-ranks tests were utilised. Following the meeting, staff reported an increase in their psychological understanding and empathy towards the client and their difficulties. Further, the meetings strengthened their belief in the consistency in their thoughts, beliefs and plans as a team. However, a number of staff still reported that they were "undecided" if the formulation meeting would help them to work better as a team. Staff rated that their	The findings provide useful information about staff experience of team formulation, and so can add to our evidence base of the usefulness of formulation. The measure created does not appear to have been validated, and so could be further evaluated in future research. This service evaluation was conducted after formulation meetings had been held in the service for many years. Therefore, future research may benefit from exploring the usefulness and experiences of team formulation in less established teams, and how

		38 of the respondents gave qualitative responses regarding their experience of the formulation meetings, which were grouped into themes.	views and opinions of the client were listened to. Qualitative feedback included that the staff found the meeting insightful, it helps bring staff together, helps individuals to stop and think about their own feelings, and they found it enjoyable and helpful.	teams increase the helpfulness of such meetings over time.
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**
Adams (2015) Formulation: An investigation into perspectives of non-psychologists within a Child and Adolescent Mental Health Service. Staffordshire & Keele (study completed for partial	12 (11 female) non-Psychology staff (Nurses, Social Workers and Psychiatrists) in a CAMHS team which uses formulation.	Semi-structured interviews were conducted with participants. Questions regarded asking participants to describe the team, their understanding of formulation within this context, and their reflections on carrying out interventions and whether the	Multi-disciplinary staff were asked to summarise their understanding and use of formulation in their CAMHS team. Four main themes were summarised.	The generalisability of findings is limited since this study was carried out in one service, and participants were mostly female. The author reflected that participants were aware of their role as a Trainee Clinical Psychologist and so this may

fulfilment of the Doctorate in Clinical Psychology).		formulation had been integrated into them. Interviews were analysed using Thematic Analysis.	Staff reported that the team did not fully understand what formulation involves, whether it is integral to their assessments, and a lack of confidence using it. However, they were utilising it, particularly in supervision, and working collaboratively with clients. Secondly, staff discussed the benefits of using formulation, such as providing tangible reasons for presenting difficulties or building a rapport with clients. Limitations of formulation were also discussed, such as needing to address immediate medical issues first, lack of	have positively biased their responses to the researcher. Data analysis was conducted using a coding template, which may have missed potential themes.

			training, and some resistance to engaging with it. Finally, the role of a psychologist was discussed. Responses included seeing them as more senior, and more experienced in and able to supervise on formulation. Participants noted a 'rivalry' between Psychologists and Psychiatrists and expressed concern about future 'imbalance' of multi-disciplinary working through increased recruitment of Psychologists and use of formulation. Some also viewed Clinical Psychologists as expensive.	

Author, Title, Setting	Participants	Methodology	Summary of Study and Key Findings	Strengths and Limitations
Blee (2015) Community Mental Health Team Members' Perceptions of Team Formulation in Practice. Lincoln, UK (study completed for partial fulfilment of the Doctorate in Clinical Psychology).	12 multi-disciplinary professionals in a community mental health team.	Inductive qualitative design. Thematic Analysis. Semi-structured interviews with three Psychologists, aimed at understanding what participants reported helpful and unhelpful aspects of team formulation, team formulation influence on clinical practice, and factors that may influence the process and outcome of team formulation. Three groups of three multi-disciplinary focus groups were also conducted. Participants were encouraged to discuss the topic, with minimal	12 staff took part in either individual semi-structured interviews or a focus group, to explore their perceptions of formulation. Two overarching themes were extracted. Firstly, 'Outcomes of team formulation'. For example, formulation can help to manage overwhelming ideas. However, they were reported to be added to care plans which can have a short 'life expectancy' and may not be revisited. Psychologists' reported not knowing if care plans are utilised but 'hoped' that they were, otherwise	Small sample size limits generalisability of findings to other settings. Further, the initial themes were developed from just three semi-structured interviews. However, excluding Psychologists from the focus groups helps reduce bias and allows participants to talk more freely. As in the above study, the researcher being a Trainee Clinical Psychologist may have positively biased participants' responses. Focus was given to the theme 'outcomes of team formulation' in the main

		intervention from the researcher.	formulation is a 'waste of time.' Secondly, the 'status of team formulation'. For example, formulation can help to stop and think about cases, but this can be difficult to implement in teams where 'work' is seen as action focused. Further, staff outlined that there needs to be a safe environment in which to formulate so you are not viewed as lacking competence. Formulation was said to help share decision making and feel less 'stuck' in clinical work but was described as a 'luxury'.	research paper, to the reduction of the findings related to the 'status of team formulation'. The author is clear about their contextualist, critical-realist standpoint. Clear clinical implications are considered, such as the need for teams to encourage colleagues to participate in formulations, to value multiple perspectives. Further, barriers to implementing resulting care plans could be discussed.
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**

Burchardt (2004) Client experience of the formulation within Cognitive Behavioural Therapy. Sheffield, UK (study completed for partial fulfilment of the Doctorate in Clinical Psychology).	8 clients (7 female) obtained via purposive sampling, from a specialist NHS psychotherapy and adult mental health service. Participants were aged 28- 63 years, and with a range of difficulties, e.g. anxiety, depression, specific phobia.	Semi-structured interviews, analysis using Interpretative Phenomenological Analysis (IPA). Questions aimed to be non-directive to aid participants to describe their experience of formulation in their own words.	Five 'master' themes were extracted: Somebody that listened and understood - Trust in therapist; Understanding what happens; A foundation and Direction - Something to start from, something to work on; Working to a plan - stopping the circle; and Effectiveness and Self-efficacy.	Participants were self-selecting, and so there may be some bias in those who took part. For example, people who had positive experiences of their formulation and therapists, in line with the extracted themes. The researcher's role and own biases may have influenced the findings, as in any qualitative research. However, IPA acknowledges preconceptions which may influence research.
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**
Glader (2009) Understanding Children's Communications in the Diagnostic Formulation of	Case studies/examples of work with children, by various psychodynamic therapists including, though not	Content analysis of archival data. Content analysis went beyond frequency of words to develop themes.	All clinicians received information about symptoms from other people in the child's environment, such as parents	An independent coder also analysed the texts with a minimum agreement rate of 80%.

Treatment: How Do We Hear What Children Want? Chicago (study completed for partial fulfilment of the Doctorate of Philosophy).	exclusively, Virginia Axeline, Anna Freud, Melanie Klein, Carl Rogers, and D. W. Winnicott.		or schools. Therapists developed hypotheses that they acted on, whether they shared them with the child or not. Children say what they want in different forms, e.g. play, questions. The researcher concluded that to truly get what children want during diagnostic formulation is to start "where the client is".	Memo writing was conducted throughout to analyse and record questions and decisions made. Two cases by the same clinician were not analysed consecutively, to reduce potential bias that could have developed through extended contact with a particular theoretical stance. It can not be assured that the texts analysed represent the actual dialogue between the original therapists and their clients.
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**
Herhaus (2014)	15 participants (five clinical psychologists, four non-	Semi-structured interviews were conducted to explore	A grounded theory study explored staff and client	After each interview, the researcher documented

Constructing shared understanding - A grounded theory exploration of team case formulation from multiple perspectives. Glasgow, UK (study completed for partial fulfilment of the Doctorate in Clinical Psychology).	psychologist professionals, and six clients). Eight were male and seven females, aged 24 – 54 years, in an early intervention in psychosis service.	experiences of team formulation and care, analysed using a social constructionist version of grounded theory. (One participant provided information in written format instead of being interviewed).	experiences of formulation and care. An over-riding theme emerged, named 'Shared understanding'. This was underpinned by two sub-categories. Firstly, 'value and function' (e.g. establishing and maintaining working relationships, sharing understanding and perspectives, reflecting on therapists' emotional responses to clients; and increasing flexibility, consistency and empathy in responses to clients). Secondly, 'processes' (e.g. negotiating professional roles, tolerating uncertainty, and	personal reflections, thus increasing reflexivity. Additionally, memos were kept from initial coding ideas to final analysis. The author acknowledged that the results were one possible construction of the data. Therefore, they included lengthy excerpts to aid readers to make their own interpretations. The analysis of client and professionals' interviews were intertwined. As clients were not actively part of team formulation and they were interviewed about their experiences of care, while staff participants were interviewed

			creating a safe space to share thoughts). Shared understanding reportedly supported better engagement and client care.	about their experiences of formulation. This limits the links that can be made across data. Similar future research could analyse and construct these data separately to increase meaning making.
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**
Hess (2000) The Effects of a Case Formulation Approach on Process and Outcome in the Treatment of Depression. Texas (study completed for partial fulfilment of the Doctorate of Philosophy).	Seven clients (18-33 years) engaged in counselling for depression with three different therapists.	Quantitative, repeated measures questionnaire design. Measures: Beck Depression Inventory, Outcome Questionnaire, Stages of Change Scale, Working Alliance Inventory, Empathy Scale, and Session Evaluation Questionnaire.	Visual inspection of graphed data did not support the hypothesis that the use of the core issue in a formulation impacts therapeutic alliance, symptoms, readiness for change or perceived impact of the session. However, participants' engagement with and	Validated/reliable measures were used. E.g. the Outcome Questionnaire has high internal consistency (.93) and moderate-high test-retest reliability (.84). The Working Alliance Inventory has good construct, concurrent and predictive validity. The study was conducted during ongoing therapy (of

		Persons (1989) proposed a case formulation model of cognitive therapy which suggests that therapeutic change occurs when the central core belief a client has is accurately reflected in the formulation. This study aimed to test the hypothesis that explicit introduction of the believed core issue in therapy affects outcome.	acceptance of the formulation was positively associated with measures of therapeutic alliance, session depth and arousal and symptom reduction.	approximately 9-18 sessions). In turn, it is difficult to differentiate the effects of formulation specifically. The researcher was also one of the therapists, which may have biased participants responses on the measures.
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**
Manuel (2016) A Grounded Theory Study of Multidisciplinary Staff Views on Participating in Team Formulation.	10 multidisciplinary professionals (non-Psychologists). 80% were female. Participants were aged 27 – 59 years and attended an average of 9.4 team formulation meetings (range =	Qualitative. Semi-structured interviews analysed using constructivist grounded theory. The author utilised Hood's (2007) conceptualisation of	Staff appeared to describe the optimum conditions for team formulation to occur. Firstly, team meetings needed to have "the right chefs" to facilitate the meeting, such as	The researcher gives clear and detailed rationale for selecting grounded theory. The researcher reflects on their epistemological position.

Cardiff, Wales (study completed for partial fulfilment of the Doctorate in Clinical Psychology).	3 – 36) over the past 12 months. Participants were working within two mental health teams in South Wales. Both services were for adults (18-65 years) who experience severe mental health difficulties; one community team and one 'locked inpatient unit'.	grounded theory as a cyclical process of data collection, coding, analysis, writing design and theoretical categorisation.	creating a safe space and helping attendees to feel valued and able to contribute their ideas. Resulting meetings were said to be a "unique environment", where unlike in other meetings the output is not fixed, there was shared ownership and there is acceptance of ambiguity. This led to positive changes for the staff such as feeling validated, understanding the client, feeling less stuck and enjoying the meetings.	They utilised Elliot et al's (1999) guidelines to ensure quality throughout the research. Memos were kept to aid defining categories and codes and identifying gaps within the analysis. The researches also kept a reflective journal throughout. Grounded theory enables rich descriptions and rigour. Participants being from community and inpatient settings increases generalisability of findings, though the sample size was relatively small.

				Participants self-selected, which may increase bias.
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**
Stewart (2016) A grounded theory analysis of patients' experience of formulation-sharing with clinical psychologists. Leicester, UK (study completed for partial fulfilment of the Doctorate in Clinical Psychology).	Three adult males engaged in support with Clinical Psychologists in a community mental health service.	Qualitative. Semi-structured interviews analysed using grounded theory.	A core category was developed titled "Formulation-sharing develops a sense of self-in-the-world". Within this, three stages of formulation sharing were discussed by participants: 1. Formulation needs to occur in an emotionally and physically safe environment. Participants described being disconnected from the world and 'stuck' in a cycle of behaviour, so potential for change seems limited.	Very small sample size. All participants developed their formulations with Clinical Psychologists. In turn, the developed theory is not yet generalisable to multi-disciplinary professionals. The author discussed important clinical implications such as the significance clinicians attending to social, political and wider systemic factors during formulation. Formulation sessions were audio recorded for this research. This increases the

			2. Participants experienced formulation as helping them recognise a potential for change, and they developed a more expansive view of the world. 3. Formulation gave an opportunity to rehearse these new understandings of themselves and the world, leading to feeling more engaged in the world.	likelihood that the participants were talking about what the research aimed to (formulation). However, it could create an observer effect in which participants and clinicians modify their responses.
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**
Weedon (2017) Multidisciplinary team members' experiences of team formulation: A thematic analysis.	11 multi-disciplinary professionals (Occupational Therapists and Nurses) from two Early Intervention services for first episode of psychosis.	Semi-structured interviews analysed using Thematic Analysis.	Three main themes were identified: 1. Team formulation offers a different perspective. For example, the structure of formulation meetings is more	Seven of the participants were only able to engage in the interviews for a limited time, which may have reduced the amount of information that could potentially have been collected. It

Leicester, UK (study completed for partial fulfilment of the Doctorate in Clinical Psychology).			flexible than other meetings. Further, diagnosis was discussed as being helpful at times, though formulation was considered to offer something more comprehensive, less stigmatising and useful. 2. The difference is valuable. For instance, it helps people thing about cases differently; find appropriate interventions but may not be as action-focussed as staff would like; staff felt more confident sharing their ideas in these meetings compared to others; and it offered a place to discuss and contain own anxieties.	All participants were self-selected, and so there may be bias in that those who volunteered considered formulation valuable. The interviews enabled participants to talk openly about some of the benefits of diagnosis as an alternative to formulation, as well as some of its limitations.

			3. Connection within the collective. For example, formulation meetings help staff feel less alone such as in managing risk, and they help staff learn from their peers.	
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**
Thew and Krohnert (2015) Formulation as intervention: case report and client experience of formulating in therapy. Bristol & Bath, UK	Case study. 32-year-old female with low mood and suicidal thoughts, and a recent inpatient admission.	Mixed methods. Outcome measures were completed pre and post formulation, and a semi-structured interview. Measures: Depression Anxiety and Stress Scale – 21-item (DASS-21; Henry & Crawford, 2005; Lovibond & Lovibond, 1995). Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1986).	Scores on all three measures were below clinical cut-off level prior to the formulation. There were no changes in the DASS-21 or RSE post formulation, though there were some small improvements on the CORE-OM post formulation. The participant described formulation as a helpful experience overall, allowing	The interview was conducted by the therapist, which can limit how open and honest the participant felt they could be, particularly regarding negative feedback. Whilst a case study design does not purport to be definitive or highly generalisable, the study offers new avenues for research, particularly evaluating BPS

		CORE Outcome Measure (CORE-OM; Evans et al. 2002). The researcher explored whether the formulation offered the benefits that the BPS DCP (2011) guidelines suggest of formulation in the interview.	her to make sense of the difficulties, but there remained unanswered questions, particularly around the onset of the difficulties. They described formulation as difficult at times as she did not want to be blaming others, but it had been helpful to recognise and contain patterns, cycles, and consequences. She was not sure that formulation had normalised her difficulties but did give her a sense of hope for the future.	perspectives of the benefits of formulation. It may have been more useful to use the measures when the participant was presenting with clinical difficulties.
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**

Summers (2006) Psychological formulations in psychiatric care: staff views on their impact. Preston, UK	25 staff on a ward in high-dependency rehabilitation service (9 nurses, 11 support workers, 2 doctors, an occupational therapist, a social worker and a drama therapist).	Qualitative. Semi-structured interviews analysed using grounded theory.	Participants described that formulation helps staff-client relationships such as better empathy and patience, and improves team working. Further, formulation was said to bring together different perspectives, increase staff knowledge and understanding of clients, and provides a space to think creatively. However, some participants said it can limit care plans, some formulations can be incomplete or excessively speculative, and too much information about a new client can lead to inaccurate perspectives. At least three participants reportedly	The researcher reflected on their prior interest in formulation and the impact this may have had on the study. However, negative responses regarding formulation were included in seemingly equal measures to positive comments, thus enhancing the trustworthiness of the project and results. A large sample size of a range of multi-disciplinary professionals was included. This may both reduce selection bias and increase generalisability.

			considered formulations as facts and held their own views with strong convictions.	
Author, Title, Setting	**Participants**	**Methodology**	**Summary of Study and Key Findings**	**Strengths and Limitations**
Berry, Haddock, Kellett, Roberts, Drake & Barrowclough (2015). Feasibility of a ward-based psychological intervention to improve staff and patient relationships in psychiatric rehabilitation settings. Manchester and Sheffield, England.	A final 36 (originally 51) patients and 74 (originally 85) professionals across 10 NHS adult inpatient wards.	A single blind cluster randomised design. Using pre and post measures such as the Working Alliance Inventory (Tracey & Kokotovic, 1989), the authors measured staff and clients' perceptions of treatment and therapeutic relationships before and after either a formulation-informed intervention or treatment as usual. Measures were taken at baseline and 6-month follow-up.	The impact of formulation-informed interventions was compared to Treatment as Usual. Findings suggested that the formulation-based interventions can be more effective than TAU regarding improving patients' perceptions of therapeutic relationships, as well as ward atmosphere and some aspects of burnout for professionals. However, the formulation-based intervention group did	A strength of this study is that it was single blind cluster randomised design. This can reduce bias regarding how the participants behave. The measures used were valid and reliable. There was a large sample size. However, there was a relatively large amount of drop-out (15 patients and 11 professionals). The number of therapy sessions may have differed between clients. However, the

		Client outcomes such as time spent on ward and using measures such as the Positive and Negative Syndrome Scale (PANSS; (Kay, Flszbein, & Opler, 1987) were also measured.	not significantly improve professionals' perceptions of relationships, staff stress or patient outcomes such as length of stay, change in treatment or relapse.	authors stated that the impact on clients' perceptions of relationships and some aspects of staff were measurable after only 3.5 sessions.
Mohtashemi, Stevens, Jackson & Weatherhead (2016). Psychiatrists' understanding and use of psychological formulation: A qualitative exploration. Lancashire, England.	12 Psychiatrists working in an NHS adult mental health service.	Qualitative. Semi-structured interviews analysed using constructivist Grounded Theory.	Psychiatrists understanding and use of psychological formulation was explored. Formulation increased with clinical experience and training, and when risk or complexity increased. Barriers included limited time, perceived pressure to conform to a medical model, and a perception that Psychologists could be a 'threat'. It was	A strength of this study was that the researchers were reflective and reflexive and thus attempted to reduce researcher bias where possible. The researchers calculated the 'internal consistency' of their model, which was rated as good and so may increase its generalisability. The main author was a Psychologist, which may have

			identified that there needs to be a good working alliance between Psychiatrists and Psychologists. Lack of reflection or formulation led to 'alternative approaches' which included trying to treat 'complexity' with multiple medications, which led to some clients repeatedly returning.	impacted the stance taken in the interviews and analysis. Further, the sample may be biased as only those interested in formulation may have participated.
Wilcox (2013). Biscuits and perseverance: reflections on supporting a community intellectual disability team to reflect. Sussex, England.	Up to 13 multi-disciplinary professionals completed a questionnaire after four out of 15 meetings, generating 29 responses in total.	Quantitative. Newly designed questionnaires used to obtain feedback following attendance to a newly set-up formulation meeting.	Feedback from and information about the experiences of multi-disciplinary professionals who attended the formulation meetings was obtained. Professionals found the meetings useful, felt like they achieved something, felt less alone in their work, increased their confidence in working with the discussed client, and increased their understanding of and ability to manage risks. However, it was noted that	This study included vast reflections on the researchers experience of setting up the meetings, and considerations regarding why people stopped attending for example. This meant that there was little information about the attendees' experiences of the formulation meeting. Further the questionnaire used was not a validated measure. Nonetheless, data add to knowledge regarding the

			attendance dropped in the meetings from 13 professionals in the first three meetings to two-four professionals in the remaining 12 meetings.	perceived benefits of formulating as a team.

Appendix 2: Table 3. Quality Review of Qualitative Research using Tracy's (2010) Criteria

X = Criteria not met **? = Criteria partly met / unclear** **✓= Criteria met** **✓✓= High standard**	**Worthy Topic** ***Relevant, timely, significant interesting***	**Rich Rigor** ***Theory, data and time in field, sample, context, data collection***	**Sincerity** ***Self-reflexivity (values, biases, inclinations), transparency (methods & challenges)***	**Credibility** ***Thick description, concrete detail, member checking, triangulation***	**Resonance** ***Naturalistic generalizations, transferable findings***	**Significant Contribution** ***Theoretically, practically, morally, methodologically, heuristically***	**Ethical** ***Procedure, culturally, relational, exiting***	**Meaningful Coherence** ***Achieves what it purports to be about, methods and procedures fit its goals, interconnects literature, questions, findings, and interpretations***
Pain, Chadwick & Abba (2008).	✓✓	✓✓	✓	✓	✓	✓✓	✓✓	✓✓
Chadwick, Williams & Mackenzie (2003).	✓✓	✓	***X***	✓	✓	✓✓	✓✓	✓✓
Redhead, Johnstone & Nightingale (2015).	✓✓	✓✓	✓✓	✓	✓✓	✓✓	✓✓	✓✓

X = Criteria not met ? = Criteria partly met / unclear ✓= Criteria met ✓✓= High standard	**Worthy Topic**	**Rich Rigor**	**Sincerity**	**Credibility**	**Resonance**	**Significant Contribution**	**Ethical**	**Meaningful Coherence**
Kahlon, Neal & Patterson (2014).	✓✓	✓	✓✓	✓✓	✓	✓✓	✓✓	✓✓
Shaw, Higgins and Quartey (2017).	✓✓	***?***	***?***	✓	✓	✓✓	✓	✓✓
Christofides, Johnstone & Musa (2012).	✓✓	✓✓	✓✓	✓	✓✓	✓✓	✓✓	✓✓
Mohtashemi, Stevens, Jackson & Weatherhead (2016).	✓✓	✓✓	✓✓	✓	✓✓	✓✓	✓✓	✓✓
X = Criteria not met ? = Criteria partly met / unclear ✓= Criteria	**Worthy Topic**	**Rich Rigor**	**Sincerity**	**Credibility**	**Resonance**	**Significant Contribution**	**Ethical**	**Meaningful Coherence**

met ✓✓= High standard								
Dinh, Groleau, Kirmayer, Rodriguez & Bibeau (2012).	✓	✓	✓	✓	✓	✓	✓✓	✓
Berry, Barrowclough & Wearden (2009).	✓✓	✓	✓✓	✓	✓✓	✓✓	✓✓	✓✓
Huisman & Kangas (2018)	✓✓	✓	✓✓	✓✓	✓	✓✓	✓✓	✓✓
Whitton, Small, Lyon, Barker & Akiboh (2016).	✓	✓✓	✓	✓	✓✓	✓	✓✓	✓✓
X = Criteria not met ? = Criteria partly met / unclear ✓= Criteria met	**Worthy Topic** ***Relevant, timely, significant interesting***	**Rich Rigor** ***Theory, data and time in field, sample, context, data collection***	**Sincerity** ***Self-reflexivity (values, biases, inclinations), transparency (methods & challenges)***	**Credibility** ***Thick description, concrete detail, member checking, triangulation***	**Resonance** ***Naturalistic generalizations, transferable findings***	**Significant Contribution** ***Theoretically, practically, morally, methodologically, heuristically***	**Ethical** ***Procedure, culturally, relational, exiting***	**Meaningful Coherence** ***Achieves what it purports to be about, methods and procedures fit its goals, interconnects***

✓✓= High standard								***literature, questions, findings, and interpretations***
Adams (2015)	✓✓	✓	✓✓	✓	✓	✓	✓✓	✓✓
Blee (2015)	✓✓	✓	✓✓	✓	✓	✓✓	✓✓	✓✓
Burchardt (2004)	✓✓	✓	✓	✓	✓	✓✓	✓✓	✓✓
Glader (2009)	✓✓	✓✓	✓✓	✓✓	✓	✓✓	✓✓	✓✓
Herhaus (2014)	✓✓	✓	✓✓	✓✓	✓	✓✓	✓✓	✓
X = Criteria not met ? = Criteria partly met / unclear ✓= Criteria met ✓✓= High standard	**Worthy Topic**	**Rich Rigor**	**Sincerity**	**Credibility**	**Resonance**	**Significant Contribution**	**Ethical**	**Meaningful Coherence**

Hess (2000)	✓✓	✓	✓	✓✓	✓	✓✓	✓✓	✓✓
Manuel (2016)	✓✓	✓	✓✓	✓	✓✓	✓✓	✓✓	✓✓
Stewart (2016)	✓✓	✓	***?***	✓	***X***	✓	✓✓	✓✓
Weedon (2017)	✓✓	✓	✓	✓	✓	✓✓	✓✓	✓✓
Thew and Krohnert (2015)	✓✓	✓	***X***	***X***	***X***	✓	✓✓	✓✓
Summers (2006)	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
X = Criteria not met ? = Criteria partly met / unclear ✓= Criteria met ✓✓= High standard	**Worthy Topic**	**Rich Rigor**	**Sincerity**	**Credibility**	**Resonance**	**Significant Contribution**	**Ethical**	**Meaningful Coherence**

Berry et al (2015)	✓✓	✓	✓	✓✓	✓	✓✓	✓✓	✓✓

Appendix 3: Table 4. Quality Review of Quantitative Research using Thomas' (2003) Criteria

	Selection Bias	**Study Design**	**Confounders (2-group designs only)**	**Blinding**	**Data Collection Method**	**Drop Outs**	**Overall Rating**
Chadwick, Williams & Mackenzie (2003).	Moderate	Moderate	N/A	Weak	Strong	Good	Moderate
Shaw, Higgins and Quartey (2017).	Strong	Strong	Strong	Strong	Moderate	Strong	Strong
Berry, Barrowclough & Wearden (2009).	Moderate	Moderate	N/A	Moderate	Moderate	Strong	Strong
Huisman & Kangas (2018)	Strong	Moderate	N/A	Moderate	Weak	Strong	Moderate
Whitton, Small, Lyon, Barker & Akiboh (2016).	Strong	Moderate	N/A	Moderate	Weak	Strong	Moderate
Hess (2000)	Moderate	Moderate	N/A	Moderate	Strong	Strong	Strong
Thew (2015)	Weak	Weak	N/A	Moderate	Strong	Strong	Weak
Berry et al (2015)	Moderate	Strong	Strong	Moderate	Strong	Moderate	Strong
Wilcox (2013)	Strong	Weak	N/A	Strong	Weak	Weak	Weak

Key - global rating for this paper: Strong (no WEAK ratings); moderate (one WEAK rating); weak (two or more WEAK ratings)

Appendix 4: Reflective Journal Extract

13/02/2019

I met my first participant today! He was very engaged and interested in the research. He was chatty and enthusiastic, and I had to keep reminding myself throughout the interview to check I was on track with the interview schedule, as I think we could have easily talked about services and research endlessly! I was pleasantly surprised by this. As I drove home, I felt very enthusiastic about the project going forward and excited about meeting more participants

15/02/2019

I recently met with my university research supervisor to review the first interview and transcript. We talked about how to maintain a more neutral stance during interviews, as I reflected that I often quite naturally agreed with the participant or gave encouraging words such as "that's true" or "that's right". My supervisor encouraged me to try more neutral responses such as "you're giving me a clear understanding of what that was like for you". I highlighted this on my semi-structured interview schedule, as I know when I am in the middle of an interview, I am likely to get enthusiastic and start giving positive feedback again, given that I developed and fell like I nurture this project!

We also reflected together on some of the more surprising responses from the client. For example, perhaps when we first planned this project, we expected ideas about how to improve the more practical aspects of formulation, but the participant is questioning the need for formulation altogether in some parts of the interview. This can have serious clinical and political implications for mental health care professionals. Therefore, I will need to think about how young people's voice is heard in my research findings and think carefully about potential clinical implications and recommendations are outlined. Furthermore, some of the responses of the participant raised new questions. For example, he had some clear ideas about the pros and cons of both diagnoses and formulation and we wondered whether and where he had heard conversations about this before. Therefore, new questions were added to the interview schedule. It seemed important to do this early on in the process so that they subsequent interviews with other participants are similar to one another.

18/02/2019

I am concerned about recruitment difficulties. I had to wait until my NHS research ethics, University and HRA approval before I could recruit, which was delayed due to loss of my DBS certificate when I moved home. This meant I was unable to recruit and interview young people over the summer on the designated research days. However, I was able to use that time to write my introduction and systematic review, and I started visiting CAMHS teams to tell the clinicians about the research. Despite starting to attend CAMHS meetings over four-five months ago sending reminder regular emails, I have only been provided three participants to interview so far. I am concerned that given I have approximately three months to find and interview around another seven participants before I need to prepare for the staff focus group, recruitment will not be fruitful. I have contacted my university and field supervisors to express my concerns.

20/02/2019

I have spoken to my partner about my concerns regarding recruitment. This helped me to think about new ideas for obtaining support for the project. I decided to email administrators of the CAMHS teams to ask them to cascade information about my research to all clinicians, not just Clinical Psychologists. Sometimes I find that I get caught in a cycle of trying the same solutions over and over again. When I take a step back and talk to others about it, I get new ideas. This reminds me of what we teach some clients in therapy – to take a bird's eye or helicopter view of their difficulties! This is difficult to do when you are in the thick of things. It seems that only after an epiphany has happened, I am able to reflect on such processes.

22/02/2019

I have noticed an intrusive increase in my anxiety levels, which is impacting my sleep and concentration at work. Despite my best efforts, I fear that I will not pass my Doctorate due to recruitment difficulties. This is despite having a high attendance score and engagement in both placement and university work throughout the past two and a half years! To help me feel less like I am 'falling behind' I have decided to ensure other aspects of my thesis are 'ready to go' once recruitment picks up. This includes considering parts of the Discussion such as potential ideas for future research and strengths and limitations of the research thus far, and inserting all of my appendices to the thesis. I am also trying to remind myself of times I have been through similar difficulties but succeeded (such as it taking nearly 12 months of effort by me to obtain ethical approval for this research!).

25/02/2019

A young person has showed interest in my project! This makes me somewhat more hopeful. I booked her in for three weeks' time, at her request. The interviews with the young people have been the most exciting part of the project and the reason why I wanted to do a project of this nature originally. I hope that I am able to see this project through to the end.

01/03/2019

I have been making contact with newly qualified Clinical Psychologists who recently graduated from Herts University, whom I know are working in CAMHS. They were already aware of the research. However, this time I was open and honest with them about my limited participant numbers and the time limit I have to finish recruitment before the staff focus group. I have also been in touch with the participation leads. They have all been understanding and I have been sent three more participants! I wondered if part of the difficulty of clinicians' telling their clients about my research was having no 'deadline' dates. As CAMHS teams in the area are very busy at the moment, it can be hard to hold in mind all of the different responsibilities. Having a set date to work towards, as well as my openness about the difficulties may both have helped the clinicians to hold the research in mind.

07/03/2019

I interviewed two participants today. I have been making notes during each interview. This has enabled me to start to think about key ideas and patterns that participants outline. For example, todays notes included:

- Young person had to repeat themselves to the Psychiatrist despite the Psychologist sharing a formulation and summary letter with them.
- Young person felt that the formulation included their own opinions and was mainly centred around them but did include some of their siblings' difficulties.
- They found it emotional talking about some of their family's difficulties during development of the formulation and struggled to put it into words. They found that having a template helped.
- They were not sure if the formulation should be shared with people such as their teachers.

- It took a few sessions to understand the formulation, but they developed an understanding of 'what was going on' and how their history and their responses to situations maintain the difficulties.
- The formulation helped them to break things down, so they did not have to work on all their difficulties at once.
- They felt listened to and developing and hearing back the formulation made them feel like a 'weight had been lifted off their shoulders'.

I have noticed that it is difficult to make notes whilst maintaining a rapport with the participants. I sometimes make notes during clinical sessions, but often the client knows you well from seeing you weekly. However, in research interviews the person only sees you once, and is there on a voluntary basis. As I have the Dictaphone recording, I have decided to make fewer notes in future interviews to maintain a positive relationship and so encourage the young people to speak more about their experiences.

08/03/2019

Interviewed another participant today. I have noticed a massive reduction in my anxiety from a few weeks ago. The interview went really well, and the participant was very engaged. I made less notes, and I found that not only did this enable me to pay more attention to the participant I was also able to reflect more in the moment. For example, I started to notice similarities between this interview and the last ones. Indeed, this participant also discussed that writing things down in a template helped them to talk about their difficulties, and it helped them to understand the triggers for their difficulties. Other key notes from the interview included that they believe that clinicians should explain more about what they are doing and how the formulation might help. Further, their formulation helped them to develop goals for therapy, identify their strengths and feel less to blame for their difficulties.

I noticed that at the beginning stage of the interview the participant often talked about their experiences of therapy in general, and sometimes merged some of their experiences of therapy with some of their experiences of the formulation. I managed this in the session by reminding them of the focus of the interview. In future interviews I will take a copy of the recruitment leaflet that I developed which outlines different types of formulation to help centre participants to the focus of the interview.

11/03/2019

I have now interviewed eight participants. I have been enjoying the process of interviewing and I feel much more settled now that I have eight participants rather than three! I have started to eyeball the data and think about initial line-by-line codes. I am not at saturation point yet as each participant has bought in some new ideas. However, for the most part there are a lot of repeating ideas being discussed by participants now. This includes: Little knowledge about formulation before entering the service and so a preference for diagnosis to feel understood; using the formulation to identify solutions, and different ways of responding for parents and teachers; feeling involved in the development of the formulation; and feeling understood when hearing a formulation which accurately summarises their experiences.

Three of the participants had an Autism Spectrum condition. Whilst I was eyeballing the data I also wondered if there is an overlap in the experiences of formulation for people with Autism. For example, each person described finding it useful to have a template or diagram to focus on what they wanted to talk about. Perhaps they find having it written out in some form makes the ideas more concrete and less abstract? Each person also seemed to enjoy developing the formulation and were able to see it as a scientific approach to understanding and managing difficulties. I wonder if the experiences of formulation for people with Autism specifically has been researched.

14/03/2019

I attended two CAMHS teams' away days to pitch my research again and ask for help with both recruitment of young people and recruitment of professionals for the focus group. having already completed eight interviews I was able to address people's concerns and questions more readily. For example, one of the clinicians wondered what language I use in the interviews as most clinicians do not use the word formulation with their clients. I was able to explain that each of the young people I had interviewed so far were aware of formulation and each had their own way of describing it, such as getting to know you sessions, the diagram, or the understanding that they developed with their clinician. In turn, I explained that I will use the participants preferred/known terms in the interviews. Furthermore, this time I highlighted that I do not ask participants about their history, difficulties or therapist, which I had not highlighted greatly when I first talked about my research with teams last summer. I noticed nods and agreement when I explained this, which I am hopeful with help clinicians to feel more

comfortable referring their clients to my research. This is an important learning point for me, which I will carry over to any future research products which I conduct.

22/03/2018

I have not heard back from the teams I visited last week with young people to participate in my research. I have sent reminder emails. I am slightly concerned that I will not find enough participants before I need to do the professionals focus group and ideally, I am looking for another 2-4 participants to see if I can reach saturation.

That said, I have received emails about people interested in taking part in the professionals focus group. There is a new Psychologist in one of the CAMHS teams who is helping to drive participation of professionals, including her emailing and texting me with updates unprompted. I am humbled by her efforts, and I am not sure how to thank her. Perhaps as with past experiences, such as Trainee Clinical Psychologists helping me to feel calmer and comfortable during my interview for the Doctorate, I can 'pay forward' the favour by helping future Trainee's with their research once I am qualified.

Appendix 5: Recruitment Advert

Would you like to take part in a project which could help improve services like CAMHS?
Are you aged 11—18 years?

Exploring Young People's Experiences of Formulation

We are looking for young people to take part in a project which aims to find out your understanding & experiences of 'formulation.' This would involve one informal face-to-face chat

Formulation is a way of understanding how difficulties may have developed and been maintained. This may have been presented to you in a diagram, letter or verbal summary. It can sometimes be used instead of or as well as a diagnosis. Whilst there is lots of research about formulation and staff opinions of it, there is little research regarding your views!

We would like to change that!

Please Contact:

xxx, tell your clinician you want to take part or put your contact details in the box at reception!

If you are under 16 years old, we will need consent from a parent or guardian for you to participate.

This study is only available to people who are currently open to CAMHS, not people who have already been discharged. This project is supervised by xxx (Senior Lecturer & Clinical Psychologist), xxx.

Appendix 6: Recruitment Presentation to CAMHS

Why Are We Doing This Project

- Formulation is a term used a lot in mental health services
- A number of uses, e.g. prioritise difficulties, plan interventions and trouble-shoot (Butler, 1998).
- Is said to help the client feel understood, & the clinician feel contained (DCP, 2011).
- Large amount of academic literature regarding formulation (e.g. Johnstone & Dallos, 2014).
- Yet, very little research regarding the effectiveness or client's experiences of formulation.
- Some initial research showed complex findings.

Background: Relevant Research

- Interviews with MDT's in CAMHS - Staff were **not clear** what formulation is, were **reluctant** to engage with it, and saw psychologists as able to supervise on formulation but **expensive** (Adams, 2015).
- Formulation for adults with psychosis – **positive impact on alliance from clinicians** but not client's perspective and HADS found no significant impact on wellbeing.
  - Semi-structured interviews - clients reported both positive emotions, e.g. feeling reassured, encouraged, optimistic, and negative emotions, e.g. saddening, upsetting and worrying (Chadwick et al., 2003).
- Participants found formulation **'blaming'** of people in their social circle. Diagnosis described as 'justifying' their difficulties but may also imply something inherently negative about the individual (Leeming, Boyle & MacDonald, 2009).
- Therapist's and young adults (19-20 years) with PTSD and First Episode of Psychosis described that formulation helps to **develop insight and make connections** between current symptoms and past trauma, but that it is a **challenging** experience (Halpin et al, 2016).

A 2-Step Process

1. Explore adolescents' **experiences** of receiving and/or developing a formulation with their clinician(s) when accessing CAMHS.

2. After, share a summary of their responses with volunteers from the **MDT** and a hold a focus group with you to discuss the findings.

Participant Inclusion Criteria

- **Inclusion criteria for participation of young people is as follows:**

* Aged between 11 - 18 years
* Males and females
* Currently open to CAMHS
* Worked with a clinician during assessment and/or therapy who used formulation
* Able to provide informed consent to participate
* Sufficient verbal communication and cognitive ability to participate in an interview about conceptually abstract matters

What Do We Need to Do?

- Cathryn (Trainee) will meet with young people who volunteer, for 1 hour, to gather their views on formulation.
- To help with this, we would need clinicians to audio record a formulation session, which the young person and Cathryn would listen to a short clip of at the start of the interview. This is just to ensure that the young person and Cathryn are actually talking about the same thing and not some other aspect of therapy. The recordings are deleted after the interview.
- **Alternatively**, they could bring a written letter or diagrammatic formulation to the interview.
- Participants (that is the young people!) are given a £10 voucher as a thank you for their time

Thank You!

- Thank you for taking the time to consider young people who may be able to participate in this research. This project will not be possible without you!
- Please contact [ ] and I when you have people who may be suitable for the project
- **Contact Details:**

References

- Adams, A. D. (2015). Formulation: An investigation into perspectives of non-psychologists within a Child and Adolescent Mental Health Service (Doctoral dissertation, Staffordshire University).
- Chadwick, P., Williams, C., & Mackenzie, J. (2003). Impact of case formulation in cognitive behaviour therapy for psychosis. *Behaviour Research and Therapy*, *41*(6), 671-680.
- Division of Clinical Psychology (2010). The Core Purpose and Philosophy of the Profession. Leicester: The British Psychological Society.
- Halpin, E., Kugathasan, V., Hulbert, C., Alvarez-Jimenez, M., & Bendall, S. (2016). Case Formulation in Young People with Post-Traumatic Stress Disorder and First-Episode Psychosis. *Journal of Clinical Medicine*, *5*(11), 106.
- Johnstone, L., & Dallos, R. (2013). *Formulation in psychology and psychotherapy: Making sense of people's problems*. Routledge.
- Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. Qualitative Research in Psychology, 3(2), 102-120.
- Leeming, D., Boyle, M., & MacDonald, J. (2009). Accounting for psychological problems: How user-friendly is formulation? In Clinical Psychology Forum (Vol. 200, pp. 12-15). The British Psychological Society.
- Willig, C. (2001) Introducing Qualitative Research in Psychology: Adventures in Theory and Method. Maidenhead: Open University Press.

Appendix 7: Recruitment Information Leaflet

What is this research?

The researchers are genuinely interested in hearing young people's views regarding what works well or not so well in CAMHS services.

This research aims to ask your opinions about 'formulation' through an informal chat with myself, For people under the age of 16 years we will need your parent/guardians' consent for you to participate.

How will it help?

Whilst there is lots of research about formulation & staff opinions of it, there is little research regarding your views!
A summary of findings (excluding details which might identify you) will be shared with services and hopefully published in an academic journal and/or at conferences. This could mean that CAMHS services (continue or) change the way formulation is used, to increase its usefulness for future young people accessing services!

CONTACT US

xxx
Trainee Clinical Psychologist
xxx

xxx
Clinical Psychologist & Clinical Tutor
xxx

Are You Interested in Helping to Improve Services?

If so, please consider taking part in our research project!

Exploring Young People's Experiences of Formulation

Researcher: xxxx

Supervised by: xxx

What is Formulation?

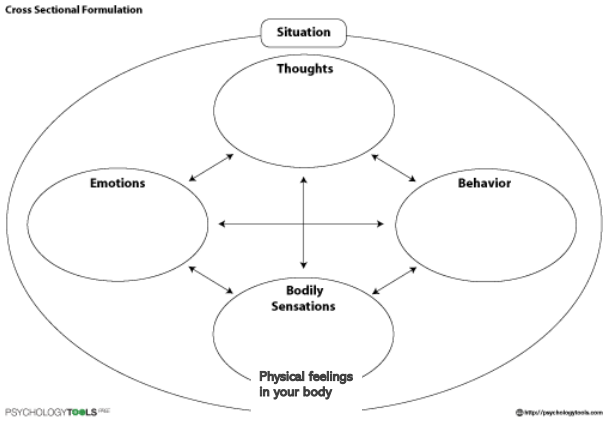
'Formulation' is an uncommon word and you may not have heard it before. It just means a way of understanding how your difficulties may have developed and what keeps them going. When you start attending CAMHS your therapist spends time getting to know you, hearing about your concerns, your past, significant events that troubled you, and maybe your worries about the future.

All this information is often used to get to know you as an individual and to help decide which treatment or support is likely to benefit you.

Formulation is often used instead of or as well as a diagnosis.

Perhaps your formulation was simply a verbal summary of your difficulties.

Or it may have been presented to you in a diagram, such as the one below which looks at the link between our thoughts feelings and behaviours.



Perhaps a formulation was developed with your family. For example, you and your clinician may have discussed how people interact or discussed major events that have happened, and how these may be linked to an individual's or families' difficulties.

It might also have been included in a letter sent to you by your clinician, and may outline factors such as your early experiences, factors that 'triggered' your difficulties, factors that keep your difficulties going, and your strengths or protective factors. These factors would then have been summarised and ideas drawn from them.

Do I have to take part?

No! Participation is completely voluntary. We hope that you would enjoy being involved in the research and having your say in how services are run for young people. If you do not wish to take part, this will not affect your care given in any way.

You can also change your mind and withdraw from the research You can also change your mind and withdraw from the research, up to one month after our meeting. This study is only available to people who are currently open to CAMHS, not people who have already been discharged.

How do I get involved?

Simply email xxx on the email address at the back of this leaflet saying you are interested and I'll take it from there! Or, just let your CAMHS clinician or parent know and they can contact me on your behalf. You are welcome to have a parent/carer or friend attend. If you are under 16 years old we will ask a suitable adult to attend, but it is your views we want to hear.

The research will run from October 2018—February 2019.

Appendix 8: NHS Ethical Approval

WoSRES

West of Scotland Research Ethics Service

Xxx

West of Scotland REC 3
Research Ethics
Clinical Research and Development
West Glasgow Ambulatory Care Hospital
Dalnair Street
Glasgow
G3 8SJ
(Formerly Yorkhill Childrens Hospital)

Date 16 August 2018
Direct line 0141 232 1807
E-mail WoSREC3@ggc.scot.nhs.uk

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

Dear Dr xxx

Study title:	**Exploring young peoples experiences of formulation & its implications for clinicians in CAMHS.**
REC reference:	**18/WS/0125**
Protocol number:	**Awaiting IRAS approval**
IRAS project ID:	**240816**

Thank you for your letter of 01 August 2018, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a Sub-Committee of the REC. A list of the Sub-Committee members is attached.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Handout - Formulation Leaflet]	2	03 June 2018
Copies of advertisement materials for research participants [Formulation poster]	4	17 July 2018
Covering letter on headed paper [Covering Letter to REC]		10 July 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance]		01 August 2017
Initial Assessment for REC		13 June 2018
Interview schedules or topic guides for participants [Provisional Interview Schedule]	3	13 July 2018
IRAS Application Form [IRAS_Form_27042018]		27 April 2018
Letter from sponsor [Confirmation of UH Ethics in principle]		24 April 2018
Letters of invitation to participant [Formulation Leaflet]	4	13 July 2018
Other [Debrief]	2	10 July 2018
Other [Public Liability]		19 July 2017
Participant consent form [Consent Form 16-18]	2	10 July 2018
Participant consent form [Parental Consent]	1	10 July 2018
Participant consent form [Consent ,16]	3	01 August 2018
Participant consent form [Staff Consent]	3	01 August 2018
Participant information sheet (PIS) [PIS]	3	13 July 2018
Participant information sheet (PIS) [Staff PIS]	3	01 August 2018
Research protocol or project proposal [Project Proposal]	1	27 April 2018
Research protocol or project proposal [Proposal]	2	13 July 2018

Response to Request for Further Information [Letter to REC committee 2]		01 August 2018
Summary CV for Chief Investigator (CI) [CI and Supervisors CV]	1	27 April 2018
Summary CV for student [Student CV]	1	10 February 2018

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

Notifying substantial amendments
Adding new sites and investigators
Notification of serious breaches of the protocol
Progress and safety reports
Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received

and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/qualityassurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

18/WS/0125 **Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

Mrs xxx
Chair

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*
"After ethical review – guidance for researchers"

Copy to: *xxx Partnership University NHS Foundation Trust*

Lead Nation England: HRA.Approval@nhs.net
West of Scotland REC 3

Attendance at Sub-Committee of the REC meeting in August 2018

Committee Members:
(Removed to protect privacy)

Also in attendance: xxx

Appendix 9: HRA Approval

Dr xxx

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

31 August 2018

Dear Dr xxx

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Exploring young peoples experiences of formulation & its implications for clinicians in CAMHS.**
IRAS project ID:	**240816**
REC reference:	**18/WS/0125**
Sponsor	**University of Hertfordshire**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales? You should now provide a copy of this letter to all participating NHS organisations in

England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your nonNHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including: Registration of research

Notifying amendments

Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: xxx

Tel: xxx

Email: xxx

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **240816**. Please quote this on all correspondence.

Yours sincerely

xxx

Senior Assessor

Email: hra.approval@nhs.net

Copy to: *xxx*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Handout - Formulation Leaflet]	2	03 June 2018
Copies of advertisement materials for research participants [Formulation poster]	4	17 July 2018
Covering letter on headed paper [Covering Letter to REC]		10 July 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance]		01 August 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Public Liability]		19 July 2017
HRA Schedule of Events	1	31 August 2018
HRA Statement of Activities	1	31 August 2018
Interview schedules or topic guides for participants [Provisional Interview Schedule]	3	13 July 2018
IRAS Application Form [IRAS_Form_27042018]		27 April 2018
Letter from sponsor [Confirmation of UH Ethics in principle]		24 April 2018
Letters of invitation to participant [Formulation Leaflet]	4	13 July 2018
Other [Debrief]	2	10 July 2018
Participant consent form [Consent ,16]	3	01 August 2018
Participant consent form [Staff Consent]	3	01 August 2018
Participant consent form [Consent Form 16-18]	2	10 July 2018

Participant consent form [Parental Consent]	1	10 July 2018
Participant information sheet (PIS) [PIS]	3	13 July 2018
Participant information sheet (PIS) [Staff PIS]	3	01 August 2018
Research protocol or project proposal [Proposal]	2	13 July 2018
Response to Request for Further Information [Letter to REC committee 2]		01 August 2018
Summary CV for Chief Investigator (CI) [CI and Supervisors CV]	1	27 April 2018
Summary CV for student [Student CV]	1	10 February 2018

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	**Assessment Criteria**	**Compliant with Standards**	**Comments**
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	Statement of activities will form agreement between sponsor and participating NHS organisations.

4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	No application for external funding made
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments
Section	**Assessment Criteria**	**Compliant with Standards**	**Comments**
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

At participating NHS organisations staff and service users will be approached to take part in the study. The researcher will conduct research activities with participants within the participating NHS organisation.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).
A principal investigator will be in place at participating NHS organisations. GCP training is not a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken
Where arrangements are not already in place, researchers would be expected to obtain a Letter of Access based on enhanced DBS checks and occupational health clearance.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix 10: University of Hertfordshire Ethical Approval

Dear xxx,

Thank you for confirming the arrangements under which you will collect your data for the study entitled *Exploring Young Peoples Experiences of Formulation & their Implications for Clinicians in CAMHS*. The Chairman of the Health, Science, Engineering and Technology ECDA has confirmed that you may quote UH protocol number LMS/PGR/NHS/02909 on your submission paperwork and exam arrangements form.

Kind regards,
xxx

University of Hertfordshire
xxx

Ethics Approval StudyNet Site available here:
xxx

ECDA email addresses:

Health, Science, Engineering and Technology – xxx
Social Sciences, Arts & Humanities – xxx

Appendix 11: Participant Information Sheet

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS
('ETHICS COMMITTEE')

PARTICIPANT INFORMATION SHEET

Title of Research

Exploring Young Peoples Experiences of Formulation in CAMHS

Introduction

You are being invited to take part in a research study. Before you decide whether to do so it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us about anything that is unclear or for any further information you would like to help you make your decision. This study is part of an educational project and is being conducted as partial fulfilment of a Doctorate.

Please do take your time to decide whether you wish to take part. Thank you for reading this.

What is the purpose of this study?

During therapy clinicians often use a process which they call 'formulation'. Formulation is generally a summary of what you are finding difficult and the various factors that might have led to or maintained these difficulties. This may have presented to you in a verbal summary, a diagram or picture, or a letter.

Despite this being used by most CAMHS clinicians no research has been published yet regarding what young people (under the age of 19 years) think about their formulation/summary. The researchers think it is important that young people's opinions are heard, and so this study aims to fill this gap in our knowledge regarding what the young people we work with understand and/or think of this method.

Do I have to take part?

No. It is completely up to you whether you decide to take part in this study. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form.

Agreeing to join the study does not mean that you must complete it. You are free to withdraw from the study without giving a reason, up to a period of one month following your participation. This one-month limit is in place because once we have met with you we will study your responses and combine them with other young people's responses. Once the responses are combined we will no longer be able to remove your responses or identify you individually from the text.

A decision to withdraw, or a decision not to take part at all, will not affect the rest of the treatment/care that you receive. This study is only available to people who are currently open to CAMHS, not people who have already been discharged.

What will happen to me if I take part?

If you decide to take part in this study, your clinician will ask you to sign a consent form. You may then be asked to audio record a session in which you develop a formulation with your clinician, or to share a written version of your formulation.

You will then be asked to meet with one of the researchers (Cathryn Marrington, Trainee Clinical Psychologist) for around one hour. Here we will listen to a short segment of your formulation recording or read through the written summary together. This is just to ensure that you and I are talking about the same thing: The researcher does not need to know what your

therapy sessions are about, so we will only listen to a short piece together. This audio recording will then be returned to your clinician and deleted.

I will ask you questions about your formulation/summary which may include what you liked or did not like about it, and what services could do differently in future. There are no right or wrong answers and I am keen to hear your view on what you understand about formulation and what you think about it. I will also audio record this meeting which I will keep in a safe place for the duration of the study (up to June 2019, see confidentiality section below).

We will meet in the CAMHS clinic, to ensure your privacy and confidentiality. You are welcome to bring a relative or friend with you if you wish, as you might do in other sessions. If you are under the age of 16 years, we will ask a parent/guardian to accompany you. If you are under 16 years of age, we will also ask a parent to sign a consent form for you to participate. However, it is your views we would like to hear.

Once I have studied and combined the information that you and other young people have given me, I would like to re-contact some of you to check that I have evaluated what you told me in a fair and accurate way. If you consent to this, I would need to keep hold of your contact details to contact you a few months after we have met, but no later than June 2019.

How will my taking part in this study be kept confidential?

During the study, I will record our conversation on a Dictaphone and I may make some notes. The Dictaphone will be encrypted so that no one can access it without my password and kept in a safe place. I will remove any information that might identify you such as your name, date of birth, the place where you live and so on from all aspects of the study. I will type up our interview and remove your details and give you a 'pseudo name' to protect your privacy. The recording will then be deleted. I will combine the typed interview with other young people's interviews. This document will be kept, password protected, for up to 5 years to enable the study to be checked by others if they wish to do so. Similarly, I am likely to ask your gender, age and ethnicity which will then be combined with other participants' information, so that we can record how many males/females and ages participated in the study.

A list of your names and contact details will be kept in a separate location (at the University of Hertfordshire) in a locked filing cabinet only for the duration of the study (up to June 2019) in case we need to contact you.

Your data will be protected according to new GDPR legislation (see Appendix 1).

Anything you tell me will be kept confidential from the CAMHS team involved in your care and friends and family. The only limit to confidentiality would be if you told me something that made me believe that you or another young person was at risk of some kind, and then I would have to tell a suitable senior member of staff, but I would let you know that I plan to do this first.

What will happen to the results of the research study?

What you tell me during the interview will be summarized into key themes and grouped with the responses from the other young people that I meet, and so any reports or articles I write will not identify you.

I will share a summary report with the CAMHS team involved. I will also be submitting a thesis regarding this study as partial completion of my Doctorate in Clinical Psychology. I will also try to have a summary of this study published in a suitable academic journal regarding Psychology, and a summary may be presented at conferences.

Who has reviewed this study?

This study has been reviewed by: WoSRES West of Scotland Research Ethics Service (REC reference number: 18/WS/0125).
NHS ethics board ID: 240816

This study has also been reviewed by: The University of Hertfordshire School of Life and Medical Sciences.
UH protocol number: LMS/PGR/NHS/02909

Who can I contact if I have any questions?

xxx

xxx

xxx

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University Secretary and Registrar.

xxx

Or contact xxx Partnership NHS Foundation Trust's complaints team:

The Complaints Manager or the Chief Executive, Trust Head Office, xxx

You can complete the online comment, compliment or complaint form via http://www.xxx.nhs.uk/contact-us/compliments-and-complaints/

or Tel: xxx

Independent Contact:

xxx

Thank you very much for reading this information and giving consideration to taking part in this study.

(Appendix 1)

GDPR Information

The University of Hertfordshire is the sponsor for this study based in the United Kingdom, England. We will be using information from you and/or your medical records in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Hertfordshire will keep your name, age, gender, ethnicity and a contact detail in a locked cabinet at the University of Hertfordshire for the duration of the study (until June 2019); information will be accessed only to contact you about the study.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information https://www.hra.nhs.uk/ and/or by contacting the University Secretary and Registrar.

xxx (DClinPsy student) from the Sponsor site (University of Hertfordshire) may collect information about you for this research study from the NHS site. This information will include your name and contact details. We will use this information to contact you if you have stated that you wish to take part in this study.

Appendix 12: Participant Consent Form, 16-18 Year Olds

UNIVERSITY OF HERTFORDSHIRE
COLLEGE LANE CAMPUS
HATFIELD
AL10 9AB

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS
('ETHICS COMMITTEE')

CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS FOR USE WHERE THE PROPOSED PARTICIPANTS ARE AGED 16-18 YEARS

Please Tick If You Consent To Each Point

- □ I consent to take part in the study entitled 'Exploring Young People's Experiences of Formulation in CAMHS.' (UH Protocol number LMS/PGR/NHS/02909; NHS Ethics IRAS project ID: 240816)

- □ I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study.

- □ I have been told that I can withdraw my consent to participate in this study before, during or after, up to one month after my meeting with the researcher.

- □ In giving my consent to participate in this study, I understand that voice recording may take place during one of my therapy sessions, and the researcher and I will listen to an extract of the recording together.

- □ Additionally, I understand that voice recording will take place during the research interview.

- □ I have been informed of how/whether these recordings will be stored.

- □ I have been informed that the recording will be transcribed and combined with other young people's interviews.

- □ I consent to some quotes (without identifying information) being used in subsequent texts.

- □ I have been told how information relating to me will be kept secure, confidential, and how it will be used.

- □ I understand that this consent form will be scanned and attached to my electronic patient record and then shredded.

 I understand that in the event that my participation in this study may reveal something that could indicate that I or someone else might be at risk, the researcher will inform a senior member of staff.

Signature of young person:
Name: ……
Signature: ……
Date……
Contact email or phone number: ……

Signature of Principal Investigator:
Name: ……
Signature: ……
Date……

Signature of Student Investigator:
Name: ……
Signature: ……
Date……

Appendix 13: Parental Consent Form for Under 16s

UNIVERSITY OF HERTFORDSHIRE
COLLEGE LANE CAMPUS
HATFIELD
AL10 9AB

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS
('ETHICS COMMITTEE')

CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS FOR USE WHERE THE PROPOSED PARTICIPANTS ARE MINORS

Please Tick If You Consent to Each Point

- ☐ I consent for my child to take part in the study entitled 'Exploring Young People's Experiences of Formulation in CAMHS.' (UH Protocol number LMS/PGR/NHS/02909; NHS Ethics IRAS project ID: 240816)

- ☐ I confirm that we have both been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study.

- ☐ I have been told that I can withdraw my consent for him/her to participate in this study before, during or after, up to one month after their meeting with the researcher.

- ☐ In giving my consent to participate in this study, I understand that voice recording may take place during one of my child's therapy sessions, and the researcher and he/she will listen to an extract of the recording together.

- ☐ Additionally, I understand that voice recording will take place during the research interview.

- ☐ I have been informed of how/whether these recordings will be stored.

- ☐ I have been informed that the recording will be transcribed and combined with other young people's interviews.

- ☐ I consent to some quotes (without identifying information) being used in subsequent texts.

- ☐ I have been told how information relating to him/her will be kept secure, confidential, and how it will be used.

- ☐ I understand that this consent form will be scanned and attached to my child's electronic patient record and then shredded.

- I understand that if his/her participation in this study may reveal something that could indicate that he/she or someone they know might be at risk, the researcher will inform a senior member of staff.

Signature of parent/carer:
Name: ……
Signature: ……
Date……
Contact email or phone number: ……

Signature of Principal Investigator:
Name: ……
Signature: ……
Date……

Signature of Student Investigator:
Name: ……
Signature: ……
Date……

Appendix 14: Participant Assent Form for Under 16s

UNIVERSITY OF HERTFORDSHIRE
COLLEGE LANE CAMPUS
HATFIELD
AL10 9AB

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS
('ETHICS COMMITTEE')

ASSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS FOR USE WHERE THE PROPOSED PARTICIPANTS ARE MINORS

Please Tick If You Assent to Each Point

- ☐ I assent to take part in the study entitled 'Exploring Young People's Experiences of Formulation in CAMHS.' (UH Protocol number LMS/PGR/NHS/02909; NHS Ethics IRAS project ID: 240816)

- ☐ I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study.

- ☐ I have been told that I can withdraw my assent to participate in this study before, during or after, up to one month after my meeting with the researcher.

- ☐ In giving my assent to participate in this study, I understand that voice recording may take place during one of my therapy sessions, and the researcher and I will listen to an extract of the recording together.

- ☐ Additionally, I understand that voice recording will take place during the research interview.

- ☐ I have been informed of how/whether these recordings will be stored.

- ☐ I have been informed that the recording will be transcribed and combined with other young people's interviews.

- ☐ I assent to some quotes (without identifying information) being used in subsequent texts.

- ☐ I have been told how information relating to me will be kept secure, confidential, and how it will be used.

- ☐ I understand that this assent form will be scanned and attached to my electronic patient record and then shredded.

- I understand that in the event that my participation in this study may reveal something that could indicate that I or someone else might be at risk, the researcher will inform a senior member of staff.

Signature of young person:
Name: ……
Signature: ……
Date……
Contact email or phone number: ……

Signature of Principal Investigator:
Name: ……
Signature: ……
Date……

Signature of Student Investigator:
Name: ……
Signature: ……
Date……

Appendix 15: Professionals Focus Group Participant Information Sheet

UNIVERSITY OF HERTFORDSHIRE
COLLEGE LANE CAMPUS
HATFIELD
AL10 9AB

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS
('ETHICS COMMITTEE')

PARTICIPANT INFORMATION SHEET

STAFF FOCUS GROUP

Title of Research

Exploring Young People's Experiences of Formulation in CAMHS

Introduction

You are being invited to take part in a research study. Before you decide whether to do so, it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether you wish to take part. Thank you for reading this.

What is the purpose of this study?

During therapy clinicians often develop a formulation with or about clients. Despite this being used by most CAMHS clinicians, no research has been published yet regarding what young people (under the age of 19) think about their formulation/summary. The researchers think it

is important that young people's opinions are heard, and so this study aims to fill this gap in our knowledge regarding what the young people we work with understand and/or think of this method.

Do I have to take part?

No. It is completely up to you whether you decide to take part in this study. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you must complete it. You are free to withdraw without giving a reason, on the day of the focus group.

What will happen to me if I take part?

If you decide to take part in this study, you will be asked to join a focus group for approximately one hour with other multi-disciplinary professionals and one of the researchers (Cathryn Marrington, Trainee Clinical Psychologist). Here I will share themes resulting from semi-structured interviews with several young people who have accessed CAMHS, regarding their experiences of formulation. You will be asked to discuss your responses to the young people's feedback and any implications their feedback may have for clinical practice.

How will my taking part in this study be kept confidential?

During the study, I will record the focus group on a Dictaphone and I may make some notes. The Dictaphone will be encrypted so that no one can access it without my password and kept in a safe place. I will remove any information that might identify you such as your name, your specific work place and so on from all aspects of the study. I will type up the focus group and remove your details and give you a 'pseudo name' to protect your privacy. The recording will then be deleted.

Your data will be protected according to new GDPR legislation (see Appendix 1).

What will happen to the results of the research study?

What you discuss during the focus group will be summarised into key themes. I may also include quotes from individuals, but without any identifying information. Any reports or articles I write will not identify specific clinicians or the CAMHS team.

I will be submitting a thesis regarding this study as partial completion of my Doctorate in Clinical Psychology. I will also try to have a summary of this study published in a suitable academic journal regarding Psychology, or conference.

Who has reviewed this study?

This study has been reviewed by: WoSRES West of Scotland Research Ethics Service (REC reference number: 18/WS/0125).
NHS ethics board ID: 240816

This study has also been reviewed by: The University of Hertfordshire School of Life and Medical Sciences.
UH protocol number: LMS/PGR/NHS/02909

Who can I contact if I have any questions?

xxx

xxx

xxx

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University Secretary and Registrar:

xxx

Or contact xxx Partnership NHS Foundation Trust's complaints team:

The Complaints Manager or the Chief Executive, Trust Head Office, xxx

You can complete the online comment, compliment or complaint form via http://www.xxx.nhs.uk/contact-us/compliments-and-complaints/

or Tel: xxx

Independent Contact:

xxx

Thank you very much for reading this information and for considering taking part in this study.

Appendix 1

GDPR Information

The University of Hertfordshire is the sponsor for this study based in the United Kingdom, England. We will be using information from you and/or your medical records in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Hertfordshire will keep your name, gender, ethnicity and a contact detail in a locked cabinet at the University of Hertfordshire for the duration of the study (until June 2019); information will be accessed only to contact you about the study.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information https://www.hra.nhs.uk/ and/or by contacting the University Secretary and Registrar.

xxx (DClinPsy student) from the Sponsor site (University of Hertfordshire) may collect information about you for this research study from the NHS site. This information will include your name and contact details. We will use this information to contact you if you have stated that you wish to take part in this study.

Appendix 16: Professionals Focus Group Consent Form

UNIVERSITY OF HERTFORDSHIRE
COLLEGE LANE CAMPUS
HATFIELD
AL10 9AB

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS
('ETHICS COMMITTEE')

CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

STAFF FOCUS GROUP

I consent to take part in the study entitled 'Exploring Young People's Experiences of Formulation in CAMHS.'

(UH Protocol number LMS/PGR/NHS/02909; NHS IRAS ID 240816)

- ☐ I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study.
- ☐ I have been told that I can withdraw my consent to participate by leaving the focus group on the day.
- ☐ In giving my consent to participate in this study, I understand that voice recording will take place and I have been informed of how/whether this recording will be stored.
- ☐ I understand that quotes by me, without any identifying information, may be included in any subsequent reports.
- ☐ I have been told how information relating to me will be kept secure, confidential, and how it will be used.
- ☐ I understand that this consent form will be kept in a locked cabinet in the University of Hertfordshire.

Signature of participant:
Name: ……
Signature: ……
Date……
Contact email or phone number: ……

Signature of Principal Investigator:

Name: ……
Signature: ……
Date……

Signature of Student Investigator:
Name: ……
Signature: ……
Date……

Appendix 17: Debrief Sheet

Debrief Sheet

Exploring Young Peoples Experiences of Formulation in CAMHS

Thank you for taking part in this interview today. The aim of this session was to learn about your understanding and opinions of formulation in therapy.

The information you have provided will be used by the lead researcher (Cathryn Marrington, Trainee Clinical Psychologist) to develop a summary of the key things that young people say about formulation. There were no right or wrong answers, it was your opinion in your words that matters. The information you have given will be anonymized during transcription and treated in confidence.

If you have any questions, or wish that your data be withdrawn at any point, please do not hesitate to contact us on the details below. If you are interested in the results of this study when they are available please let me know and I can email you in due course.

Once again, many thanks for your help in this activity.

If you have any questions about this study, please contact:

xxx

And/or xxx

This study has been reviewed by the University of Hertfordshire ethics committee (UH protocol number LMS/PGR/NHS/02909) and an NHS Research Ethics Committee (West of Scotland Research Ethics Service – WoSRES; REC reference number: 18/WS/0125; NHS IRAS ID: 240816)

Appendix 18: Youth Council Feedback and Response

Youth Council Feedback – 29.3.18

The council had questions about formulation itself:

- The term sounds like something scientific
- They have not heard the term before but when I described what it is they said it sounds like their initial "getting to know you" sessions.
- Further they felt that if you call it a technique then people might speak less in first few sessions
- They did not like the idea of formulations being shared in letters as this would breach confidentiality if their parents/carers got a copy
- They expressed some concern about formulation replacing diagnosis entirely because they find a diagnosis helps them and their parents/carers understand what's happening and it helps services talk to each other.
- Further, they were concerned about inconsistencies – e.g. are some people getting formulations and some aren't?

Leaflets:

- There was a question about what "bodily sensations" means on the CBT maintenance cycle image that I included on the 'what is formulation?' leaflet that I made
- They wondered if it would be better to move some of the information around – e.g. the suggestion that formulation might be a verbal summary shared by therapist could be moved to the start of the leaflet as this is more common
- They did not like the BPS leaflet regarding 'what is formulation?' because they found it had too many words; the image of the young person on the front looked too posed; and it contained jargon. However, they did like the arrows used in the BPS leaflet and wondered if something similar could be added to our leaflet
- Regarding the poster advert, they suggested making the itunes/amazon voucher offer bigger to entice young people to start reading it.

- Similarly, they suggested phrasing the advert in a way which demonstrates that they can help improve services and there is a reward for them.

Recruitment:

- The council strongly disliked the idea of me being in CAMHS waiting rooms to recruit. They explained that often young people are anxious at that time and just want time alone to think and process.
- Instead, they suggested that we could give receptionists the recruitment leaflets to hand out to all new clients who attend, and/or leave leaflets on the reception desk
- They also explained that young people are unlikely to email me. They suggested recruiting through a range of options to access all kinds of young people. E.g. a text message option or a confidential box in the CAMHS waiting room that they could write their contact details on for me to contact them. If we use the box idea, they suggested that we put some cards inside it, so the young person does not feel that they are the only one/different for applying to be in the study. Likewise, they felt a text message option would enable them to apply discreetly without others wondering or asking what they are doing.
- They suggested that we do the interviews in CAMHS, once they are settled in, rather than at home or school.

Summary Letter to the Youth Council

You Said…

"Formulation" sounds like something scientific. When I explained what it is you said it sounds like the initial "getting to know you" sessions in CAMHS.

We Did….

We added the term "getting to know you sessions" to our information leaflet to help young people understand what the study is about before they volunteer.

You Said…

However, you wondered if formulation/getting to know you sessions gets called a technique then people might speak less in first few sessions. Some of you also did not like the idea of formulations being shared in letters as this would breach confidentiality if parents/carers got a copy. Finally, some of you expressed concern about formulation replacing diagnosis entirely because a diagnosis can help young people and their parents/carers understand what's happening, and it helps services talk to each other.

We Will…

This is exactly why we are doing this study! 😊 We will be doing interviews with young people currently in CAMHS to ask them for feedback on the issues you raised, amongst others.

You Said…

On the leaflet I made it included the word "bodily sensations" and you asked what that means.

We… changed "bodily sensations" to "physical feelings in your body".

You Said…

Also, on that leaflet, you wondered if it would be better to move some of the information around – e.g. the suggestion that formulation might be a verbal summary shared by the therapist could be moved to the start of the leaflet as this is more common.

Regarding the poster advert I made, you suggested making the iTunes/amazon voucher offer bigger to entice young people to start reading it.

Similarly, you suggested phrasing the advert in a way which demonstrates that they can help improve services **and** there is a reward for them.

We Did… Exactly as you suggested!

You Said…

You did not like the 'BPS' leaflet regarding 'what is formulation?' because you found that it had too many words; the image of the young person on the front looked too posed; and it contained jargon.

We Will… Not use that particular leaflet to advertise the research study.

You Said….

Some of you strongly disliked the idea of me being in CAMHS' waiting rooms to recruit. You explained that often young people are anxious at that time and just want time alone.

Instead, you suggested that we could give receptionists the recruitment leaflets to hand out, and/or leave leaflets on the reception desk.

You also explained that young people are unlikely to email me, so you suggested recruiting through a range of options. E.g. a text message option or a confidential box in the CAMHS waiting room that they could write their contact details on for me to contact them. If we use the box idea, you suggested that we put some cards inside it, so the young person does not feel that they are the only one/different for applying to be in the study. Likewise, they felt a text message option would enable them to apply discreetly without others wondering or asking what they are doing.

We Will….

- Not recruit face-to-face in waiting rooms!
- Give receptionists the leaflets to give out to new clients, and leave some on the reception desk and table in the waiting room
- Create a closed in box with comments cards
- Keep the email option as well
- We looked into a text message option, but unfortunately we will be unable to do that at this time as we do not have work mobiles.

Thank you so much for all your time and feedback! We want to make this research study as accessible and as least anxiety-provoking as possible for those who volunteer, and you have helped us to think about how to set up the study in this way!

Appendix 19: Semi-Structured Interview Guide

- Can you tell me what you know or understand about formulation?
- Had you heard of it outside of your conversations with services?
- Could you tell me a bit about how a formulation was shared with you?
    - Can you remember anything that you particularly like or disliked about developing the formulation?
    - Did you feel involved in the process or was it presented to you?
    - If it was drawn, was it on a blank page or were you filling in a template?
    - *(Only if they did not feel involved)* Were you able to challenge the formulation?
    - *(If not)* What got in the way?
- How close was the clinicians' formulation to your own experiences, leading up to going for therapy?
    - Did the formulation make sense?
    - How did it make you feel seeing or hearing it?
    - What did you think about the clinician's approach at that time?
    - Did it tell an explanatory story?
- Did you feel that you were at the centre of the formulation? If not, whose experiences or stories were paid most attention to?
    - How did that feel? Was it helpful/not helpful?
    - Was your formulation written in first or third person?
    - Did you feel like you could challenge your formulation?
- Did you and your therapist think about your environment, situations and relationships in your formulation? (e.g. peer relations, family relations, school)
    - Or was it centred around factors about you?
    - How did that feel?

- Did you share your formulation with anyone, or did your clinician share it such as through a letter to your parents or GP?
    - Did your clinician give you the chance to read the letter before it was sent out?
    - Do you think you were given a choice whether to share it or not?
    - Did this have any impact, such as on you or your family?
    - Did you or your family do anything differently after reading or hearing the formulation?
- Do you think there are any positive aspects or advantages of formulation?
    - What are they?
- Do you think there are any negative aspects or disadvantages of formulation?
    - What are they?
- Is there anything that you think services should do differently regarding formulation?
- Did you also receive a diagnosis?
    - How did you feel about that?
    - What do you think about the use of diagnosis in services?
    - What has influenced your views about formulation and/or diagnosis?
    - E.g. social media? Peers?

Appendix 20: Professionals Focus Group Interview Guide

- What did you think about what the young people said?
    - (Separate focus group discussion into each theme)
    - How do you make sense of what the young people have said? (Probe for how the findings fit in both the individual context in CAMHS and the wider societal level)
    - How did the reading the themes make you feel?
    - Do the findings match your experiences as a clinician?
- Are there any clinical implications following what the young people said?
    - If yes, what are they?
    - How might these be implemented?
    - What needs to happen next?
    - If no, why not?
    - Can you give examples of things you are already doing that the young people showed preferences for?
    - (Consider if focus group is 'stuck' on positive or negative ideas. If so, probe. Which findings were positive? What has challenged you and what might need to change at a local level?)

Appendix 21: End of Study Letter to Ethics Boards

Young People's Experiences and Views of Formulation, and its Clinical Implications for Mental Health Professionals.

Summary of Research

Introduction

A qualitative research project employing semi-structured interviews with young people to explore their views and experiences of 'formulation' was conducted. Following the young people's interviews, the findings were shared with two focus groups made up of NHS Child and Adolescent Mental Health Services (CAMHS) multi-disciplinary professionals to reflect on the young person's views and how they might relate to clinical practice. Both the interviews and the focus group were transcribed and analysed using Thematic Analysis.

This project was conducted for partial qualification of a Doctorate in Clinical Psychology, at the University of Hertfordshire; a training course which values and teaches a Social Constructionism and Constructivism approach (Gergen, 2009; Burr, 2015).

Background

Formulation is a key competency for Clinical Psychologists (Division of Clinical Psychology, 2010; DCP), and the Health and Care Professions Council outline it as a skill that each school of psychologists should have (Health and Professions Council, 2009). It may be defined as, "…a hypothesis about the causes, precipitants and maintaining influences of a person's psychological, interpersonal and behavioural problems" (Eells, 2011). Furthermore, formulation has a range of purposes including to facilitate a shared understanding of a client's difficulties; prioritise issues and problems; plan specific interventions; and trouble-shoot lack of progress (Johnstone & Dallos, 2013). Further they can provide an accurate overview and explanation for a client's difficulties, which is hypothetical and collaborative (Tarrier & Calam, 2002). Finally, formulation may help the client feel understood, help the clinician feel contained and strengthen the therapeutic alliance (DCP, 2011).

The term formulation can vary, with labels such as ‘case conceptualisation’ often used in Cognitive Behavioural Therapy (CBT; Beck, 1997), ‘dynamic formulation’ in psychodynamic therapy (Malan, 1995) or ‘reformulation’ used in Cognitive Analytic Therapy (CAT; Ryle, 1995). No type of formulation was consciously excluded throughout this research. There may also be some discrepancies regarding what is considered a formulation. For instance, some may consider ‘formulation-as-a-process’, utilised throughout assessment, therapy and feedback in recursive manner. Others might consider ‘formulation-as-an-event’, such as a written summary and formulation in case notes, or a letter to client or GP (Ingram, 2006). Further, formulations can differ in their amount of detail. Some may contain a detailed summary of large amounts of a person’s history, and people may re-formulate as more information is discussed. In contrast some may consist of simple diagrammatic formulations. There are various templates available to aid summarising a formulation, such as biological, social, interpersonal factors (Weerasekera, 1996), or ‘the five P’s’ (presenting difficulties, predisposing, precipitating, perpetuating and protective factors). It is reported that the five P’s format is used in psychiatric training (Royal College of Psychiatrists, 2010). Additional information that may be useful in formulations yet more rarely integrated can include factors such as transference and counter-transference; client experiences of diagnosis or medication; stigma; social factors such as class and power relations; and ethnic and cultural factors.

The British Psychological Society (BPS) Division of Clinical Psychology published good practice guidelines on the use of psychological formulation (BPS, 2011). These guidelines outline that formulation is a core competency for Clinical Psychologists, alongside assessment intervention, evaluation, audit and research, teaching and service delivery. Further, formulation is included in UK psychiatry training (Royal College of Psychiatrists, 2010), though is likely to have differences compared to psychology training. The BPS guidelines also outline that formulation should include an integration of interpersonal, biological, social and cultural factors. It should not just be a list of factors though, and should integrate possible causes of the presenting difficulty, cultural understanding of the difficulty, and critical awareness of the wider societal context. Further, it should be “constructed rather than discovered” in a collaborative manner (Harper & Spellman, 2006), using accessible language. Each one should be unique to the individual and concerned with the ‘personal meaning’ to the clients and should be assessed on their usefulness rather than as a ‘truth’ (Butler, 1998; Johnstone, 2006). That said, it should also draw on relevant psychological theory and evidence-based practice as well as policies such as NICE guidelines and Cochrane reviews. Overall, a formulation should

include reflective practice, and should be offered as a tentative explanation (Christofides et al., 2011) which is not imposed on a client or team. Further, it should be carefully constructed to acknowledge real difficulties whilst avoiding diminishing hope or agency.

Previous Research

There are infinite articles regarding formulation. However, few explore client's thoughts and experiences of it. Therefore, the following literature review focused on finding articles which focus on client's experiences or opinions specifically. Furthermore, articles regarding professionals and teams' experiences of formulation were included. Six databases were searched: Scopus, Pubmed, APA PsychNet, CINAHL (Ebsco), ProQuest and Google Scholar. Twenty-three studies were included in the literature review: 15 used qualitative designs, four used quantitative, three used mixed methods and one was a systematic literature review.

Overall, the literature suggests that there are many advantages of formulation. For instance, clients described that formulation helped them understand their problems, feel understood and accepted (Redhead, Johnstone & Nightingale, 2015; Burchardt, 2004), and make sense of difficulties (Thew and Krohnert, 2015). Further, it gives a direction from which to work on and helps them recognise a potential for change (Burchardt, 2004; Stewart, 2016).

However, formulation did not impact therapeutic alliance from client's perspective (Hess, 2000; Chadwick, Williams & Mackenzie, 2003), though did help develop a shared understanding (Herhaus, 2014). Further, clients reported both positive and negative reactions to formulation (Pain, Chadwick & Abba, 2008) and can find it saddening, upsetting and worrying, at least in the short-term (Chadwick, Williams & Mackenzie. 2003).

For professionals, formulation did increase alliance from their perspective (Chadwick, Williams & Mackenzie, 2003; Shaw, Higgins & Quartey, 2017; Pain, Chadwick & Abba, 2008). Further, professionals reported that formulation increases understanding of client and clearer sense of direction (Pain, Chadwick & Abba, 2008). Moreover, developing formulations can increase more helpful attitudes and empathy towards their clients, and reduces feelings of the client being to blame or causing their difficulties (Berry, Barrowclough & Wearden, 2009; Summers, 2006).

However, some staff described that formulation can limit care plans, or be excessively speculative (Summers, 2006), and some multi-disciplinary professionals did not fully understand what formulation involves and described needing to prioritise addressing medical needs first (Adams, 2015).

Finally, explorations of team formulation outlined that formulation meetings give space and a framework to help make sense of client's difficulties together, practice more effectively (Christofides, Johnstone & Musa, 2012) manage overwhelming ideas (Blee, 2015) and contain their own anxieties and feelings (Weedon, 2017; Whitton, Small, Lyon, Barker & Akiboh, 2016). Further, team formulation enables sharing of knowledge, understanding and risk (Weedon, 2017; Dinh et al., 2012). Interestingly, team formulation meetings were seen as a different environment to other meetings such as being more flexible and offer, or need to offer, a safe space to share ideas (Weedon, 2017; Manuel, 2016; Blee, 2015; Dinh et al., 2012).

However, concerns were raised that team formulations may be added to care plans which can have a short 'life expectancy' and may not be revisited and are difficult to implement in teams where 'work' is seen as action focused (Blee 2015; Weedon, 2017).

Rationale for the Current Research

Research regarding formulation is in its relative infancy though there is increasing interest in this area of late. Therefore, our knowledge of people's experiences of formulation and the impact of formulation for therapy, clients and teams is exciting yet limited. Additionally, there appears to be no research into young people's or carers/families' experiences of formulation. Furthermore, the findings we do have can be complex and somewhat contradictory, though research is in its infancy and would benefit from further exploration and more in-depth qualitative analysis. Additionally, research in this area has so far been disorder-specific, conducted with adult clients and professionals, and have used relatively small, mostly female samples.

Research Questions

The main research questions of the study were:

- What are young peoples' understanding and experiences of formulation?
- What are CAMHS clinicians' reactions to this, and what impact might the findings have on clinical practice?

Methods

This project utilised a qualitative, exploratory design, using semi-structured interviews to find out about participants' understanding, opinions and experiences of formulation. Data from interviews was analysed using Thematic Analysis (TA).

Following analysis of the semi-structured interviews, a focus group was held with CAMHS clinicians in the same service(s) to share the main themes that arose. Staff were asked to discuss their responses to the young people's ideas as well as any potential implications for clinical practice. Again, TA was utilised to analyse data from the focus group.

Participants

Participants were recruited through local NHS CAMHS. A field supervisor (a qualified Clinical Psychologist) supported the project, particularly recruitment. A purposive sampling approach was used in which participants were selected from within the population (Guarte & Barrios, 2006) of four CAMHS teams in the same county, based on who was provided to the researcher by the services' clinicians and participants who volunteered themselves from an advert (Appendix 4). Clinicians and CAMHS waiting rooms were also provided with recruitment leaflets (Appendix 5) for young people to have, to help them understand what the researcher meant by 'formulation' and to decide if they wished to participate.

Inclusion and exclusion criteria were as follows:

- Aged between 11 - 18 years
- Males and females
- Currently open to or recently discharged from an NHS CAMHS service
- Worked with a clinician during assessment and/or therapy who used formulation

- Able to provide informed consent to participate
- Sufficient verbal communication and cognitive ability to participate in an interview about conceptually abstract matters

For the focus group, any multi-disciplinary professionals (not just Clinical Psychologists) were invited.

Nine participants were recruited for the semi-structured interviews with young people. There were two males and seven females, aged 13 to 17 (average age = 15.44 years), all were White British.

Five participants developed their formulations with Clinical Psychologists, three completed theirs CBT Therapists/Mental Health Nurses, and one with a Clinical Social Worker. Formulations discussed included those in the style of longitudinal CBT, systemic and Interpersonal Therapy.

All participants had moderate-severe mental health problems, as is inclusion criteria to access Tier 3 CAMHS services. Individuals were not asked about their specific mental health difficulties, to preserve privacy and reduce possible distress during the semi-structured interview.

For the staff focus group, there were 13 participants (two males, 11 females). There were three Clinical Psychologists, two Assistant Psychologists, one Trainee Clinical Psychologist (not the researcher), two Child Psychotherapists, one student Mental Health Nurse, two CAMHS Practitioners, one Social Worker and one Family Therapist.

Findings

Three main themes were developed from the semi-structured interviews with young people.

Theme 1: Shared Sense Making

- Subtheme 1.1: Method of Formulation and Accessibility for Clients

- Subtheme 1.2: Collaboration, Power and Openness to Formulation
- Subtheme 1.3: Perceived 'Validity' and Meaningfulness of the Formulation for Clients

Theme 2: Formulation Process as a Therapeutic Intervention

- Subtheme 2.1: Shared Decision Making and Impact of Formulation for Professionals and Wider Network
- Subtheme 2.2: Therapeutic, Affective and Cognitive Effects of Formulation for Clients

Theme 3: The Purposes and Uses of Formulation

- Subtheme 3.1: Formulation Explains Causes and Maintenance of Difficulties
- Subtheme 3.2: Formulation Steers Direction of Interventions

Regarding young people's understanding of formulation, many of the young people were not aware of the term formulation until they were invited to this study. That said, they understood it to have specific purposes including to identify key difficulties, causes of difficulties, solutions, or prevent behaviours which maintain their difficulties. Further, some understood it as a tool which helps clinicians to plan, make sense of and remember client's difficulties and intervention.

Regarding their experiences of formulation, there was variation. Some described it as a one-off process, whereas others used it throughout therapy. All described their formulations as collaborative and felt at the centre of it. Most felt that could challenge their formulation, which was impacted by both interpersonal factors such as not seeing their clinician in an authoritative role, and intrapersonal factors such as self-confidence. Further, formulation impacted the working alliance positively. Some commented that the formulation also helped their parents to understand their difficulties. However, one participant described finding her formulation

confusing. Following the formulation, there were therapeutic effects such as believing that their difficulties were valid and seeing their difficulties as more manageable. One participant described developing the formulation as temporarily upsetting, whilst some reported that formulation helped to process their emotions.

Three main themes were also developed following the focus groups with CAMHS multi-disciplinary clinicians.

Theme 1: The impact of young people's experiences of formulation on clinical practice.

- Subtheme 1.1: Reflecting on the therapeutic impact of formulation
- Subtheme 1.2: Clinical practice in context of young people's experiences of formulation
- Subtheme 1.3: Importance of good working alliance and communication

Theme 2: Clinicians reflections on their role and their reactions to the young people's findings

- Subtheme 2.1: Clinicians reflections on their skills, preferences and limitations
- Subtheme 2.2: Clinicians reactions to young people's experiences

Theme 3: Wider network and societies' expectations of CAMHS and knowledge of formulation

- Subtheme 3.1: Network's expectations of CAMHS
- Subtheme 3.2: Need for education regarding formulation and diagnosis in services and wider society

CAMHS clinicians' reactions to the young people's experiences of formulation included hopeful surprise that the young people were articulate and curious about formulation and therapy. Further, clinicians reflected on what seems to work well, such as a good working alliance, and the apparent therapeutic effects of formulation. The findings also aided clinicians

to reflect on their own skills, and at times lack of confidence, regarding doing formulation. There were some discussions and at times discrepancies regarding young people's understanding and preferences for formulation or diagnosis. For example, some did not completely agree that formulation is to help identify strategies. Further, some described that whilst some young people wanted a diagnosis, there may be negative effects of one.

Regarding what impact the young people's responses might have on clinical practice, there were many implications identified within the service. This included a need to check accuracy of formulations and written correspondence, a want for more sharing of knowledge amongst the team, and a desire for more creative ways of working and inclusion of more societal level factors in formulations. There were also implications discussed for wider services and networks, including a hope to educate wider society about formulation and the limitations of diagnosis, and possible changes in communication such as how letters are written to schools or GPs for example.

Discussion

Strengths of the Study

A major strength of this study was that it was (to the researcher's knowledge) the first of its kind to explore views and experiences of formulation from the perspective of people under 18 years old. Given that formulation is routinely used with young people accessing mental health services, it is important to ensure that it is accessible, useful and acceptable to them.

Another strength of the study was the involvement of young people in the design of the research materials. This may increase the accessibility and relevance of recruitment materials and

interview questions. Further, it increases the involvement of and perhaps power to young people in another aspect of their care.

Furthermore, this study utilised the findings of the research with the young people to explore clinical implications they might have for professionals. This may increase the usefulness of the findings and gives more in-depth information as it is gathered from two different sources.

Limitations of the Study

One limitation of this research was the small sample size. Moreover, all participants accessed formulation/therapy within one NHS Trust. Together, this may limit the generalisability of findings to other young people, and services. That said, guidelines for formulation are national. Further, there is likely to be some variation regarding how formulation is presented by all clinicians, even within one service.

Another limitation of the current research is that the questions asked and then the codes and themes developed will be influenced by the researcher's epistemological positioning. To limit such biases, memo keeping, reflective journaling, and checking data with a peer researcher, a research supervisor and members of the participants were all conducted.

Similarly, bias may have been present in both the young people and the clinicians who participated. Firstly, only professionals who were confident with the quality of their formulations may have told their clients about the research or volunteered in the focus group. Secondly, only young people and clinicians who were particularly interested in the topic or had positive or negative (not neutral) experiences of formulation may have volunteered. That said, one of the focus groups was held in a regular monthly "visitors' slot" after the CAMHS team's

standard team meeting, which may have increased the likelihood that a more balanced representation stayed for the research group.

Clinical Implications and Recommendations

Findings from young people suggest various clinical implications.

- When working with young people it may be difficult to make sense of a complex situation whilst not making it too simplified. Clinicians could check understanding with the clients when developing a formulation.
    - Similarly, when writing letters to caregivers and other professionals, a balance regularly needs to be explored to increase the ability for the clients to make use of the initial written formulation in meaningful or therapeutic way as well.

- An accurate formulation increased young people's trust in their therapist, which also gives feelings of validation from being accurately heard.
    - Ensuring collaboration, shared meaning-making and checking one's understanding is important for supporting a good working alliance both in the short and long-term.

- Diagnosis is more familiar than formulation, and so a diagnosis can help others to understand their difficulties. If formulation were more familiar outside of mental health services perhaps others would not need 'a name' to their difficulties to feel understood or to get support.
    - One implication then could be that services and professionals need to be proactive at making wider systems more aware of formulation.

- The PTMF (Johnstone & Boyle, 2018) suggest that questions that are asked by mental health services should include questions about what people did to ‘survive’ and their strengths, to gather a full story of the person. However, only one of the participants in the current study mentioned strengths being a factor in their formulation.
    - Ensuring inclusion of strengths can both gather the full story of a person and provide some catalysts for change.

Appendix 22: Example Extract from Young Person's Interview

RESEARCHER 0:03
So I just wanted to start off by asking you if you could tell me what you understand or know about formulation?

PARTICIPANT 1 0:12
It's basically um kind of a placeholder ish for diagnosis-is *(diagnoses)*, so it identifies the problem and then in the form of a visual aid allows both the clinician and, and the person well a patient to see what the problem is and how that problem could potentially be solved.

RESEARCHER 0:29
Okay. And is that kind of something that you developed yourself or was told to you?

PARTICIPANT 1 0:43
Um, it, I mean, that was never told to me, it's just something that I gathered from our sessions, so

RESEARCHER 0:54
Mmm okay,

RESEARCHER 0:56
So tell me a little bit then about how the formulation shared with you when it was done

PARTICIPANT 1 1:02
So normally the session works by well it's based basically around formulation so we would start off um getting into has been hard stuff and then for the main problems, we would write them down then using the visual aid, we would write in stuff resembling flow charts and stuff like that filled with all the details and possible solutions and trying to evaluate and er basically find the source of the problem.

RESEARCHER 1:41
Okay, and um so how was that done, was it like you did it together with *(clinicians name)*,

PARTICIPANT 1
Yea
RESEARCHER
Or…

PARTICIPANT 1 1:45
we, we do it together, so er if she an idea she writes it down, if I have an idea she writes it down. So yeah,

RESEARCHER 1:54
okay. That sounds brilliant

RESEARCHER 1:57
and then does she summarize it at all, did she kind of explain any of this?

PARTICIPANT 1 1:59
It's kind of self-explanatory um so er cause everything that's note down is basically an abbreviation of what we've already discussed so it's kind of like a almost like a compaction method,

RESEARCHER 2:16
Mmm. Just sort of summarizing the evidence

PARTICIPANT 1
Yea

RESEARCHER
and compacting it all together?

PARTICIPANT 1
Yeah, yeah.

RESEARCHER

Okay.

RESEARCHER 2:24
Can you remember anything that you particularly liked or disliked about developing all of this? *(Pointed to formulation diagrams)*

PARTICIPANT 1 2:31
Um it's definitely a very useful style of visual aid. And it has resulted in a lot of um progress in my treatment, for example, recently, it sparked a suggestion of doing a survey, which I did big graphs and 50 people did it and it was really good fun and yeah,

PARTICIPANT 1 2:54
but sometimes, as much as um what I've been told is that it can be used as a replacement for a diagnosis.

RESEARCHER
Mmm

PARTICIPANT 1
But sometimes I feel that that myself and other people need that name to it. Now, I don't I don't stop I don't mean for every single problem go and diagnose it with as medical term as you can but for almost like reoccurring problems, it there potentially be something then I think will be more useful to um to get it diagnosed first, and then go off what the recommended treatment for the diagnosis is rather than just winging it as such,

RESEARCHER 3:44
Mmm ok. So the diagnosis might help to pick what happens next?

PARTICIPANT 1
Yeah.

RESEARCHER 3:50
Okay. Can you tell me a bit more about that? So you said that that might be helpful instead of like winging it?

PARTICIPANT 1
Yeah

PARTICIPANT 1 3:59
I know, I personally being autistic love consistency and structure and certainty.

RESEARCHER
Mmm

PARTICIPANT 1
And and for, and if I'm, obviously I'm fine with formulation. But if I know there's an alternative, which is more structural then I and and more certain as such, then I would rather prefer that option, but it's not as much as a necessity.

RESEARCHER 4:28
I see, okay. So it gives a sense of certainty.

PARTICIPANT 1
Yes.

RESEARCHER
And structure. Were you given a diagnosis and formulation or was it just one for you?

PARTICIPANT 1 4:43
Er for me, I have been given multiple diagnoses says the diagnosis-es, diagnos-i? diagnoses-es?

(MUM – lots of diagnosis-is)
All Laugh

PARTICIPANT 1 4:45
Um I got a multiple diagnosi, I'm going to call them diagnosi. But um I have been given a few like Autism and stuff like that, er some which I we have discussed to you have looked into, but

we are continuing to look into, but um I feel that that's that process is a lot slower when you're also going when you're also doing um a lot of work around formulation. And yeah.

RESEARCHER 5:21
So let me check my understanding that so the formulation, does it slow down diagnosis?

PARTICIPANT 1
Yes. Yeah

RESEARCHER
Yeah?

PARTICIPANT 1 5:28
Definitely. I before I went for I started formulation, um the diagnosis-is they they came they came a lot quicker and they were more certain. Obviously, I was in a different place, at the time of receiving certain diagnosis-is, but and that may have um a factor, but that may play a part. But I think as I think even if it's not can't be done as quick as they were before, I still think they can be done quicker.

PARTICIPANT 1 6:07
Um I'm not saying get rid of formulation.

RESEARCHER
Mmm

PARTICIPANT 1
But I'm saying maybe temporarily put it on hold. if, if, if a diagnosis presents a better option.

RESEARCHER
Okay. (big pause) Yeah, that makes sense. Do you think that the formulation could be done quicker or..?

PARTICIPANT 1 6:28

I think formulation is done at the pace of the patient and no matter what, because I we discuss things and then we discuss things and then we kind of write it down in the style of formulation.

RESEARCHER
Mmm

PARTICIPANT 1 6:44
So it's really it doesn't have a set pace, whereas I feel like the process of getting that a DI, a diagnosis is a lot more I don't wanna say simple, but it's more it's, it's got at least it's got some more consistency, like it's identify symptoms, match those symptoms up give a diagnosis, instead of to discuss the problem, find a source of the problem, write down that and use your visual aid to continue doing that. And I find it it can help a lot in finding alternative methods, which aren't obviously, like documented,

RESEARCHER
Mm

Participant 1
but it can, but it can also take, it's also more time consuming.

RESEARCHER 7:30
MM. Okay. Yeah, that makes sense. Um. Let me just check where we are.

RESEARCHER 7:43
I guess the next question really is bearing in mind what you just told me, do you feel that you were able to challenge the formulation or say that you didn't want it and you'd rather have a diagnosis?

PARTICIPANT 1 7:56
Um I have brought it up occasionally um saying, I would prefer to at least be checked out if I do have this um if this condition/disorder because it's not really a disorder or condition it's just a diagnosis. But um I've never actively I mean, I've always felt I'm able to I just generally don't like confrontation.

RESEARCHER
OK

PARTICIPANT 1
And that sort of stuff. So.

RESEARCHER 8:31
So tell me a bit more about that. Because you don't like confrontation what affect might that have

PARTICIPANT 1
Well

RESEARCHER
On this kind of thing?

PARTICIPANT 1 8:36
Well I kind of feel like, you know, you're the professionals and as much as they will say, like, the customer's always right, it's kind of a similar thing, which they're not, but it's it, I feel like I trust their opinion on this more than I trust my own. If that makes sense?

RESEARCHER
Mmm

PARTICIPANT 1 8:58
Cause they've got Like if you're you go to the doctors with like with a er wasp bite, you most likely you trust their medication more when you would trust something you would make up yourself

RESEARCHER 9:09
right. Ok. Yeah. Yeah, that makes sense. So for you personally you felt you did bring up that you prefer diagnosis is that right?

PARTICIPANT 1

Yeah

RESEARCHER

But then on the other hand, you're thinking, well, if I say too much that could create confrontation. And you're kind of putting your trust into this, this person that you know, they're kind of the doctor if you like,

PARTICIPANT 1

Yeah

RESEARCHER 9:36

Okay.

What was it like when you did express preference for diagnosis how was that responded to?

PARTICIPANT 1 9:41

Um I, went I went away and did some research and basically looking at it um looking at er possible diagnosis. Um did a lot of reading on papers that people have done um go through some of the symptoms and a lot of symptoms matched up and I mentioned it a couple of times after, but nothing in terms of at least evaluating for about diagnosis has come out of that.

RESEARCHER

Right.

PARTICIPANT 1

So yeah,

RESEARCHER 10:14

So you were presenting possible diagnosis that you found.

PARTICIPANT 1

Yeah, and they match up with, with multiple, very specific symptoms of mine. So

RESEARCHER
And you shared that with *(clinician)* is that right?

PARTICIPANT 1
Yeah, she agrees that it's definitely a possibility. And that a lot of symptoms are similar. But the it the whole process just wasn't followed up on which are I obviously tried to, I mentioned a few times, but yeah,

RESEARCHER 10:45
So how did you feel about that not being followed up on?

PARTICIPANT 1 10:48
I mean, I'd rather have the diagnosis, or at least, No, I'd rather be evaluated for the diagnosis. If she er already evaluated me and said, I don't think you have it, then that's fine. But if there's a possibility, then I just want to know, because I kind of have an obsession with knowing things, (to his Mum) you know what I'm like,

RESEARCHER 11:12
that's, that's fair enough um

RESEARCHER 11:18
Um I don't want to go off topic too much. But I'm really interested in what you're saying. And I'm just wondering, what could a therapist what could they do to make you feel like it had been researched properly, and given the right consideration?

PARTICIPANT 1 11:32
Well, at least recognition. So obviously be it was considered but I never got recognition that it was um I never got recognition that it was evaluated which I doubt it was and whether it was assessed or, and at least even if um even if you even if, say, a psychotherapist knows, hey, this child definitely hasn't got autism, then it'd be useful to actually know how do they know because if it's a case of um I know, you don't have this disorder, this diagnosis then that's okay by me, because I trust um your professional expertise in this, but I at least want to know why,

RESEARCHER

Mmm

PARTICIPANT 1
instead of just being told now, or just not being told anything at all, which is seems to be what happens, at least from my experience,

RESEARCHER 12:31
Mmm. So it doesn't really it sounds like you're saying, it doesn't really matter how they get to the answer but you want to know how they got there?

PARTICIPANT 1
Yeah

RESEARCHER
Yeah.

PARTICIPANT 1 12:38
Yeah as long as there is like, a process.

RESEARCHER
Yeah.

Appendix 23: Example Extract from Professionals Focus Group

I: So, has anyone had a chance to read any of the quotes from Theme 1?

P3: I did look at those, yes.

I: So, Theme 1 is about, basically, how the formulation is done. So, the first bit is about whether they found it too complex, whether it is was simple, whether it was easy to understand, all those sorts of things, and whether it was used as a one off in one session or whether it went across lots of different sessions. Then they go on to talk a bit about diagnosis.

So, I wondered if you could maybe start just by telling me or talking about what you think, basically, what the young people were saying.

P1: How long did you go up to? 2 to 11?

I: Yes.

P1: OK, good.

P4: So, I think something that stuck out for me was it sounded like the relationship was quite important in the formulation. So, it wasn't necessarily about the formulation or the outcome of it, but more about the process.

P3: Yes, I agree. It is a lot about the relationship because the young person then knows that the therapist has understood and heard the right things in order to be able to feed it back as a formulation, isn't it?

P4: Yes.

P1: I think I noticed, as well – well, it is not different, it is kind of the same as – that it seems like you could almost imagine that some therapists were working with their formulation for them and some were doing it more actively in the room as a live, working document with the other person's collaboration, which is what you are saying. Because some people are saying, 'It is a piece of paper that is over there,' and it is kind of like, 'I haven't looked at it for ages.' There was one amazing comment of what we did, talking about recovery goals: 'It is helpful because you can take it away. It is on paper, you can look at it,' and it mentions recovery goals as well. You think there is a clinician who has really laid out the beginning, the middle and the end of the therapy. Whereas there were other comments where you can tell that it is just a bit more like, 'This is my resource' the therapist is holding close to them, to help them in their supervision or something. So, that was kind of interesting.

So, I agree with what you said, P4, about that it is something that is going on in the relationship, rather than the formulation being the magical resource. It is keeping it live and fresh as part of the dialogue.

P3: A work in progress.

P1: Yes.

I: And how does that match with your clinical work, then? Is it the same? Is it what you would expect young people to say, that sort of stuff?

P4: It is interesting you said that about whether the formulation is for the young person or for the clinician, because, actually, it made me think about times when perhaps I am not so confident or I feel quite confused and where I will try and use formulation, perhaps, more to put myself at ease. Then I am not sure how collaborative it becomes or how therapeutic it is or how much I am bringing it into the sessions. So, I guess, yes, it made me reflect on my clinical practice as well and what the purpose is of formulations and when I bring them in and how I am sharing them and developing them.

P2: I think that is a good point because I normally start off with a longitudinal one and then, when it has not worked or I am not too sure, I have used a different one before and maybe thought about that in supervision and then gone back to the young person with it. So, maybe that wasn't as collaborative as it was initially, when we did it together.

P1: I agree. I thought it was really funny. It reminded me recently what someone said to me – I said something in the therapy and the person said, 'That's really good. I want to write that down! That's everything that I mean,' and, of course, I couldn't remember what I had said; it had instantly vanished. And I said something like, 'Well, don't worry, because we are going to share a formulation,' but I wonder if that was because I was using a formulation because she had given me a clue that I had hit the nail on the head. So, I was feeling boosted. Whereas, I absolutely agree, if I haven't got a clue what is going on, I am not going to go, 'So, let's think about how we develop our shared understanding, because mine is zero at the moment.'
So, I think, yes, it is interesting about whether we use it and how we use it in supervision as well and hold the young person's view of the formulation. But I think it is one of those things: if it is too rigid, it somehow loses its meaning. That is the other thing. I like a formulation that is just a story or a description-

P3: Because that is life.

P1: -rather than CBT, like the use of cognitions. So, I kind of find myself switching off when formulations are like that. So, yes, I am more about the messy bits than the real-life bits. So, it has to be a story.

I: I think there are a lot of young people saying that they are doing the vicious circles and the CBT-type formulations.

P1: Yes.

I: I think there are lots of different types that are being used. So, one said, 'It is like a letter that you get from your grandma, like a Dear …, or whatever – Dear …, I'm just writing to you to say x, y and z.' And some were saying that they find the CBT style quite anchoring; it makes things easier to understand and that sort of thing, and it is quite easy to use again and again, whereas ones, like more letters, who are also finding very useful. So, there doesn't seem to be a valid or more reliable type. Every single person-

P1: That is a clinician skill, isn't it? Matching what it is and in what media to share it, the formulation. In IAPT, we always write a letter, a formulation letter using IAPT, but I wouldn't do IAPT with everyone just because I am trained in IAPT. So, who do you do CBT with? Who do you IAPT with? So, you are already, when you are first meeting them and hearing about their goals, you are getting a read as to what therapy approach would suit them best or how would you deliver a formulation: as a cartoon or as a letter or just say it out loud? But, underpinning that, you are right, it is the therapeutic relationship, isn't it? Getting someone. Mentalising about them. Them being able to talk to you about what they need in order to help them in their recovery.

I: Have people had a chance to look at pages 6 to 10? If you take a look at those sorts of quotes.

P4: Yes. So, there were bits in there that were quite interesting. To me, it seemed like the young people were making the distinction between diagnosis and formulation, and they were describing it as two very different things, which I thought was quite helpful. It was helpful for me to know that they were saying that diagnosis is something that is more of a label and can be helpful but can be unhelpful, whereas formulation is something that is bigger than this, bigger than the one word.

P1: I love this participant. Participant 3: "Diagnosis doesn't help you understand everything. That is more formulation." Yes. That is what we need the world to understand.

I: Yes. That kind of leads to the point above that, on page 5, where the participant discusses the diagnosis as more familiar than formulation. So, some show a preference for that. If you want people to understand, then you say, 'I have a question,' then they will know they shouldn't push you too far.

P1: That is really interesting, isn't it, because it is actually saying, 'And we would change the pace of mental health if we could tap into this dynamic.' It is saying, 'Diagnosis leads to sick role, leads to escape, avoidance, what can we get out of, how can we use it as a label?' So, it is a kind of dead end route. Whereas formulation is a beginning of the journey into resilience and empowerment and accepting that we all have ups and downs, and perfection.

I: Yes.

P3: Yes.

P1: And we are not striving for perfection. We should be encouraging adolescents to feel low content, a range of emotional things, not this striving for perfection or depression. But it is fantastic, the young people are already starting to recognise that, that diagnosis can be a bit of a dead end, really, or certainly have a negative connotation. It is just you have all the other issues that can lead to sick role as well.

I: And some were saying that diagnosis, it can open doors to access, particularly with neurodevelopmental stuff. They were saying a diagnosis helps get medication, assessments, support, especially in schools. And some of the young people had experienced at school, were saying, 'We need you to go and get a diagnosis.'

P3: Yes.

I: And then they are coming here and, obviously, we are doing our clinical work. I wonder what might be the clinical implications, then, of young people noticing there is a difference between diagnosis and formulation, and those different roles that they take. How do we put into practice in our current CAMHS?

P1: Sack psychiatrists. Give ourselves a pay rise.

I: That is going to be the title of my research.

P4: Or increase communication and working collaboratively with psychiatry or just within the MDT, because, to me, it feels like they are both helpful things, but, like you said, they are both needed in different contexts and to get different services and input. But then, if the young person might feel conflicted with both of them, is it about some kind of coming together or opening something up within the team? Or finding what is common between these things.

P1: We have become more crisis-led as a service over the last five years, I would say. So, we used to do a lot more: see people, formulate, match an evidence-based approach or a temperamental fit, like, 'Oh, I think P3 would really suit this person because they would really respond well.' So, that is as valid. Now, people come in with demands from the network, risks, and it is really interesting what happens to formulation in that: it disappears. So, you can have multiple conversations about a younger person that is risky and no one even thinks to share a formulation because things feel like they are crisis-led. We just changed, didn't we, in our High Risk meeting: we thought we would change the name of it to Risk Formulation meeting and, actually, try and formulate about the risk.

But I just find it very interesting that thinking stops when risk is high, and that we, therefore, do less of it, maybe.

P3: Yes.

P1: Whereas young people are saying that they find it more beneficial as well.

P3: Yes. I think, definitely, I agree about the increase of high risk.

P1: Supposedly high risk, yes.

P3: Yes. And there is so much anxiety, I think, in other professionals, projecting onto CAMHS about CAMHS being this thing that is going to sort everything out. If the child is under CAMHS, it is going to be alright; they are going to sort it all out, and expect you to do that as well.

P1: Yes. People don't want to decision-make, so they just push up, push up, push up-

P3: No, they are scared.

P1: -or signpost, signpost, signpost. And then you can lose. The very opposite of what we know is good practice happens, then. Some young person is repeating their story, they are not being heard and formulated about, and they are not in a relationship, one therapeutic relationship with someone. So, the old-fashioned stuff, which was just see, wait a while, treat and have a good outcome, really they did feel a bit like the good old days, than this kind of like frenzy of emails and medication requests.

P4: Yes, and I think that is missing. Like what you were saying, the anxiety coming up from the system through schools and doctors and referrers, there is no formulating that comes into us, even if it is like, 'This is an initial hypothesis that we have.' Sometimes you will get referrals that will say, 'This young person is self-harming,' or one sentence, and you kind of think, 'Was there a conversation around this or did you just leave the young person and go, 'Oh, I'm going to do one referral'?'. Do you

know what I mean? The formulation, I also don't understand what it has to happen in CAMHS.

P1: Has to wait until Tier 3.

P4: Yes.

P1: I know. That is a really good point. Why don't people in Tier 1 formulate?

P4: Yes. And, actually, that might be containing enough; that, 'This is my understanding of what is going on at the moment. It doesn't necessarily need to go to CAMHS.' Or share it with us, at least.

P3: Yes, I agree, because, when someone is passed onto us, they have to have really been seen to be working with other services and so on. You find that, as soon as self-harm is talked about, it is like, 'No.' It is just this push, isn't it, and there isn't that talk about the young person and, like you say, any kind of formulation, is there? It is just like, 'You take them. We can't manage it. It is too much for us.'

P2: So, if there was that formulation beforehand, then you might realise that they don't need to come to us, because you don't think about the context.

P4: Yes.

P3: Yes, and before the panic.

P2: Yes. They might have self-harmed or they might have done this impulsively or whatever, but, if there was a formulation around that, you might realise, actually, maybe it is not as risky as it seems.

P1: Yes, it makes me think about the spa stuff we are getting. I know they don't do a formulation, but they do this risk thing, and you read it, and, whenever I go back to it, I read what they have written and I am like, 'Everything, **[0:16:45]**, there are no risks.' And I will look at the way they are interpreting the information and building a picture of risk, and I think, 'Really? This is someone's record.' And I just noticed here that someone says that it is really important because we type it up and it goes into your notes.

P4: Yes.

P1: So, formulations are, basically, hypotheses that seem to have the best fit. So, they have to be corroborated. They have to be agreed, don't they, by the other person, because they are just a few ideas. So, I think that is really important, in a way, that we get people's agreement on it, because it is clear that they do feel a power dynamic there, don't they? That we have the power to change their story, in a way.

P2: I think that is why the relationship thing, like you mentioned before, is really important, because then they feel like they can say, 'Oh no, that's not quite right,' or you are constantly checking in with them, otherwise they might just feel obliged to go along with it. Then, obviously, the therapy doesn't work that well if you are thinking of something else. And then, if it is in their notes and it is not quite right, it is not very helpful.

P3: I agree that there is a big power imbalance. We see families across Hertfordshire. I have worked in different places over Hertfordshire and there is a power imbalance that is different in different areas for whatever reason. I think sometimes, well, for myself, we can just assume that this is OK with the families to come here and spill or tell us everything – we ask very personal questions. I think we need to be mindful of how it impacts what we say to them, because they soak up your every word because they are desperate, so they believe everything you say, don't they?

P4: Yes.

P3: You are going to make it right. You are giving them what they need to hear that it is going to be OK.

I: There was quite a bit about that, actually. I can't remember which page it is on, but young people were saying, 'I trust you as the doctor. I trust your opinion as the professional.'

P4: Yes.

P3: It is a big responsibility.

I: And a lot of the young people were saying, 'I will speak up if I don't agree with you, because people are coming across as friendly, and you are not teachers and we feel that we can,' and things like that. But, at the same time, they do trust your opinion when they get here.

P3: We see so many young people and it is just so fast. Everything is fast. It is easy to forget that, actually.

P1: Yes. I think the other thing that I think, though, is it is actually a really powerful intervention tool. This is what I think, please feel free to disagree with me, but, in my short-hand brain, I think most of the time people have had a good choice appointment with a working formulation, very brief formulation, and then they go onto a partnership therapist who, after three sessions of getting to know that person in more detail, does another formulation. By then, the symptom trackers show the most recovery at the point of sharing the formulation. So, in IAPT, if I look at all my

symptom trackers, it is the point at which I shared the formulation that someone's symptoms start to come down. So, most of the work is done by just delivering the formulation, so that makes it quite a powerful intervention rather than a beginning point. Then, afterwards, the actual intervention, it just feels like it either flows naturally or it is just a few follow on pragmatic bits, really.

I: I wonder if we could have a look at some of the quotes on pages 14 and 15, because that matches with what you were saying; they are alluding to it being a therapeutic intervention in itself-

P1: OK.

I: -the effects that it has. I think, the thing with young people, they didn't know what a formulation was, but, by the end of it, they were able to say, 'Well, actually, this happens and that happens.'

P1: It is a terrible word.

P4: Yes.

P1: It is a terrible word. I don't use it as much.

P3: Which word, sorry?

I: Formulation.

P1: Formulation. For a young person-

P3: Yes, what does it mean?

P1: -or a person, they think, 'What's that?' I can remember starting my training and they would just talk about models all the time, and I used to think, 'Where are all these models?' like people. I had never heard that word before, because I hadn't really been **[0:21:40]** very long. So, it is weird how you get jargon, I suppose, and I guess that touches on what you were saying, P3, doesn't it, that that really matters, where people come from, how much they will listen to you, how much authority they think you have got and how we can keep that going, that power imbalance going by using jargon. So, I think we need a different word for formulation. We call it shared understanding – that is quite long-winded.

P3: Yes. I do think the language is a big thing.

P1: Yes.

P3: I come from a social work background, and we were always told that don't assume that people know what you are talking about, if you are using acronyms. And that is what it is. We live in a world of acronyms: in the NHS, in children's services, adults,

and we just say them as though everyone is supposed to understand what we are talking about. Then they might feel silly for saying, 'I don't know what that is.'

P1: Yes.

P3: Well, I feel silly sometimes saying, 'I don't know what that is.'

P4: Following on from what you were saying as well about delivering formulations, I have just started doing choice appointments and I think I am having to be very mindful of how I might share my understanding and, I guess, what parts you might say and what parts you might not share explicitly or in the same way that you would discuss it in MDT, or the way that you are thinking about in the choice appointment. I think, like you were saying, you have to be quite sensitive to how you deliver your understanding because they will hang on every word. And I think, especially in the choice appointment, it feels like you are trying to do a lot of work in one appointment, and a big part of that is the shared understanding. And I think I am having to be very mindful of not being- So, when you start to understand something in your mind, not just blurting it out, just trying to have some kind of filter and be aware that this is a young person and their family that is with me. And it is not about trying to share that as you would in a case discussion or in an MDT meeting or a seminar or anything.

I: How do we strike that balance, then, clinically, because they young people are saying, 'We want to know that you are doing formulation, we want you to say, 'This is the theory behind it and this is why it helps,'' but, at the same time, you want to be mindful, like you say, that they are young people and families and what do they need to hear? How do we strike that balance?

P3: I agree with P4, you do have lots of things going round in your mind, lots of thoughts, you are trying to understand the people in the room, within a relatively short space of time, really, isn't it, when you think about what you are asking from them. I think their minds must be so full up and chaotic, thinking about all the different aspects of what is happening – the emotional side of it. So, I think we need to be clear. And, yes, you can have flexibility within that. You can be concise but flexible at the same time, in terms of formulation.

P1: What you were talking about, P4, is the first formulation, isn't it, which does need to stay more flexible. It is still hypotheses, is actually what you reminded me of. So, what I might do, to answer your question, is, say someone has got low mood or depression – they think they have got depression, I would call it low mood, but it doesn't really matter, we get to the core symptoms of that, and I sometimes do this

thing called supported choosing. So, I say, 'So, if you think that you are experiencing this low mood because you are seeing everything through a negative filter, then we might think that we could do some adjustments in therapy with that,' and then I would give a briefish explanation of CBT. But I would say, 'If you felt that you were suffering low mood because there are lots of arguments in your family, then we might think of doing something different. There is no point adjusting things in your mind, because actually what you are saying is a really valid clue as to how you are feeling. So, we might see you and mum.' So, I might give them options, and then there should be a feedback loop into their choice or respecting their position on what they think the problem is.

P3: Absolutely, yes.

P1: But you can't do that everyone and you can't do that with this risky set that we get more of-

P3: Yes.

P1: -or the people who are, 'We must get into your service,' and this spiel kind of thing.

P3: Yes.

P1: But, sometimes, when you are onto what I call your average meaty psychological case, you can do that; that feels quite good-

P3: Yes.

P1: -because it means the assessment is being therapeutic as well.

P3: Yes, and what do you want as a young person within this? What is realistic? We can sit here and reel loads of different things off, but options.

P1: Yes, because the world out there things everyone needs one-to-one therapy, and we know that is not the case. A lot of these kids need better lives in the life that they are living rather than the one hour that they could spend here. I am very impressed at the knowledge base, though, with your participants. It sounds like it was a very rich discussion.

I: Yes, and a lot of them came not knowing what this word meant, but, once they-

P1: Yes.

I: -did, 'Oh yes, I do remember doing that,' so kind of like, 'The impact it had on me.'

P3: Yes. So, how many young people have you seen?

I: Nine in the end, and it is across the county. So, a couple from here, a couple from St Albans, that sort of thing. And they had all had different types: CBT, REBT, some family work.

P4: That was the other thing, on the bottom of page 6, Participant 2, when I think about formulation, I guess there are different types of formulation as well, and there are the more explicit ones, which is what I feel like we do in CAMHS, but then, if you are using other models, you are not going to collaboratively formulate with the young person; you are not necessarily going to share the formulation.

I: So, are you looking at this quote at the bottom here, where it says, "She is **[0:28:47]** on my parents' divorce"?

P4: Yes. It made me think, when I have worked in different ways and used other models and not explicitly formulating with the young person but holding quite a lot of strong ideas with the team, and that didn't sit right with me; it felt quite uncomfortable. I understood why I did that, but then I think that quote brought that to my mind. And I guess it also depends on the model we are using and how we are working.

P1: Yes, going back to the meeting before, P3, the difference between the Daubert and the choice, Daubert is just a checklist of you have got this symptom.

P3: Yes.

P4: No formulation.

P3: Yes.

P1: So, if they all come to therapy – I had to be careful how I framed it – then we know that the Daubert overdiagnoses people. So, they are potentially being diagnosed without their consent and without formulation.

P3: Yes.

P1: So, obviously, with that one, I felt that I had to accept it because it was so clearly OCD.

P3: Yes.

P1: But there were very few cases like that that I think I would accept. I don't think I would accept something just because it is depression, because it could be depression for 15 different reasons.

P3: Oh yes. But I was just saying that is what **[0:30:06]** used to do or someone used to do.

P1: It will be if you let him. But it is interesting, isn't it?

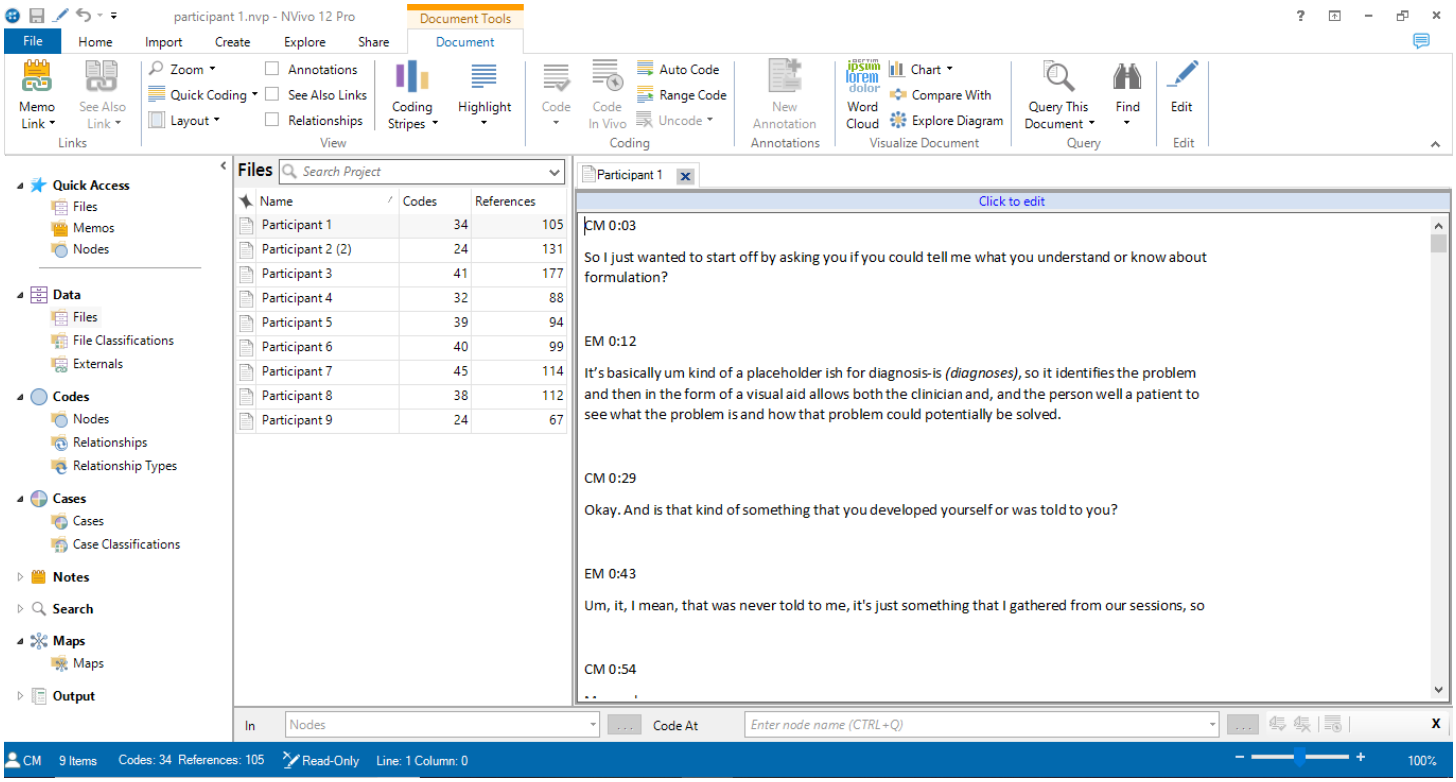
P3: Yes.

P1: That is a very different model; it hasn't got any formulation in it; it is really just a parent report.

Appendix 24: Evidence of Stages of Data Analysis

As in Braun and Clarke's (2006) article regarding the use of Thematic Analysis in Psychology, six steps of data analysis were conducted, as follows.

Step 1: Familiarisation with data – data was transcribed by the main researcher and then read through.



Step 2: Transcribed interviews were coded line-by-line using NVIVO (version 12).

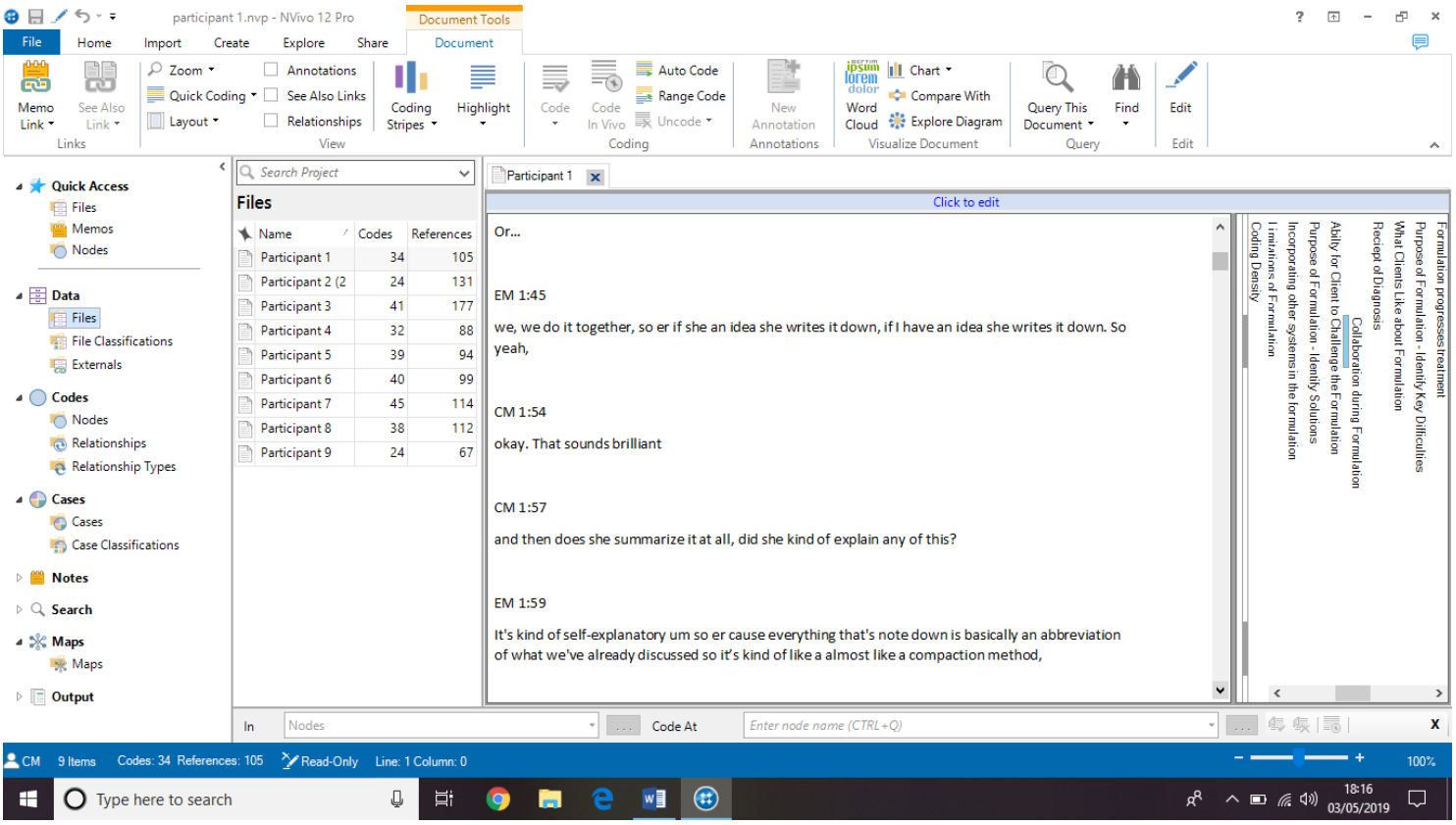
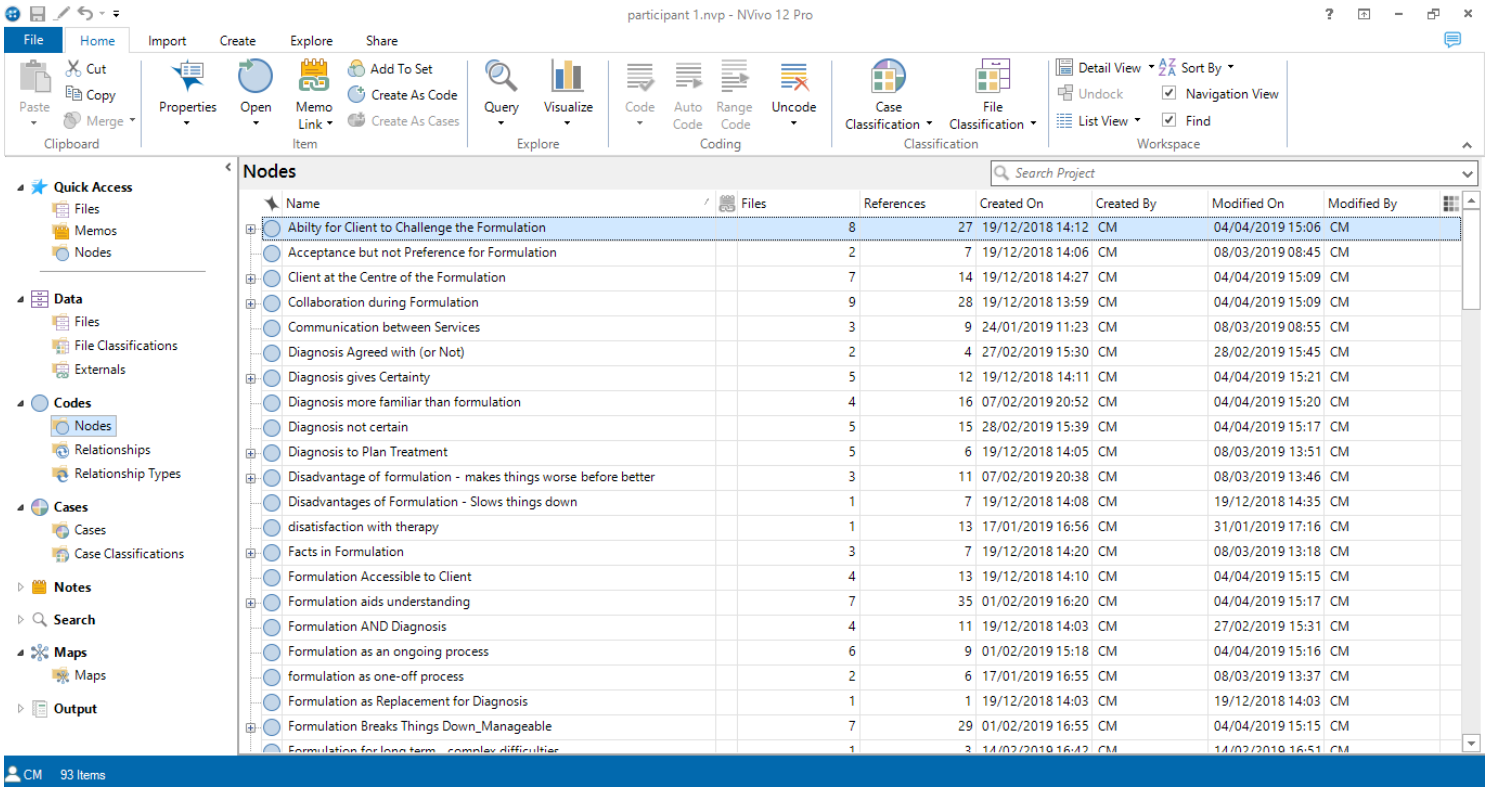


Figure 6. Extract of interview with coding stripes on the right-hand side.


participant 1.nvp - NVivo 12 Pro
File
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Open
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Add To Set
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Create As Cases
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Query
Visualize
Explore
Code
Auto Code
Range Code
Uncode
Coding
Case Classification
File Classification
Classification
Detail View
Sort By
Undock
Navigation View
List View
Find
Workspace
Quick Access
Files
Memos
Nodes
Data
Files
File Classifications
Externals
Codes
Nodes
Relationships
Relationship Types
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Cases
Case Classifications
Notes
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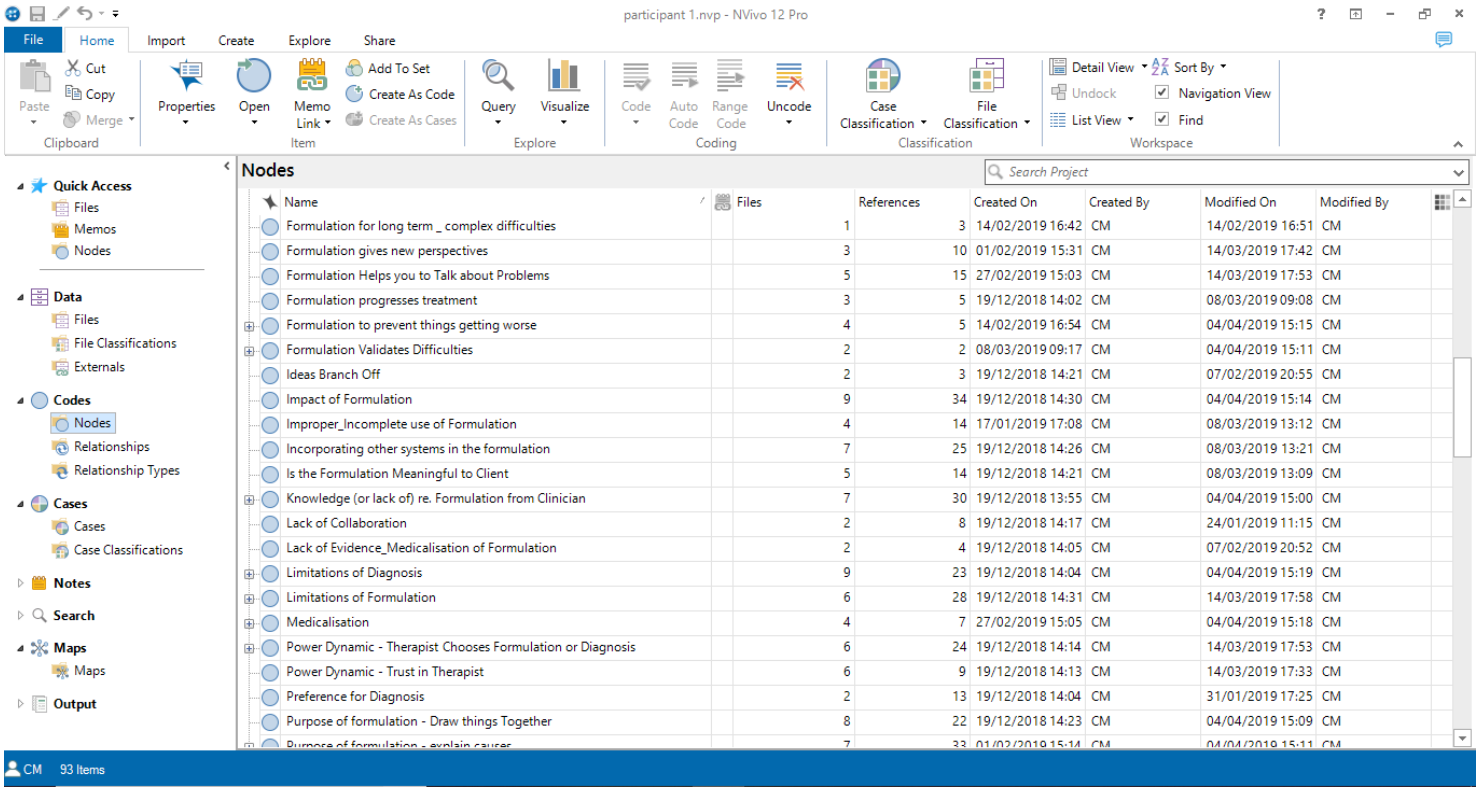
Maps
Maps
Output
Nodes
Search Project
Name
Files
References
Created On
Created By
Modified On
Modified By
Abilty for Client to Challenge the Formulation 8 27 19/12/2018 14:12 CM 04/04/2019 15:06 CM
Acceptance but not Preference for Formulation 2 7 19/12/2018 14:06 CM 08/03/2019 08:45 CM
Client at the Centre of the Formulation 7 14 19/12/2018 14:27 CM 04/04/2019 15:09 CM
Collaboration during Formulation 9 28 19/12/2018 13:59 CM 04/04/2019 15:09 CM
Communication between Services 3 9 24/01/2019 11:23 CM 08/03/2019 08:55 CM
Diagnosis Agreed with (or Not) 2 4 27/02/2019 15:30 CM 28/02/2019 15:45 CM
Diagnosis gives Certainty 5 12 19/12/2018 14:11 CM 04/04/2019 15:21 CM
Diagnosis more familiar than formulation 4 16 07/02/2019 20:52 CM 04/04/2019 15:20 CM
Diagnosis not certain 5 15 28/02/2019 15:39 CM 04/04/2019 15:17 CM
Diagnosis to Plan Treatment 5 6 19/12/2018 14:05 CM 08/03/2019 13:51 CM
Disadvantage of formulation - makes things worse before better 3 11 07/02/2019 20:38 CM 08/03/2019 13:46 CM
Disadvantages of Formulation - Slows things down 1 7 19/12/2018 14:08 CM 19/12/2018 14:35 CM
disatisfaction with therapy 1 13 17/01/2019 16:56 CM 31/01/2019 17:16 CM
Facts in Formulation 3 7 19/12/2018 14:20 CM 08/03/2019 13:18 CM
Formulation Accessible to Client 4 13 19/12/2018 14:10 CM 04/04/2019 15:15 CM
Formulation aids understanding 7 35 01/02/2019 16:20 CM 04/04/2019 15:17 CM
Formulation AND Diagnosis 4 11 19/12/2018 14:03 CM 27/02/2019 15:31 CM
Formulation as an ongoing process 6 9 01/02/2019 15:18 CM 04/04/2019 15:16 CM
formulation as one-off process 2 6 17/01/2019 16:55 CM 08/03/2019 13:37 CM
Formulation as Replacement for Diagnosis 1 1 19/12/2018 14:03 CM 19/12/2018 14:03 CM
Formulation Breaks Things Down_Manageable 7 29 01/02/2019 16:55 CM 04/04/2019 15:15 CM
CM 93 Items


participant 1.nvp - NVivo 12 Pro
File
Home
Import
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Query
Visualize
Explore
Code
Auto Code
Range Code
Uncode
Coding
Case Classification
File Classification
Classification
Detail View
Sort By
Undock
Navigation View
List View
Find
Workspace
Quick Access
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Relationships
Relationship Types
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Cases
Case Classifications
Notes
Search
Maps
Maps
Output
Nodes
Search Project
Name
Files
References
Created On
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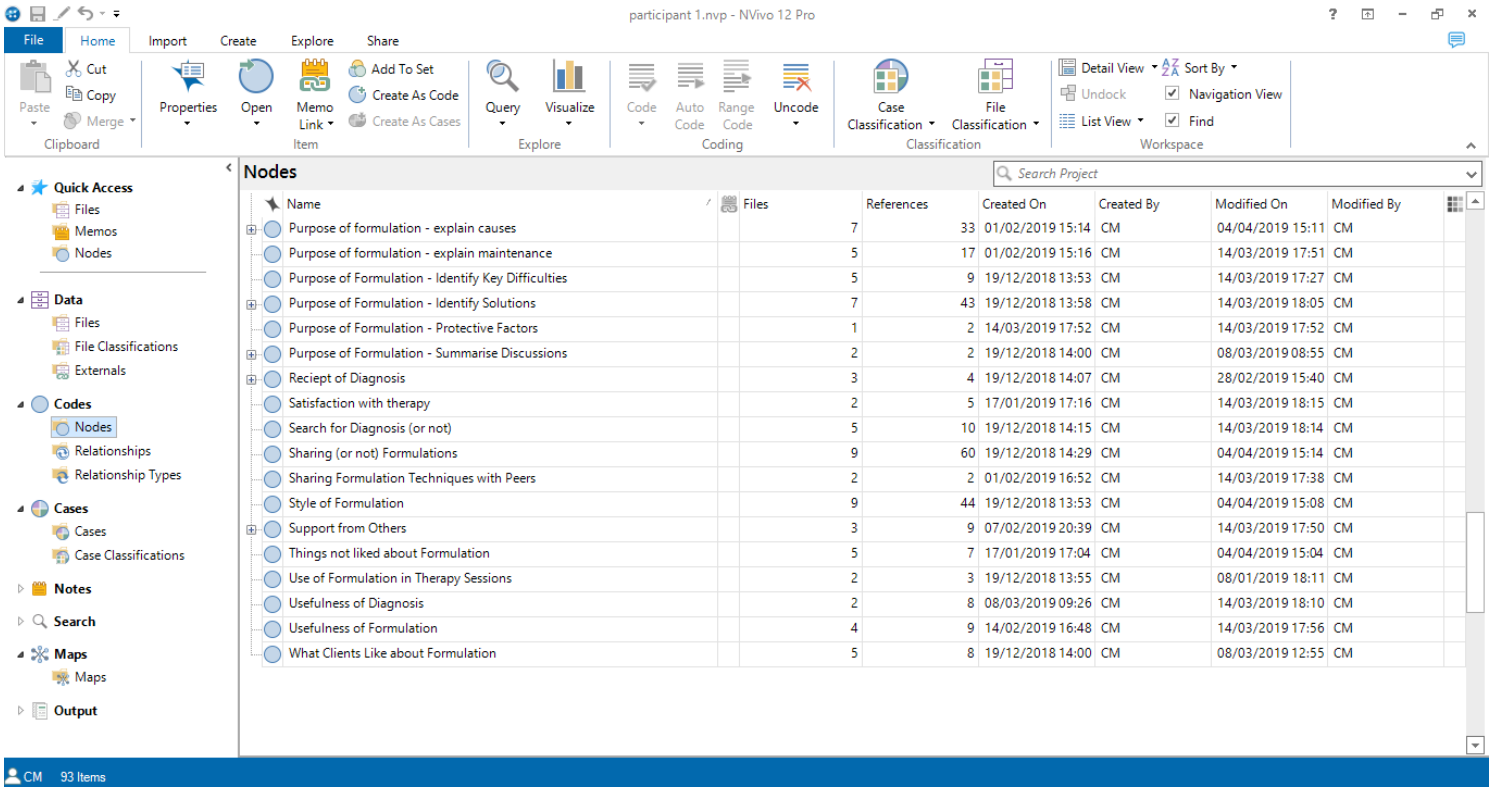
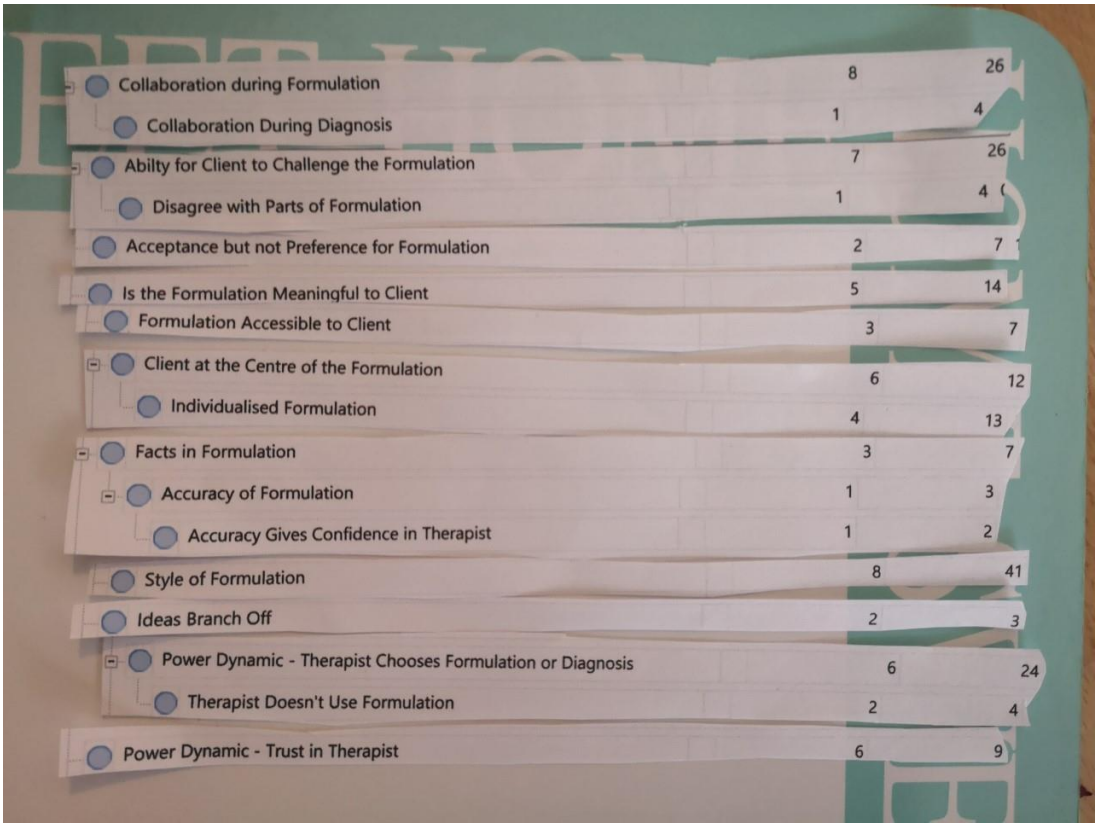
Modified On
Modified By
Formulation for long term _ complex difficulties 1 3 14/02/2019 16:42 CM 14/02/2019 16:51 CM
Formulation gives new perspectives 3 10 01/02/2019 15:31 CM 14/03/2019 17:42 CM
Formulation Helps you to Talk about Problems 5 15 27/02/2019 15:03 CM 14/03/2019 17:53 CM
Formulation progresses treatment 3 5 19/12/2018 14:02 CM 08/03/2019 09:08 CM
Formulation to prevent things getting worse 4 5 14/02/2019 16:54 CM 04/04/2019 15:15 CM
Formulation Validates Difficulties 2 2 08/03/2019 09:17 CM 04/04/2019 15:11 CM
Ideas Branch Off 2 3 19/12/2018 14:21 CM 07/02/2019 20:55 CM
Impact of Formulation 9 34 19/12/2018 14:30 CM 04/04/2019 15:14 CM
Improper_Incomplete use of Formulation 4 14 17/01/2019 17:08 CM 08/03/2019 13:12 CM
Incorporating other systems in the formulation 7 25 19/12/2018 14:26 CM 08/03/2019 13:21 CM
Is the Formulation Meaningful to Client 5 14 19/12/2018 14:21 CM 08/03/2019 13:09 CM
Knowledge (or lack of) re. Formulation from Clinician 7 30 19/12/2018 13:55 CM 04/04/2019 15:00 CM
Lack of Collaboration 2 8 19/12/2018 14:17 CM 24/01/2019 11:15 CM
Lack of Evidence_Medicalisation of Formulation 2 4 19/12/2018 14:05 CM 07/02/2019 20:52 CM
Limitations of Diagnosis 9 23 19/12/2018 14:04 CM 04/04/2019 15:19 CM
Limitations of Formulation 6 28 19/12/2018 14:31 CM 14/03/2019 17:58 CM
Medicalisation 4 7 27/02/2019 15:05 CM 04/04/2019 15:18 CM
Power Dynamic - Therapist Chooses Formulation or Diagnosis 6 24 19/12/2018 14:14 CM 14/03/2019 17:53 CM
Power Dynamic - Trust in Therapist 6 9 19/12/2018 14:13 CM 14/03/2019 17:33 CM
Preference for Diagnosis 2 13 19/12/2018 14:04 CM 31/01/2019 17:25 CM
Purpose of formulation - Draw things Together 8 22 19/12/2018 14:23 CM 04/04/2019 15:09 CM
CM 93 Items



Figures 7, 8 and 9: Final line codes from all nine transcripts

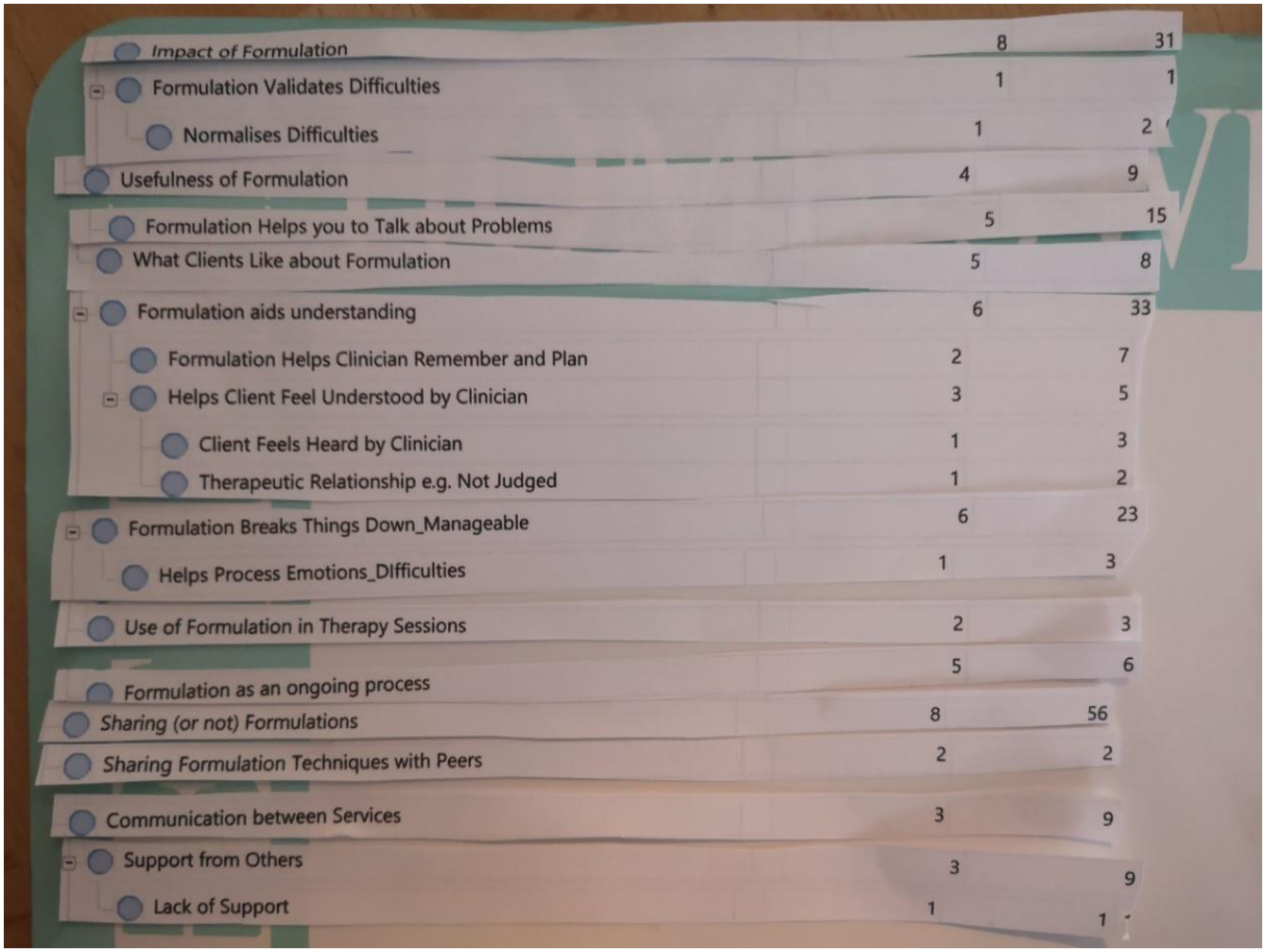
Step 3: Generating initial themes – codes were grouped into potential themes manually

Theme 1: something to do with collaboration between client and therapist/power dynamic/whether the formulation is actually meaningful for the client

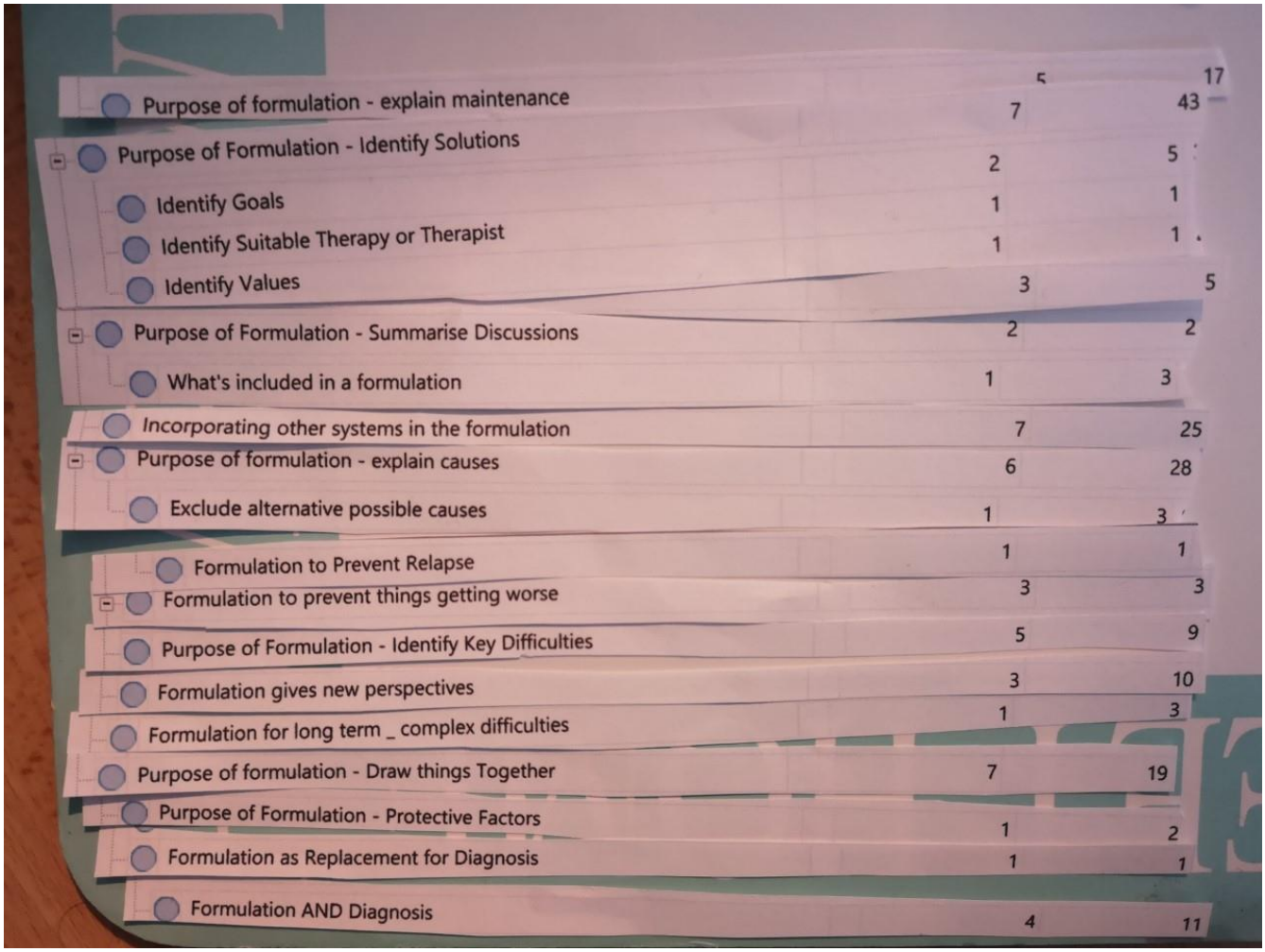


Memo: The inclusion of the codes regarding power dynamic may have been influenced by the epistemological viewpoint of the researcher and the Doctorate of Clinical Psychology within which this research was conducted. The power imbalance between clinicians and clients is often discussed and reflected on throughout the Doctorate. For example, perhaps researchers from other courses and/or epistemological viewpoints may have coded lines regarding the clients' trust in their therapist to make the 'right' decisions as something else, such as skills of the professional.

Theme 2: the impact that formulation has for the client

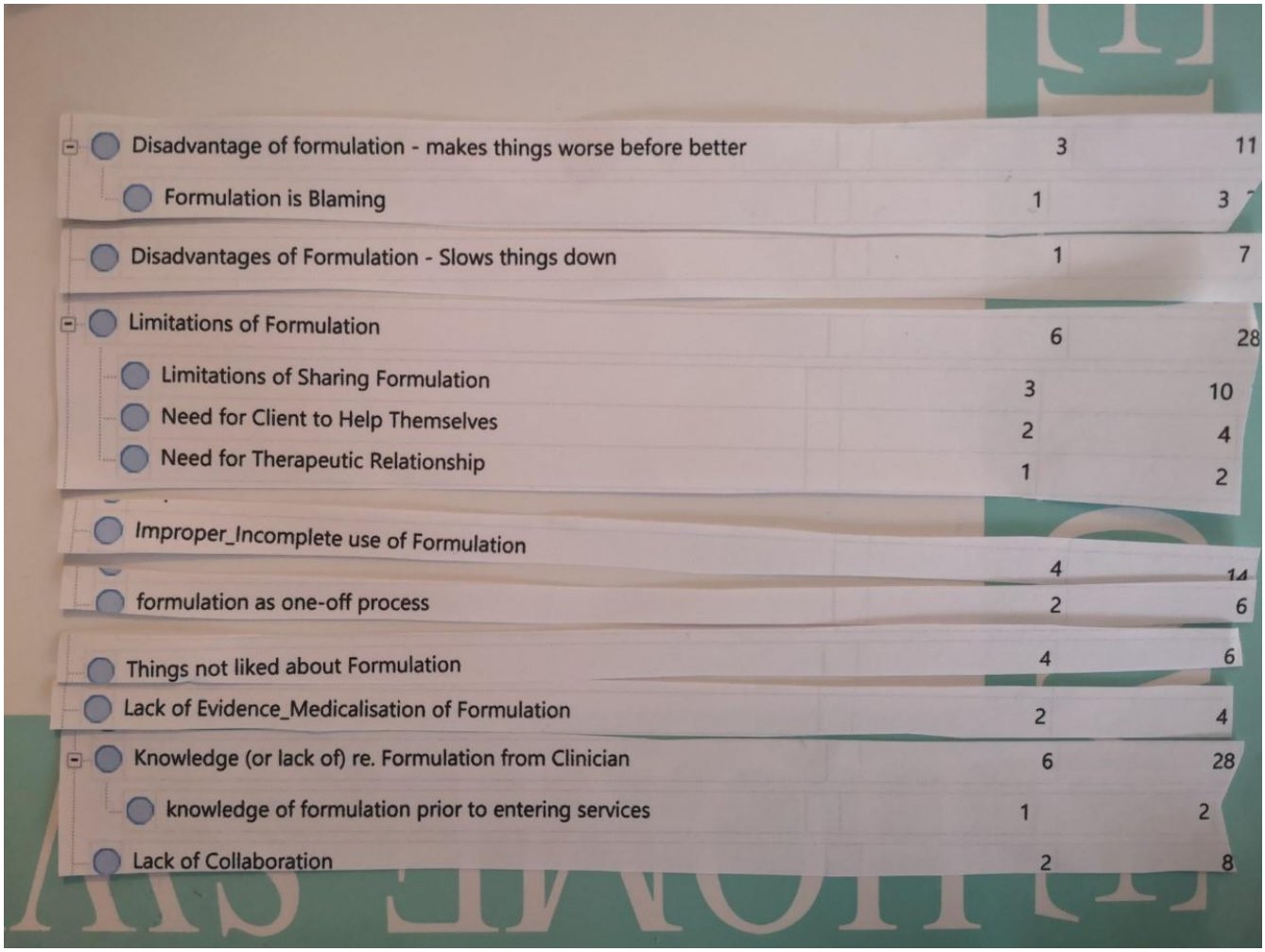


Theme 3: the purposes and uses of formulation



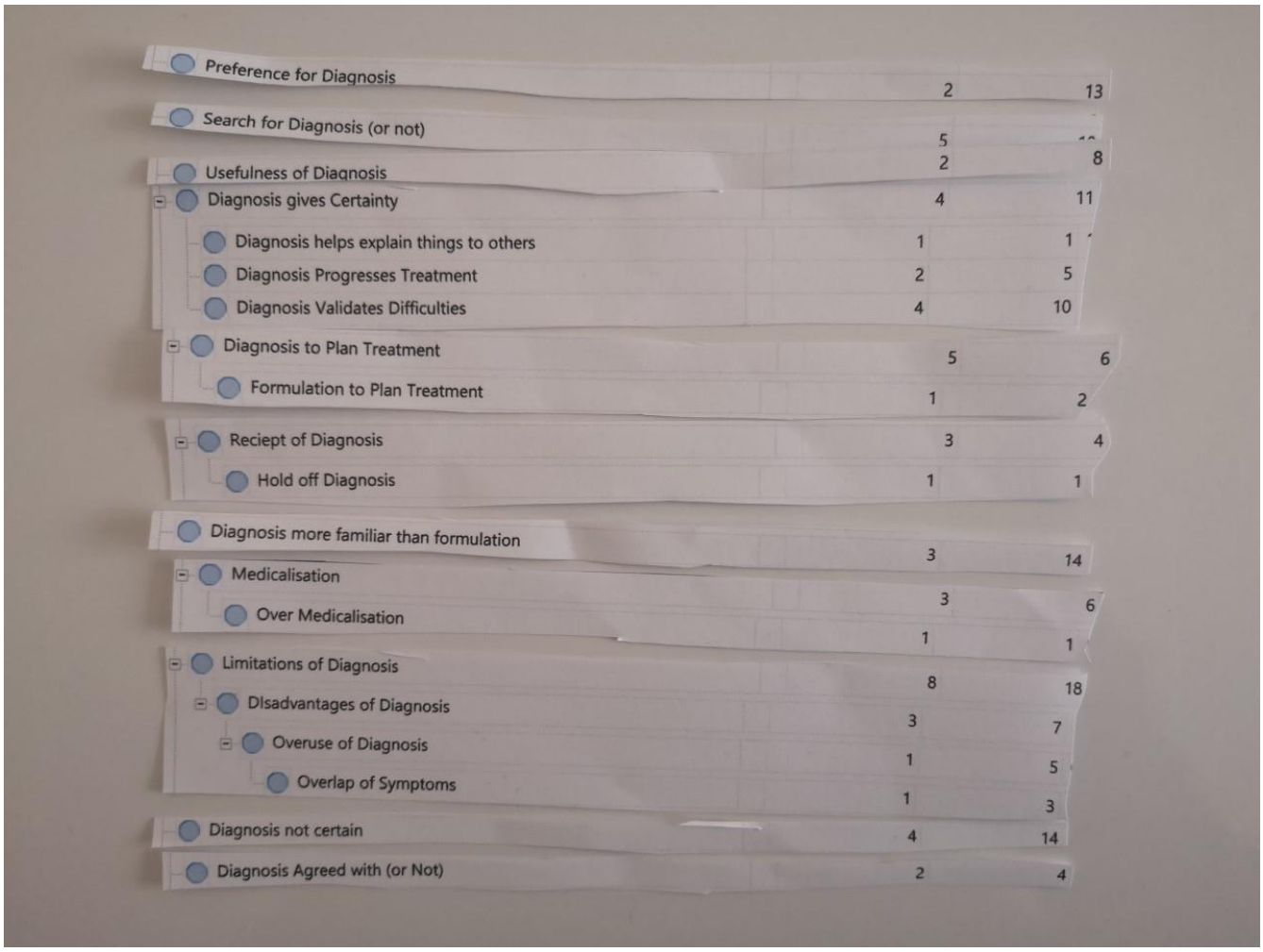
Memo – what impact is the literature having on the development of this theme? The codes map onto existing literature such as Johnstone and Dallos' (2013) book. Interestingly, there was not a specific question in the semi-structured interview about the purpose of formulation. These findings therefore add to our existing knowledge. However, perhaps my pre-existing knowledge and biases could have impacted the coding of participant's transcripts.

Theme 4: the disadvantages and limitations of formulation



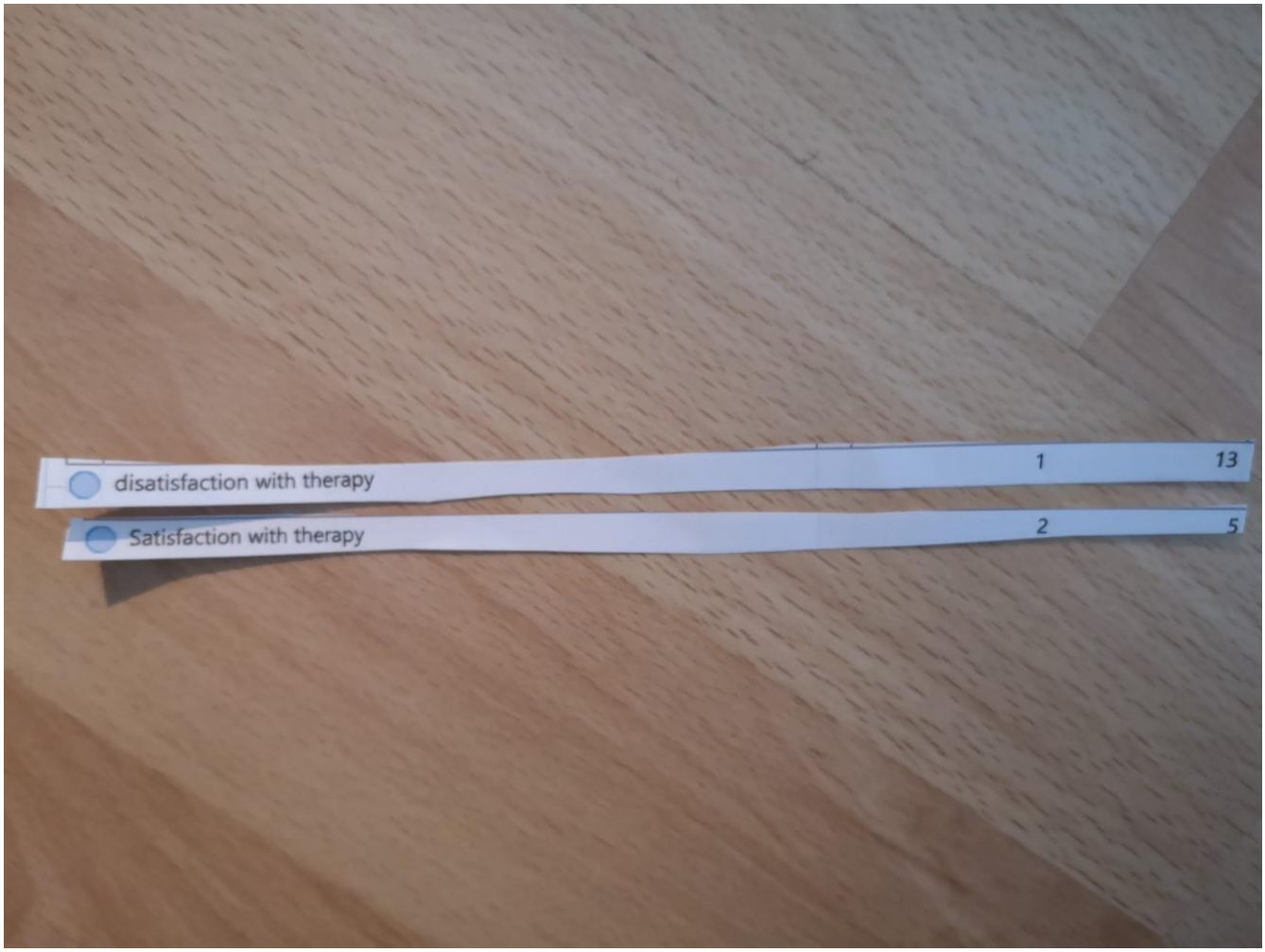
Reflected on whether these themes are being developed based on the questions asked in the semi-structured interview, which is not the aim of data analysis. I.e. I asked all participants what the limitations or disadvantages of formulation might be. Few spontaneously talked about the disadvantages. I need to frequently remind myself what the research question is (What are young peoples' understanding and experiences of formulation?), so that my data analysis is based on what is meaningful in that context.

Theme 5: diagnosis - I may need to group together client opinions, strengths and limitations of diagnosis all in one?



Memo: These codes could have been grouped into separate themes, such as one regarding the strengths of diagnoses and one regarding the limitations of diagnoses. However, the research questions were focused on young people's experiences of formulation, not diagnosis specifically, and there needs to be a limit on the number of themes that are included in Thematic Analysis. Therefore, the analysis of information regarding diagnosis is limited.

The following is likely to need to be discarded as doesn't directly link to my research questions



Step 4: Review potential themes – these were discussed with the research supervisor. It was discussed that there was too much emphasis on diagnosis, given the research question. Further, it was discussed that theme four could be integrated across the other three themes.

Summary of potential themes

Theme 1: Shared Sense Making

- Collaboration and Power
- Method of Formulation and Accessibility for Clients
- Perceived 'Validity' and Meaningfulness of the Formulation for Clients

Theme 2: Formulation Process as a Therapeutic Intervention

- Impact of Formulation for Professionals and Wider Network
- Therapeutic Effects of Formulation for Clients

Theme 3: The Purposes and Uses of Formulation

- Formulation Explains Causes and Maintenance of Difficulties
- Formulation Develops New Perspectives
- Formulation Steers Direction of Interventions

Theme 4: Both Formulation and Diagnosis Have Limitations

- Uncertainty and Overuse
- Unintended messages

Step 5: Define and name your themes, and step 6 – producing the report - were completed following the above four steps. See Results chapter for final theme and report.