

A grounded theory analysis of patients' experience  
of formulation-sharing with clinical psychologists.

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## Declaration

All parts of this research is the original work of the author and has not been submitted for any other academic award. It is submitted as partial fulfilment of the Doctorate in Clinical Psychology at the University of Leicester.

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## Thesis Abstract

This thesis investigates the experience of patients working with clinical psychologists in therapy. Specifically, it is interested in the patients' experience of formulation-sharing in psychological therapy. The study is presented in three parts: (i) a literature review investigating past research on psychological formulation (ii) the main research report and (iii) a critical appraisal of the research process.

### *Literature Review*

The literature review highlights that studies on the effect of formulation on important therapeutic variables have produced mixed findings. The review aims to highlight the factors that research suggests may influence the formulation process.

### *Research Report*

The research report aims to contribute to an under-researched area of psychological formulation-sharing in everyday clinical practice. It explores patients' experience of this process using grounded theory methodology and provides a process model based on patient's perspective of the process.

### *Critical Appraisal*

The critical appraisal is based on the researcher's notes and reflective journals kept throughout the project. The appraisal reflects on the researcher's involvement in the project, the process of recruiting and interviewing patients, analysis of the data, the development of a model of formulation-sharing and the academic supervision process.



## Part 1 – Critical Literature Review

A critical literature review of factors that influence psychological formulation.

## Literature Review Abstract

### ***Aims***

The current review aims to highlight factors which research suggests may influence the process of formulation. It also aims to suggest how these findings can be used inform future studies and address the gap and conflicts in formulation research findings.

### ***Method***

In consultation with academic staff and peers, a search protocol was outlined and used to search relevant literature databases to find research papers investigating the formulation process. Duplicates and papers that did not meet the inclusion and exclusion criteria were removed. Twelve suitable papers were included for analysis.

### ***Results***

Twelve papers were reviewed which identified the effect of formulation on important therapeutic factors. Key themes identified were: the impact of practitioner experience on formulations, impact of formulations on therapeutic alliance, impact of formulation on treatment agenda, impact of formulation on multi-disciplinary teams and the impact of formulations on patients.

### ***Conclusion***

Investigating the relationship between formulation and important therapeutic factors remains a challenge, with contradictory results found within individual studies as well as across them. Past research can be broadly categorised in terms of formulation being beneficial or not. Developing a more rigorous but flexible approach in defining and controlling variables in formulation research may help increase consistency in findings.

## 1 - Introduction

### *1.1 – Formulation and mental health research and services*

As an increased level of importance continues to be placed on addressing mental health difficulties (Department of Health, 2011) it has become paramount that effective and timely interventions are systematically employed across the mental health sector. It has also become particularly important to address the medicalisation and diagnostically-led approaches to mental health care that have dominated discourse and practice (Double, 2002; Sayre, 2006). Organisations have been directed to re-examine how mental health services are delivered at systemic and practitioner levels with increased importance being placed on the experience of the patient. In this context the promotion of psychological therapy would appear ideally suited towards this move with its vision of improving access to talking therapies and increased service user involvement (British Psychological Society, 2009). However, assessing psychological interventions and outcomes in systematic and standardised ways does not always fit easily with the psychotherapeutic approach. Consequently a conflict exists that will continue to present mental health services with difficulties as they are challenged to account for the delivery of their work in increasingly formulaic and cost-effective ways (Department of Health, 2013).

The use of psychological-formulation presents one example of this challenge in clinical psychology practice. Formulation is seen as a marked and deliberate step outside the medical model of mental health which attempts to inform intervention collaboratively with the patient. This collaboration can take into account the personal and situational factors that contribute towards and maintain individual difficulties. The nature of formulation can be viewed as being an explanatory model, as opposed to that of diagnosis which seeks only to describe clients' problems (Mace & Binyon, 2005). This has become increasingly important, not just in the field of clinical psychology, but in other professions such as probation, residential care, nursing and social work, where services are expected to work with clients who may present with a range of mental health problems (Brown & Völlm, 2013; Falvey, 2001). However, the use of formulation is not always easily accounted for or measured in standardised ways.

Despite the collaborative, fluid and idiosyncratic nature of formulation processes, many researchers and organisations will continue to interrogate the empirical rigour in demonstrating its efficacy. Though some standardised protocols have been employed as a way of supporting the use of formulation across a range of factors, such as monitoring treatment outcomes (Berking *et al.*, 2005) or assessing the congruence of assessment-to-intervention plans (Godoy & Hayes, 2011), they have produced mixed-results. Issues of validity and reliability continue to be debated on the use of formulation and how it is researched. Under such scrutiny therapists will regularly have to defend or account for their practice. For example, issues of practitioners' information-processing and judgemental biases may be investigated in an attempt to evaluate if formulations are accurate and relevant to treatment goals (Mumma, 2011). However, the use of standardised approaches when using formulation can become problematic, especially when the complexity of any given case increases (Godoy & Hayes, 2011).

The study of formulation as a measurable concept is problematic as it is often defined in a number of different ways. It is common for research studies to refer to similar processes by different names such as case formulation, case conceptualisation or transference interpretation. A further aspect that can often cause difficulty is that different theoretical orientations in psychology, such as cognitive-behavioural or psychodynamic, place a different emphasis on how therapists make sense of people's difficulties. At a basic level though, formulation is understood as a way of using psychological theory to help clients and health professionals make sense of ongoing difficulties that impact on daily functioning (Division of Clinical Psychology, 2010). Though some research has explored the idea that formulations should be reproducible regardless of the therapist producing them (Luborsky *et al.*, 1988), others argue that achieving this is too difficult due to the wide range of subjective factors that could underlie any aspect of the formulation process (Butler, 2006). It may be that trying to find a balanced approach to researching formulation is the most prudent way forward.

The scientist-practitioner model, where scientific methodology and evidence-based research is applied to day-to-day decisions and practice, is the underpinning of most clinical psychology training within the UK (Division of Clinical Psychology, 2011). This principle, applied to formulation, encourages psychologists to develop and test

their hypotheses with patients as part of the therapeutic process. There is recognition that this is a distinct factor in identifying patients' unique set of difficulties and circumstances (Division of Clinical Psychology, 2011).

These processes reflect the continuing evolution of formulation as being a fluid and person-specific communication tool. Beyond this the practice of formulation-sharing has placed a greater emphasis on the use of the reflective-practitioner model (Division of Clinical Psychology, 2011). Adopting a reflective approach when working with patients can help practitioners avoid a number of problems when sharing formulations. This includes reducing the risk of making biased interpretations that do not fit with a patient's experience or leaving more scope to allow for challenging from patients when necessary (Division of Clinical Psychology, 2011). In some models, such as cognitive analytical therapy, there is an explicit expectation on practitioners to openly share and emphasise formulation-sharing as a central component the patient-therapist dynamic.

Developing research in this area may add support to the current demands of mental health services, particularly clinical psychology, in their work to help patients develop an alternative and beneficial perspective on their difficulties. This may be possible by conducting research that takes into account the 'intuition, flexibility and critical evaluation' (British Psychological Society, 2011) of people's experience and that, without such reflection, there is a risk of developing a narrow and rigid sense of people's distress.

### *1.2 - Past reviews on formulation*

Three review studies have been carried out on the impact of formulation and they highlight the variability that exists in formulation research. Bieling and Kuyken (2003) reviewed the use of cognitive case formulation across a number of therapeutic models. Though they suggested that practitioners regularly produced reliable formulations and improved working relationships with patients, there was not enough evidence to suggest this led to improved outcomes for patients. A review from Aston (2009) on the use of formulation in cognitive behavioural psychotherapy adopted a thematic analysis approach. He observed that there was a distinct lack of research into formulation as a reliable and valid tool for improving mental health treatment decisions and outcomes.

Though he said that there was some limited evidence to suggest formulation may improve patient outcomes, the evidence base for this was weak. Mumma (2011) examined the issue of validity in the use of cognitive behavioural case formulations. In it he also highlighted the paucity of research that exists in evaluating case formulations. The review pointed towards the difficulty that such research has in demonstrating validity across factors such as formulation content, its predictive-ability and its links to treatment interventions. The review argues that though this continues to be a concern for formulation research, reviewing the design of such studies would counter many issues to improve the robustness of the studies and its conclusions.

The three papers did not adopt a systematic approach and consequently reviewed a range of different papers with different research interests. Also, due to the idiosyncratic nature of the studies it was difficult to draw any generalisable conclusions from the reviews. This has placed formulation research in the unenviable position of being viewed as one of the core foundation skills to be evidenced in clinical practice, but also one that has yet to evidence its usefulness through peer review processes. However, Bieling and Kuyken (2003) point out that for formulation to be seen as having value it might not be necessary for research to focus on producing objective, replicable data and outcomes. For example, they suggest that it is plausible to carry out research which demonstrates the production of reliable and valid formulations which have no demonstrative benefits on outcomes. The current paucity of research in this area presents an opportunity for researchers to find innovative ways to address the current state of flux in formulation research and produce something which is more consistent in its findings.

### *1.3 - Aims of the current review*

Previous reviews agree that there is a significant gap in existing literature on the impact of formulation against important therapeutic targets, including treatment goals and therapeutic alliance. Such factors are considered to be key determinants in measuring the success, or lack thereof, of formulation as clinical skill-set. In part this appears to be related to two key factors (i) a lack of a coherent approach in determining how to measure impact and (ii) the debate on how to define validity in formulation research. It is apparent that research which continues to follow the same lines of enquiry, in non-

systematic ways, will continue to produce mixed-findings as to the benefits of formulation. It is therefore important to develop a better understanding of how we begin to clearly define the impact of formulation-sharing and tackle any issues of validity in this area of research. The current review aims to synthesise the existing literature on benefits of formulation-sharing by (i) highlighting the factors that research suggests may influence the formulation-sharing process and (ii) suggest how these findings can be used inform design of future studies to address the gap and conflicts in formulation research findings.

## 2 - Method

### *2.1 – Database search*

A consultation with peers and psychologists was carried prior to the systematic literature search to determine useful search terms (Appendix A). This was used to carry out a scoping search of a recognised psychology database (PsycINFO) which informed the final search terms for systematic review. This initial step stemmed from the understanding that many academic papers use the keyword ‘formulation’ but have nothing to do with psychological formation. For example, psychiatric studies often refer to pharmaceutical formulation when discussing drug trials. Including such studies as part of the initial search would have led to an unmanageable number of articles being returned. Once the terms were finalised a search for journals related to psychological formulation-sharing was carried out. Several research databases were consulted using a variation on the search terms *case formulation*, *psychological formulation*, *reformulation* and *clinical formulation* (Appendix B). The search filter criteria included peer-reviewed journals in English, published between 1993-December 2014. Returned articles were screened electronically to remove duplicates. Abstracts were read and reviewed against inclusion and exclusion criteria. Where it was unclear if articles could be included or not the paper was kept for a full reading. The remaining papers were then systematically reviewed using an adapted data extraction pro-forma (Appendix C) for use in health psychology literature reviews (Jones, 2012). The search procedure (Appendix D) ended with twelve papers being selected for review (Appendix E).

## *2.2 – Appraisal of selected papers*

The papers selected for review adopted quantitative, qualitative and mixed-methods approaches to their analysis. Appraisal of these papers was adapted according to the methodological features of the paper and taking into account important factors such as the choice of outcome measure, generalisability, sample, bias issues and quality of the reporting of formulation processes (Appendix F). All papers outlined the aims, methodological features and outcome of their research adequately and had a clear idea of what their focus of formulation impact was. This was helpful in considering them for inclusion in terms of the current review aim of discovering the influence of formulation on different variables. Though validity issues were not discussed fully in three of the papers they were included for review. This was due to the previously highlighted issue that validity, in general, has not been well-defined in formulation studies therefore exploring this further was merited. Similarly, four studies that did not discuss bias issues were also included as this may have helped interpretation of why mixed-findings occur in formulation research. Half of the papers did not discuss the generalisability of their findings, though they did recognise this was a consequence of the recognised limitations of their research methodology.

## *2.3 - Inclusion and exclusion criteria*

In addition to the word-mining protocol, inclusion and exclusion were arrived at with reference to previous reviews (Aston, 2009; Bieling & Kuyken, 2003; Mumma, 2011) which suggested the mixed findings on the usefulness of formulation was a result of many differing or confounding variables. The broad aim of the current review's criteria was to capture studies where it was reported that formulation did or did not have an effect on any subjective or objective factors. The rationale underpinning this was the acknowledgement that as there is no one way of formulating (Butler, 2006), it may be useful to identify as many common factors as possible which could be controlled for in future studies. Studies were included for review if:

- they referenced the psychotherapeutic model used with patients
- an effect on clients, practitioners or teams was reported



These factors were felt to be broad enough to capture a range of studies that would highlight the benefit, or not, of formulation.

Papers were excluded if they:

- were review papers
- referred to, but did not investigate, formulation as part of a different research focus. For example, if the focus was on assessment skills but formulating was mentioned in the study
- were studies that focussed on specialist psychological techniques which were similar to ‘formulation’ but did not explicitly research formulation as a concept in its own right. For example hypothesis-testing or transference interpretation

Excluding the papers mentioned above was felt to be important in attempting to keep the review boundaried around ‘formulation’ as a key concept in its own right.

### 3 - Results

#### *3.1 - Impact of practitioner experience on formulation*

Three studies investigated if practitioner experience had any impact on the quality of produced formulations. Kuyken *et al.* (2005) recruited 115 practitioners and their level of experience was measured by defining (i) their professional background (ii) whether they were pre-qualified therapists or the number of years that had passed since their qualification and (iii) if their profession was accredited by the British Association of Behavioural and Cognitive Psychotherapies. Participants reviewed the same case description and developed their own case formulation based on this. Formulations were developed by participants by using a systematic Case Conceptualisation Diagram (CCD) approach which had been taught to the participants as part of a formulation skills workshop. The reliability and quality of formulations were assessed against a benchmark formulation provided by the author of the CCD. This benchmark formulation took into account such factors as developmental issues, core beliefs and compensatory strategies. Researchers reported that there was a positive relationship between the level of participant experience and the quality and reliability of their formulation. However, despite this positive relationship, researchers also reported that over half the formulations delivered were not of good enough quality. Overall these formulations were assessed as 22.1 per cent being ‘very poor’, 33.6 per cent ‘poor’,

34.5 per cent ‘good enough’ and 9.7 per cent as ‘good’. The conclusion drawn from these findings was that, despite the content of the formulations being relevant to the case description, there was a level of coherence missing which could not explain or illustrate how such content linked together in a meaningful way.

Eells *et al.* (2005) recruited 65 participants who were assessed as working at the level of a ‘novice’ therapist (clinical psychology students, n=24), an ‘experienced’ therapist (psychological therapists with over 10 years of experience, n=19) or an ‘expert’ therapist (psychiatrists or clinical psychologists who were recognised as national experts on formulation, n=22). Each group was asked to provide formulations for six vignettes with varying degrees of disorder complexity. Participants gave a verbal account of their formulations and outlined a treatment plan for each vignette. These were subsequently transcribed and then quality-assessed across eight factors considered to be integral to the development of good formulations: comprehensiveness, formulation elaboration, precision of language, complexity, coherence, goodness-of-fit to the treatment plan, treatment plan elaboration and the extent to which the therapist used a systematic process to developing their formulation.

Results indicated that there was a significant difference between expert therapists and their experienced and novice colleagues. This effect was observed regardless of the therapeutic orientation of the therapist. Specifically, expert therapists were seen to produce more complex, systemic formulations with clearer links to treatment plans. Some discrepancy was reported in that novice therapists performed better than experienced therapists in overall formulation quality. Researchers hypothesised that by developing a fuller understanding of the term ‘experience’, beyond such factors as qualifications or length of time in the profession, they could explain their findings. For example trainee clinical psychologists develop and demonstrate their formulation skills in supervision on a more regular basis in such a way that it may benefit them in such studies.

The idea that training and supervision benefits ‘experience’ was investigated by Ng and Cheung (2007). They suggested that these processes may improve therapists’ practice competencies, including that of producing a formulation of patient difficulties. They

examined the impact that targeted training and supervision had on participants' ability to produce cognitive-behavioural formulations based on two vignettes presented to them. In their study each participant undertook a 12-week training course covering a range of skills, including how to develop cognitive formulations for patients with a diagnosis of psychosis. Participants then continued to work with one patient each whilst attending weekly supervision sessions with the trainer, a psychiatrist with 16 years of experience in this field. During supervision they would discuss and review video cases of the individual therapy sessions. This combination of didactic learning and supervised practice was used as the basis for measuring participants' ability to develop cognitive case formulations based on the standardised vignettes presented to them. Practitioners were asked to produce a formulation on two case vignettes at two points in time, (i) after their didactic learning and then (ii) after the 6-month supervised practice period. To assess the quality of the formulations the Quality of Cognitive Case Formulation Scale (QCCFS) was used and it was suggested that systematic training and supervision had a beneficial impact on the quality of formulation delivered. Table 1 illustrates this finding.

*Table 1 – Change in quality of case formulation before and after group supervision*

Quality of Formulation Rating	After didactic training pre-supervised practice (n=24)	After didactic training and post-supervised practice (n=20)
Very Poor	10	0
Poor	9	5
Good enough	5	14
Good	0	1

### *3.2 - Impact of formulation on therapeutic alliance*

Three studies looked at the effect formulation had on therapeutic alliance. Chadwick *et al.* (2003) investigated this by measuring patient and therapist scores on the Helping Alliance Questionnaire (HAQ-P and HAQ-T respectively). These measurements were taken at four different points in time with baseline measurements taken before the formulation-sharing process. Formulation-sharing happened after two therapy sessions had been carried out. Researchers concluded that though there were individual patient scores indicating some improvement in therapeutic alliance over time, the overall

analysis did not support this. Conversely there was a significant increase in alliance ratings from the therapists' perspective. These findings also were reflected in the analysis of semi-structured interviews with both groups (see section 3.5).

Shine and Westacott (2010) carried out a mixed-methods approach to their study in which five patients completed the Working Alliance Inventory (WAI-SR) on a week-to-week basis after several sessions of cognitive analytic therapy. During one of these sessions patients received a written reformulation of how the therapist understood their difficulties and again the WAI-SR was completed by patients. Researchers concluded that the formulation-sharing process had no significant impact on rated levels of therapeutic alliance. Evans and Parry (1996) also reported that quantitative measures of therapeutic alliance using the Penn Helping Alliance Questionnaire suggested the formulation-sharing had no impact though there was little insight given into the analysis of this.

### *3.3 - Impact of formulation on treatment agenda*

Four papers highlighted the impact of formulation on treatment plans or targeted outcomes. Gladwin and Evangelini (2013) examined the use of written case formulation with patients diagnosed with anorexia nervosa. This study adopted a retrospective, single-case series design in which they accessed the clinical records of patients and carried out a post-hoc analysis of their files. The researchers examined the case notes of adult women where they quality-assessed a written case formulation which had formed part of patients' therapy. The impact of the formulation was measured by recording the weight change in 14 patients. Researchers ensured that (i) all patients met key diagnostic criteria for an eating disorder and (ii) repeated, objective measures of outcome were used. The quality of formulation was measured using the Case Formulation Content Coding Method-Revised which took into account such things as the comprehensiveness, elaboration of explanatory mechanisms, precision of language, complexity, coherence, treatment plan elaboration and formulation-to-treatment fit. Weight and Body Mass Index measurements had been recorded in the case notes prior to, and throughout, therapy. Researchers found that in 9 out of 15 cases weight increased significantly after formulation had been shared with clients. There were some problematic findings in that 'high quality' formulations were associated with patient

failure to gain weight. There may have been a number of methodological explanations for this, such as the small sample size, reduced patient motivation or increased effort from therapists to develop their formulation. However, it was apparent that there were a number of unexplored or unidentified factors in the formulation process suggesting that empirical measurement of formulation and outcomes may only form one part of our understanding in this field.

Chadwick *et al.* (2003) employed a mixed-methods approach to their study and suggested that formulation did not have any significant impact on key therapeutic targets for patients with psychosis. In their research they adopted an empirical-based approach to analyse whether formulation would positively impact on patients' (i) levels of depression and anxiety and (ii) their perception of their delusional and self-evaluative beliefs. There were 13 clients included in the study which measured their scores on the Hospital Anxiety and Depression Scale (HADS). Baseline measurement saw clients complete the HADS before any formulation-sharing had occurred. Two structured therapy sessions were used to develop an individualised formulation with the patients. This was shared through the use of diagrams and an accompanying letter which outlined such concepts as understanding triggers to any difficulties, critical incidents, cognitive distortions, core beliefs and key formative/developmental beliefs. An additional component of the research was to employ a semi-structured interview with patients to try and understand the experience of formulation-sharing from their perspective. The researchers reported that based on statistical analysis of scores on the HADS formulation-sharing had not impacted on levels of depression and anxiety. Qualitatively however, 11 out of 13 clients reported that they found the process helpful as it developed their understanding of their difficulties and enabled them feel more optimistic and encouraged about the future.

Persons *et al.* (2006) were interested in comparing the benefits of formulation with other available interventions. In their study of 58 patients with symptoms of depression and anxiety, they compared the use of an individualised formulation-sharing approach with that of other empirically supported therapies (ESTs) such as mindfulness based therapy or behavioural activation therapy. EST data was derived from previous meta-analyses research on its efficacy in treating mood and anxiety disorders. Patients were

treated using a formulation-driven CBT approach in which therapists built an idiosyncratic understanding of their difficulties which was then used to inform the selection of an appropriate CBT treatment protocol. Formulation included a range of key factors including a list of the patients' problems, their causes and how these were being maintained. Individualised formulations were written up and shared. Patients completed a set of standardised measures, the Becks Depression Inventory and the Burns Anxiety Inventory, prior to and after therapy. Results showed that patients showed significant reduction in their symptoms of anxiety and depression at pre and post-treatment stages of their formulation-driven therapy but that these changes were broadly comparable with patients who received a different EST.

Groenier *et al.* (2014) explored whether or not formulation had an effect on treatment planning. They identified that case formulations often provide descriptive accounts of presenting problems without accompanying explanatory information. They carried out a study exploring the complexity of clients' difficulties and if this would influence case formulation development. There were 211 participant psychologists recruited into the study who were asked to analyse two vignettes. One presented a client with problems of low complexity and the other of high complexity. Participants were then asked to identify what diagnosis the patient might fit into, describe how the presenting problems developed and identify an appropriate treatment strategy from a list of 18 available to them. Case formulations were coded using an appropriate quality rating scale and quality-assessed across the factors such as the explanatory hypotheses, relationships between causal factors, relevance, consistency, specificity, testability and positive indicators for treatment. Additionally the relationship between the quality of formulation and treatment decision was analysed using the Content Coding Method. Contrary to expected results, statistical analysis demonstrated that clients with less complex problems received a higher quality formulation than those with highly complex problems. Similarly, researchers found that there was only a weak relationship between formulation and intervention plans regardless of the level of complexity of presenting problem.

### *3.4 - Impact of formulation on multi-disciplinary teams*

Two papers highlighted the use of formulation-sharing with multi-disciplinary team (MDT) members. Christofides *et al.* (2012) researched how clinical psychologists account for their use of formulations at a systemic level. Using a thematic analysis approach they interviewed ten participants about their use of formulation-sharing in MDT settings. This was primarily an exploratory study aimed to address a gap in this area of research. They reported that clinical psychologists placed increased importance in being able to develop the psychological understanding of clients' problems with colleagues in an informal manner. This included making suggestions in meetings or ad hoc conversations about patients in the workplace. Clinical psychologists felt this process was beneficial to clients as it helped team members develop their clinical thinking and intervention strategies with their cases. It was also suggested that MDT members felt empowered to contribute to clinical practice more meaningfully and that with their input formulation could become more informed and meaningful. It suggests that though collaborative one-to-one formulation-sharing with clients is important, its complexity and relevance can be enhanced by those with access to additional and relevant information.

Summers (2006) also highlighted the benefits of formulation-sharing in team settings. In this study the researcher carried out a grounded theory analysis of interviews with 25 staff members in a high-dependency mental health ward setting. The semi-structured interviews asked staff about their experience of attending psychology-led formulation meetings on a fortnightly basis. Textual or diagrammatic representations of discussed formulations were produced after the meeting for use by staff in their work. From the interviews the researcher noted that staff had found the experience of formulation-sharing to be a positive one overall and that the process had led to better working relationships with patients and improved team dynamics. However, though this was not the main focus of the study, staff members generally felt that their exposure to the formulation-sharing process did not result in better outcomes for their patients.

### *3.5 - Impact of formulation on patients*

Four studies included the investigation of formulation-sharing from the patients' perspective. Pain *et al.* (2008) said that the process of studying formulation required an

in-depth analysis that moved beyond standardised outcome measures. They felt this was particularly important when considering cases that presented with more complexity. They recruited 13 patients who were interviewed about their experience of the formulation-sharing process during cognitive behavioural therapy. Interview data was analysed using a contents analysis methodology. Researchers discovered that patients' experience of formulation-sharing was complex across a range of factors which were thematically derived from the interview data. These factors included patients having varying emotional reactions to formulation, perception of the therapeutic value of formulation, understanding of the formulation process, change of the experience over time, feelings of optimism/pessimism and adapting behaviourally to the formulation. Overall, individual patients reported having both negative and positive reactions to the process of formulation-sharing. However, these experiences also tended to vary and change over time which further highlighted the complex nature of formulation-sharing with clients.

Chadwick *et al.* (2003) carried out semi-structured interviews with patients about their experience of formulation. They queried how relevant and helpful the process was and how patients reacted to it. It was suggested that 9 of the 13 patients interviewed felt that case formulation helped by enhancing their understanding of their problems. Patients reported mixed emotional reactions to hearing formulations with six responding negatively and six positively to the process. Though there was some suggestion from the researchers that understanding these mixed responses is a complex matter, no further analysis of patient responses was presented beyond some anecdotal comments that were made. In the same study researchers also found that therapists were more likely to give a generally positive appraisal of their working relationship with patients, indicating there may be some disconnect in the patient-therapist dynamic that could be explored further.

Evans and Parry's (1996) study interviewed four patients after they had received their reformulation whilst attending cognitive analytic therapy (CAT). Patients described the process of formulation-sharing as leading to feelings of being listened to and developing a better understanding of their problems which had a considerable impact on them. However, as with the study by Chadwick *et al.* (2003) there was little further



analysis of these interviews. Shine and Westacott (2010) followed a more structured approach to interviewing patients about their experiences of CAT and formulation-sharing. Template analysis was carried out on the interview transcripts and their findings suggested that a longer-term, increasingly significant impact on patients may have occurred. Patterns emerged that after formulation-sharing patients felt heard, had more space to talk, felt accepted, understood their patterns of behaviour more clearly and were working together well with their therapist.

## 4 – Discussion

### *4.1 – Overview of findings*

From the reviewed papers it is evident that investigating the relationship of formulation with important therapeutic factors remains a challenge. This was highlighted by contradictory findings within individual studies as well as across them. For example, whilst Gladwin and Evangelini (2013) reported that formulation-sharing improved weight outcomes in anorexia nervosa patients, other patients made no improvement despite a higher-quality formulation input. Similar contradictory findings were found in four out of the five areas reviewed with one, practitioner experience, showing some promise of concurrence. In general, studies attempted to indicate the perceived benefits, or not, of formulation. Table 2 below presents a brief summary of this.

*Table 2 – Summary of basic findings from reviewed studies*

Area of impact (number of studies)	Beneficial	Not beneficial
Practitioner experience (3)	Improves quality	
	Improves reliability	
	Improves quality with training and supervision	
Therapeutic alliance (3)	Improved therapeutic alliance (clinical psychologists' perspective)	Does not improve therapeutic alliance (patients' perspective)
		Does not improve therapeutic alliance (patients' perspective)
		Does not improve therapeutic alliance (patients' perspective)
Treatment agenda (4)	Improved outcomes with lower quality formulations/less complex cases	No improved outcomes in with higher quality formulations/more complex cases
	Improvement in daily functioning (patients' perspective)	No improvement in measured outcomes
	Improvement in measured outcomes	
		No relationship with treatment agenda

Impact on MDT staff (2)	Beneficial to working relationships and intervention decisions	
	Beneficial to working relationships with patients	No impact for patient outcomes
Impact on patients (4)	Some positive emotional/behavioural response to formulation	Some negative emotional response to formulation
	Some positive emotional/behavioural impact	Some negative emotional impact
	Some positive emotional/behavioural impact	
	Increased positive emotional/behavioural impact over time	

It may be that future studies are designed to take in to account the effect that confounding variables linked to the participants, researchers, environment and the demands of the study and control for these accordingly.

#### *4.2 - Areas to address in future research*

The reviewed papers highlighted that there is a limited amount of patient involvement in developing our understanding of the formulation process. For example, in Gladwin and Evangelis's (2013) research there was little scope to understand the mechanisms that explained the relationship between formulation and outcome. Commentary on variables such as level of engagement, motivation or how clients experienced their case formulation may have allowed researchers to develop their naturalistic study towards more robust and meaningful conclusions. Of the papers reviewed here, only two (Chadwick *et al.*, 2003; Pain *et al.*, 2008) pro-actively sought the views of patients regarding their experience of formulation-sharing. It is clear from their findings that practitioners and researchers need to be attuned to the subjective understanding of the patient when constructing and delivering formulations with them. Their research showed that clients experienced both positive and negative reactions to hearing formulations though their appraisal of this evolved over time. This presents professionals and researchers with a fundamental difficulty in approaching their formulation work in any standardised way and suggests that a degree of reflexivity should be adopted. Further, it is not sophisticated enough to assume that negative experiences or reactions to formulation is unexpected or unwelcome. Rather than this being a barrier to progress it may indicate something more transitional and complex where change begins to occur for the patient.

One area where there was a level of agreement was in the identification that the experience of therapists had positively correlated with the quality of formulation delivered. Eells *et al.* (2005) and Kuyken *et al.* (2005) both indicated that formulations delivered by more experienced practitioners were more clearly defined and better matched to intervention approaches. In addition Ng and Cheung (2007) suggested that the ability to deliver higher quality formulations could be enhanced through appropriate training. Such findings would indicate that expertise can be understood in a variety of inter-related ways, including the practitioner's level of qualification, the number of years of professional practice gained, the amount of training gained in formulation delivery and how this is assimilated by the individual. As such controlling for the variable of 'experience' or 'expertise' may be a useful consideration in future studies.

Quality of formulation was identified as being an important factor in the reviewed studies. Researchers approached this with a view that it could be measured readily and that it would be possible to extrapolate clear conclusions from this. However, the findings indicate that if this is possible there has not yet been a consistent way to demonstrate it. For example, whilst Gladwin and Evangelini (2013) reported an overall positive relationship between formulation-sharing and targeted outcomes they also noted that, individually, 'high quality' formulations had no impact on these same outcomes. Two studies (Christofides *et al.*, 2012; Groenier *et al.*, 2014) may point towards why such findings continue to occur in research. They highlighted that when a case was more informed and more complex it could either enhance or worsen a formulation. This suggests that any studies into the 'quality' of formulation need to acknowledge the limitations in defining such a variable. Taking in to consideration that formulation appears to work in a fluid manner, and therefore not easily operationalised, should direct future researchers' approach in order to improve the congruence, reliability and validity of its findings.

Formulation will continue to be an area of interest for research given its position as a core competency in the field of clinical psychology. Based on the review presented here future research could attempt to address the mixed findings on the benefits through a series of controlled studies which has an equitable approach to objective and subjective measures. Such research could ensure, for example, that experienced practitioners are

studied separately from students or newly-qualified members of staff. Similarly, ratings of formulation quality could be enhanced by adopting objective and subjective measures to inform findings. Future studies may benefit from deeper definitions on what constitutes an improved outcome for patients. Liaising more closely with patients and MDT staff could help achieve this.

#### *4.3 - Clinical implications*

Despite some of the mixed findings presented here research still maintained that formulation-sharing is an important part of good practice in mental health delivery. It may be that mental health difficulties, where they stem from and how they are maintained are so varied and complex, that studies which focus on only objective measures, such as accuracy of fit or outcome scores on psychometric measures, are bound to produce varied results. One way of addressing this may be a greater push towards analysis of the patients' subjective experience of quality and measuring the impact of formulation in more flexible and idiosyncratic ways. This may prove challenging in services where efficacy tends to equate to objective measures. However, there is an increased recognition of service users' views in health settings and by adopting this as being as important as standardised measures we can seek to redress the balance.

It may also be useful for mental health services to place a greater degree of importance on the development of case formulation as a skill set. Though complex cases will require the direct input of experienced therapists, it is also evident that developing other MDT members' skills through training programmes or supervision can enhance a range of outcomes. This includes improving the decisions and treatments offered to patients as well as fostering positive, clinically beneficial working relationships between professionals and patients. A key area for mental health services to address is how we account for the variability that will inevitably occur in formulations whilst still promoting them as useful or valid. Perhaps in this respect it is how we address treatment outcomes that provide the key. Developing more sophisticated quantitative and qualitative tools in partnership with the unique perspective offered by patients may aid this.

#### *4.4 - Limitations*

A significant limitation to the current review was the broad approach used to include a range of papers that would highlight factors associated with formulation. Though this was a decision made in order to address the relative paucity of research that exists in the field, the search methodology did result in a high degree of clinical and methodological diversity. As such this did not allow for a firm conclusion to be made about the findings from the papers. Further, it became apparent that some studies that did not use the term ‘formulation’ may have been suitable for review but would not have been identified during the search process. Future literature reviews could aim to address this with more clearly defined search terms, inclusion and exclusion criteria and expand beyond peer reviewed journals. Much work has been written in academic texts on the use of formulation that may have been useful as part of a broader literature search. For example, the increasing use of team formulation is becoming a well discussed topic (e.g. Johnstone & Dallos, 2014) as an approach to working with clients yet it receives relatively little attention in peer-reviewed database searches.

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## Part 2 - Research Report

A grounded theory analysis of patients' experience  
of formulation-sharing with clinical psychologists.

## Research Report Abstract

### *Aims*

The current research aims to contribute to an under-researched area of psychological formulation-sharing in everyday clinical practice with focus on patients' experience of the process. The research also aimed to provide a model of the formulation-sharing process based on patient's perspective.

### *Method*

Participants were interviewed using semi-structured interview schedules based on recordings of their previous therapy sessions. Excerpts of their therapy sessions were also played back to them during interview. Grounded theory methodology was used to analyse transcriptions of the audio-recorded interviews with the participants.

### *Results*

A process model of the experience of formulation-sharing was produced. A core category of "Formulation-sharing develops a sense of self-in-the-world" was conceived as encapsulating the formulation-sharing process from the participants' perspective.

### *Conclusions*

Formulation-sharing was experienced as being a bringing together of several different factors that encourages movement, both internally and externally, for the patient. This dynamic was seen as creating the potential for both individual change and change in the outside world. The process of rehearsing and embedding this new perspective allowed participants initiate new ways of thinking and acting and connect more closely with their social world.

## 1 – Introduction

### *1.1 – Formulation*

Formulation is recognised as a core competency in clinical psychology practice (Division of Clinical Psychology, 2011) and therefore an area that is of significant importance in research. Though there are various descriptions of psychological formulation there a number of common elements that can be found across most definitions. This includes formulation being understood as a psychologically-informed and theoretically driven hypothesis that attempts to explain individuals' difficulties (Johnstone & Dallos, 2006). There is also recognition that the common purpose of formulation, regardless of theoretical positioning, is as a tool to help identify and guide interventions that benefit the patient (Johnstone & Dallos, 2006).

### *1.2 – Impact on patient*

Though it has been highlighted that formulation-sharing is an important process in trying to understand where patients' problems may stem from and how they are maintained (De Kwaadsteniet & Hagmayer, 2010) there is also an apparent lack of research in this (Bieling & Kuyken, 2003). To compound this, most studies do not focus on the patients' experience of formulation-sharing or of the therapeutic process generally (Shine & Westacott, 2010). Though some studies have attempted to address this, findings on the benefits of formulation have been mixed (Chadwick *et al.*, 2003; Evans & Parry, 1996; Pain *et al.*, 2008; Shine & Westacott, 2010). Patients in these studies reported various experiences of the formulation-sharing process. On the benefits they acknowledged that they were making psychological improvements, gaining clearer insight into their difficulties and developing a good therapeutic alliance with their therapist. In contrast to this however, some patients have described experiencing increased levels of distress when having to engage with aspects of their difficulties and that this made them feel more vulnerable. So whilst some patients can find the process of formulation-sharing helpful and reassuring there is also the potential for them to feel upset and overwhelmed by it.

The potential to undo well-intentioned therapy with patients can easily arise and result in them finding them finding it an insensitive or disempowering process (Johnstone &

Dallos, 2006). Past studies have generally focussed on exploring standardised ways of measuring the benefits or costs of formulation-sharing. Enhancing this with input from the perspective of the patient has received less attention. Such findings should necessitate a move to discover more about the immediate and longer-term impact of formulation-sharing with patients. It is also imperative that while our understanding of patients' views on the formulation process remains limited it should be addressed as a matter of priority (Aston, 2009).

### *1.3 – Naturalistic formulation-sharing*

Typically the medical-model dominates assessment in the field mental health practice with a focus on patients' difficulties from a biological standpoint (Sayre, 2006). It is perhaps as a consequence of this discourse that most studies of formulation-sharing tend to be carried out in structured and standardised ways. Bieling and Kuyken (2003) argue that this kind of approach is not typical of everyday practice in clinical psychology. They suggest that the process of studying formulation-sharing requires a more flexible methodology that fits with the daily changes that are inevitable in patients' lives and their care-pathways.

Though there are many that state the importance of formulation as a clinical process (De Kwaadsteniet & Hagmayer, 2010) there is an apparent lack of research into understanding this (Bieling & Kuyken, 2003) or investigating the patients' experience of therapy generally (Shine & Westacott, 2010). A review of the literature base reinforces the limited amount of research which promotes a more typical, idiosyncratic approach to formulation-sharing. The development of clinical psychology towards a more scientific-practitioner model further highlights the importance of researching the formulation-sharing experience. It should proceed in a way that takes into account the 'intuition, flexibility and critical evaluation' (British Psychological Society, 2011) of people's experience and that without such reflection there is a risk of developing a narrow and rigid sense of people's distress.

Though previous research into formulation-sharing from a qualitative and naturalistic approach remains sparse there have been notable examples of a move towards this. Weiste and Peräkylä (2013) for example investigated the differences in formulating

styles in psychoanalytic and cognitive therapies. Adopting a conversational analysis approach, researchers compared 53 audio-recordings of therapy sessions. From nearly 50 hours of recording they identified 224 points of formulation-sharing which were transcribed and analysed. From this they discovered four different types of formulating style were used. Of these two were common to both modalities and two which were exclusive to one or the other therapies. Though analysis of the data clearly gave a focus to the clinical psychologists' and patients' perspective there was no follow-up with them, which may have elucidated the findings further. The present study addresses this by analysing session data in a similar way but following this up with interviews with the patient. This may have the advantage of reducing the risk of making assumptions about the mechanisms of formulation-sharing and discovering novel processes as the study progresses.

Pain *et al.* (2008) identified this in their study in which patients were interviewed about their experience of formulation-sharing in cognitive analytic therapy. Using semi-structured interviews and audio-recordings, patients were asked how formulations had impacted on them at the time of therapy and in the present (i.e. during the interview 2-3 weeks later). Interviews were transcribed and analysed using a content analysis methodology. Categories identified from the analysis included: reactions to formulation, therapeutic value, behaviour change and therapeutic relationship. This was a helpful study in gaining further insight into patients' reactions to formulation; though the descriptive limitations associated with content analysis may have had a reductive effect on responses and therefore our understanding of formulation-sharing. In this respect following a similar approach may have revealed other ideas if analysed using a more explorative methodology. The present study addresses this by adopting a grounded theory approach which also has the advantage of being focussed on discovering emerging ideas in under-researched areas.

Eells (2007) suggests that whilst inaccurate formulations can be problematic, even accurate formulations can discourage patient engagement if it resonates with unconscious conflicts at the time. The present study seeks to address this by asking patients about their experience after a significant period away from therapy and in the

process of sustained recovery. This may have the advantage of discovering if the longer-term impact of hearing difficult or worrying formulations is of benefit overall.

Taking into account these previous approaches and findings, the present study focuses on (i) formulation-sharing as it occurs during everyday practice between patients and clinical psychologists and (ii) the patients' experience of this after a significant period away from the therapeutic process. Developing research in this area may add support to the current demands of mental health services, especially in clinical psychology, who attempt to work with patients in developing an alternative perspective on their difficulties. It may be that to discover a higher level of concurrence in such studies there is a need to develop a way of facilitating the patient experience as a tool for measurement.

#### *1.4 – Aims*

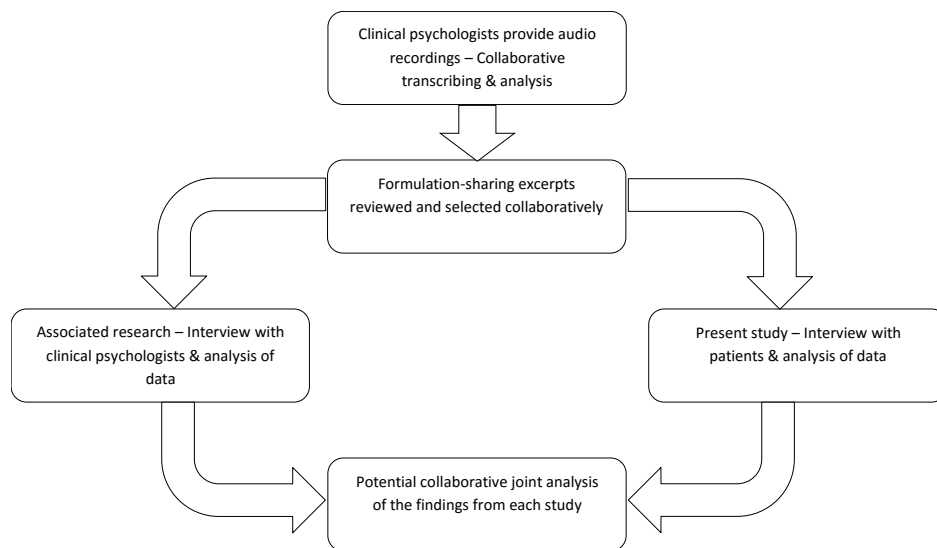
The aim of the present study was to contribute to the under-researched area of psychological formulation-sharing in everyday clinical practice with a specific focus on patients' experience of this. The study also aimed to provide a model of formulation-sharing based on patients' perspective of the process. This was to be achieved by obtaining naturalistic data from clinical therapy sessions.

## 2 – Method

### *2.1 Associated research*

The present study was linked to another research project that focused on clinical psychologists' perspective on the use of formulation-sharing. The present study began with the same data source (i.e. audio recordings of therapy between clinical psychologists and patients) but with a focus on the patients' experience formulation-sharing. In the initial stages of the two studies there was collaboration between both researchers. After this initial phase was completed researchers continued with their separate studies with no further collaboration. A future aim was for both researchers to collaborate on their findings. Figure 1 (page 40) illustrates the collaborative and individual research pathways that were carried out.

*Figure 1 – Collaborative and individual research pathways*



## 2.2 – Participants

Participants were three, English-speaking, adult male patients who had previously been referred to NHS mental health services for clinical psychology support. They were recruited through their clinical psychologists who were taking part in the associated study. Table 3 below provides a brief overview of the patient/clinical psychologist pairings and model of therapy used.

Patient	Clinical Psychologist	Mode of Therapy
Luke	Zoe	Rational emotive behaviour therapy & cognitive behavioural therapy
Chris	Sarah	Integrative
Sarah	Gemma	Integrative

*Table 3 – Overview of participants in current and associated research studies*

Though a number of clinical psychologists were approached, only four were able to identify suitable patients to take part in the associated research project. From these four patients, one, an adult female, was withdrawn from the present study for reasons of ill-health. Despite the small number of participants identified it was determined through academic, ethical and peer review that this would provide a manageable dataset which

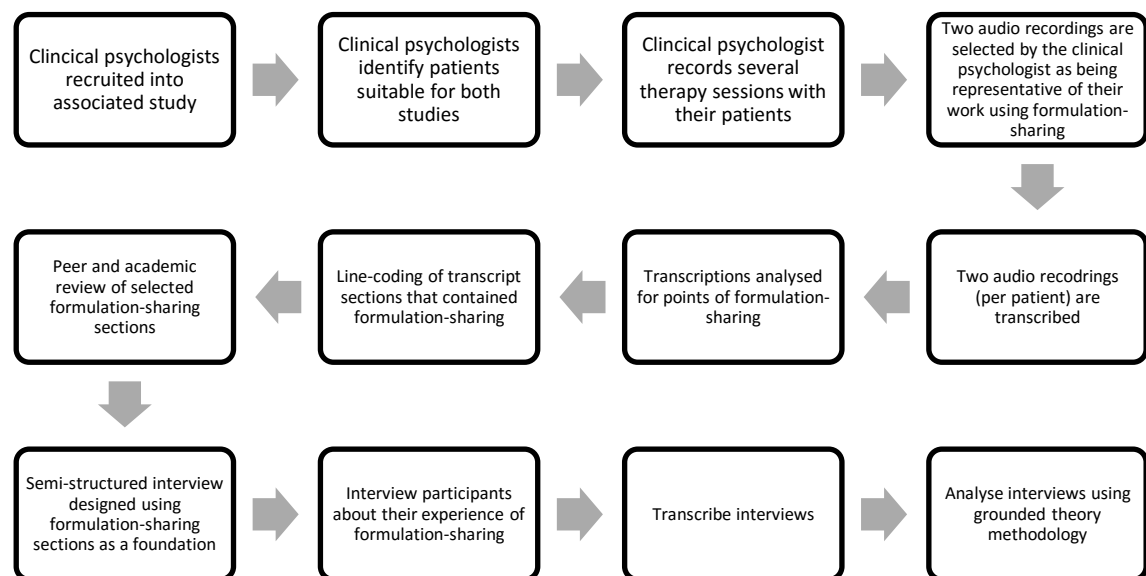


was appropriate to grounded theory analysis and in keeping with DClinPsy course requirements. Patients were assessed by their clinical psychologists as having the capacity to understand the aims and objectives of the study, give informed consent and were not presenting any significant risk of harm issues. Patients had also agreed to their therapy sessions being recorded for further analysis. When the present study was proposed to clinical psychologists, patients also agreed to review excerpts of this audio with the researcher in a follow-up interview. The interviews were carried out around 12 months after the initial therapy sessions.

### 2.3 – Procedure

Clinical psychologists were recruited through the associated research study where local ethical approval was gained. The present study was proposed shortly after this and favourable opinion from local NHS REC (Appendix O) sites was gained. Figure 2 below provides an overview of the present study's procedure.

*Figure 2 - Overview of the procedure*



To maintain the integrity of the research and provide a recognised link, the researcher made contact with clinical psychologists and forwarded them the relevant information (Appendix G). Clinical psychologists were given the final decision as to whether or not patients would be suitable for interview. Once patients had agreed in principle to the interview, clinical psychologists provided them with further information about the study

(Appendix H) and acted as a link for arranging interview. It was during this stage that one of the patients was identified as being unsuitable for follow-up interview due to reasons of ill-health. The three remaining patients were approached and consent was gained for them to take part in the study (Appendix I).

Clinical psychologists provided the researcher with two self-selected audio recordings of therapy sessions with their patients. These recordings were transcribed and line-coded to identify points where formulation-sharing had occurred. To ensure quality this part of the process was done in conjunction with the associated researcher, alongside academic supervision. For each patient a total of 4 excerpts from the transcripts were selected and used as the basis for a semi-structured interview schedule (Appendix J). The main focus of the interview was to investigate patients' experience of formulation-sharing.

The interview took into account the length of time that had passed since the therapy sessions, which had been over 12 months prior. It was decided that the selected audio excerpts of formulation-sharing would be played back to the patients as a prompt for recall. Similar structured process recall methods have been used in other research as a way of understanding the individual experience of psychotherapy (Elliott, 1986). In conjunction with a clearly defined research focus they can also provide a significant quantity and depth of qualitative data for analysis (Kvale, 1996).

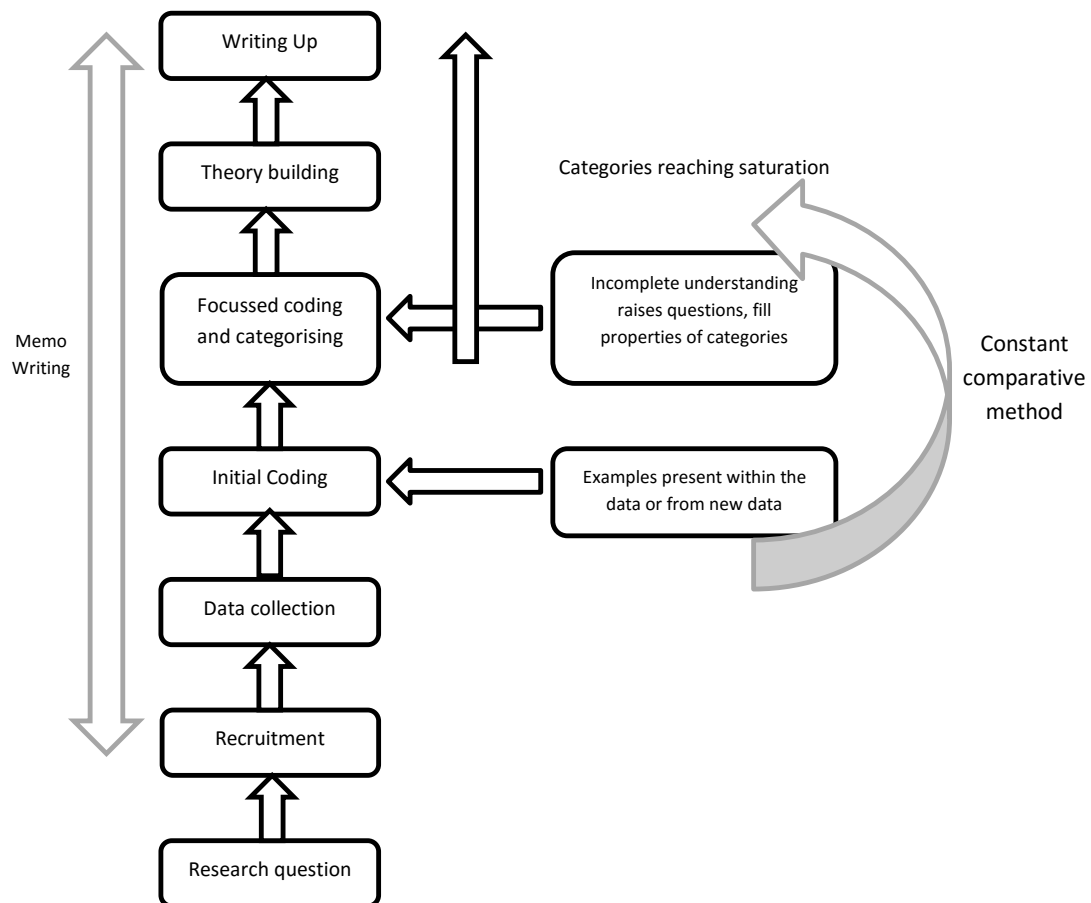
The semi-structured interview guide contained a mixture of general open-ended questions that all patients were asked, as well as individually tailored questions for each patient. Patients (from here on participants) were interviewed in one session which lasted between 60-to-75 minutes. Interviews were then transcribed, anonymised and analysed using grounded theory methodology.

#### *2.4 –Research design and analysis*

Interviews with participants were audio recorded and transcribed verbatim by the researcher aided by additional notes made at the time of the interview. The decision to carry out verbatim transcription was taken in order to produce a text that was as faithful as possible to participants' responses. This was achieved through the active-listening to

participants' accounts during interview, re-listening to this via the audio recordings and reviewing it in conjunction with additional notes made at the time of interview. Proceeding in this way helped to develop an understanding of the data over and beyond that of just reading the text in isolation (Lapadat & Lindsay, 1999). Analysis of the finished transcripts followed a grounded theory approach as adapted from Charmaz (2014) and illustrated in Figure 3 below.

*Figure 3 – Overview of grounded theory method used in present study.*



This was seen as being an appropriate method of analysis for several reasons. Firstly, grounded theory posits that it is possible to derive a theory from social research data (Glaser & Strauss, 1967) which fitted with the focus of the present study. Further, a social constructivist approach to the analysis allowed the researcher to stay connected to the participants' accounts of how they construct their world (Mills *et al.*, 2006). Based on Charmaz's (2001) constructivist approach, it was felt that the analysis would expand on the individual experiences of participants to develop a more theoretical

understanding of formulation. Grounded theory was also regarded as a methodology which could address the current lack of exploratory research into formulation-sharing experiences and potentially provide a model of understanding in this area. Symbolic interactionism was influential in deciding upon grounded theory as an approach for the present study as it offered the researcher the benefit of being able to combine “theory and method into a coherent, unified whole without forcing their data and ideas into a prescribed set of concepts” (Charmaz, 2014).

Initial coding of the transcripts involved reading the data line-by-line to generate the first codes (Appendix K). This line-coding approach was chosen over others, such as incident-with-incident coding, as the researcher was very familiar with the data due to the transcribing approach. Line-coding was deemed an appropriate way to counter any pre-conceptions about the data and to develop new ideas that may have otherwise been missed. Memo-writing was used throughout the whole analytic process (Appendix L). Two main methods of memo-writing were adopted by the researcher: (i) the use of a memo-journal during focussed data analysis and (ii) an electronic memo-taking app which could be used as and when ideas occurred. As with line-coding this allowed the researcher to develop themes with less constraint whilst still adopting critical engagement to make sense of the data.

Following the initial-coding, focussed codes were generated in order to discover important themes emerging from the data (Appendix M). A process of constant comparison was carried out where initial codes were examined to see what was revealed, indicated or occurred frequently. Assessing these initial codes, focussed codes and memos against the data and each other, developed the comparative approach to a more analytical level that informed the raising of new, but tentative, categories and sub-categories. Once these categories had been defined and related back to the codes and data a number of diagrams were produced to build an understanding of the relationships between the categories. This helped inform a process-model of formulation-sharing. Unfortunately it was not possible to test this model further through theoretical sampling due to the limitations of the study. As such, theoretical saturation of the categories was not achieved from this perspective. However, based on such limitations the theoretical

categories derived were felt to be sufficient to the point where there were no new properties found in the patterns of the examined data (Charmaz, 2014).

### 2.5 - *Quality assurance*

As indicated previously, a gap exists in the research of patients' experience of formulation-sharing that could be addressed through qualitative research. This is of particular importance as including this kind of data, alongside more common quantitative outcome measurements, may aid our interpretations of what does and does not work in therapy. However, alongside this there must also be a transparent approach to how quality is achieved. In the present study a quality assurance plan addressed 3 stages of the research process: (i) the design of the study, (ii) the data collection approach and (iii) the data analysis. Table 4 below highlights each area of quality assurance that was identified and what was done to achieve reasonable standards of quality throughout.

Area of Quality Assurance	What was addressed?	How was this achieved?
Design	Identifying theoretical and epistemological positioning	Use of reflective diaries and memos to act as bracketing tools to reduce bias and assumptions on the research topic and to develop epistemological ideas; review of supervision notes and previous clinical placement reports to review theoretical approaches taken by the researcher in their clinical work; review of qualitative methods that would address research focus in line with theoretical and epistemological ideas.
	Choosing methodology and qualitative analysis	Reviewing the research question in line with previous gaps in the literature, the researcher's epistemological positioning and limitations of the study; academic supervision.
	Ethical concerns	Peer and academic supervision; ethical review; independent checking of the consistency of ethical recommendations against research protocol and associated materials.
Data collection	Interview schedule	Design schedule in line with research protocol and ethical standards; peer and academic supervision; pilot interview schedule with peers and clinical psychologists.
	Interview with participants	Clear communication with participants about the aims of the study and the interview process; discussion and review of information and consent sheets; awareness of interview style and impact on participants; responsivity to participant cues; flexible approach to semi-structured interview to prompt and reflect where necessary whilst still within the boundaries of the research focus; participant validation throughout

		interview (i.e. summarising responses, checking for accuracy, inviting clarification).
	Transcribing	Researcher carried out the interviews and the transcription of these to ensure accuracy; double-check of final transcripts against the audio files and notes; consistent notation of speech, pauses, gestures etc.
Data analysis	Coding	Discussion with peer and academic supervisor about the coding procedure and reference to relevant guidance; initial use of line-by-line coding to reduce risk of bias/assumptions about the data; use of reflective diaries and memos; audit trail of coding chronology.
	Exploring alternative perspectives within the data	Reflective diaries; peer and academic supervision; comparing new insights against existing literature.
	Interpretation and conclusions	Reflective diaries; peer and academic supervision; checking any findings against researcher biases and assumptions and inviting alternative explanations from peers; reviewing findings against current literature.

*Table 4 – Quality assurance approach for the present study*

As outlined above, to enhance the reliability of the analysis, additional techniques such as keeping a reflexive journal of thoughts, memo notes, peer and academic supervision were used throughout the analytical process. An analysis and statement of epistemological positioning as outlined by Madill *et al.* (2000) (Appendix N) also framed the approach taken to analysis.

### 3 - Results

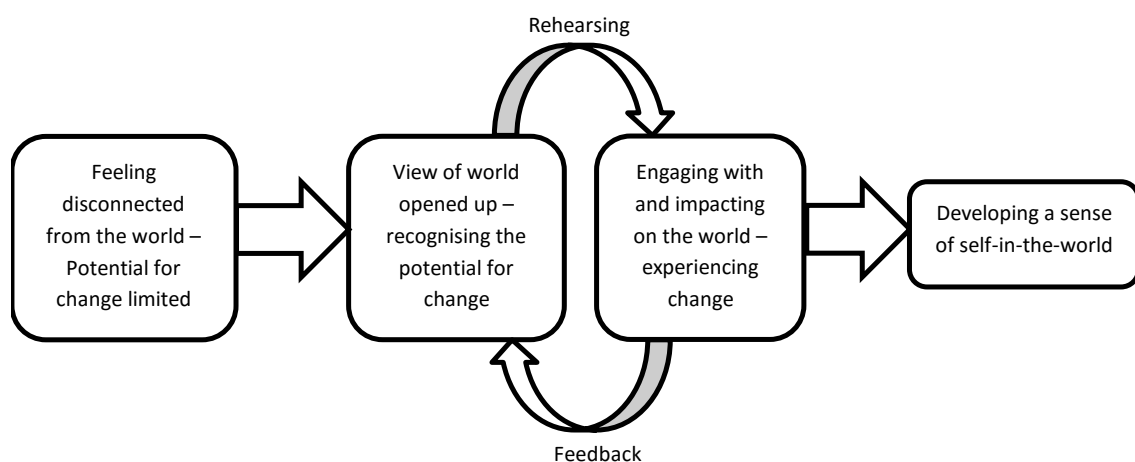
#### *3.1 - Overview*

After analysis of the transcripts was completed a core category was identified as being, “Formulation-sharing develops a sense of self-in-the-world”. The process of formulation-sharing was experienced by participants in three stages. In the first stage participants spoke about formulation-sharing as having to occur in an environment which provided emotional and physical safety. At this point participants viewed themselves as being disconnected from the world and being stuck in unhelpful cycles of behaviour. The move towards therapy offered a sense of comfort which allowed for formulation-sharing to occur in a way that participants could explore their difficulties purposefully.

In the second stage, as therapy progressed, participants experienced formulation-sharing as an aid that helped them recognise a potential for change in terms of their thinking styles, emotional responses and everyday interactions with people. Developing this change was determined by a number of factors: recognising alternative explanations, learning to tolerate internal and external stressors, planning for the future and negotiating meaning. The development of these concepts was seen as a way for participants to have a more expansive view of the world and develop a belief in the potential for change. This shift towards a more dynamic sense of self, that can develop, adapt and influence its world, was a step towards the third stage.

In the third stage, formulation-sharing was experienced as being an opportunity to rehearse these new understandings of themselves and the world. This provided the participant with new information to use in further therapy sessions, resulting in a learning-rehearsal feedback-loop which moved them closer to feeling a sense of self-in-the-world. Figure 4 below shows the final process model that illustrates participants' experience of formulation-sharing.

*Figure 4 - A process model of the experience of formulation-sharing*



### 3.2 - Findings

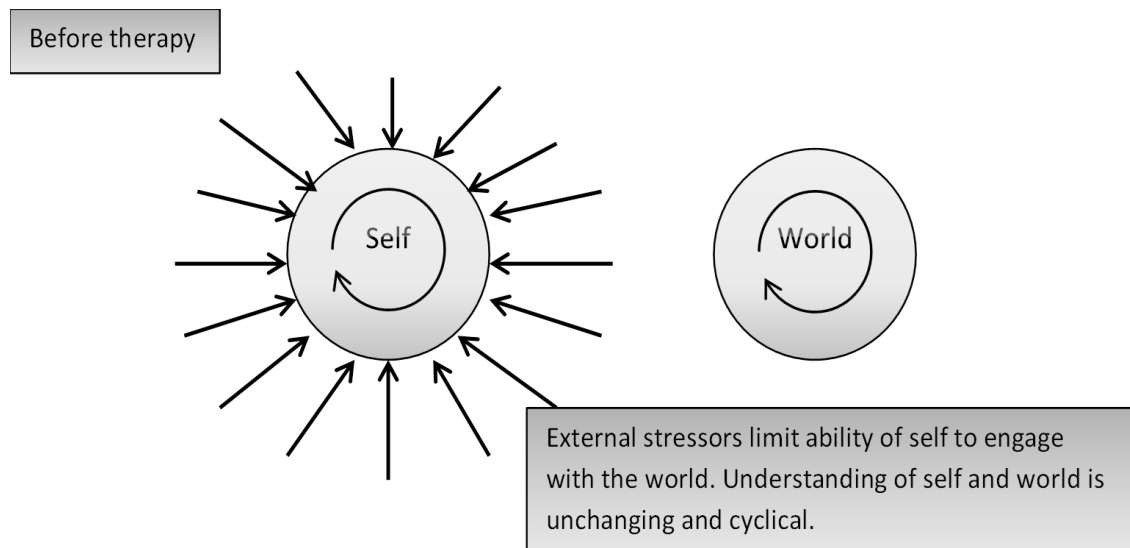
Participants' experience of formulation-sharing was explored through an analysis of six therapy transcripts and three interview transcripts. The findings presented here include verbatim quotes from participants in response to questions about their general experience of therapy and their specific experiences of formulation-sharing.

#### 3.2.1 - Stage 1 – Conditions for formulation-sharing

##### *Pre-therapeutic experience*

An important part of the formulation-sharing experience that participants spoke about was the need for an environment that was felt to be a caring, holding one. This allowed them an opportunity to reduce the intensity of external stressors in their life as illustrated in Figure 5 below.

*Figure 5 – View of self and world prior to therapy*



In one sense this referred to the physical location of therapy as a way of providing thinking space. Paul compares his experiences of talking with mental health professionals on a hospital ward, with that of therapy with his clinical psychologist, Gemma:



*Paul: “a psychology situation, when we had them in hospital they were like 10 minutes, and that was that it, 10 minutes...with Gemma though, these were hour-long sessions, one-on-one. When I did the first 10 minutes in hospital I was a bit nervous, all the other service users were in there, and I would talk about just my basic symptoms and stuff like that. Whereas working with Gemma I got a bit more in depth”*

In this respect Paul spoke of the brief nature of interventions common to many patients in receipt of mental health services. One which, though well-meaning, is not boundaried or structured enough to facilitate a more significant and beneficial examination of their difficulties. However, the kind of structure as offered by therapy, gave participants something more than just time and a safe-space. It was apparent across all participants' accounts that they felt safe to venture into areas previously not talked about and to have this handled sensitively. Luke talks about his sense of security and belief in his therapist's approach in her appraisal of his difficulties:

*Luke: “Zoe is clearly a learned and experienced psychologist, and she had that air about her...I very strongly got the impression that she knew what she was talking about, and I thought that her appraisal of me was pretty accurate really...now I don't know if that's a result of her psychological training, her experiences or her individual character, or possibly a combination of all three, but I did develop faith and trust in her”*

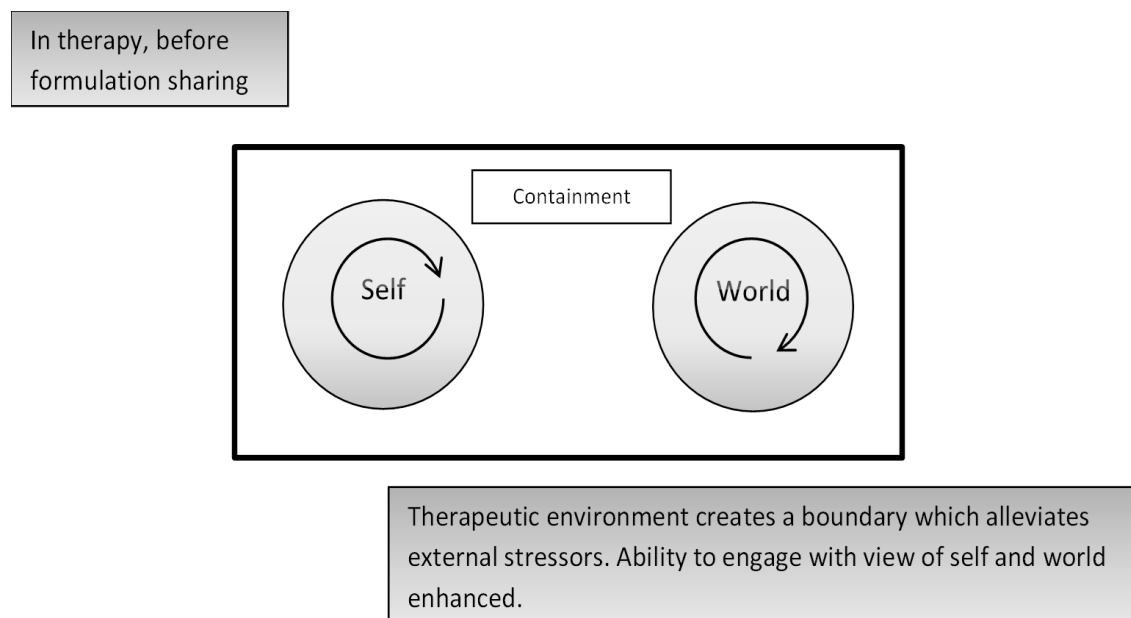
As with Luke's experience, other participants felt that the formulation-sharing experience was one where vagueness and doubt was replaced with informed appraisals and a curiosity about their lives. In addition to this participants talked of a much more basic experience, that of feeling cared about. In this sense formulation-sharing was seen as a way for the clinical psychologist to hold on to participants' anxiety and project it in a more boundaried, yet nurturing way. Chris talks of his experience here:

*Chris: “ultimately that is what you're so desperate for at the time is to be feeling a little good, a little hopeful, erm, you just don't feel quite so desperate, it's a bit of a positive hit, what you so desperately crave and yeah, really, she*

*does genuinely seem to care, I don't know, it's just having someone who cares and wants you to do well, I don't look in to it too deeply but she just manages to make me think or feel certain ways that just improve my well-being"*

This stage of therapy was described as providing a strong foundation point for participants. A place where the source material for formulation-sharing, the details of participants' life, their difficulties and distress, could be held and re-interpreted in an accessible manner. It was viewed as first step in a journey towards recovery, as well as a way of engaging with the reality of the world outside of therapy. Figure 6 below illustrates this process.

*Figure 6 – View of self and world in the initial stages of therapy*



Luke further encapsulates this process in his account of the beginning of formulation-sharing:

*Luke: “when I recount experiences I’ve had in my life, I put a lot of expectation upon myself, and I can clearly remember Zoe’s voice saying “just survive you don’t have to be perfect, peerless, flawless, fantastic at something, just survive” and I can still hear her saying that, you know that’s very, very helpful. Sometimes when I am getting het up and stressed and my head’s spinning, I*

*remember very strongly those words, you've just got to survive you know, you don't have to be... brilliant, just survive this experience"*

### 3.2.2 - Stage 2 – Process of formulation-sharing

#### *Recognising alternative explanations*

During therapy, formulation-sharing was experienced as a tool for reflection, where participants could look for inconsistencies that existed in their thoughts, feelings and behaviours. In this sense participants began to acknowledge that there may be alternative explanations to their perception of the difficulties they experienced. They described this experience in a number of different ways. For example, an important element of formulation-sharing was its ability to help participants distinguish between the way people viewed their difficulties and how much validity participants gave to this. Throughout interview participants said they had received many different messages about their mental health difficulties and their subsequent life problems. Such messages tended to be rigidly defined and inflexible. Formulation-sharing was experienced as being able to 'free up' these concrete interpretations. In this excerpt Paul talks about this movement from fixed-to-flexible understandings:

*Paul: "a lot of the labels for mental health, they're just sort of like umbrella terms, you know, it's like saying someone's autistic, or learning disabilities, it's like one term that covers many things. Yeah I think Gemma helped me identify what points are me rather than just the label...and that was better because, say if somebody asked me, then I could explain... my doctor couldn't really tell me very much about it so I just sacked that one off... but because Gemma has talked to me more I could explain it better... like when my sister said to someone, "oh yes, he's got schizophrenia" and they were like, "oh, so he turns into another person?" .... I'm like, 'no' ... It's sort of in the same umbrella but completely separate to what's going on with me...everyone hears the term but not everyone understands it, before Gemma I didn't really understand it myself"*

A further element of this process was the participants' sense that while they were going through an emotionally difficult period, formulation-sharing offered a more objective

stance to analyse alternative perspectives and neutralise any negative reactions they might experience. In this excerpt Luke reflects on a formulation shared with him about a stressful interaction he had with his cousin and his beliefs about it. Formulation-sharing offered him an opportunity to explore it in a different way to the one in which he saw himself as being to blame:

*Luke: “again I think it's a perfectly reasonable, objective observation by Zoe of the kind of things that happened, I think we're a marriage made in hell my cousin and I and it makes me question my own motivations towards her. I thought that Zoe's appraisal of the experiences that I have, again, was very accurate and cut through the emotional maelstrom that I feel...just the anxiety that I feel of the prospect of going to see my cousin, was an area where I had to work on..erm.. and watch my mind very carefully, very closely, and you know, give myself a break”*

Sometimes alternative explanations came in a much more explicit and direct manner. In this excerpt, where Chris talks about the worries he had with recurring dreams and its relationship with his mental health difficulties, formulation-sharing was experienced as a simple way of highlighting the difference between the two:

*Chris: “I think in that moment, erm, I think she might have just been making me feel alright about the dream and not tying it too closely to the psychosis, and making a distinction between the two and actually making it OK as a dream and not worrying about it quite so much ...just accepting the dream and moving on from it and just treating it as a dream”*

Across these experiences participants gave accounts of developing alternative perspectives in distinct but related ways. Formulation-sharing helped participants: draw unambiguous distinctions between subjective and objective experiences, develop within themselves a sense of movement (e.g. challenging rigid beliefs), and realise the potential that their day-to-day circumstances could also be re-interpreted.

### *Tolerating internal and external stressors*

Participants spoke about how they were able to identify ways in which formulation-sharing allowed them to engage with stressful feelings. This was seen as an important part of therapy as it challenged their belief that this kind of tolerance was a trait people did or did not have. Rather it allowed them to discover a range of resources and protective factors that are potentially available to everyone. Participants spoke about this in relation to developing their ability to ‘sit’ with emotional stress. Sometimes this involved thinking about difficult interactions with people in their social circle, as Paul talks about in this excerpt:

*Paul: “I think the group of friends I was talking about, that I’d had since school up until I went into hospital, I was talking to Gemma quite a bit about them because, I’d known them for like 12 or 13 years... I think I got to a point where I was like “they’re still not bothering with me, even though I’m messaging them, leaving missed calls on the phone and stuff”, so it got to the point where I got my emotional shield ...I think it’s made me a bit harder with my new social group, I think if they started ignoring me, like not answering messages or calls, erm, I think I’d be able to deal with it a lot better because I sort of went through it last year, yeah I don’t think it would have as much of an effect on me”*

Such examples appear to be more than just getting through a difficult period, rather it is about experiencing something uncomfortable and finding a way learn from it. This way future difficulties can be addressed in a more proactive, engaging manner. This aspect of testing and tolerating discomfort was also apparent in terms of thinking patterns and physiological reactions to formulation-sharing, as talked about here when Luke reflects on a formulation shared to him:

*Luke: “in the past, my past interactions with people I’d notice I’m just not wanting to meet them head-on, you know, but there, it seems like there’s a bit more honesty there, it’s just interesting listening to Zoe and quite useful listening to the areas that she is talking about. Also when I said something along the lines of “I know that most people, really, rationally don’t mean you any harm” she was asking me to elaborate on that positive area I’d spoke about, in*

*that “you’ve just mentioned something positive, rather than you clinging on and elaborating on all these negative aspects of your experience, let’s look at that. Why are you convinced that most people are essentially okay and don’t mean you any harm?”, which is the trait that you should be looking to develop. And it is a testament to Zoe’s skill which is clearly there, you know, “why don’t you concentrate on the positive thoughts that you have? Why are you so hung up on the negative ones?” it’s informative and yet you know a bit of a slap in the face... I’d liked for her to have done a bit more of a number on me*  
*\*laughs\* ...but I mean, my mood over the course of a session could change, I could be more het up at the start and then working through it and relaxing as it goes on”*

In this excerpt, as with other participants’ experiences, Luke acknowledges that his therapist is testing his ability to think about difficult scenarios that were initially stressful for him. However the exploration and guidance through formulation-sharing allowed him a structure in which this could be resolved.

A further aspect of how participants began to view key relationships in their life was in terms of the potential for support. Often a source of anxiety and conflict, participants began to view relationships as a resource for sharing difficulties and getting help. These supportive connections also allowed them to challenge beliefs that people have fixed and unhelpful ways of responding to their difficulties. Here Chris talks about recognising the void that existed when his brother left and how filling the void with exercise did not help:

*Chris: “I think Sarah was right again, I think, there was an intensity in my lifestyle which started to build after John went away, because he was living with me for a while, and we had a fantastic time together, my brother and I, but after he left I felt like I need something to fill the void, I mean, really started to work out hard, which you have to do to a certain extent but I took it way too far, way, way too far, to the cost of other things, and yeah, there was an intensity to that and I did become a bit imbalanced almost immediately after he went away and it just built from there, there’s certainly a correlation there... when talking with*

*Sarah there I realised I need to be close to my family, I don't constantly need to be around them but I certainly need to have them within touching distance...I sort of need them to be more involved in my life than not be"*

### *Future self*

Participants spoke of how they began to develop a view of themselves in the future as a result of formulation-sharing. This was highlighted as being something that stemmed from realising they could develop skills that would allow them to cope with difficulties more effectively. In this excerpt Paul highlights how formulation-sharing helped him to develop ways of tackling rumination. This in turn helped to promote a sense of self-agency in his social interactions:

*Paul: "when I was working, I was making machines, and because it is repetitive I think that's when I started working on my ruminating... I think before that, my mind was going....like, every time I started doing a new panel it was like I sort of 'reset' to the beginning of my thoughts again and started going round and round...and erm, by the time we got to the end of the panel I'd be almost crying or be really angry... yeah a negative emotion, I was either upset or anger ....erm, and after, when I'd been learning about ruminating, I'd be like, 'okay, let's take a break from it' and I'd get up and I'd walk around the room or walk off to the toilet, go and get some water or something, just to break down the process a bit, so distract myself erm, I think though, using that in a social situation, I would just have to snap myself out of it... just be like, 'just focus on the group thing, what's going on' ...try and stop being inside my head and try to be with everyone else"*

This highlighted the idea that formulation-sharing can lead to simple cognitive restructuring for the participant. A further element of future planning that participants spoke of was their improved ability in setting goals for themselves. The formulation-sharing process itself appeared to have direction and purpose which carried over into the participants' view of their life. Chris reflected on feeling positive, both during and after his interaction with his therapist, and how this translated into goal-setting behaviour:

*Chris: “I think it’s helped me come up with a plan, erm, or to plan. I think it’s helped me look at things in a more positive manner, erm, yeah, and ultimately I did feel better after the sessions, almost instantly and when I put in to practice the things we talked about erm, from the planning side of things, that feels good, it feels like you’re achieving something...yeah it just feels good ultimately, on both fronts, feels good in the immediate afterwards, and then working on things afterwards...erm, just as simple as it sounds, going to the gym and planning to do exercise and , talking that through and deciding to do it and to commit to that, that has been hugely beneficial, erm, it was, it seemed liked an obvious solution but talking it through and truly realising it was something I needed in my life...yeah talking that through and having this re-affirmed, just, Sarah helped me, the way that we talked it through, she helped me to push myself to initially start exercising and you know, the endorphin kick that I get has helped tremendously me to combat the depression, that’s been huge I’d say”*

Participants indicated throughout the interviews that the sharing of formulations led to increased engagement, both internally (e.g. developing an awareness and re-structuring thought processes), or externally (e.g. by taking part in activities or being around others). This engagement led to participants monitoring and re-evaluating their progress in a cyclical manner. Luke referred to this when he talked about his progress on tackling black-and-white thinking styles, such as categorising himself and others, at classes he attended in a local community centre:

*Luke: “that was an area that she looked at quite a lot, and was mentioned in the report that Zoe sent me, is my own sense of identity, and how I perceive myself, and how I perceive I’m perceived...it’s a testament to Zoe’s skill to speak of your positive aspects and to get you to look your expectations again, and to look at how you view your own self.....it must be quite frustrating for Zoe if someone does display a modicum of potential and think ‘come on, you can really have quite a nice life if you apply yourself’, to think your way out of this little box you got yourself into”*



The idea that future planning was an important result of formulation-sharing was also noticed by those close to participants:

*Chris: “certainly my parents would just see that I felt ok about things basically, perhaps a bit accepting of the situation, have bit more of positive outlook, you know, I certainly came up with a bit of planning and talk about the future a little and I think I’d feel a bit more comfortable with it”*

#### *Active collaboration*

Participants said that their experience of formulation-sharing was like a dynamic-shift from being a passive recipient of therapy, towards being an active agent in the therapeutic process, in which their influence needed to be felt. Shared content from formulation-sharing became something to discuss, analyse and generally engage with. How participants’ content was attended to was experienced as being a means towards achieving a specific purpose. Often for participants this meant bringing things to the surface that they were already aware of but not acknowledging, as Chris talks about here:

*Chris “I think she hit the nail on the head again actually, I think she was just re-affirming something that I perhaps knew deep-down, but in the immediate present I didn’t, and I think she just brought it to the forefront as it were”*

Similarly, participants would often interpret their response to formulation-sharing as avoidance and they felt they were not always contributing anything to the process. Again this was seen as being part of a progression in bringing unconscious themes to the surface so that the content could be discussed and analysed:

*Chris: “I’m not sure if I’m quite listening to Sarah there, I think she’s trying to get through quite a big message there, not that I...I was listening but I didn’t seem to respond there, I think I was going off on a tangent...I think Sarah was trying to make quite an important point there about attachment and being away from home....perhaps I’m not being quite being as accepting as I could’ve been there, but yeah there’s still the start of an exchange going on”*

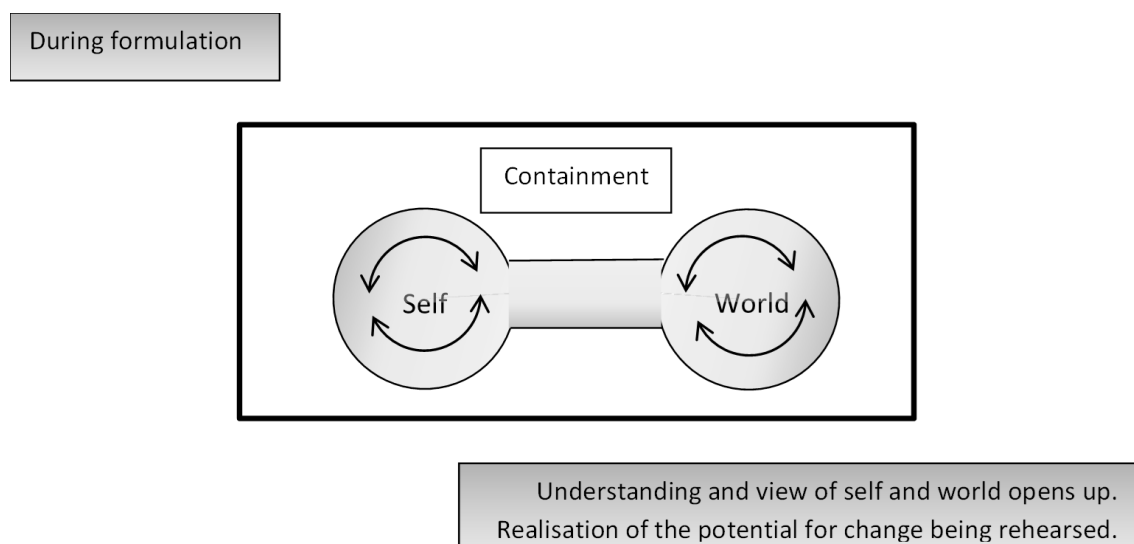
*Paul: “I don't know, I think I just got a better understanding of the jargon but was feeling like I was just feigning it to start with... I knew what she was talking about ...and it makes perfect sense now.. \*laughs\* it was like I didn't want to be an annoyance to her or something, then I saw that's not the best way to go about it”*

This was an important for participants to experience. Without this development of an awareness that the details of their lives was something to talk about and engage with, they may have continued to hold a rigid view of themselves and others. In this excerpt Luke talks about how the formulation he heard needed to be adapted:

*Luke: “when someone is giving you notes about your life it can be a hindrance...but then you create something between each other, which is important, it's not one agent affecting another, it's a joint thing”*

This ability to begin collaboration in an equitable way was important for participants in feeling like they could move towards meaningful action in their lives. Figure 7 below illustrates the shifting dynamic that participants described in relation to their internal and external worlds.

*Figure 7 – View of self and world during formulation-sharing experiences*



### 3.2.3 - Stage 3 – Rehearsal and feedback

#### *Feeling connected*

Participants noticed that as formulation-sharing progressed they became more aware of how they were beginning to connect with the outside world. They noted that a key aspect of this was that the individualistic nature of formulation-sharing was enhanced by their clinical psychologist's ability to link it with a broader world-view. These two excerpts provide a contrast of how participants began connecting with the world through formulation-sharing, and the clinical psychologists' role with this:

*Paul: "I think I just took security in being alone, you know, this is my little world, my bubble and nothing can hurt it, no one is around to contaminate it"*

*Luke: "I got the impression with Zoe that even if she wasn't a psychologist, she would be somebody that would have erm, quite a rounded worldview, and erm, would probably be quite erm, intelligent and humane in whatever it, if her life were different and she, she did something else for living, she would be very good at it...I think she has erm... a worldly intelligence. When people say worldly, I suppose I'm not entirely sure what they mean, I suppose I, I use the word.. worldly instead of wise, but I suppose it's..erm... an understanding of the workings of the world that's not necessarily a mechanistic understanding, it's to some extent, erm... I use that word again, I think that she had a visceral quality"*

Participants began to notice that this would have clear impact on their personal relationships with people. It also gave them an ability to interact with broader systems in their life, such as healthcare support or community projects. Here Chris and Paul talk about how close friendships began to improve:

*Chris: "well the interesting thing is, I think my relationship with her ironically got better, because it seemed my energy, the energy that I had or the energy that was building, she seemed to enjoy that"*

*Paul: “I hardly talked any of my friends before being in hospital.....but now I’m completely fine with being around them and their children....my friend said that he’d rather trust me with his baby than some other people, and said to someone, ‘just cos he’s got mental health problems doesn’t mean there’s gonna be a danger’ ...it’s probably a thing from the media as well, that people with mental health problems are dangerous”*

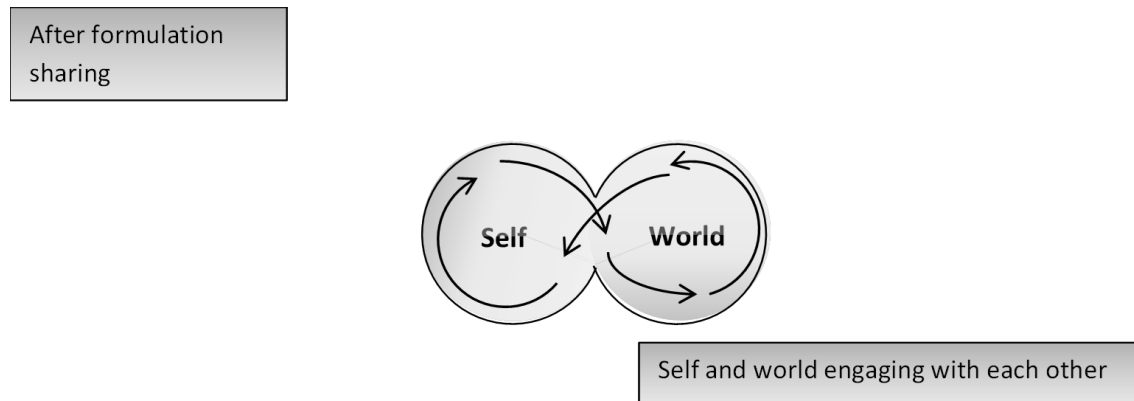
This latter example demonstrated the ability that formulation-sharing had in allowing participants to understand how mental health difficulties are often a construction that filters down into individuals’ beliefs. That formulation-sharing was able to challenge and contextualise such constructions was felt as being a positive way forward in connecting with others. This final excerpt underlies the importance that participants placed on feeling connected to their world rather than being isolated from it:

*Luke “obviously from a patient’s point of view I don’t want to go into hospital I don’t want to go in on an order section I don’t want to have my freedom constrained I’d rather be supported in the community and get through a rough patch... I mean from my experiences with Zoe from the things that she said to me she knows that I have hang-ups about my diagnosis, my illness, what I reveal to people, what I don’t reveal people....she mentioned that my sense of identity and how I perceive myself is important and using this allowed me to volunteer at the community centre”*

### *3.3 - Summary of findings*

Participants described a journey through therapy where formulation-sharing acted as an agent towards greater connectedness with their internal thoughts and feelings which impacted on their actions. By testing these out, firstly through collaboration in therapy, and secondly in the ‘real’ world, participants became more connected with their world and did so in a more empowered manner. Figure 8 (page 61) provides an illustration of this final step in the transition towards a sense of self-in-the-world.

*Figure 8 – View of self and world after formulation-sharing experiences*



#### 4 - Discussion

The present study aimed to investigate how participants experienced the process of formulation-sharing with clinical psychologists in one-to-one therapy sessions. This discussion evaluates the findings by looking at where it fits with existing psychological theory, where it confirms or differs from previous research on formulation-sharing, what the implications for clinical practice might be and the limitations to the research process. Three key areas are explored that may be important for the future direction of clinical psychology work with patients: (i) pre-conditions to formulation-sharing (ii) variables that inform formulation and impact on therapy and (iii) how participants integrate formulation-sharing into their daily lifestyle.

##### *4.1 - Pre-conditions to formulation-sharing*

Findings suggest that before formulation-sharing can occur in a meaningful way it is necessary for participants to feel a sense of containment. In this respect containment was influenced by two factors: the setting in which formulation-sharing takes place and participants' perception of the therapist. The former was in keeping with research about how the immediate, physical environment is perceived to be beneficial when time and space afforded to explore complex difficulties (Hazler, 2001). This kind of availability improves a sense of self-esteem by enabling safe exploration of various problems (Johnstone & Dallos, 2014).

In this respect participants gained an ability to work in the ‘here-and-now’ and remove the distraction of past or future thinking-styles. In ward settings, for example, participants often talked through their difficulties with other mental health professionals yet a sense of containment was not felt, making meaningful progress difficult. Consequently, the perception of clinical psychologists was deemed to be an important part of the containment they felt. Participants noted that they had often been offered interpretations about their difficulties from friends, family and other health professionals. However, these tended to have limited impact on their sense of well-being or worse, aggravated their distress. It may be that, in line with other findings, such interpretations are often saddled with additional worries, for example, a diagnosis or risk assessment (Mohtashemi, 2014). As such participants felt a sense of relief and unburdening just by virtue of receiving a one-to-one, therapeutic service that was not seen as having any other agenda attached to it.

In addition to this, the introduction of a perceived specialist service appeared to facilitate an easier transition towards a broader therapeutic alliance, something which has clear links with improved outcomes for patients generally (Lambert & Barley, 2001). This was developed through the understanding that clinical psychologists were clear about their role and how they would work towards a clear set of standards and boundaries. This included outlining which aspects of formulation-sharing might be important to consider. This fits in line with guidance that encourages clinical psychologists to think clearly about how formulations may impact on individual patients as well as wider systemic and organisational aspects of their life (British Psychological Society, 2011). As a consequence participants’ focus was guided towards a shared sense of collaboration with the formulation-sharing processes.

The experience highlighted here is one in which participants identified containment as a precursor to helpful formulation-sharing rather than, as some research suggest, being a consequence of it (British Psychological Society, 2011). The sense of containment as described by participants is one that continued throughout, and after, their sessions. Rather than the containing process feeling like it was being ‘done’ to them however, it was one which stemmed from open-dialogue and collaboration, which is essential for any therapeutic progress (Finlay, 2016). This helped pave the way for a more intensive exploration of any difficulties participants were experiencing.

This pre-condition stage of the formulation-sharing process allowed participants to filter out the multitude of external and internal factors which would have prevented them from moving towards meaningful formulation-sharing. Containment for participants may be seen as being experienced as being the beginning of a process of analytic-holding (Casement, 1985).

#### *4.2 - Factors that inform formulation*

One of the most challenging aspects in accounting for the impact of formulation has been determining whether or not the way patients experience formulation-sharing is a direct result of the process, as opposed to any other variables, such as therapeutic alliance or model of therapy (Johnstone, 2011). The findings in the present study suggest that our understanding of formulation as a single, distinct object or concept may need to be developed. Participants indicated that therapeutic progress was facilitated by several interacting factors which informed and defined the experience of formulation-sharing for them.

This concurs with previous research which suggests that the process of change in therapy is experienced gradually, in a variety of different ways which progressively come together to make things better (Carey *et al.*, 2007). What was added here is the participants' awareness in experiencing a specific element of therapy, formulation-sharing, as being the mechanism that drives this change. That this mechanism was made up of various factors was also highlighted by participants. For example, developing discrepancy was a process participants became aware of through their need to confront unhelpful thoughts, behaviours or situations and evoke change. The idea that an internal schism within participants allowed them to set alternative goals is well documented within research on motivational interviewing (Miller & Rose, 2009) and appeared to be an important aspect here. Such explorations may have been difficult for participants had it not been for their ability to develop and strengthen their sense of resilience. They spoke about resilience in a number of different ways, such as being able to sit with difficult emotions in the room or identify potential networks of support in their life. The notion of resilience to tolerate emotional distress and integrate this into daily life is also understood as being an important step forward to self-actualisation (Richardson, 2002).

If these factors can be understood as creating movement for participants then the ideas they expressed about hope might be understood as giving that movement direction. Participants were able to identify that through formulation-sharing they started to think about what they would like for the future and how to make plans to achieve this. In some aspects this would involve relatively simple tasks, such as going to the gym regularly, or more complex ones, like confronting a close relative with a long-standing grievance. However, the shared aspect that formulation-sharing gave them was an associated feeling of hope. Research into hope as a function of the therapeutic process suggests that it is more than just a feeling of optimistic advice-giving and that it requires clear aims and plans to be of full benefit (Snyder *et al.*, 2000). In this respect the value of formulation-sharing in a clinical setting appears to become evident. The explorative nature, in conjunction with a sense of direction, gives participants permission to do likewise in making sense of their situation. So rather than being advice-driven, (e.g. “you should do...”), formulation-sharing has a more curious stance (e.g. “how do you think you would cope if...”). Such enquiries move participants to think of alternative ways of being in the world whilst giving them confidence to do so, a type of approach that promotes a level of commitment from participants.

The experience of negotiating meaning was something participants learned through formulation-sharing, though this was not always consciously so. Indeed participants noted on several occasions that they did not always respond to psychologists’ formulations or, if they did, it was just to confirm things they had always felt to be ‘true’. Such passivity however was not borne out in closer analysis of the original therapy sessions. When participants were interviewed further about this it seemed that there was a modicum of modesty in accepting their role in the formulation-sharing process. This is understandable as negotiating meaning in therapy is a highly complex process that can feel uneasy at times (Safran, 1993). However, participants’ ability to negotiate and collaborate in the process was evidently a necessary step in adding a nuanced level of context to formulation-sharing. Again research indicates that in terms of responding well to therapy this dynamic of developing a shared understanding makes for a more meaningful progress (Stiles *et al.*, 1998). Such progress was felt by participants on an individual and systemic level. The interaction between these two



states, individual and systemic, encouraged a sense of becoming ‘unstuck’ that allowed them to engage in therapy, and consequently in daily life, in a more positive way.

#### *4.3 – Integrating formulation-sharing*

One area highlighted by all participants was their sense that they could not specifically identify where or when positive change in their life occurred. All expressed that it was only upon listening to the audio recordings of their therapy that it struck them how much they had forgotten their experiences. This might be accounted for by framing the formulation-sharing experience as a learning process. Applying a model of learning would suggest that, throughout formulation-sharing, participants will reflect on this during and after therapy and embed their new ideas in their day-to-day life (Kolb, 1984). Though such models have been used to help understand the development of how therapists develop their practice (Feinstein *et al.*, 2015) it may be that this is also reflected in the participants’ journey. It may be, therefore, that they have had so much practice in new cognitions and behaviours since their formulation-sharing experiences that they no longer actively think about how to do it (Flower, 1999).

#### *4.4 - Previous research*

Participants’ experience of formulation-sharing in the present study appears to have some parallels with previous research into how formulation is used. Weiste and Peräkylä (2013) for example highlighted that psychologists helped patients to develop discrepancies by using ‘rephrasing formulations’ and ‘exaggerating formulations’. Though the process of developing discrepancies was described differently in the present study it did appear to be an important part of making progress in therapy. Past studies have also indicated that the process of formulation-sharing can give rise to both positive and negative emotions and cognitions (Chadwick *et al.*, 2003). In the present study participants also alluded to this, pointing out that though it felt like an empowering and productive experience, it also meant having to confront difficult things about themselves and others. The difference in the present study was that aversive experiences were viewed as being a conduit towards positive progress. This may account for mixed findings which suggest patients have positive and negative reactions to formulation-sharing (Pain *et al.*, 2008) and that looking at the function, rather than the description, of such reactions may be more meaningful.

In the present study it was difficult to account for what evidenced an improvement in participants' lives. Throughout they spoke of many things which suggested a positive change, such as improved relationships, a greater sense of agency or an improved locus of control. However these factors were not measured or controlled for and it may be that future studies attempt to define outcomes in a much broader manner. This may explain why previous research has found it difficult to determine if formulation improves outcomes or not (Chadwick *et al.*, 2003; Gladwin & Evangeli, 2013; Pain *et al.*, 2008; Persons *et al.*, 2006) and how we decide to measure this in the future may require a greater level of participant validation.

#### *4.5 – Clinical implications*

The findings from the present study suggest that further examination of formulation-sharing could be carried out in order to determine what delineates it from other therapeutic factors. Currently the use of formulation-sharing remains under debate, both in terms of its validity and reliability in impacting positive outcomes for patients (Lane & Corrie, 2006). It may be possible therefore to strengthen the use of formulation as valid and reliable alternative to tackling mental health difficulties. One of the ways this may be achieved is through regular recording of therapy sessions and follow-up interviews with patients to get their feedback on how formulations impacted on them. It may also be possible to assess such feedback qualitatively in order to design questionnaires or templates that assess the impact of formulation-sharing on patient outcomes. Though a move towards a standardised approach may seem to be at odds with the flexible and individualistic nature of formulations, it was apparent that participants attributed positive progress in their life to therapy, but at times found it difficult to articulate why this was. Helping patients and clinical psychologists account for such interventions could empower the position of both.

The present study also highlighted the importance of clinical psychologists' ability to respond to ongoing changes at individual and systemic levels. A significant part of what participants' alluded to was the significance of formulation-sharing's ability to attend to social, political and wider systemic factors. In this respect the importance of clinical psychologists' ability to operate in a reflective and reflexive way should be supported

within mental health settings. Also, given the importance of wider systemic influences, the use of ethically-informed team formulations may provide the basis for a system that supports one-to-one therapies. This may become increasingly more important at a time where divisions within the mental health system are becoming apparent. For example, the recent publication of the 5<sup>th</sup> edition of The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) has led to a renewed call in challenging the diagnostic and medical models of mental health. However, there is a risk that such debate leads to a misunderstanding of many clinical psychologists' motives who may seek only to balance out reductionist approaches to patients' difficulties. The promotion of team formulation in this respect could help allay such concerns by simultaneously allowing for idiosyncratic understandings of patients difficulties whilst keeping them, and clinical psychology, connected to wider support systems.

#### *4.6 – Limitations*

In terms of recruitment there were two aspects to consider, recruitment in the associated study and how this impacted on the present study. In the former, four clinical psychologists were recruited from NHS mental health services. Though there were more who wanted to participate they were unable to gain consent from any other patients. Aside from this limiting the number of participants available, it could also be argued that participants who did consent would present a different perspective in therapy and on the therapeutic process generally. Often patients can present with various levels of engagement which may result in varying approaches to formulation-sharing becoming apparent. In the present study it appeared that the dynamic was not problematic and was collaborative in tone. However analysis of therapy with patients who were more resistant might have provided a different type of data-set and analytic result. Also, as participants were effectively pre-determined this, not only limited the number of participants, but also a range of important demographic variables, especially gender, age and ethnicity. Given the limited range of data sampling it would be difficult to draw any firm conclusions or generalisations from the findings and as noted theoretical saturation was not achieved in the present study.

Though it was agreed that sessions would be carried out in the usual and naturalistic manner, it may be argued that the introduction of audio recording could create an observer effect in which participants modify their responses due the awareness of being observed. In relation to this, the selection of sessions supplied to the researchers was solely at the clinical psychologists' discretion. However, the selection of the formulation-sharing excerpts was done collaboratively between the associate researchers which ensured some level of independent selection in the procedure. A further limitation was the setting in which formulation took place. Interaction was on a one-to-one basis, with clinical psychologists' own theoretical orientation not controlled for. It may be that any conclusions presented here would need adopted if formulation-sharing occurred within a group or team session or if theoretical positions were different. The stage of therapy that participants were at was also not controlled for so their response to formulation-sharing may have been different dependent on what stage of recovery they were at.

The use of a structured recall method through use of audio recordings also raised some issues when considering the findings of the present study. One of the main criticisms of using this type of approach is that it may contaminate the very area of research we are interested in. So it may be that whilst discussing significant therapeutic points with patients, such as formulation-sharing, we unduly affect our area of study as the patient begins to process thoughts and feelings in a way that they did not do at the time of therapy. Balancing this by asking participants un-prompted questions about therapy before playing audio excerpts addressed this issue to some degree, as did the use of clarifying question styles after excerpts were played.

#### *4.7 - Conclusion*

Formulation-sharing was experienced as a bringing together of several different factors that encouraged movement, both internally and externally, for participants. This dynamic gave sight to the potential for individual change and conceive of the potential for change in the outside world. This continual process of framing and re-framing of the self and the world was a significant process that participants experienced through formulation-sharing. It gave them an ability to connect and understand their difficulties in a more manageable manner. The process of rehearsing and embedding this new

perspective allowed participants to initiate new ways of thinking and acting and in turn, connect more closely with their social world.

Formulation can be understood as a dynamic process which is a collaborative and reflective piece of work between patients and therapists (Johnstone & Dallos, 2014). Central to this dynamic are a range of negotiations stemming from the therapeutic relationship, where therapists and patients use the emotional and cognitive processing of therapy as a pre-condition towards change and formulation development (Safran & Muran, 2006). In addition to this is the attempt to understand the social and relational context of an individual's world, a theme often present in participants' accounts but not explored in much research. Ensuring that this dynamic process continues, both in the 'here-and-now' of therapy, as well as at a broader, systemic level, is essential in nurturing the possibility of change (Milson & Phillips, 2015) and achieving good outcomes for patients and services.

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### Part 3 – Critical Appraisal

## Critical Appraisal

### *Introduction*

This critical appraisal is based on the research notes and reflective journals kept throughout the project. The appraisal reflects on how I became involved in the project, challenges encountered in developing my own research from an already ongoing study, the process of recruiting and interviewing patients, analysis of the data, developing a model of formulation-sharing and academic supervision.

### *How I became involved in the project*

One of the easier aspects of becoming involved in this project was that key elements of design and data collection were already in place. The associated researcher's study, as described earlier, was already clearly defined and in the process of collecting data for examination. Due to my initial research project being changed at a late stage of my studies I was very grateful to my colleague's generosity in allowing me to collaborate in her study. The process of collaborative research was a new one to me and I learned a number of things from the process. Firstly, I found the process of negotiating with my colleague to be positive and encouraging start to the project. This was pleasing as I had initially had some reservations about how we might find common areas of interest given that our focus would be on different aspects of formulation-sharing. Perhaps it is testament to my colleague's patience and ability to think beyond her own research interests that this part of the study was relatively straightforward. Indeed when I think back on it now I feel that my own research focus was enhanced by having to take into consideration the associated study's aims and objectives. However it was also apparent to me that in terms of co-working I did underestimate how long it would take to complete certain tasks, such as transcription of therapy session data, and that this would have undoubtedly had an impact on my colleague.

Prior to being involved in the research I was finding it very difficult to find a new project after my original research project was changed. When presented with a study that was already underway this seemed like an ideal solution from a practical stance. It was only when I began to write up the project that I realised how challenging it was to explain this, albeit temporary, joint venture. I also noticed that I could be easily

distracted thinking about how my colleague's research was proceeding and how it would fit in with my own project. This required me to remain mindful to my own research goals which I coped with following the grounded theory methodology which gave guidance on staying close to my data (Charmaz, 2014).

### *Recruiting participants and interview*

Though the recruitment of clinical psychologists had already been completed before my input I still had the responsibility of recruiting patients into my own study. In one respect this was straightforward as the element for any decision-making about recruitment around this had been removed. There were four clinical psychologists and four patients and they would agree to the study or not. It is a reflection of my limited scope for complexity at that time that such binary decisions had become appealing to me. Though I could easily justify such an approach I felt that this was indicative of behaviours in other areas of my life where I would take the path of least resistance just to feel a sense of regret later. I was concerned about the limited amount of data I could gather from four patients and my anxieties were increased when one of the patients had to withdraw due to reasons of ill-health. When I was told about this from the clinical psychologist I had no difficulty in removing the patient from the study, and having reflected on this I am confident it was the correct decision. However, I began to wonder if I was becoming resigned to the limitations that came from taking on a piece of research that was already in progress.

It would be remiss not to acknowledge that during this part of the process I had taken the decision to continue my studies part-time while I took time to support family through a difficult period. There was a real sense of loss at this point which significantly lowered my motivation levels. One of the ways that I coped with this was to keep my focus on clinical work, which I enjoyed, and view any potential contact with participants as a reflection of this work ethic. This was helpful to me as over the course of three years I had found clinical work to be a positive, helpful and rewarding process. Thinking about interviewing patients through this kind of lens helped to keep me motivated and engaged with the process. I was however slightly apprehensive about asking patients to review therapy sessions they had taken part in nearly 12-months

prior. To address my anxieties, and any ethical concerns that could have arisen, I liaised with clinical psychologists to act on my behalf in recruiting the patients into the study. The area of research that I enjoyed and felt most comfortable with was interviewing patients despite some of the challenges encountered. I have reflected on this aspect many times in clinical supervision, or in my past role as a social worker, and I feel there is something in the power dynamic between professionals and clients that I find containing. This may be for a number of reasons, but growing up I did find the power differential between school teachers and myself to be quite aversive. Avoiding similar power imbalances is something I think I try to avoid in my practice, more so because it makes me feel at ease, and if it has a similar effect for patients too then that only reinforces the approach I adopt.

One of the first things that I noticed was that participants would often revisit their initial referral difficulties when answering some of my questions. They would speak towards their difficulties in much the same way as you would expect to hear in a therapeutic session. I found this quite a difficult and sensitive area to negotiate. On one hand I wanted to acknowledge and remain sensitive to the details of participants' lives, and on the other hand I did not want to stray too far from the experience of the formulation-sharing aspect itself. The use of a semi-structured interview guide helped me to strike this balance, as did taking on a clinical practitioner mind-set. It helped me to maintain a stance of curiosity about the experience of the formulation-sharing process for participants rather than becoming too drawn in to focus on their past difficulties. A further challenge that I became aware in each interview was the sense of vagueness in participant responses. For example, it was not unusual for first responses to open questions such as, "*how did you feel about that?*" to vary along the lines of "*I'm not sure*" or "*I don't know*". Though I expected this on occasion it was difficult not to ask leading questions in an attempt to produce more in-depth responses, especially with the relatively short time we had together.

I found one of the most pleasing aspects of interviewing participants was their genuine approval of the therapeutic process. Though acknowledging and appreciating the feedback given to the profession, I also wanted to stay boundaried. This was particularly important when such appraisal was accompanied with criticism for other

aspects of the NHS. For example, one participant spoke about how unhelpful it had been to only get medication and nothing else and I was very conscious of the allegiance I felt towards him at this point. I knew that if I engaged with this too deeply the conversation may have been a lengthy one, taking in critical detours of the world of psychiatry or medical-models of mental health, which would have taken away from the focus of our interview topic.

### *Analysing the data*

To aid with analysis of the interview data I decided to transcribe the interviews myself. I found this task to be extremely challenging for a number of reasons. The main difficulty I faced was my slow typing-speed. Initially this appeared to be a trivial issue and one that could be accommodated through time management. However, as the process of transcribing progressed, I noticed that my constant rewinding and reviewing of the audio meant that I was being exposed to the same data over and over again. Therefore, even before my analysis had started I was becoming very familiar with certain aspects of participants' lives. I had wanted to avoid this as during interview I had observed that I related to some aspects of participants accounts more than others and that it may have influenced my interview style. Similarly, during the transcription I did not want to let this bias my interpretation of the data. Keeping reflective journals aided this process to some degree but the most useful aspect of the data analysis was line-coding the transcripts. As line-coding involved looking at short, discrete aspects of the transcript it kept me close to the data with little scope for over-interpretation (Saldana, 2013).

Moving beyond line-coding had initially proved to be quite an enjoyable process, often identifying emergent categories and themes was much like a 'lightbulb' moment, as if I had realised the answer to a particularly tough crossword clue. Generally however, I found the whole process to be very difficult to keep track of. Though I tried numerous techniques to cope with this, I found that the only way to get through the analysis was to just keep going at it, one bit of data at a time. At times I fell in to traps of becoming too descriptive with the data, writing down things that were quite literally, word-for-word what participants had said. I linked this lack of an analytical lens to feeling overwhelmed with the seemingly infinite amount of variation that could be interpreted

from the interview. One way that I coped with this was to remind myself of the possibility of finding something new about formulation and reflect on the positive way that participants had taken part in the study.

### *Developing a model of formulation-sharing*

The process of developing a model of formulation-sharing felt to me like a very reductive piece of work. My first diagrams took up two pages of A4 and I initially believed that this was the best representation of the participants' experiences. This is where I found supervision to be a very useful process. Much like my clinical work I have a tendency to try and include as much information about patients' lives as I can, feeling it would be invalidating not too. I was thankful for the feedback that suggested my initial model was too complicated, but I still felt compelled to include the removed elements elsewhere in the research to offer extra contextual information.

Reflecting back on the proposed model that suggests formulation-sharing is experienced as a tool that promotes a sense of self-in-the-world, I do wonder if this was influenced by my own background as a social worker. I had spent several years where my main focus was to try and empower and support people on the margins of society and to derive a model that alluded to this principle was an interesting revelation to me. It resonated with me however that the concepts of 'self' and 'world' can be very flexible terms to use. In terms of individuals' personality, history, language, morality, culture or any other aspect of their identity, the model appeared to be able to adapt to this. As such I was pleased that with further work it may have the beginnings of a new way to understand patient outcomes and the formulation-sharing process. There was certainly a bit of a rebellious nature to this as I had recently taken against many aspects of the newly published DSM-V. Though I never 'saw' anything in the data that encouraged me to think that patients prefer reductionist approaches, I am also aware that I never pursued this line of enquiry either. However I also did not pursue other lines of enquiry that might have produced a broader understanding of the formulation-sharing process, such as team-formulations for example. Though I was able to justify this to myself by referring to the limitations in time and scope of my research, I feel on reflection that the containment I referred to earlier when working one-to-one with patients might have closed off certain lines of enquiry in the moment of interview.



### *Academic supervision*

Reflecting on my experience of the research process is a difficult experience for me. I have read over many of the reflective journals I kept during this process and they suggest to me that it was a stressful and unhappy journey for many reasons. At certain points in the research I would have given up and offered to do this at one stage. Had I not been given a lot of support from staff on placement and at university I am sure this would have happened. My relationship to supervision generally is an anxiety-provoking one. I feel that this is something that I have done very well to disguise in my various roles over the years but I could not avoid so easily here. I was very fortunate to have a supervisor that I could talk through these difficulties with quite easily, but during the whole research process I continued to be very avoidant of that dynamic. The irony of trying to disassociate myself from supervision, whilst writing about similar accounts from the participants, was not lost on me. However, I was very grateful for the understanding that was shown to me from my supervisor and I feel that from the whole process I now have some additional areas to work on to better understand and improve this part of my approach to any future work.

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## Appendix A - Search terms used for initial scoping search

1	Formulation (searched in Title)
2	Psycholog* OR *therap* (searched in Title, Abstract, Keywords, Topic)
3	Patient OR client OR participant OR individual (searched in Title, Abstract, Keywords, Topic)
4	Impact OR experience OR outcome* (searched in Title, Abstract, Keywords, Topic)

PSYCInfo consulted for English peer reviewed journals and dissertation abstracts, 1993-2014, Adults (18 years and over).

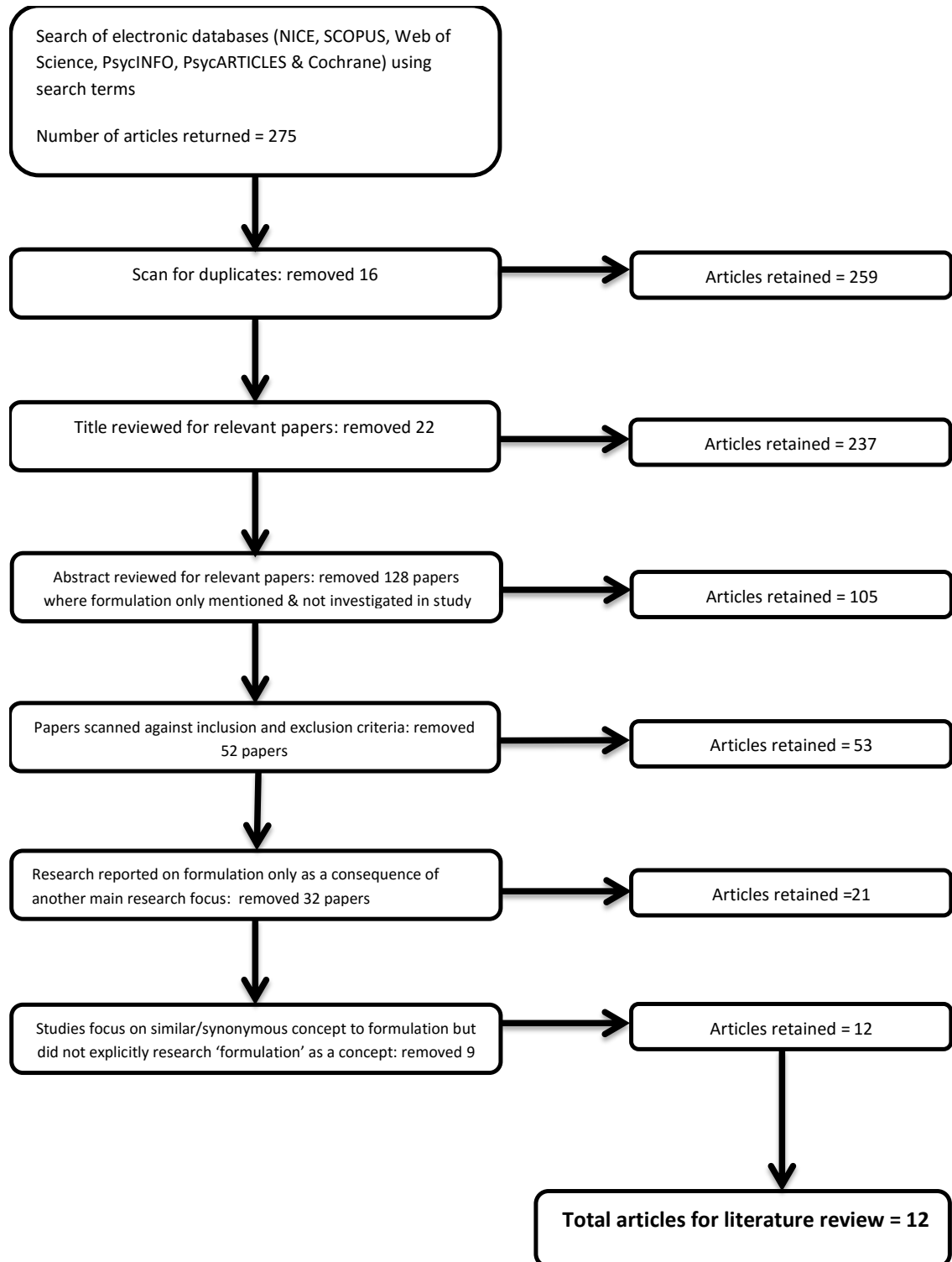
## Appendix B - Literature search terms and databases

Database	Search Terms
PsycINFO	(case formulation OR clinical formulation OR psychological formulation OR reformulation) AND (Impact OR experience OR outcome) AND (Patient OR client OR participant OR individual OR service user)
Scopus	(case formulation OR clinical formulation OR psychological formulation OR reformulation) AND (Impact OR experience OR outcome) AND (Patient OR client OR participant OR individual OR service user)
Web of Science	("case formulation" OR "clinical formulation" OR "psychological formulation" OR reformulation) AND Topic=(Impact OR experience OR outcome) AND Topic=(Patient OR client OR participant OR individual OR service user)
NICE Healthcare Database	(case formulation OR clinical formulation OR psychological formulation OR reformulation) AND (Impact OR experience OR outcome) AND (Patient OR client OR participant OR individual OR service user) in Title and Abstract

## Appendix C - Data extraction pro-forma

Title	
Authors	
Publication Date	Volume, pages
Aims	
Hypotheses	
Design/ methodology/ Data collection method	
Variables measured	
Participants	
Definition of Formulation	
Model	
Context/ setting	
Analysis	
Findings	
Conclusions	
Clinical Impact	
Limitations	
Included in review?	

## Appendix D - Search procedure for literature review



## Appendix E - Summary of articles included in literature review

<b>Paper Number (Type of study)</b>	<b>Authors, Publication date</b>	<b>Title</b>	<b>Aims</b>	<b>Formulation process</b>	<b>Sample</b>	<b>Model of therapy</b>	<b>Findings</b>
1 (Mixed-method)	Chadwick, P., Williams, C., & Mackenzie, J. (2003).	Impact of case formulation in cognitive behaviour therapy for psychosis.	Assess the impact of CF on (i) therapeutic relationship and (ii) levels of distress, distressing secondary delusions & negative self-beliefs for patients with psychosis.	2 sessions devoted to exploring and refining CF which was comprised of a developmental diagram & accompanying letter. End of 1 <sup>st</sup> session client took CF home for refinement & completed in 2 <sup>nd</sup> session. Timing of CFs was naturalistic with CPs formulating when they normally would with clients.	13 patients with diagnosis of psychosis (6 women, 7 men, mean age=31.5) 2 CBT therapists with 6 & 15 years' experience in field of psychosis & specialist trainee clinical psychologists	Cognitive behavioural	Case formulation had little or no impact on variables. Descriptive data from patients and therapists suggested other benefits beyond these measures.
2 (Qualitative)	Christofides, S., Johnstone, L., & Musa, M. (2012)	'Chipping in': Clinical psychologists' descriptions of their use of formulation in multidisciplinary team working.	To investigate the use of psychological formulation in MDT settings.	Predominately through team meeting settings and 'chipping-in' ideas once clinical psychology role within the team was felt to be 'developed'.	10 clinical psychologists (6 female, 4 male) qualified from 1-11 years (mean=5), working in a range of services between 1-10 years (mean=3).	Integrative - various models used: cognitive-behavioural, schema-focussed, systemic, social, recovery-model, narrative, attachment & psychodynamic.	Formulation-sharing more likely to be shared by clinical psychologists through informal team discussions as opposed to formal & designated settings. Staff experience & service context impacts on how explicitly team-formulation occurs and that formulation-sharing improved clinical services overall.
3 (Quantitative)	Eells, T. D., Lombart, K. G., Kendjelic, E. M., Turner, L. C., & Lucas, C. P. (2005)	The quality of psychotherapy case formulations: A comparison of expert, experienced, and novice cognitive-behavioural and psychodynamic therapists.	Assess the quality of case formulations of expert, experienced and novice therapists.	Participants listened to an audio-recording of a case vignette and took notes. They were then given 5 minutes to 'think aloud' their conceptualisation of the case and construct a formulation. They were then given a further 2 minutes to 'think aloud' a treatment plan.	65 therapists made up of: 24 clinical psychology trainees (11 psychodynamically oriented, 13 cognitive-behaviourally oriented); 19 therapists with 10+ years' experience (11 psychodynamic, 8 cognitive-behavioural); 22 formulation-specialist therapists (11 psychodynamic, 11 CB)	Cognitive behavioural Psychodynamic	Formulations from experts were assessed to be more comprehensive, complex, elaborated and systemic. Other formulations were as coherent as experts. Overall ratings of quality effect sizes ranged from medium-to-large.
4 (Mixed-method)	Evans, J. & Parry, G. (1996).	The impact of reformulation in cognitive-analytic therapy with difficult-to-help clients.	Evaluate the short-term impact of formulation on client's perception of (i) helpfulness, (ii) therapeutic alliance & (iii) individual problems.	Patients completed measures before therapy & after 5 sessions presented with a reformulation. Measures were re-administered.	15 adult females with a mean age of 22.2 years (range 19-35)	Cognitive analytic	No change in symptom reduction, therapeutic alliance or helpfulness observed after reformulation.
5 (Quantitative)	Gladwin, A. M. & Evangeli, M. (2013).	Shared written case formulations and weight change in outpatient therapy for anorexia nervosa: A naturalistic single case series.	Examine the relationship between the delivery of written shared case formulations and weight change in anorexia nervosa patients.	Case notes were reviewed for evidence of a written case-formulation being reported and shared with patients.	15 female patients with diagnosis of anorexia nervosa; Age 19-35;	Cognitive analytic	Some evidence to support an association in weight change with delivery of written case formulation in individual cases. Higher quality case formulation related to no changes.
6 (Quantitative)	Groenier, M., Pieters, J.M., Witteman, C.L.M. & Lehman, S.R.S. (2014)	The effect of client case complexity on clinical decision	(i) Test if more complex client difficulties, influences the quality of	2 vignettes were presented to participants in standard psychological report format and they were asked to describe in their	211 psychologists (67% female, 33% male), average age 45 years, average experience 16.1 years,	Cognitive behavioural Cognitive Psychodynamic	Case formulations were of higher quality for less complex problems &

		making.	case formulation and (ii) to what extent case formulations explain treatment decisions for complex and simple problems.	own words how they thought the clients' problems came about.	working with clients on average 18.5 hours a week. Theoretical background in cognitive-behavioural (35%), eclectic (31%), cognitive (14%), psychodynamic (9%), solution-focussed (5%), system-theoretical (1%), humanistic (2%).	Solution-focussed System-theoretical Humanistic Eclectic	treatment plans more likely to be aligned with reported symptoms rather than being based on formulations.
7 (Quantitative)	Kuyken, W., Fothergill, C. D., Musa, M., & Chadwick, P. (2005).	The reliability and quality of cognitive case formulation.	Assess whether mental health practitioners with different levels of experience could produce reliable formulations using a standardised approach.	Participants were provided with an assessment summary of a patient and received training in the CCD formulation method. Participants completed a provisional formulation diagram using the CCD method.	115 mental health practitioners (35 clinical psychologists; 29 pre-qualified students; 19 psychiatric nurse; 14 counsellors; 6 cognitive-behavioural therapists; 6 psychotherapists; 2 occupational therapists; 1 counselling psychologist; 1 psychiatrist; 1 teacher). Professionals had average of 7 years post qualified experience.	Cognitive-behavioural	Participants able to produce similar formulations based on descriptive measures but agreement decreased when measured on theory-driven aspects of formulation. Quality of formulations ranged from very poor to good. Reliability & quality of formulation associated with levels of experience.
8 (Quantitative)	Ng, R. M. K., & Cheung, M. S. M. (2007).	Supervision of cognitive behavioural therapy for psychosis: A Hong Kong experience.	Assess if trainee therapists, provided with didactic learning and supervision, can produce satisfactory case formulations for patients with psychosis.	Participants were presented with 2 case vignettes and asked to prepare a cognitive-behavioural formulation after taking part in a training programme.	12 experienced care support workers (8 females, 4 males) in services which provided secondary support (housing, employment, community outreach, workshops) for clients with mental health difficulties. 11 were social workers & 1 a nurse. Mean age 38.7 years.	Cognitive-behavioural	Trainees were able to produce a satisfactory quality case formulation after training and supervision.
9 (Qualitative)	Pain, C. M., Chadwick, P., & Abba, N. (2008).	Clients' experience of case formulation in cognitive behaviour therapy for psychosis.	Explore patients and therapists' experience of case formulation in CBT for psychosis.	Written case formulation was shared with patients over two sessions in a naturalistic manner (i.e. minimal difference to usual clinical practice). The mean number of sessions before formulation-sharing occurred was 10 (range, 5-18). CF facilitated through Beckian developmental diagram and accompanying letter.	13 clients (8 male, 5 female), mean age 32.2 years. Referred to the study if they were experiencing enduring (6+ months) & distressing psychotic experiences. 11 lived independently, 1 in-patient care, 1 in supported accommodation. 2 clinical psychologists with 6 and 16 years' experience in CBT for psychosis.	Cognitive-behavioural	Therapists found that case formulation helped them to increase their understanding of their patients. Patients had varying and opposing cognitive, emotional and behavioural reactions to case formulation.
10 (Quantitative)	Persons, J. B., Roberts, N. A., Zalecki, C. A., & Brechwald, W. A. G. (2006).	Naturalistic outcome of case formulation-driven cognitive-behavior therapy for anxious depressed outpatients.	Demonstrate that case formulation-driven CBT produces significant change in patients with symptoms of anxiety and depression.	Clinicians wrote an individualised case formulation in case records after 3-4 sessions which were used to inform CBT with patients who completed weekly measures of treatment goals. If weekly measures did not improve formulations were revised & new interventions planned.	58 patients (35 female, 23 male), mean age 36.4 years, selected if adequate data was available for symptoms depression/anxiety which had been monitored weekly & patients had taken part in individual therapy.	Cognitive-behavioural	Patients who received case formulation driven therapy reported improved levels of anxiety and depression.
11 (Mixed-method)	Shine, L. & Westacott, M. (2010).	Reformulation in cognitive analytic therapy: effects on the working alliance and the client's perspective on change.	Investigate whether the reformulation process in cognitive analytic therapy has an impact on working alliance, and to explore the client's perspective of the reformulation process.	The Working Alliance Inventory Revised Short-Form and Simplified Personal Questionnaire were given on a weekly basis and the session in which the written reformulation was presented provided a marker. To address the second research question a qualitative approach was used. Template analysis was used to analyse interview transcripts.	5 participants (4 female, 1 male). Age range 22-63.	Cognitive analytic	No significant impact of the reformulation process on a measure of working alliance  Themes in the qualitative data indicated some benefits of reformulation and negative reactions to reformulation.
12 (Qualitative)	Summers, A. (2006).	Psychological formulations in psychiatric care: Staff views on their impact.	To understand the benefits and limitations for using psychological formulation with patients experiencing severe mental health difficulties.	Formulations were written in textual and diagrammatic form and were shared with staff members either through their attendance at regular formulation meetings or by staff reading formulations in case notes or both.	25 staff members (9 nurses, 11 support workers, 2 doctors, 1 occupational therapists, 1 social worker, 1 dram therapist).	Cognitive-behavioural & object-relations approaches.	Participants reported that formulation-sharing benefitted care planning, staff-patient relationships, team working & staff satisfaction.



Appendix F - Quality appraisal table

	1	2	3	4	5	6	7	8	9	10	11	12
Aims and hypothesis clearly stated?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Theoretical and research content provided?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗
Method and design described?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sample described?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bias addressed?	✓	✓	✗	✗	✓	✓	✗	✓	✗	✓	✗	✓
Statistical results reported?	Partially	N/A	✓	✓	✓	✓	Partially	✓	✓	✓	✓	N/A
Reliability and validity addressed?	✓	✗	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓
Aims/hypothesis addressed?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alternative perspectives explored?	✓	✓	✓	✓	✓		✓	✓	✓	✓	✗	✓
Limitations outlined?	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓
Generalisability discussed?	✗	✓	✓	✗	✗	✓	✓	✓	✓	✗	✗	✗

## Appendix G - Information sheet for Clinical Psychologists



### Participant Clinical Psychologist Information Sheet

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**Date:** 11<sup>th</sup> December 2013

**Version Number:** 1

**Chief Investigator:**

Michael Stewart

Trainee Clinical Psychologist

University of Leicester

104 Regent Road

Leicester

LE1 7LT

0116 223 1639

[ml305@le.ac.uk](mailto:ml305@le.ac.uk)

**A grounded theory analysis of patients' experience of formulation-sharing with clinical psychologists.**

As you will be aware psychological formulation is a central part of Clinical Psychology practice. However, research into the use of psychological formulation in practice is sparse (Bieling & Kuyken, 2003; British Psychological Society, 2011). That is, despite the importance placed on formulation in Clinical Psychology, evidence into its use in practice is limited.

This study aims to examine how psychological formulation is used in sessions with patients who have had experienced mental health difficulties. This will involve an analysis of naturalistic data from audio recorded therapy sessions and interviews with patients asking them about their experience of formulation-sharing in therapy.

**What you will be required to do as part of this study**

If you participate in this study, I will be available throughout to support you with this process. You will be asked to identify a suitable patient and gain their consent to (i) have their clinical sessions audio recorded and (ii) be interviewed by myself about their experience of having formulations shared with them in therapy. This will require you discussing the research with the patient. I will provide information sheets and consent forms for patients. I will also meet with you so that we can discuss the research further. The patient's decision to agree to have their

## Appendix G (cont.) - Information sheet for Clinical Psychologists

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sessions recorded will need to be written in their clinical notes. You will be required to ensure the patients meet the inclusion criteria including ensuring ongoing capacity to consent to their sessions being recorded.

I will also provide you with an audio recorder and tapes. You will be asked to record all therapy sessions with the patient and then identify two sessions where psychological formulation is discussed. You will be required to keep the audio recorder and session recordings securely locked at your NHS base.

You will then be sent sections of the transcripts of the two sessions and some of the initial analysis. You will be asked to read this before an interview with the patient is set up. At the interview I will ask the patient about their experience of how formulation was used in the sessions.

I will ask you to be available to talk with the patient before or after my interview with them should they want to. This is to ensure that the patient feels comfortable re-visiting themes from their therapy sessions and has access to additional support if required.

Please be assured that the researcher will in no way be judging or evaluating your clinical practice and is interested and curious to understand how formulation is used in day-to-day practice. The aim is that sessions be as realistic and natural as possible. It is therefore important that you do not feel pressured to do anything differently to your usual practice.

### **Withdrawal from the study**

You are free to withdraw from the study at any time without giving any reason. If you would like to withdraw from the study please contact Michael Stewart.

### **Dissemination**

This research will use verbatim quotations from sessions, interviews and focus groups when written up as a report.

This research is being carried out as a requirement for the Doctorate in Clinical Psychology at the University of Leicester and a copy of the full research thesis will be kept by the University of Leicester. It may also be published in scientific journals and presented at conferences.

If you would like a copy of the summary research report please indicate this on your consent form.

If you would like to participate in this study please contact Michael Stewart.

**Client Information Sheet**

**Date:** 11<sup>th</sup> December, 2013

**Version Number:** 1

**Chief Investigator:**

Michael Stewart  
Trainee Clinical Psychologist  
University of Leicester  
104 Regent Road  
Leicester  
LE1 7LT

0116 223 1639

ml305@le.ac.uk

**A grounded theory analysis of patients' experience of formulation-sharing  
with clinical psychologists.**

The purpose of this information sheet is to provide you with more information about this research. This is so that you have enough information to decide whether you would like to participate.

**About this study**

Psychological formulation is a way of describing a patient's problems and explaining how they develop and are maintained, based on psychological theory (British Psychological Society, 2011). This is an important part of the work of Clinical Psychology (British Psychological Society, 2011) and research into how this is done is valuable for psychologists. One way of studying how psychological ideas are discussed in therapy sessions is to audio record these sessions and then ask patients questions about them.

## Appendix H (cont.) - Information sheet for participants

This study will involve audio recording (using an audio tape recorder) therapy sessions between you and your Clinical Psychologist. I will listen to the recording of the session and will type up what was said. I will then look at what was said to examine how the Clinical Psychologist shares a psychological formulation with you. I will also interview you to ask you about your experience of a formulation being shared with you. These interviews will also be typed up. I will look at the sessions and interviews to identify any themes that explain how formulation has been used and how it you experienced it.

### **What will happen if I agree to participate?**

If you agree to take part, your therapy sessions with your Clinical Psychologist will be audio recorded. If at any time during your therapy you have any questions or concerns about your sessions being recorded, you can speak to your Clinical Psychologist or to me (the Chief Investigator) about this. I will also set up an appointment with you so we can talk about what it was like talking to your Clinical Psychologist about formulations in these sessions.

### **How will the session recordings be kept?**

Your Clinical Psychologist will store the session tape recordings securely on NHS premises and the tapes will not have your name or any personal details written on it. When I talk to you this interview will also be audio recorded.

I will listen to the audio recordings and type up what has been said. I will remove names, as well as other potentially identifiable information that are discussed in the session when I type it up. The University of Leicester will store the anonymous typed up sessions in a locked room for five years, after which they will be destroyed. When I report the results of the research, both verbally in presentations and in written reports, I will not include any actual names.

### **Withdrawal from the study**

You are free to withdraw from the study at any time without giving any reason and this will not affect your medical or psychological care or legal rights. If you

## Appendix H (cont.) - Information sheet for participants

would like to withdraw from the study please contact your Clinical Psychologist who will inform me of this.

### **Reporting of Research**

I will use verbatim quotations from sessions when I write this research up as a report. I am carrying out this research as part of my Doctorate in Clinical Psychology at the University of Leicester. Therefore I will provide a copy of this research to the University of Leicester and they will keep a copy of this. I may also publish this research in scientific journals and present it at conferences.

If you would like a copy of the summary research report please indicate this on your consent form.

### **What to do if you would like to participate**

If you would like to participate in this study please inform your Clinical Psychologist. You will also need to complete a consent form to confirm that you agree to participate.

If you have any concerns or wish to make a complaint, please contact the Patient Advice and Liaison Service (PALS) at Leicestershire Partnership NHS Trust, Ground Floor, Bradgate Mental Health Unit, Groby Road, Glenfield General Hospital, Leicester, LE3 9EJ; Telephone: 0116 225 6647; E-mail: [pals@leicspart.nhs.uk](mailto:pals@leicspart.nhs.uk).

## Appendix I - Consent form for participants



Centre Number:

Study Number:

Patient Identification Number for this trial:

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### CLIENT CONSENT FORM

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Title of Project: A grounded theory analysis of patients' experience of formulation-sharing with clinical psychologists.

Name of Researcher: Michael Stewart

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated 11th December 2013 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical or psychological care or legal rights being affected. ☐
3. I understand that data collected during the study, may be looked at by individuals from the University of Leicester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data. ☐
4. I agree to my clinical therapy sessions being audio recorded and to verbatim quotations from the sessions being used anonymously in reports which may be published in scientific journals. ☐
5. I agree to be interviewed about my recorded clinical therapy sessions and for this interview to be audio recorded. Verbatim quotations from the interviews may be used anonymously in reports which may be published in scientific journals. ☐
6. I agree to take part in the above study. ☐

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Person taking consent.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

please tick this box if you would like a copy of the summary research report.

☐

Appendix J - Semi-structured interview schedule and examples of formulation-sharing extracts

**Introduction to patients to offer re-assurance, clarity of my role (especially in relation to their service and CP)**

e.g. "My name is Michael Stewart and I'm a 3<sup>rd</sup> year Trainee Clinical Psychologist at the University of Leicester and before we begin I wanted to thank you for allowing me to interview you about experiences of therapy with your psychologist (name). Just so you are aware, though I have had contact with your CP to arrange today's interview, I have no direct contact with your service and anything we talk about today will only be around the two therapy sessions that were recorded last year. I will speak with your CP after today just to say we met but we will not talk about the content of our interview which will also be anonymised. Is there anything you would like to ask about before we start?"

**Foundation questions before exploring specific excerpts**

"So it's been about a year since your sessions with CP (Name). What do you remember of that experience?"

"In general what effects did therapy have on your life?"

- follow-up "Can you give me an example of that?";

"Sometimes when people have had therapy there are key moments that stick out for them. Can you tell me about that?"

- follow up "Why does that stick out for you?"

**Excerpt 1 (13:55-16:53) August 2013**

CP: Mmm so I guess in terms of thinking about your vulnerability to paranoia at this stage in your life erm the way in which social isolation might link in with that is that, because of being socially isolated you missed out on opportunities for these feelings of mistrust and abuse or of failure to be rejected or to be balanced out a bit.

P: Ok.

CP: Does that make sense?

P: Yeah.

CP: So I guess I'm thinking erm that there are ways in which having social connections can give us more information or more diverse information.

P: Mmm.

CP: About who we are as a person.

P: Yeah.

CP: Whereas you know your experience of work was highlighting these elements of your sense of yourself but if you were going out and socialising you might have noticed more



## Appendix J (cont.) - Semi-structured interview schedule and examples of formulation-sharing extracts

other elements so you might either have had experiences of achievement or of being cared for or nurtured erm or you might have just had more information about how things were going at work from your friends that could have helped you to balance these feelings out a bit.

P: Yeah.

CP: Does that make sense?

P: Yeah that does.

CP: Yeah I guess the other thing is that erm as you kind of mentioned earlier thinking about how you've been in the past the way in which the schema approach works is to think about how these schemas or life traps or whatever we choose to call them develop when we're very young and so they're kind of stronger or weaker at various stages in our life.

P: Yeah

CP: And what we're presuming is that they might have been sort of strengthened around that time erm so I guess, what is it about sort of your feelings of social isolation that maybe more longitudinally throughout your life that might also have prevented you from getting more balancing information at that time? So do you think more generally there are things that you do when you're around people that could have contributed to feelings of paranoia? Does that make sense the question?

P: Er yeah.

CP: Mmhm

P: Erm but I'm not sure really. I know that in the past when I've excluded myself erm -

CP: Mhm

P: I've usually like withdrawn into films, computer games things like that and -

CP: Mhm

P: I think erm I excluded myself socially a lot when I was working in challenging behaviour.

### **Questions after excerpt 1**

What was it like hearing that back? + follow up questions if necessary

Listening to that now what thoughts come to mind about the experience?

Do you remember that bit where \*CP name\* says that when thinking about your vulnerability to paranoia "being socially isolated you missed out on opportunities for these feelings of mistrust and abuse or of failure to be rejected or to be balanced out a bit" - what did you think of that? What do you think she was trying to say to you? How did that impact on you?

Appendix J (cont.) - Semi-structured interview schedule and examples of formulation-sharing extracts

**Introduction to patients to offer re-assurance, clarity of my role (especially in relation to their service and CP)**

e.g. "My name is Michael Stewart and I'm a 3<sup>rd</sup> year Trainee Clinical Psychologist at the University of Leicester and before we begin I wanted to thank you for allowing me to interview you about experiences of therapy with your psychologist (name). Just so you are aware, though I have had contact with your CP to arrange today's interview, I have no direct contact with your service and anything we talk about today will only be around the two therapy sessions that were recorded last year. I will speak with your CP after today just to say we met but we will not talk about the content of our interview which will also be anonymised. Is there anything you would like to ask about before we start?"

**Foundation questions before exploring specific excerpts**

"So it's been about a year since your sessions with \*CP Name\*. What do you remember of that experience?"

"In general what effects did therapy have on your life?"

- follow-up "Can you give me an example of that?"

"Sometimes when people have had therapy there are key moments that stick out for them. Can you tell me about that?"

- follow up "Why does that stick out for you?"

**Excerpt 1 (16:20-19:35)**C: Not when society you know places values on.

CP: Well this is a huge thing isn't it and let face it as much as you love the states the states is the opposite to Eastern philosophy because it's all -

C: (overlapping) (inaudible) time materialism and ego centric.

CP: That's right individualism ego centric, meritocracy sort of you know it's all how the individual does you know to prove your worth individually.

C: Yeah and that's another ironic thing as well you know so I'm in this I'm in a very highly successful organisation there's a lot of competition and yet my managers and directors are doing the complete - well they're just taking care of their selves but it just wasn't honourable really erm I didn't see it as honourable erm or sort of worthy.

CP: And I think this triggers of some sort of values of yours doesn't it?

C: It does yeah yeah oh absolutely.

CP: Because you've got some deep values haven't you.

## Appendix J (cont.) - Semi-structured interview schedule and examples of formulation-sharing extracts

C: Yeah I like to think morally and principally I'm pretty not sound but I think I have good morals and principles and you can debate what what you can go off at philosophical but yeah I'd say by typical western standards I've got good morals and good principles and yeah erm yeah the folks in America a lot of the Americans are great but in my particular team I don't think I don't think they were erm erm morally or principally right really I think yeah they erm they just didn't want to be held accountable for anything and it just became a very ego central sort of battle and it shouldn't have done it should have been about the problem and working together to solve it but they didn't want to lift a finger really so.

CP: That's fascinating because this is if you like the zeitgeist in the news at the moment about the value system in the financial services and that sort of thing about integrity and wanting to bring back integrity.

C: It's a perfect parallel it was very much like that you know and I'm working in a financial team essentially so the parallels are uncanny really so. That's like the macro version I suppose you could say but yeah.

CP: And you having your micro version of that where your values er and integrity er are coming up against a culture in a team you know not in a whole you know industry but you know it's the same sort of thing which you know which really clashes and I think that's that would make it very stressful actually because our values are so core to ourselves you know I've always had the feeling with you about these sort of morals.

C: It goes pretty deep yeah so you know and yeah and so they just yeah they weren't they weren't good enough for my opin- and the situation wasn't good enough in my opinion and needed addressing and erm I took it upon myself because no one else really wanted to so for whatever reason they didn't so so I unboarded all that pressure the first time especially you know -

### **Questions after excerpt 1**

What was it like hearing that back? + follow up questions if necessary

Listening to that now what thoughts come to mind about the experience?

Do you remember that bit where \*CP name\* says that your "values and integrity are coming up against a culture and that's stressful because our values are core to ourselves" - what did you think of that?

## Appendix K - Line coding example

	Excerpt of interview with Luke:
<p> Feeling stuck  Unresolved situation  empathising  collaborative relationship/equitability  imagining self  self-awareness  lowering expectations  generalising view of others  deferring/view of expertise in therapist  more sophisticated view of life  enjoyment/comfort </p>	<p>Luke: Yes...er...I think I get caught betwixt and between...erm...because I try to and put myself in the shoes of people that I work with, and sometimes I think, well am I...the perception that they have of me, to some extent, y'know I can't expect people y'know, I've mentioned that erm... Zoe was very learned and she has a kind of worldly, a worldliness about which I like very much</p>
	Mike: Mm-hm
<p> gratitude/receiving special attention  lowering expectations  collaborative talk  identifying systems  emotional responding  emotional deduction  deducing  identifying other approaches  reducing sense of entitlement </p>	<p>L: and I found a privilege to work with...erm... but, I can't expect somebody that I'm working with from mental health services to have that, erm, to have a visceral, sort of, er, intuition about reading between the lines and, y'know, 'I can read your mind', it's not necessarily what you say it's the right, y'know I can't expect people to have that, so I erm, I think sometimes with me, and it's, again it's an area that I revisit with the CPN say, or support workers, is that, I have moments when I have to spit things out, so "Look, this is what's happening" I have to just lay a brick *bangs table with hand* on the table and go like that</p>
	M: Yeah
<p> reflecting  labelling self  hiding pain; prioritising  breaking routines  purging  visualisation  explaining/exasperation  exemplifying  inviting empathy </p>	<p>L: y'know because I think sometimes I'm too, sort of when I tried to put on a brave face I think it's important, I do have moments where I, I will... vomit something of real, a big concrete lump out on to the table, and say "oh look, this is why, this is the kind of thing that makes this situation difficult for me" so it's erm</p>

## Appendix L - Example of memo notes

*Reflective journal extract – this extract reflects some thoughts I had which were moving towards the concept of the participants ‘world’ and how they began engaging with it.*

After reading an article about cases of abuse in the Catholic Church it struck me that the use of dogma has many parallels with Chris’ accounts of his time in the work place. He never questioned anything he was asked to do even though it made him feel emotionally very uncomfortable or distressed. I do wonder what makes the difference between someone who would feel anxious yet challenge an authority figure and someone who wouldn’t. Does it suggest that some people view their world as being ‘incontrovertibly true’ in the same way someone holds their religious beliefs, but they don’t have anything to give them comfort from this, as someone’s faith might do. It reminds me of The Wizard of Oz – look there he is behind the curtain, that’s what’s really going on, now you know that, you can do something about it. It does appear that from Chris’ account he felt like therapy showed him how he could challenge his colleagues, or anyone else, if he felt uneasy, and moreover, his mental health team would support him with that if necessary.

*Extract of notes on electronic memo app – this was used much more loosely and concisely than journal writing but would inform the journal entries and subsequent analysis.*

Paul talks as if he enjoys being an underdog, in the way that ‘everyone loves an underdog’, but when he was very ill he was much more downtrodden than this, that he viewed himself as a ‘loser’ more than an ‘underdog’. There are some interesting themes about how one (underdog) would be up for the challenge whereas the other (loser) is in a state of self-helplessness. What shifts this perspective?

Zeitgeist – this word came up a few times in the interview, explore this a bit further and see how it fits with worldview ideas you were identifying in the analysis.

## Appendix M - Focussed coding example

<p>Recognising repeated patterns of behaviour</p> <p>Challenging boundaries on disclosure</p> <p>Developing confidence in therapist's view</p> <p>Developing agency from different knowledge</p> <p>Increasing collaboration through perceived gender traits</p> <p>Feeling contained</p> <p>Recognising role of empirical knowledge</p>	<p>Excerpt of interview with Luke:</p> <p>Luke: it's kind of a recurring experience, but yeah that was erm...the most... private thing I've ever revealed to a member of the mental health services</p> <p>Mike: mm, so when you say that Zoe had a worldliness about her what do you mean by that?</p> <p>L: erm...I just felt that erm..... I think with, with Zoe I got, I got, I got the impression with Zoe that even if she wasn't a psychologist, she would be somebody that would have erm, quite a rounded worldview, and erm, would probably quite erm, intelligent and humane in whatever it, if her life were different and she, she did something else for living, she would be very good at it... I think she has erm... a worldly intelligence... when people say worldly, I suppose I'm not entirely sure what they mean, I suppose I, I use the word.. worldly instead of wise, but I suppose it's..erm... an understanding of the workings of the world that's not necessarily a mechanistic understanding, it's to some extent, erm... I use that word again, I think that she had a visceral quality and I found that, erm..... curiously, I've generally found that, erm, in mental health services, I find it easier to work with women, maybe I imbue that, I project that quality on to them, but erm, they tend to have more of a caring, nurturing side, I didn't feel that from Zoe, but again, erm, Zoe certainly has a visceral quality which is perhaps, erm, underplaying the experience and, and the academic achievement which she has in her life</p>
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## Appendix N - Epistemological Statement

The epistemological position taken by the research was a contextual constructionist one which recognises that subjective participation and meaning is an core part of any interpretation. As such the participant's meanings and researcher's interpretations will influence the knowledge derived from the interaction. This accepts that variations in researcher, time, place and so forth would produce different interpretations of data.

## Appendix O - Research Ethics Letter



20 January 2014

Mr Michael Stewart  
Trainee Clinical Psychologist  
Leicestershire Partnership Trust  
Department of Clinical Psychology  
104 Regent Road  
Leicester  
LE1 7LT

Dear Mr Stewart

<b>Study title:</b>	<b>A grounded theory analysis of patients' experience of formulation sharing with clinical psychologists.</b>
<b>REC reference:</b>	
<b>Protocol number:</b>	
<b>IRAS project ID:</b>	

Thank you for your letter of 15 January 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered by the Chair.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator

### 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.



## Appendix O (cont.) - Research Ethics Letter

### **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).

#### **Conditions of the favourable opinion**

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

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

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System 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 approvals 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 contest the need for registration they should contact Catherine Blewett ([catherineblewett@nhs.net](mailto:catherineblewett@nhs.net)), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

## Appendix O (cont.) - Research Ethics Letter

**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).**

### Approved documents

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

<i>Document</i>	<i>Version</i>	<i>Date</i>
Advertisement		17 December 2013
Covering Letter		
Investigator CV		
Investigator CV		
Participant Consent Form: Client		15 January 2014
Participant Consent Form: Clinical Psychologist		14 January 2014
Participant Information Sheet: Clinical Psychologist		14 January 2014
Participant Information Sheet: Client		14 January 2014
Protocol		11 December 2013
REC application		16 December 2013
Referees or other scientific critique report		31 October 2013
Response to Request for Further Information		15 January 2014

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

## Appendix O (cont.) - Research Ethics Letter

### Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

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**Please quote this number on all correspondence**

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

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

Yours sincerely