CHAPTER ONE

Case formulation and its role in professional practice

> "Case formulation is not a treatment procedure. It is a method for understanding the patient and their problems that allows for the selection and design of treatment procedures based on the knowledge of their case"
>
> (Adams, 1996, p. 78)

> "The significant problems we face cannot be solved at the same level of thinking we were at when we created them."
>
> (Einstein, 1879–1955)

Introduction

Formulation is deemed to be a cornerstone of skilled psychological practice and, over the course of our careers, much time will be spent engaged in the process of making sense of the psychological puzzles that confront us. However, the ability to master this skill is confounded by a range of factors. These include the myriad and often complex reasons for which clients seek help,

implicit agendas driving the request for help of which the practitioner may not be aware, and the extent to which individuals are able to identify, describe, and address their needs within a psychological framework. Similarly, practitioners vary in how they approach a client enquiry in terms of prior training and experience, theoretical preferences, and their level of interpersonal and conceptual skill. All factors play a critical role in decision making and represent potential obstacles to arriving at a clear and useful account of a client's circumstances and needs.

The challenge of arriving at a clear explanatory account is complicated further by the lack of any universally agreed definition of formulation, a dearth of substantive guidelines on how to teach this skill to trainee practitioners, and an ambiguous literature concerning the extent to which formulation, despite official rhetoric, is actually related to outcome. Moreover, although the concept of formulation has a long history within psychology, its status is contentious: for some, it is the central feature around which our data collection and interventions coalesce for client benefit, whereas for others, formulations are essentially therapists' stories imposed on clients. As a skill, therefore, formulation has not only proved controversial, but it has also proved difficult to operationalize, measure, and teach.

The aim of this chapter is to raise awareness of the current debates surrounding formulation and to help the reader navigate what might otherwise appear to be a literature confounded by unanswered questions and contradictory findings. We begin by considering the functions that formulation is widely believed to serve. We then consider some of the different ways in which formulation has been defined and some of the factors that contribute to different interpretations of its role in practice. The chapter then reviews the controversies surrounding the accuracy and effectiveness of individualized formulations and examines the implications of this for professional practice. Drawing on these debates, we make the case for understanding formulation as a device that helps us organize our thinking about what might be helpful and when; not solely an attempt to "explain" presenting issues from one theoretical approach or another, but, rather, a framework that can support both creative and rigorous thinking in generating potential solutions. We conclude with an exercise to stimulate reflection on

how these debates relate to your own practice, in whatever context that takes place.

Before engaging with the chapter, we invite you first to reflect on your own approach to formulation. Specifically:

- what (if anything) do you believe an individualized formulation offers a client that a clinical, educational, or psychometric diagnosis does not?;
- to what extent do you see your formulation as needing to be factually accurate in order to be helpful?'
- is your formulation derived primarily from "evidence-based" models of practice external to the client or crafted principally from the client's account of the world?;
- who owns the formulation and, therefore, is entitled to endorse, refute, or change it: you, your client, or a third party?

We invite you to revisit your answers as you work through the debates outlined in this chapter. You may also find it helpful to hold in mind a particular case and to consider how the issues raised might be relevant to that case. At the end of the chapter, we will ask you to think about what resonates and why.

The function of formulation in applied psychology practice

There is fairly broad agreement that constructing a formulation is critical to psychology practice (Atter, 2009; British Psychological Society, 2005; Corrie & Lane, 2006; Health Professions Council, 2009; Johnstone & Dallos, 2006; Lane & Corrie, 2006). Indeed, Butler (1998) goes as far as suggesting that, at least in the clinical domain, the process of formulation is what makes us accountable for our work, separating responsible, effective practice from informal, supportive conversations. Malkin (personal communication, cited in Lane, 1990) makes the same point in relation to educational work.

As noted in the Introduction, in general terms, formulation can be understood as an explanatory account of the issues with which a client is presenting. This account forms the basis of a shared framework of understanding that has implications for change. As a psychological explanation of a client's needs, a formulation can

reasonably be expected to draw upon a wide range of data, including psychological theory, general scientific principles (such as how to test hypotheses), research findings from the wider literature (the latter becoming particularly influential since the political and professional endorsement of empirically-supported interventions and evidence-based practice), supervision, and prior professional experience.

Although there are many ways of defining formulation (we address this later in the chapter), there is broad consensus about the range of functions that it can serve. These include:

- clarifying key hypotheses and identifying relevant questions;
- facilitating understanding of the client's needs as a whole;
- prioritizing client issues and concerns;
- planning and selecting appropriate intervention strategies;
- determining criteria for a successful outcome, including organizing practitioner and client around the same goals;
- predicting client reactions to specific interventions;
- predicting obstacles to progress;
- thinking systematically and productively about lack of progress;
- identifying patterns in a client's actions and responses that can be examined conjointly and impartially;
- identifying missing information;
- helping refine the search for relevant theoretical constructs or processes;
- deriving a coherent understanding of the links between past and present;
- forming judgements about the extent to which a case is typical (and how any intervention plan may need to be adjusted in the light of atypical features).

(See Bieling & Kuyken, 2003; Butler, 1998; for a fuller description of these issues.)

From these criteria, a number of essential themes can be identified. First, and most obviously, a formulation equips the practitioner with a systematic means of applying psychological knowledge to a client's story, problem, or dilemma for the benefit of the client and others involved. The information provided by clients and gleaned from various assessment tools is typically complex and

ambiguous. Understanding the client's needs is, therefore, a process of constructing a sense of meaning out of the mass of data obtained. In this context, the formulation functions as a framework for clarifying those questions which are likely to drive the enquiry forward. It creates thematic links between past events, present circumstances, and future aspirations, and refines the search for any additional information that is needed.

A second component of formulation is to identify which areas of a client's experience or behaviour will be prioritized. It is not possible to change everything. Informed decisions must be made about which concerns will be addressed, the most appropriate goals of the enquiry (based on a psychologically-informed understanding of what is amenable to change) and what interventions might be used in the service of those goals.

A third function of formulation is to aid empathic understanding, particularly in those cases where the client's actions or presenting concerns may challenge the practitioner's empathic skills (see Haarbosch & Newey, 2006; Sheath, this volume). Difficulties in terms of insufficient progress, apparent "resistance", or obstacles to collaboration that might otherwise contribute to problems in working together can be reflected upon in an impartial manner in order to identify ways forward.

In a similar vein, formulation can help protect against decision-making biases that could impede effective working. The literature on practitioners' decision making and judgement skills (see Lane & Corrie, 2006, for an overview) has consistently demonstrated the range of biases that permeate our work, often without our awareness. By ensuring that practice-based choices are underpinned by a systematic, psychologically informed account of the relationship between different aspects of a client's experience, it becomes possible to articulate and, where necessary, challenge the thinking that underpins the approach taken. Formulation, then, permits a degree of transparency in the decision-making process. It has the potential to protect our clients and contribute to the enhanced effectiveness of psychological interventions.

A further function of formulation—and one that is often overlooked—is its use as a form of professional communication. In its most straightforward form, this can mean the development of a shared understanding that benefits the client through ensuring a

consistency of approach. If a client's journey through services entails contact with a number of professionals, for example, there is the potential for the client to be subjected to conflicting opinions that hamper effective service provision. A formulation can, therefore, unite the many professionals who may be involved in a client's care around the same issues, priorities, and goals.

However, at a more tacit level, formulation also has the potential to become a means of communicating with other professionals about the status of one's knowledge, representing a distinct form of political leverage in the workplace. For example, in an already overcrowded market, the degree of sophistication, complexity, and explanatory power of their formulations may become part of how certain professional groups differentiate themselves from others. In this sense, being able to construct formulations and using these as a basis for communicating with other professionals (1) provides practitioners with a degree of reassurance about their ability to explain clients' concerns and, thus, their own competency, and (2) provides a vehicle for communicating with other professionals about the veracity of their knowledge and the authority of that knowledge (we explore this in Chapter Three, where we consider the implications for ourselves and our clients of what Mair, 2000, terms "tribal membership").

It follows, then, that the act of formulation can serve many purposes, some of which will be more explicit than others. At the most obvious and official level, it supports decisions about the content of a psychological enquiry (e.g., knowing what to prioritize, which hypotheses to test, and which interventions might be useful). It also supports understanding of process (e.g., by allowing the practitioner to predict and interpret clients' reactions to the work undertaken). However, formulation may also serve a more political function, enabling the practitioner to demonstrate their epistemic authority in the understanding of client concerns and the stories they can construct about those concerns.

The historical context of formulation and its place within professional practice

The political function of formulation as a means of professional differentiation can be further understood through considering its

historical context. In her review of the use of the term in clinical work, Crellin (1998) has traced some of the historical and social contexts in which the concept emerged and evolved, highlighting how formulation came to represent a form of political leverage through which psychology established its autonomy from psychiatry. At the time, she notes that psychology was a fledgling profession, competing with other professions claiming to treat emotional distress, and needing to establish itself as an independent profession.

For many years, psychology remained within the grip of psychiatric description through the use of symptom matching and diagnostic labelling. As Bruch and Bond (1998) have pointed out, clinicians were traditionally expected to define their clinical work in terms of psychiatric categorization systems, with treatment determined by these criteria. Influential psychologists at that time, such as Eysenck (1990) and Shapiro (1955, 1957; Shapiro & Nelson, 1955), later argued for an approach which emphasized clinical–experimental work (the beginnings of the scientist–practitioner model in the UK) centred on learning principles and, thereby, challenged these expectations. This was elaborated by Meyer (see Bruch & Bond, 1998), who summed up the problems from the clinician's point of view by pointing out that (1) not all clients sharing the same complaint respond to the procedural requirements of techniques, and (2) psychologists are rarely presented with clients with isolated complaints, particularly in mental health settings.

Meyer developed an alternative approach that rejected diagnostic formulations and instead advocated an approach based on individualized formulation, shared with the client rather than imposed on them (see examples in Bruch & Bond, 1998). Further key contributions were made by Lane (1974, 1978, 1990), Turkat (1985), and other reformulations have followed (see Kinderman & Lobban, 2000; Lane & Corrie, 2006; Mumma, 1998). Formulation based on diagnostic models was, therefore, counterbalanced by formulations derived from a scientist–practitioner perspective (see Lane & Corrie, 2006). Specifically, in arguing for an approach related to the individual client, the relationship between the accuracy of any data collected and their utility in terms of value to the client became central.

Since its introduction to clinical psychology regulation in 1969, formulation has become a defining skill (Division of Clinical Psychology, 2001) and, as Johnstone and Dallos (2006) observe, is a core competency expected of all newly qualified clinical psychologists. However, the use of the term now extends to all major disciplines within the psychological professions. The British Psychological Society (2005) outlined the basis of different forms of applied psychology in which five areas of psychology are presented: clinical, forensic, counselling, educational, and health. While for clinical, forensic, and counselling psychology, formulation is identified as a key competence, the extent to which formulation has a scientific basis and is drawn directly from psychological theory varies between disciplines. While its assessment pedigree is emphasized for clinical and forensic specialities, for counselling psychology, formulation represents a more collaborative and unfolding process. Within educational psychology, priority is given to the knowledge building process and the structuring of interventions with individuals and systems. The formulation of policy and practice is seen as a central part of the psychologist's role. For health psychologists, the application of research to formulation of health policy and health promotion is key. The act of formulation cannot, therefore, be seen as consisting of one enterprise, uniformly defined and undertaken in the same way by all disciplines. Navigating the different definitions and understanding what different professionals mean when they use this term can be a challenge in itself. This is considered next.

Dealing with definitions: different interpretations in different contexts

While there is fairly broad agreement about the wide ranging functions that formulation serves (at least at the level of official discourse), there is less agreement on the specific components or tasks of which a formulation should comprise. Reviewing even a small sample of standard definitions highlights that not all practitioners understand formulation in the same way. Consider, for example, the following, taken from the clinical, educational, forensic, and behavioural medicine fields.

- "A formulation is . . . a concept that organizes, explains, or makes clinical sense out of large amounts of data and influences the treatment decisions" (Lazare, 1976, p. 97).
- "[Formulation is] conducting hypothesis-driven interventions that are constantly monitored for effectiveness" (Bruch & Bond, 1998, p. xviii).
- "[A formulation is] a tool used by clinicians to relate theory to practice . . ." (Butler, 1998, p. 2).
- "Formulation is . . . a provisional explanation or hypothesis of how an individual comes to present with a certain disorder or circumstance at a particular point in time" (Weerasekera, 1996, p. 4).
- "Formulation is the summation and integration of the knowledge that is acquired by the assessment process (which may involve a number of different procedures). This will draw on psychological theory and data to provide a framework for describing a problem, how it developed and is being maintained" (Division of Clinical Psychology, 2001, p. 3).
- "[Formulation is] the elicitation of appropriate information and the application and integration of a body of theoretical psychological knowledge to a specific clinical problem in order to understand the origins, development and maintenance of that problem" (Tarrier & Calam, 2002, pp. 311–312).
- "[Formulation] is a process whereby therapist and client work collaboratively to first describe and then explain the issues a client presents in therapy . . . Its primary function is to guide therapy in order to relieve client distress and build client resilience" (Kuyken, Padesky, & Dudley, 2008, p. 759).
- "Hypotheses are put forward to explain the situation and formulate a plan of action to try to overcome the difficulties presented" (Fell & Coombs, 1994, p. 113).
- "The clinical formulation is a series of working hypotheses based on assessment information and relevant psychological (and other) models. It is a means of trying to understand the person's difficulties, in terms of the biological, psychological and social factors and events, which may have contributed to the current behaviours." (Haarbosch & Newey, 2006, p. 143).
- "Central to this approach is the clinical–experimental procedure which guides hypotheses generation in pursuit of a

> clinical theory about the problem(s) under investigation . . . the case formulation . . . provides a potentially useful framework for helping clinicians formulate problems and design treatment interventions in the context of health related problems" (Nikcevic & Kuczmierczyk, 2006, p. 8).

From the above sample, we can extrapolate a number of apparently different ideas: for example, that formulation is a concept, a tool, an account, and a process. It is described by some as a hypothesis, and by others as an entity that helps organize assessment data. It leads to the identification of relevant questions, yet also explains the client's experience. The different ways in which these definitions position themselves highlights Ingram's (2006) point that formulation can be interpreted as both a noun and a verb. It is both a product of an enquiry (in the sense that it is derived from theory, research data, and the client's self-told story) and a process that underpins the enquiry that unfolds. In consequence, the term "formulation" may be used to describe the attempt to understand the psychological "mechanics" of a particular client concern; an attempt to understand the person of the client or an attempt to appreciate the impact of the environment in which the client finds themselves.

The extent to which a psychological enquiry involves formula*tion* or formulat*ing* will reflect the ways in which different theories attempt to create the conditions for change. A psychodynamic formulation will, for example, aim to identify the pervasive themes that are central to the client's concern, that can be traced back through the individual's personal history and used to explain how their attempt to resolve these central conflicts have been unhelpful as well as helpful. In this sense, the approach may be principally one of formulat*ing*. In contrast, cognitive approaches tend to focus on more specific components of experience (often derived from information processing theory), which can be operationalized and measured. The approach is principally one of constructing a formulat*ion* (albeit evolving). Systemic and experiential approaches (e.g., Greenberg & Goldman, 1988), in contrast, share a concern about applying predetermined categorizations and psychological constructs which run the risk of obscuring clients' experiences and opportunities for change. Formulation, in this sense, is an ongoing

dynamic process in which hypotheses are continuously revised in the light of present moment events (Eells, 1997).

In her review of the literature, Butler (1998) highlights how, traditionally, formulations have focused on predisposing, precipitating, and perpetuating factors that relate closely to individual, internal, or intrapsychic events, tending to neglect social, cultural, and historical factors, including socially and culturally shared assumptions about gender roles and the behaviours it is appropriate for each gender to display. For example, what constitutes collaborative working might need careful consideration and redefining with a client whose culture of origin views subservience to authority as a sign of respect. Similarly, as social expectations of each gender differ from generation to generation, the practitioner will need to be mindful that the perceived options for change available to female clients raised in the 1980s may be very different from those raised in the 1940s.

Recognition of the tendency to focus on internal events at the expense of wider interpersonal and social influences has led to the development of trans-theoretical models that require the practitioner to embrace a more holistic and inclusive approach. Perhaps one of the best known of these is Lazarus's multi-modal model (1973, 1981), typically known by the acronym "BASIC ID". Each letter stands for a particular sensory modality which, Lazarus argues, is important to examine. Thus, behaviour (B), affect (A), sensation (S), imagery (I), cognition (C), interpersonal factors (I), and the need for drugs/pharmacology (biology) (D) are assessed. (More recently, in response to a growing awareness of the need to encompass spirituality in our client enquiries, Ingram (2006) has introduced a spiritual domain, transforming the acronym to "BASIC SID").

In his critique of traditional forms of therapy, Lazarus (2006) argues that most theories are implicitly trimodal, organizing the practitioner to think about clients' concerns from the perspective of cognition, affect, and behaviour. However, by adopting a seven-point perspective, practitioners can achieve a more comprehensive approach to data gathering that is less likely to be unhelpfully biased by prior theoretical attachments. Although the acronym BASIC ID does not explicitly include social, cultural, and political influences, it does, none the less, enable the practitioner (and client)

to more effectively track those modalities that are being prioritized and neglected, either in how the client shares their story or the way in which the data-gathering process has been constructed, enabling a more in-depth approach to the enquiry. Questions that might be relevant here include those listed below.

- Through which modalities does the client tend to describe their concerns and share their story? Which modalities does the client tend to neglect?
- When listening to a client's story, which modalities do I tend to favour and which do I tend to neglect?
- Based on the data gathered so far, which modalities do we know most about? Which modalities do we know least about?
- What modalities do we now need to learn more about? What type of data-gathering strategy would furnish us with the necessary information?

Approaching formulation from a different perspective, Wilkinson (2004, cited in Lane & Corrie, 2006) is similarly concerned with the issue of how to be sufficiently inclusive in thinking about the areas of a client's life that might be relevant to explore. She describes some of the challenges of teaching formulation skills to doctoral trainee counselling psychologists where humanistic and existential values are paramount, but where trainees are also expected to work effectively within psychodynamic and cognitive–behavioural approaches. For Wilkinson, this dilemma is managed by encouraging trainees to begin making sense of clients' concerns by drawing upon a broad-based "psychological mindedness". Starting from this position, trainees are better able to identify, reflect upon, and apply their implicit theories about why a client may be experiencing a particular difficulty in a specific way at a given time in their lives. Through trying to make sense of clients' presenting issues from an initial position of psychological mindedness, they can then consider how different psychological theories might add to, or challenge, their implicit models. At an early stage of the formulation process, therefore, critical questions include: "What information do I need to reach an initial understanding of what has contributed to this person struggling with this issue?" and "Does this explanation make sense, to me, my client, and to others involved?"

Viewing formulation through this lens renders it less of a tool that holds together theory and practice and more of a pantheoretical framework, underpinned by knowledge of broad psychological principles, that enables practitioner and client to organize information from myriad sources. It also ensures that categories of information that might be overlooked as a function of the practitioner's predilections are given adequate consideration. Although there are challenges that stem from adopting a pantheoretical approach (at worst, it may foster an undisciplined "mix and match" approach that results in the melding of theoretically incompatible constructs), there is much to recommend a broad-based approach. Human experience and behaviour are complex and dynamic, and understanding clients' circumstances and needs requires an ability to remain open to a wide range of data that may be of relevance.

However, the lack of any consensual definition poses a number of challenges at the level of training, research, and practice. If individual practitioners use the term to mean different things, then it follows that efforts to operationalize formulation for the purposes of training and research will be fraught with difficulty. How, in this situation, can the conscientious practitioner be reassured that they are engaging in "best practice"? Equally, how can their clients be certain that the explanations being constructed are fit for purpose?

Matters of accuracy and effectiveness: does the evidence match the rhetoric?

For a long time, the assertion of Eysenck, Shapiro, and Meyer that individualized case formulation drawn from specific experimental tests provided the most accurate representation of the client's issues held sway over clinical practice. As described previously, formulation continues to be identified as central to the work of the professional psychologist (British Psychological Society, 2005).

However, the relationship of formulation to outcome is equivocal. Despite its exalted position within psychology practice, the question of whether formulation has any substantive, beneficial impact on outcome is yet to be empirically substantiated. Indeed, there is some evidence to suggest that practitioners' faith in formulation as a means of achieving improved outcomes may be misplaced.

Schulte, Kunzel, Pepping, and Shulte-Bahrenberg (1992), for example, compared standardized *in vivo* approaches and formulation-based interventions in the treatment of phobias. The former responded at least as well as, if not better than, the latter.

Wilson (1996, 1997), among others (e.g., Meehl, 1954), has expressed doubts about the relative merits of individualized case formulation on the grounds of accuracy, arguing in favour of manual-based, empirically-validated interventions over individually tailored approaches on the basis that formulations always rely upon potentially flawed professional judgement. He favours an actuarial approach, an argument put forward by others (see Dawes, 1994; Dawes, Faust, & Meehl, 1989; Meehl, 1954, 1986) who have similarly expressed concern over the ways in which decision making in professional practice falls short of statistical methods. In these cases, practitioners should, it is argued, restrict their work to actuarial data rather than poorly validated technical procedures based on clinical reasoning.

Within a cognitive–behavioural approach, a number of attempts have been made to evaluate the inter-rater reliability and predictive validity of formulations (see Barber & Crits-Christoph, 1993; Horowitz & Eells, 1993; Persons, Mooney, & Padesky, 1995). Bieling and Kuyken (2003) argue that while practitioners can agree at the descriptive level about key features of a case, their interpretations of the more explanatory components vary widely. They make the useful distinction between top-down and bottom-up approaches. The former works from inferences from theory or research applied to the single case. Hence, theoretically-driven approaches use the theory to structure the understanding of the client's issues. Assumptions from the theory influence both the information sought and the interpretative lens through which the client's story is understood. Bottom-up approaches (that is, those that adopt a data-driven approach to enquiry) work from an attempt to map a reliable and valid case formulation on to the client's presenting problems. The practitioner works back to theory as necessary to elaborate upon that understanding.

Based on research into one theoretically-driven approach (cognitive–behavioural), Bieling and Kuyken (2003) argue that accuracy is too varied to provide confidence in any formulation achieved. If we add to this what is known about some of the biases in professional

decision making (Lane & Corrie, 2006), it is not easy to have confidence in the formulations generated, even when the task is undertaken by highly experienced practitioners.

Kuyken, Padesky, and Dudley (2008, 2009) have responded to some of these challenges by proposing a metaphor of formulation as a crucible in which collaborative empiricism, evolving levels of conceptualization and client strengths are guiding principles. They propose that one of the reasons why formulation is not more positively received by clients, or, at least, the research shows ambiguous findings for this, is that it tends to focus on a unilaterally derived, therapist-driven account presented to the client, rather than being constructed in partnership. Their use of the metaphor of a case conceptualization crucible identifies three defining features: (1) heat drives chemical reactions in a crucible (they propose that the collaborative empiricism between therapist and client provides the heat); (2) like the chemical reaction in a crucible, the formulation develops over time, starting with more descriptive elements and then being elaborated to include a consideration of predisposing and protective factors; (3) the new substances formed in a crucible are dependent on the characteristics of the chemical compounds put into it.

Finding ways to bridge the tension between what our science tells us and what our practice demands of us is an ongoing issue. In reflecting on the issue of reliability and the relative effectiveness of manual-based *vs*. individually tailored approaches, Butler (1998) reminds us that the issue is more complex than a direct empirical comparison of both might indicate. She highlights how practitioners bring to their enquiries theoretical knowledge that shapes how they listen, respond to, and understand their clients' concerns. Hence, they operate using covert formulations that direct the process of the enquiry from the outset. Indeed, the ability to develop these "covert" formulations may represent an important example of practice-based evidence. Here, local evidence derived from knowledge of the client's story and the lessons from our own professional experience form the basis of effective and ethical practice (Corrie, 2003, 2010; Sternberg, 2006).

Significantly, Butler (1998) proposes that formulations do not have to be "100% accurate or complete" (p. 8). The reason for this is that, in her view, the formulation is not concerned with providing

answers but, rather, with generating a rich source of questions and ideas that potentially add value to the work. Interpreted in this light, investigating the effectiveness of formulation should perhaps focus on the properties of powerful questions and how those questions can be used to create leverage for change (Adams, 2004). Thus, the benchmark criterion may be one of usefulness rather than accuracy, as determined by the client's response to the intervention.

Who owns the formulation?

A critical and often neglected issue underpinning the different definitions is the question of who owns the formulation and, thus, who is entitled to change, refine, or discard it. Thus far, we have seen that the use of formulations, and the processes by which they are created, have proved contentious. As we explore later, labels bring assumptions that are not always to the advantage of the person to whom they are applied. Moreover, there are conflicting findings about clients' reactions to formulation. In the context of cognitive–behaviour therapy specifically, while some clients appear to find the process beneficial, others report the experience as unhelpful and distressing (Chadwick, Williams, & Mackenzie, 2003; Evans & Parry, 1996), perhaps as a result of feeling exposed. Although this is less likely to occur if the process is conducted in a collaborative fashion, there is a broader issue that needs to be considered. Not everyone finds our carefully constructed accounts helpful and, indeed, some may even find them undermining and disempowering. This raises the question: "For whom is the formulation required and for what purpose is it really sought?"

In her review, Crellin (1998) expresses reservations about the idea that we can frame clients' problems as testable hypotheses. Translating clients' experiences into empirical constructs may make them manageable, but can fall prey to a reductionism that prevents the quality of understanding that is required for a meaningful encounter between practitioner and client. By translating human experiences into something we can readily investigate, she asserts that we lose the essence of the phenomena we seek to understand. Meyer's position that the client is a partner in the formulation process would also be challenged by Crellin, who goes further and

argues that the formulation has to be the client's story, owned by them and perhaps emerging at the end of the therapy. In this sense, a formulation is not, as Lane (1990) or, more recently, Kuyken, Padesky, and Dudley (2009) proposed, a new understanding or worldview that provides the basis for an intervention. Rather, it is the outcome of the therapeutic process itself. Crellin, in arguing from a phenomenological position, challenges theoretically-driven approaches to formulation for failing to give adequate consideration to the client's own experience of themselves and their world.

The challenge presented by phenomenology is not discounted by those operating within those models of practice that are more wedded to a scientific overview. For example, the necessity of attending to phenomenology is noted by Salkovskis (2002) who, in describing the relationship between theory, practice, experimental psychology, and outcome research, explains how professional practice is ". . . both the target of our work and a source of information and inspiration that drives other aspects of the process of empirically grounded interventions" (*ibid*., p. 4). In order to ensure ongoing refinement of cognitive theory and practice, he argues that it is essential to have a thorough grasp of the phenomenology that underlies the psychological material we seek to understand.

Salkovskis' outlook on phenomenology would be very different from that adopted by humanistic or existential psychologists, but the importance of allowing understanding to emerge gradually from clients' stories is still incorporated. This is because, according to Salkovskis, it is these stories that inspire research questions and that represent the ultimate validating criterion against which the research data must be compared. However, Crellin's argument remains compelling. Specifically, she alerts us to how we could, when formulating, run the risk of terminating avenues of exploration before the key issues have had sufficient opportunity to emerge. This echoes the earlier concerns of Davison (1991; cited in Davison & Gann, 1998) who argued that psychological problems are typically the constructions of practitioners that are imposed on clients, rather than conjointly developed understandings of client concerns. Understood from this perspective, ownership of the formulation must lie with the client, not the practitioner, and it is necessary to work within the context of the client's own theory of change (Duncan & Miller, 2000).

Towards a clearer definition and understanding of formulation: some preliminary conclusions

It is hardly contentious to suggest that psychological theories will never be sufficient to capture clients' experiences in their entirety. Indeed, it may not always be the case that we have to formulate everything in order to identify a helpful avenue for intervention. There may be times when formulating a discrete part of a problem is sufficient to create change, and other times when a much fuller understanding of the problem in context is vital (Lane, 1978).

Where formulation is defined as being essentially concerned with arriving at an explanatory account of clients' concerns, we should consider how much information we need to start working with our clients in a meaningful way. Rather than concerning ourselves exclusively with the content of our formulations (including questions about how accurate they are), we should perhaps aim to combine this with closer attention to the processes through which they are constructed; that is, how we arrive at one particular formulation over another, and the skills required to arrive at an explanation that is fit for purpose in each case. A critical question in this regard would seem to be: "Does this formulation move us closer or farther away from where the client wants to be?"

When thinking about our approach to formulation, we are, then, to some extent, dealing with choices. It may be acceptable for the nature of the problem to emerge over time providing certain foundations are in place (e.g., a decision is made that a psychological intervention is preferable to a social intervention, or that the client is willing and able to explore their issue within a psychological framework). Similarly, it may be appropriate to work exclusively within a specific theoretical framework providing there is an appreciation that being too wedded to any particular theory too early on in the process could result in mistaking the psychological map for the actual territory. Being able to articulate these choice points and to recognize the advantages and disadvantages of choosing one approach over another is, perhaps, the critical issue. Moreover, as we move from work with single clients to work with groups or organizations, these narratives may become broader still. Yet, the process of creating a "shared concern" which can form the basis of a journey of exploration enables the possibility of a co-operative

enterprise between psychologist and client in which each party contributes their own views as "expertise".

From the debates reviewed in this chapter, it can be seen that there can be no single, correct way to go about formulation. Different disciplines will approach the task differently, which reflects the legitimate use of professional judgement in the context of client diversity. Moreover, not all clients sharing the same complaints respond to the procedural requirements of technique. The myriad definitions of, and approaches to, formulation reflect the inherent complexity of the task in hand. The task comprises arriving at a distinct (if inevitably partial) understanding that can be explicitly shared with others (the product) and a journey in its own right (the process). The implication is that using a single way to formulate in every situation with every client may unhelpfully distort a client's reality. Focusing on a narrow part of their experience that is then transformed into the dominant story may be less than ideal.

In later chapters, we argue that formulation, as a framework for practice, can be usefully understood as a particular type of story characterized by specific properties that are informed by the context in which the story is created. It is not a neutral, impartial, non-political statement of fact based on evidence leading to the best possible intervention for the client. Rather, it is a story told to meet specific needs—an account agreed between the stakeholders to access whatever change process seems to them to be appropriate at that time.

Before proceeding, however, we invite you to revisit your answers to the questions posed at the start of this chapter in light of the debates reviewed. The purpose of the questions that follow are: (1) to help you think about the impact of the debates raised, and (2) to consider the implications of these debates for how you approach formulation.

Exercise 2. Questions to help you navigate the debates on formulation

First:
In considering a recent case or project:

1. Which of the issues raised in this chapter resonated with you? What factors made these issues seem relevant?

Exercise 2. (continued)

2. Which, if any, issues raised in this chapter evoked discomfort and why (e.g., possibly as a result of raising questions in your mind about how you practice)?
3. Were there any issues or debates reviewed that evoked irritation? If so, what triggered that reaction?
3. Were there any issues which you disputed? What is that dispute based upon?
4. Which issues made you pause for thought? How might these issues lead you to reconsider aspects of your practice?

Second:
In your opinion, who should "own" the formulation?

1. Do you see it as your responsibility to construct a formulation for the client?
2. Do you see it as your responsibility to help the client arrive at their own formulation?
3. Do you see it as something that you construct together?
4. Whose needs, primarily, does your formulation serve?

Third:
To what extent do you see accuracy as a central component of a helpful formulation?

1. If you see accuracy as essential, how do you decide whether your formulations are accurate? What criteria do you use?
2. If you do not see accuracy as essential, how do you decide if a formulation is helpful? What criteria do you use?
3. In what circumstances would you be prepared to abandon a formulation and start over (this might be due to a lack of accuracy, lack of utility or some other factor)?