Experiencing psychological formulation: a qualitative study of service user perspectives

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Thesis portfolio abstract

Context: Formulation is considered a core skill for clinical psychologists (Division of Clinical Psychology, 2011) and is a central component in most therapeutic approaches. There is no universally agreed definition of formulation, and the purpose and use varies depending on the theoretical perspective taken. The definition used in the Division of Clinical Psychology Good Practice Guidelines (2011) is 'formulation summarises and integrates a broad range of biopsychosocial causal factors. It is based on personal meaning and constructed collaboratively with service users and teams'. There is debate around the validity and reliability of formulation as an intervention; however, an alternative recommended way to explore formulation is to understand its usefulness, particularly whether it is felt to be useful to the service user. To date, research into service user experience of formulation is lacking.

Aim: This thesis portfolio aimed to understand the service user perspective on, and experience of, psychological formulation and operationalise the factors that impact on this, with the hope that this knowledge will help to improve the overall experience of formulation.

Design: The project is presented in a thesis portfolio format combining two main research papers; the systematic review explored service user experience of formulation developed with a psychologist as part of the therapy process. The qualitative empirical paper used Thematic Analysis to explore formulation developed with member of the Multi-disciplinary Team (MDT), who has not been psychologically trained, as part of the care co-ordination role, within a community mental health service.

Results: The systematic review developed an initial four-phased process of formulation that service users progress through iteratively and in a non-linear fashion. The experience of each phase and overall formulation process were impacted by specific factors. The empirical paper

identified six themes describing the service user experience of formulation with a non-psychologically trained member of the MDT and factors that impacted upon it.

Conclusion: Findings are provided tentatively, and further research is required to develop findings from both papers. However, the findings from this thesis portfolio add to the literature base around service user experience of formulation and identifies potential factors that may inform clinical practice and service delivery.

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Chapter 1. Introduction to the thesis portfolio

This thesis portfolio consists of two main papers: a systematic review, and an empirical paper, exploring service user experience of psychological formulation. A bridging chapter links the two papers together. Also contained in the portfolio are extended methodology and reflections chapters. The portfolio ends with an overall discussion and critical evaluation that considers the relationship between the findings of each paper and their wider implications for research and clinical practice.

What is formulation

Formulation is considered a core skill for clinical psychologists (Division of Clinical Psychology, 2011) and is a central component in most therapeutic approaches. There is no universally agreed definition of formulation and the purpose and use varies depending on the theoretical perspective taken. The definition used in the Division of Clinical Psychology Good Practice Guidelines (2011) is 'formulation summarises and integrates a broad range of biopsychosocial causal factors. It is based on personal meaning and constructed collaboratively with service users and teams' (p.2). Both the clinician's knowledge derived from theory, research and clinical experience and the service user's expertise in their own life are drawn upon as equally important sources of knowledge to co-create a useful formulation and shared understanding of the service user's difficulties (Johnstone, 2018).

Ridley, Jeffery and Roberson (2017) identified four prominent differences in formulation: 1) the degree of complexity and explicitness; 2) the type of information seen as essential to include in a formulation; 3) the emphasis placed upon theory; and 4) the attention to cultural information. However, despite these differences, Johnstone and Dallos (2013) identified common, important features across all formulations: "summarising the client's core problems; indicating how client's difficulties may relate to one another, by drawing on

psychological theories and principles; suggesting, on the basis of psychological theory, why the client has developed these difficulties, at this time and in these situations; giving rise to a plan of intervention which is based in the psychological processes and principles already identified; and are open to revision and re-formulation" (p.6).

Butler (1998) argues that the differences between formulation types are relatively unimportant to understanding the function of formulating; the overall aim is to approach any form of distress with the assumption that 'at some level it all makes sense'. Formulation can provide a structure for helping the service user understand their experience and how to continue their recovery journey.

It is thought that formulation can serve multiple purposes: identifying the best way forward and informing the intervention; providing an overall picture or map; prioritising issues and problems; selecting and planning interventions: helping the service user to feel understood and contained; strengthening the therapeutic alliance; encouraging collaborative work with the service user; emphasising strengths as well as needs; normalising problems; reducing service user self-blame; and increasing the service user's sense of agency, meaning and hope (DCP, 2011, p.8).

Although much of the theory and research from which formulation draws is established, there is only limited evidence to support it as a specific intervention in its own right.

Reliability and Validity

Questions have been raised about the reliability and validity of formulation (Bieling & Kuyken, 2003). Easden and Kazantzis (2018) undertook a systematic review and concluded that findings are variable and are often dependent on a range of factors including: the reliability analysis used, the study design, and the level of formulation being assessed.

The level of reliability varied across studies from almost no agreement to 100% agreement, this aligned with an earlier review (Flinn, Braham & das Nair, 2015). The level of inter-clinician consistency increased when more structured data collection and complete case material such as a recorded session were used rather than a case vignette (Easden & Kazantzis, 2017). Clinicians show a higher level of reliability for descriptive elements of a formulation and less agreement on the more theory-driven and inferential aspects (Bieling & Kuyken, 2003).

Formulation benefits and usefulness

Although formulation has not been seen to demonstrate validity and reliability consistently across studies, it has been questioned whether this is an appropriate measure of assessing formulation (Johnstone, 2013). Appraising formulation as an alternative to diagnosis, Johnstone (2018) questions whether formulation can be evaluated as true or accurate when it is a shared narrative. Instead assessing formulation in terms of its usefulness in promoting the benefits identified by Butler (1998) and the DCP (2011) may be more beneficial (Johnstone, 2018). Research is beginning to focus on understanding service user experience of formulation, to consider the service user perspective on its perceived usefulness, however this research is in its infancy.

Benefits

Research into benefits of formulation report mixed findings. Evaluating the impact of formulation on the therapeutic alliance and service user distress found no significant changes in alliance or a reduction in distress (Shine & Westacott, 2010; Chadwick, Williams & Mackenzie, 2003). Qualitative exploration of service user experience of formulation, on the other hand has identified a range of positive outcomes, many of which relate to the benefits described in the DCP guidelines (2011). Service users have described how the formulation

serves to increase an understanding of the mental health difficulties, with a particular focus on how the difficulty links to past experience, how it has developed and what is maintaining the mental health difficulty (Chadwick et al., 2003; Evans & Parry, 1996; Rayner, Thomas & Walsh, 2011; Halpin, Kugathasan, Hulbert, Alvarez-Jimenez & Bendall, 2016). This increased understanding supported service users to normalise and reframe difficulties (Redhead, Johnstone & Nightingale, 2015; Kahlon, Neal & Patterson, 2014), informed the psychological treatment plan and helped to develop new skills (Kahlon et al., 2014; Rayner et al., 2011; Redhead et al., 2015; Shine & Westacott, 2010). Service users felt understood and accepted by the therapist, which increased the therapeutic relationship (Chadwick et al., 2003; Evans & Parry, 1996; Redhead et al., 2015; Pain, Chadwick & Abba, 2008; Rayner et al., 2011). These findings suggest psychological formulation can be useful to the service user.

Emotional reactions

Although many service users described the usefulness of formulation, the process of developing a formulation has been shown to evoke a range of emotions. These range from positive feelings such as relief, hope, optimism (Chadwick et al., 2003; Pain et al., 2008; Redhead et al., 2015; Rayner et al., 2011) to negative emotions, including distress, shock, and feeling overwhelmed (Chadwick et al., 2003; Evans & Parry, 1996; Halpin et al., 2016; Pain et al., 2008). Studies have attempted to understand what factors may impact on these negative reactions, and proposed the following: recounting experiences (Halpin et al., 2016; Shine & Westacott, 20101; Evans & Parry, 1996); the formulation being difficult to understand (Rayner et al., 2011; Pain et al., 2008; Chadwick et al., 2003); the accuracy of the formulation (Redhead et al., 2015); formulation having a negative impact on identity (Kahlon et al., 2014; Redhead et al., 2015); and creating a belief that problems are long standing and therefore difficult to change (Chadwick et al., 2003).

Within the literature there appear to be factors that can serve to increase the perceived usefulness of the formulation. These include the formulation being developed collaboratively (Kahlon et al., 2014; Rayner et al., 2011; Shine & Westacott, 2010), the formulation being accurate, according to the service user (Kahlon et al., 2014; Redhead et al., 2015) and the therapist's guidance and accepting stance (Kahlon et al., 2014). Pain et al. (2008) provided a useful overview of the current difficulties in understanding service user experience of formulation: "individual reactions were personal, complex and involved opposing reactions" which is further complicated by the assumption that service users' reactions appear to change over time, reflecting that formulation is a process.

Research into formulation is beginning to move towards understanding whether formulation is perceived as useful to the service user and considering what factors may impact upon this. However, there appears to be gaps in the literature especially around conceptualising what factors impact upon the different experiences of formulation and whether it is seen as useful to the service user. The systematic review within this thesis portfolio aims to identify and review current research into service user experience of psychological formulation with therapists and understand what factors impact upon this experience.

Formulation in the NHS

A number of NHS Mental Health Trusts are introducing the use of psychological formulation within the care co-ordination process, specifically with staff members who have not received extensive psychological training. The purpose of this is to increase service user involvement in, and experience of mental health care. It is recognised that service user involvement should be at the heart of services, and there should be 'no decision about me, without me' (Department of Health, 2012). Care planning should be individualised and

collaborative with the service user (CQC, 2013; Department of Health, 2012). Formulation is proposed to support improvements in these areas, particularly relating to supporting mental health professionals to work alongside service users to develop useful treatment plans (Crowe & Farmar, 2008). One of the main recovery frameworks used with NHS services is CHIME; a framework of five interrelated recovery processes: Connectedness, Hope and Optimism about the future, Identity, Meaning in life, and Empowerment (Leamy, Bird, Boutillier, Williams & Slade, 2011). The CHIME research concluded the need for greater emphasis on the assessment of strengths and increasing self-narrative within mental health to support recovery; this is something that fits with many of the core purposes of psychological formulation, along with increasing the understanding that recovery is an individual experience, unique to the service user (Leamy et al., 2011). Bensa & Gregg-Rowbury (2016) argues that the individual and collaborative nature of formulation meets many of the NHS values set out in the 6Cs approach to care: care, compassion, courage, communication, commitment and competence (Roach, 1984).

Although incorporating formulation into overall mental health service delivery has many potential benefits, to date there is no research into the service user perspective or experience of this process. Research exploring service user experience of psychological formulation requires further development to understand the perspective of service users and the factors that impact on the usefulness of formulation for service users. Service users have described mixed emotional reaction to formulation developed with psychologists, and psychological formulation sits within a broad framework of essential features and expectations (DCP, 2011). Research suggests training in a specific formulation template, such as the 5 Ps; a framework for CBT formulation that helps link the person's experience to the cognitive model by using the five areas; presenting issue, precipitating factors, perpetuating factors, predisposing factors and protective factors (Dudley & Kukyen, 2013), can increase

mental health staff knowledge, confidence and competence in formulation skills (Bensa & Gregg-Rowbury, 2016). It will be important to not only understand how service users experience formulation with mental health staff, who have not received extensive psychological training, but to consider how and if this differs to the overall purpose of psychological formulation. To date, this understanding is missing from the literature, the empirical paper within this thesis portfolio aims to fill this gap.

N.B: This thesis portfolio uses the term service user to refer to the participants in the systematic review and empirical paper. The carers and service users who formed part of the formulation steering group, and supported across the research, are referred to as experts by experience throughout the portfolio.

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Chapter 2: Systematic Review

Systematic review prepared for submission to Clinical Psychology & Psychotherapy

Experiencing psychological formulation: a thematic synthesis of service user experience across psychological modalities

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Abstract

Aims: Research into service user experience of formulation remains in its infancy. The primary aim was to review the current research into service user experience of formulation, undertaken by therapists, and identify what factors impact on this experience.

Method: A systematic review of the literature was conducted using the MEDLINE, PsycINFO, EMBASE and CINAHL databases alongside relevant manual searches. Eleven studies fitted the inclusion criteria and the data from each study were collated following the principles of thematic synthesis. Study quality was evaluated using the Critical Appraisal Skills Programme qualitative assessment checklist (CASP). The review was developed in collaboration with four experts by experience.

Results: The findings suggest a phased model of the formulation process, which is likely to be iterative and non-linear, with specific factors that impact upon the service user's experience of the formulation process. The model comprises of four superordinate categories: rawness of telling my story; feeling understood by the therapist; own self-discovery and meaning making; and gaining hope through autonomy. Each superordinate theme had sub-groups of factors which impact on service user experience through the process.

Conclusions: This systematic review offers an understanding of the factors influencing service user experience of formulation. Research into this area is in its infancy and further exploration of the identified phased model and factors could be beneficial. The small data set used to inform the model and individual differences pertaining to the formulation process should be recognised. Future research and clinical implications are suggested.

Introduction

Psychological formulation is perceived as a core skill of clinical psychologists and is perceived to be the foundation for delivering effective interventions (DCP, 2011). It requires clinical psychologists to use their clinical skills to develop a shared account of the person's mental health difficulties by combining psychological theory, and personal thoughts, feelings and meaning through a process described as 'ongoing collaborative sense-making' (Harper & Moss, 2003:8). Psychological formulation 'summarises and integrates a broad range of biopsychosocial causal factors. It is based on personal meaning and constructed collaboratively with service users and teams (DCP, 2011, p.2). The development and use of formulation vary across psychological traditions however there are some common features across all (Johnstone & Dallos, 2013) and the main purpose of formulation is to inform the intervention (DCP, 2011).

The Division of Clinical Psychology 'Good Practice Guidelines on the use of psychological formulation' (2011) identified a number of potential purposes and benefits of developing a formulation including: providing an overall picture or map; selecting and planning interventions; feeling understood and contained, increased collaboration, normalising problems, reducing self-blame and increasing sense of agency, meaning and hope (DCP, 2011, p.8)

The empirical base for formulation has been questioned due to variable findings in research looking into reliability, validity and quality as well as the impact on mechanisms of change and therapeutic alliance (Easden & Kazantzis, 2017; Flinn, Braham & das Nair, 2014). Johnstone (2013) questions the usefulness of assessing reliability and validity of formulation as it assumes there is one truth and often fails to take the service user's perspective into account. One alternative perspective is to consider the usefulness of

formulation, particularly whether it is useful to the service user (Johnstone, 2013). This would require research to focus on understanding the service user's perspective and experience of formulation. Currently service user experience is lacking in formulation research.

A case study by Thew and Krohnert (2014) used the benefits outlined by the DCP (2011) to guide an interview, with one service user, to understand the experience of developing a formulation. The results showed evidence for all the identified benefits apart from feeling the mental health difficulty was normalised (Thew & Krohnert, 2014).

Further research into service user experience of the usefulness of formulation have shown formulation increases service user's understanding of the mental health difficulty, how it developed and is maintained (Chadwick, Williams & Mackenzie, 2003; Pain, Chadwick & Abba, 2008; Kahlon, Neal & Patterson, 2014; Redhead, Johnstone & Nightingale, 2015; Shine & Westacott, 2010; Tyrer & Masterson, 2019). Additionally, most studies identified how the formulation was linked to the treatment plan and supported the service user to engage in therapy (Shine & Westacott, 2010; Tyrer & Masterson, 2019; Kahlon et al., 2014; Redhead et al., 2015). The formulation process can impact upon a service user's sense of self or identity, both positively and negatively (Kahlon et al., 2014; Redhead et al., 2015).

A recurrent theme derived from qualitative research into the experience of the formulation process has been the mixed emotional reactions related to it (Chadwick et al., 2003; Pain et al., 2008; Kahlon et al., 2014; Redhead et al., 2015; Shine & Westacott, 2010; Tyrer & Masterson, 2019). Emotional reactions ranged from hope and relief to sadness, worry and helplessness (Chadwick et al., 2003). To date, the limited research into service user experience of formulation has shown mixed reactions, both emotionally and relating to the potential benefits.

There has been some consideration around the factors that may impact upon service user experience of formulation. One common factor related to the development of the formulation being a collaborative process (Shine & Westacott, 2010; Kahlon et al., 2014; Redhead et al., 2015). Although collaboration is seen as a key part of formulation development, service user experience of this is variable (Kahlon et al., 2014). The accuracy and pacing of the formulation process are also thought to impact on service user experience (Shine & Westacott, 2010; Kahlon et al., 2014; Redhead et al., 2015), along with perceived complexity (Kahlon et al., 2014; Shine & Westacott, 2010). Redhead et al. (2015) suggested three reasons for the distress reported by their participants: greater clarity about the nature and pervasiveness of the mental health difficulty; implications for the service users' sense of identity; and the therapist suggesting inaccurate formulations.

Rationale and aim

Research into service user experience of psychological formulation is emerging. The findings suggest formulation development is perceived as useful to the service user and many of the benefits set out by the DCP (2011) have been observed. However, it also evokes a range of emotional reactions and service user experience appears to vary. There remains a lack of clarity around whether formulation is perceived as useful to the service user and what specific factors impact upon this. This review aims to begin answering this by identifying and reviewing current research, considering any gaps or limitations in the literature and operationalising potential factors that may serve to impact upon service user experience. To the researcher's knowledge there have been no other systematic reviews relating to service user experience of formulation.

Research Question

The primary research questions were identified as:

- To explore service user experience and perspective of the process of developing a psychological formulation with a therapist.
- What factors impact upon service user experience of psychological formulation?
- What recommendations can be drawn from a thematic synthesis of the findings?

Method

ENTREQ: The enhancing transparency in reporting the synthesis of qualitative research (Tong, Flemming, McInnes, Oliver & Craig, 2012) and PRISMA statement were used in the production of the systematic review.

Eligibility criteria

A PICO (Population, Intervention, Comparison and Outcomes) table (Methley, Campbell, Chew-Graham, McNally & Cheraghi-Sohi, 2014) was used to help develop the parameters for search terms and eligibility criteria. The review examined peer reviewed, primary research, which incorporated qualitative methodology to explore service user experience of the formulation process. Inclusion criteria were intentionally broad due to a limited number of studies indicated in the initial scoping exercise. Additional inclusion criteria were: 1) participants in the study to have a mental health diagnosis, 2) formulation to be completed across any setting including: primary care, secondary care, inpatient, forensic services, 3) study to look into the experience of service users completing formulation, 4) participants could include children, adults and older adults. Studies where formulation was not the sole focus were included provided, they made specific comments relating to formulation separate to the therapy process.

Studies were excluded if they only included quantitative methodology around patient experience. Studies not written in English were excluded from the study due to time constraints placed on the review. Papers solely focused on staff perceptions, or about the

quality, reliability or validity of formulation were excluded, as this was not the aim of the review. Studies were also excluded if they were case studies or intervention protocols which did not report outcome data, conference abstracts, critique or commentary articles or book chapters.

Search Strategy/ Information sources

Four electronic bibliographic databases covering appropriate topic areas were searched from inception to 10th September: MEDLINE, PsycINFO, EMBASE and CINAHL. Reference lists of accepted articles were also hand searched along with the DCP Clinical Psychology Forum articles. Search terms were developed by assimilating keywords on the topic of formulation and through discussion with research supervisors. Search statements were tested and refined through scoping searches within the selected databases.

The PICO table identified a three staged search strategy: formulation, experience and service users. The search terms used for formulation were: psychological formulat* or case formulat* or clinical formulat* or shared formulat* or reformulat* or case conceptuali* or formulat*. To obtain papers relating to experience the following terms were added to the strategy: experience* or perspective* or view* or response* or understanding. Finally, to narrow the responses to focus on service user experience the following terms were used: service user* or patient* or client*. Additional MESH terms were included to further focus the search, these were amended for each database.

Study selection

Initial screening of titles of all articles was undertaken by the first author. At this stage all duplicates and studies that were clearly not eligible (e.g. related to medical formulation) were excluded. Titles and abstracts of the remaining articles were screened against the eligibility criteria, where eligibility was unclear the article was included in the full text

review. A full text review of all remaining articles was conducted by the first author, rationale for exclusion was documented on EndNote. Uncertainties were resolved by discussion between the first author and research supervisors.

Table 1: extracted demographic and methodological information

	Participants	Age range	Sample size	Data collection	Length of interview	Time between formulation and interview	Analysis	Clinical presentation
Halpin et al (2016)	Clients and therapists	15-25	3	Semi-structured interviews	Approx 1hour	Two participants = 6months One participant = 1month	IPA	PTSD and First Episode Psychosis
Kahlon, Neal & Patterson (2014)	Clients	19-54	7	Semi-structured interviews	Not stated	Not stated	TA	Depression
McManus et al (2010)	Clients	Adults	8	Semi-structured interviews	45 – 60 mins	Within 2 years of completing CT for social phobia	IPA	Social phobia
Pain, Chadwick & Abba (2008)	Clients and therapists	Adults	13	Semi-structured interviews	10 – 45 mins	2–3 weeks after sharing CF	Content analysis	Psychosis
Rayner et al (2011)	Clients	Adults	9	Semi-structured interviews	45-90 mins	Av 5 months (range 2–16 months)	Grounded theory	Range of presenting problems
Redhead, Johnstone & Nightingale (2015)	Clients	Adults 24-67	10	Semi-structured interviews	32-54 mins	Within 1 month of completing CBT	TA	Depression and/or anxiety
Shine and Westacott (2010)	Clients	Adults	5	Mixed – Semi-structured interviews (Client Change Interview)	No more than 1 hour	"soon after reformulation"	Template analysis	Suffered from an axis 1 disorder

Small et al (2018)	Clients and therapists	Adults	8	Mixed - Semi-structured interview	25 and 121 min	During or after therapy	TA	Range of presenting problems
Threw and Krohnert (2015)	Client	Adult	1	Mixed - Semi-structured interviews	Not stated	Not stated	Framework analysis	Depression
Tyrer & Masterson (2018)	Clients and therapists	Adult	6	Mixed – Semi-structured interview (Client Change Interview)	Not stated	3 to 6 weeks after the end of therapy	Template analysis	Range of presenting problems
Evans and Parry (1996)	Clients	Adults	4	Mixed - Semi-structured interview	Not stated	Between the third and fourth sessions following reformulation	Unknown	Difficult to help

Table 2: Study characteristics

	Therapeutic stance	Staff doing formulation	No of formulation sessions	Focus of the study	Context of formulation	Form of formulation
Halpin et al (2016)	CBT	Clinical Psychologist x 2	Guideline of 1-2 but did not collect data on this	Focus on formulation	Part of a PTSD protocol	Collaborative formulation letter (Psychologist and service user)
Kahlon, Neal & Patterson (2014)	CBT	Clinical Psychologists & Psychological Therapists	Not stated – completed as part of therapy	Focus on formulation	Referred to psychological services for treatment of depression	CBT
McManus et al (2010)	Cognitive Therapy	Therapists	Not stated – CT sessions: mean 10 (5-18)	Focus of the study was experience of CT in general	Part of CT for social phobia	Clark & Wells formulation model
Pain, Chadwick & Abba (2008)	CBT	Clinical Psychologists, Trainee Clinical Psychologists & CBT Nurse Specialist	2 sessions	Focus on formulation	Cognitive therapy for psychosis service	Beckian developmental diagram and letter
Rayner et al (2011)	CAT	CAT practitioners	Not stated – completed as part of therapy	Experience of CAT with a focus on reformulation	Clients from current or previous caseload	CAT diagram and reformulation letter
Redhead, Johnstone & Nightingale (2015)	CBT	High intensity workers	Not stated – completed as part of therapy (range 8-20 sessions)	Focus on formulation	Clients from IAPT services	Not stated

Shine and Westacott (2010)	CAT	Qualified CAT practitioners	Varied on client needs	Impact of reformulation	Local NHS services	CAT diagram and reformulation letter
Small et al (2018)	Not specified	Clinical Psychologists, Counselling Psychologists and Assistant psychologists	Unknown – completed as part of therapy	Psychological therapy in inpatient service	Inpatient service	Not specified – study was not specifically focused on formulation
Threw and Krohnert (2015)	CBT	Not stated	Three sessions	Focus on formulation	Case study	Formulation diagram
Tyrer & Masterson (2018)	CAT	CAT practitioners	Unknown – completed as part of therapy	Influence of reformulation on change	Clients from NHS adult psychological therapy services	CAT diagram and reformulation letter
Evans and Parry (1996)	CAT	Clinical Psychologist	Unknown	Impact of reformulation	Clients described as difficult to help	CAT diagram and reformulation letter

Data extraction and quality review

A pre-identified table was used to extract relevant information from the studies (table 1). This included details on the setting, participant's age, sample size, data collection method, therapeutic stance, qualitative methodology, and formulation process. Table 2 details additional information about study characteristics.

Assessing methodological rigor allows the researcher to make judgements on the methodological limitations of studies that contribute to synthesized findings (Noyes et al., 2018). Therefore, all studies were quality assessed using the Critical Appraisal Skills Programme qualitative assessment checklist (CASP, 2013). The CASP checklist was chosen because it maps onto the domains recommended by the Cochrane Qualitative and Implementation Methods Group guidance Series: paper 3 (Noyes et al., 2018).

An overall quality rating was assigned to each paper; low, moderate or high. Quality was assessed by the main author, in discussion with research supervisor and recorded in an Excel database (Appendix A). The four areas identified by GRADE-CERQual (Lewin et al., 2015): methodological limitations, relevance, coherence and adequacy were also considered when reviewing the quality and impact of each included study.

Thematic synthesis

The decision around what classified as data for the review was informed by previous research, guidance from the Thomas and Harden (2008) and Noyes et al. (2018) papers and discussion with research supervisors. It was decided both the results and discussion sections of papers would be included as data. Many papers discussed their interpretations in the discussions section, it was felt that to enhance the review these data should be included.

Thematic synthesis involves the development of descriptive and analytical themes, going beyond initial coding. The thematic synthesis followed the three stages described by

Thomas and Harden (2008): 1) free line-by-line coding of the findings of primary studies; 2) the organisation of these 'free codes' into related areas to construct 'descriptive' themes; and 3) the development of 'analytical' themes', this is the 'stage of interpretation whereby the reviewers 'go beyond' the primary studies and generate new interpretive constructs, explanations or hypotheses' (Thomas & Harden, 2008, p.1).

Data were initially coded with the research question loosely in mind to help focus the theming strategy whilst still allowing for a broad perspective. Additional codes were added to the coding list as coding moved across papers. To finalise this stage of synthesis the first author examined the text in each coded area to check consistency of interpretation and to see whether additional levels of coding were needed (Thomas and Harden, 2008).

The current thematic synthesis is focused on understanding service user experience, therefore, involving experts by experience throughout the review was seen as valuable. The experts by experience formed part of a formulation steering group, which had been set up to support the development and implementation of a formulation template within an NHS mental health service. Therefore, all four experts by experience had a good understanding of the concept of formulation, and one member had developed a formulation with a clinical psychologist. A brief description of themes, along with corresponding data, were discussed with the experts by experience. The original data and provisional themes were reviewed collaboratively, including whether the proposed themes captured the essence of the data. During this process themes were merged, adapted and renamed to relate more to service user experience. This step involved inferring meaning about the themes to identify factors that impacted upon service user experience.

The third level of interpretation involved returning to the research question to understand the factors that impact on service user experience of formulation. This led to the

mapping of a process that service users go through and the factors that impact upon their movement through this process.

Researcher characteristics and reflexivity

The lead author was a trainee clinical psychologist at the time of the systematic review, using and enhancing her knowledge of formulation in theory and clinical practice. The lead author chose the thesis topic due to her interest in understanding and improving service user experience in mental health services. The primary research supervisor was a clinical psychologist, who had previously worked in an NHS mental health service promoting the use of formulation and at the time of publication was working at the university as a lecturer on the clinical psychology doctorate. The secondary supervisor was a research clinical psychologist working in a local NHS Trust, and formed part of the group implementing the use of formulation more widely within the Trust. All three authors had prior interest in the use of psychological formulation. A reflexive diary and discussion within supervision was used to consider the impact of personal beliefs on the study findings. The author aimed to remain close to the original data in the interpretations and triangulated the findings with experts by experience.

Results

Study selection

The search strategy yielded 3963 papers of which 1010 were duplicates leaving 2953 papers. Following the title and abstract review, 56 were selected for full text review against the inclusion criteria. Eleven articles met the full criteria and were included in the synthesis.

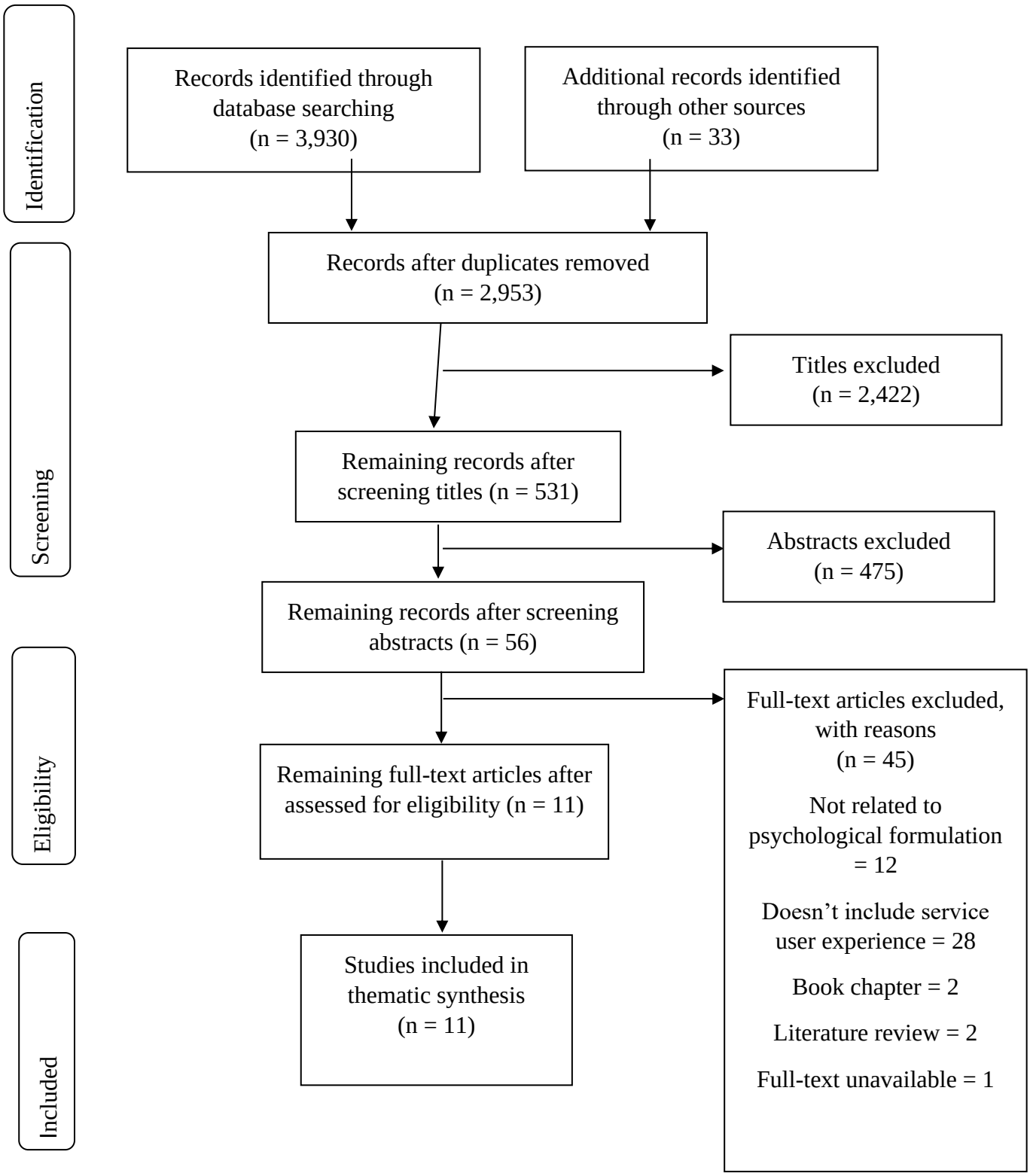

Figure 1. PRISMA diagram to show the process of reviewing studies.

Study characteristics

In total there were 74 participants across the 11 studies, ranging from a case study to 13 participants. The majority of studies interviewed adults (10 studies), with one (Halpin et al, 2016) focusing on young people aged between 15 and 25. The diagnostic inclusion criteria varied across papers; PTSD and first episode psychosis (1), depression (2), depression and/or anxiety (1), social phobia (1), psychosis (1), Axis 1 disorders (1), range of presenting problems (3) and participants classified as 'difficult to help' (1). The studies focused on a specific therapeutic stance: Cognitive Behaviour Therapy (CBT) (5), Cognitive Therapy (1), Cognitive Analytic Therapy (CAT) (4) and unknown (1).

The aim of the studies varied, with some focusing purely on service user experience of formulation (8). Of the remaining three studies, formulation formed part of a wider discussion around cognitive therapy for social phobia, service user experience of the process of change in CAT, and experience of psychological intervention in an inpatient service. Due to formulation not being the sole focus of these three studies, they could be classified as being of partial relevance to the review question, according to the CERQual's assessment of confidence (Lewin et al., 2015). The majority of studies (7) were qualitative, and the remaining four were classified as mixed methods design. The qualitative exploration of service user experience was a secondary research question in these papers. All data were collected through semi-structured interviews with service users.

In relation to the process of formulation, most studies (8) conceptualised formulation as part of the overall therapy process. The number of sessions taken to complete a formulation with participants was only stated in one study (Pain et al., 2008). This finding links to previous reviews which have commented on the difficulties of defining formulation as a concept (Geach, Moghaddam & De Boos, 2017). These differences also raise questions

around how formulation was developed with the service user and the quality of the formulation. Previous research has suggested formulation quality varies between clinicians (Eells, Lombart, Kendjekic, Turner & Lucas, 2005). The time between completion of the formulation and interview ranged from 2-3 weeks to 6 months post completion. Four studies did not state the timescale for interviews. The studies varied on whether they interviewed participants after the completion of the formulation or the overall therapy process, this difference may impact upon the service users. Previous research has suggested service user experience of formulation varies over time (Kahlon et al., 2014). The time difference also varies within studies, with one study (Halpin et al., 2016) citing difficulties with data collection.

The analysis plan varied across studies: Interpretative Phenomenological Analysis (IPA) (2), Thematic Analysis (3), Template Analysis (2), Content Analysis (1), Grounded Theory (1), Framework Analysis (1), and one paper that did not state the analysis plan. These differences further highlight the methodological difference in researching service user experience of formulation and led to differences in the richness of data collected across the studies. The use of IPA was questioned during the quality assessment, due to the lack of rationale and detailed findings.

Quality

Overall, the quality of most papers was assessed as being high (8 papers), with the remaining three rated as moderate. The research team decided to include all papers regardless of their quality review to allow for additional data, as research into service user experience of formulation is in relative infancy. Quality assessment of included studies linked to the first component suggested by the CERQual's assessment of confidence for individual review

findings from qualitative evidence syntheses, that of methodological limitations of the qualitative studies contributing to a review finding.

The quality assessment highlighted many studies did not discuss the impact of the relationship between researcher and participant on data collection and analysis. Additionally, the data analysis plan was often not discussed thoroughly with a coherent rationale, this relates to previous comments around the variety of data analysis. Studies were successful at having specific aims that were felt to be met by a qualitative methodology. They also included detailed descriptions of the service users and inclusion/exclusion criteria allowing the reader to consider the generalisability of the findings. All studies included a wealth of participant quotes to ground their interpretations in primary data and included clinical considerations and the value of the research.

Results

The overall inductive thematic synthesis, derived from data of included studies, is represented in a model of factors identified as influential on service user experience of formulation (figure 2). The findings suggest a phased model of the formulation process, which is likely to be iterative and non-linear, with specific factors that impact upon the service user's experience of the formulation process. The model comprises of four superordinate categories: rawness of telling my story; feeling understood by the therapist; own self-discovery and meaning making; and gaining hope through autonomy. Each superordinate theme had subgroups of factors which impact on service user experience through the process. Quotes from the studies have been included to give further clarity to the themes. Both first and second order data were used to identify the themes.

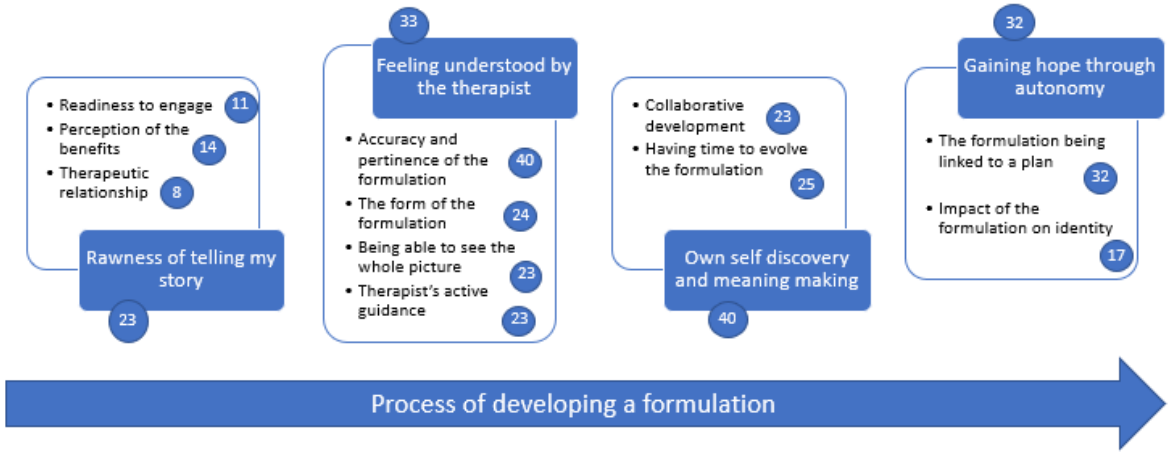

Figure 2: Proposed theoretical model

Rawness of telling my story

The theme *rawness of telling my story* was identified across 9 of the 11 papers, with a total of 23 references. This theme encapsulates the rawness many service users experience when asked to talk about their past experiences as part of the formulation process. Within the expert by experience group this was described as the process of opening an old wound, which on the surface may appear healed; however, when you start to look deeper the pain and rawness remains. The literature suggests talking about the past is more difficult for service users than talking about present difficulties:

> *"I don't think I felt so uncomfortable talking about the present day difficulties I'm having, but I did feel very uncomfortable talking about my family"* service user cited in Shine & Westacott, 2010:171.

Sharing their story with a clinician evoked a range of emotions from participants including sadness, pain and shock.

> *"It (waking up suddenly in the night) reminded me of when I had the abortion. It was only when we (participant and therapist) talked about it that I put those things together. And I burst into tears when I realized"* service user cited in Redhead et al, 2015;461

For some, the distress evoked by telling the story was overwhelming meaning the formulation was unable to be completed.

> *"Because I'm trying to put that in the past with (name) beating me and stuff like that and when it got up to (name) I'm just like I can't."* service user cited in Halpin et al, 2016:6.

Some participants were surprised at how much they felt able to discuss and disclose to the therapist and found the process also enhanced feeling hopeful about the future.

> *"I wasn't expecting to be able to talk about things, bring things up, and realising and getting to sort of the root of the problem in a sense"* service user cited in Tyrer & Masterson, 2018:172.

The overall experience of telling the story appeared to be impacted by a number of factors: readiness to engage in the formulation process, service user's perception of the benefits of telling the story and the therapeutic relationship. These factors independently and combined improve service users experience of telling the story and overall completion of formulation.

Readiness to engage in the formulation process:

Readiness to tell and explore one's own story is another factor impacting on service user experience of the formulation process. This factor was highlighted across 5 papers with 11 references. Discussing the past and becoming more aware of the perpetuating cycle of

difficulties can be difficult for service users to see when they are not ready for that part of therapy or the impact that information might have on their personal identity.

> *"It still eats me. It (his difficulties) ruined a 9-year relationship. And I'm not able to draw a line under it yet. I can't, it still makes me feel really low and depressed, not only about my relationship ending, partly because of it, but about things I've missed 'cause of my excuses"* service user cited in Redhead et al, 2015:461.

Formulation is a cognitively loaded task, for service users whose mental health difficulty impacts on daily functioning, the process of completing a formulation was overwhelming.

> *"I just couldn't get my head around it (SDR), at the time I was just like hazy with all the stuff that was going on, I was worried that I just couldn't take what he was saying"* service user cited in Tyrer & Masterson, 2018:172.

Having an explanation for the purpose of completing formulation, which is agreed by both therapist and service user, can impact on the service user's readiness to undertake formulation.

> *"It did help highlight where it all stemmed from but it doesn't feel like it's really helped me much . . . It didn't feel relevant to what I'm going through now"* service user cited in Halpin et al, 2016:5.

Service user perception of the potential benefits of formulation

This factor identifies the importance of understanding the potential costs and benefits of completing a formulation and making a conscious decision to engage in formulation due to a belief that the benefits outweigh the potential costs, particularly the possible emotional impact. This theme was found across 6 papers with 14 references.

> *"Yes, I was a bit wary at first in case it wasn't for me or, in case, or I would do something wrong because that is what I have always been afraid of, but you don't really have anything to be afraid of because it does work and it is more of a relief when you realise that"* service user cited in Kahlon et al, 2014:19.

Service users who had a good understanding of the rationale behind talking about their past and how it links to present difficulties appeared to have a more positive experience. There was an awareness of needing to go through the discomfort of acknowledging painful emotions in order to gain an understanding and making sense of mental health difficulties. One participant described it as a 'necessary evil'.

> *"You know, I nearly got there with the last lot of group CBT, but we just didn't get to the root of it...I think if we'd got to the abortion thing properly, it's really unfortunate actually, because I could have sorted this out sooner"* service user cited in Redhead et al, 2015:463.

Service users who were supported to weigh up the costs and benefits and make a decision felt they had more control, ownership and hope of the story telling process and therefore greater positive impact.

> *"I knew that it upset me, realising that it was all about having that abortion, but you do have to process it, and you do have to talk about it, and, you know, find some sort of outlet"* service user cited in Redhead et al, 2015:461.

Therapeutic relationship

This factor was identified in 4 out of 11 studies with 8 references. Developing a positive and trusting relationship with the therapist enabled service users to feel safe to talk about difficult topics and emotions. This suggests the need to build a therapeutic relationship

before sharing a formulation with the service user in order to ensure a more helpful experience.

> *"The relationship between therapist and patient has been quite a useful one, it hasn't been awkward talking about things and, erm yeah, I've never felt judged or anything really, sort of in a nasty way. And I think that's sort of useful for being honest"*
> service user cited in Shine & Westacott, 2010:170.

Feeling understood by the therapist

The early stages of formulation involve pulling together the service users' story to begin to understand how the past impacts on the present and what is maintaining it. This led to service users feeling understood and accepted by the therapist. This understanding seems to enable the service user to begin to reframe the mental health difficulty. This theme was found across 8 papers with 33 references.

> *"I think the letters are important to actually see a stranger being objective but still being kind, listening to you and putting it into black and white, for you then to look at, which makes you consider your own behaviour and it's frightening and it's upsetting in many ways but then it can help you deal with it I suppose or reassess things or just, it's literally just taking stock, standing still, taking a breath again and going "oh my god, I am doing what she did," or "I am doing this because of what she did to me"*
> service user cited in Tyrer & Masterson, 2018:170.

Feeling understood and accepted increased trust in service user's relationship with the therapist and showed the therapist had listened and understood their difficulties.

> *"It was quite upsetting things being put in black and white like that (in the reformulation letter), um but it was useful when he (therapist) picked things out, he's very astute. I think I was upset as well because I think I'd realised that no-one had*

> *listened to me, no-one, I had not had that in my life, you know, it was like having a supportive relative that I'd never had"* service user cited in Tyrer & Masterson, 2018:172.

Formulations that showed the therapist had understood the service user increased a sense of trust in the therapist.

> *"I thought, are they taking it all in, do they care. I couldn't trust them, but it's different now. At first I felt the same with my therapist, but since I've had the reformulation I've had 100% trust in her and don't hold anything back now"* service user cited in Evans & Parry, 1996:112.

Service users described how feeling understood by the therapist helped to validate and normalise the mental health difficulty. This seemed to reduce a sense of shame and stigma, and made problems seem more manageable.

> *"I'd got it all out and someone hadn't gone, 'you're stupid'. He'd just taken it in and understood. And him getting it and explaining it, it helped me come to terms with it"* service user cited in Redhead et al, 2015:460.

Four factors were identified as impacting on service users feeling understood and accepted by the therapist: the accuracy and pertinence of the formulation; the form of the formulation; being able to see the whole picture, and therapist's active guidance.

Accuracy and pertinence of the formulation impacted on feeling understood

In order to feel understood by the therapist, the formulation had to be accurate and meaningful from the service user perspective as well as the therapist and theoretical point of view. This factor was found across 7 papers with a total of 40 references

> *"It all just made sense. I got it (the formulation), because it was true. It seemed true to me anyway, it was all what (sic) I felt"* service user cited in Redhead et al, 2015:459

Inaccurate formulations led to a range of negative emotions such as upset, irritation and anger and suggested the therapist hadn't listened or understood.

> *"There were some factual things in it (the diagram), things she got wrong. Some judgemental things about the relative importance of different issues. But it wasn't worth arguing about, as I don't know what knowledge she had that I don't, from her training...she could have been right"* service user cited in Redhead et al, 2015:461.

The formulation needs to feel meaningful to the service user, if they do not feel it fits with their current understanding it is unlikely to feel beneficial. The service user feels less connected to the formulation if it includes some inaccuracies.

> *"I was even more surprised that one or two things hadn't been included, it sort of stood out even more that they hadn't' and 'I still think it's a bit pointless"* service user cited in Pain et al, 2008:133.

The form of the formulation impacted on feeling understood

This factor relates to how the formulation was presented to service users and whether it was understandable to them. Many service users valued having the formulation in a visual format. Seeing the information gave a different perspective to the mental health difficulties and allowed the service user to be more objective and empathic about the mental health difficulties. This factor was identified across 7 papers with 24 references.

> *"I definitely think that's (referring to SDR) helped a lot because as much as people can go on about things and say things to you, it's when you can see it written down it*

> *makes you more aware of it, and you take that on because you've got something to go back to and refer to"* service user cited in Tyrer & Masterson, 2018:171.

Formulations that were perceived as complex by the service user inhibited the service user feeling understood by the therapist and reduced the understanding of the mental health difficulty. They were also seen as less helpful. Those who found the formulation technically difficult and hard to understand did not connect to their formulations and preferred a simpler model with parts being added in stages rather than all presented at once.

> *"When I first looked at it, it was like a great sort of gobbledegook, with different bits everywhere. I'm an everyday sort of person. And that's not everyday sort of language is it? And it's not. I want a Cognitive Model of Panic for dummies"* service user cited in Redhead et al, 2015:458.

Being able to see the whole picture

One factor that increased a sense of being understood by the therapist was the role of the formulation in highlighting the whole picture of the service user story. This included making links between past experiences and current difficulties along with recognising maintenance patterns. This engendered a compassionate understanding and supported the service user in their recovery journey. This factor was found across 8 papers with 23 references.

> *"[therapist] helped show me the whole picture and then I realised I had it all wrong. I was missing important information out and blaming myself for things that were not my fault. I guess, I'd say therapy really helped me to have a more balanced view of things"* service user cited in Kahlon et al, 2014:24.

Developing an understanding helped to give an alternative perspective of the mental health difficulty by looking at the whole picture during the formulation process. This

understanding of the different factors impacting on the mental health difficulty allowed for a more normalising and compassionate view.

> *"It has actually made me realize that this has come back from way back, not just something in the present"* service user cited in Threw & Krohnert, 2015:8.

Therapist active guidance in developing the formulation:

There were a range of therapist skills that factored in the service user feeling understood. These were: being accepting, non-judgemental and normalising. This was found across 8 papers and 23 references.

> *"The relationship between therapist and patient has been quite a useful one, it hasn't been awkward talking about things and, erm yeah, I've never felt judged or anything really, sort of in a nasty way. And I think that's sort of useful for being honest"* service user cited in Shine & Westacott, 201:170.

The therapist's questioning style and active guidance tailored to meet the service user's needs increased a sense of feeling understood. *"She led it, and I needed that"* (service user cited in Redhead et al, 2015, p:459).

Own understanding

The review highlighted that for the formulation to feel effective from the service user view it needed to move from something the clinician has explained to something the service user takes ownership over. This increased self-awareness. This factor was found across 10 papers with 40 references

> *"My thoughts were all floating around at random, it was like a sort of storm inside my brain. But the diagram kind of took the pressure off...understanding it all was just like, phew, the storm was gone"* service user cited in Redhead et al, 2015:460.

Once service users had developed the formulation or discussed it with the clinician, a process of acknowledging and reframing began. This started a journey of sense making.

> *"Yeah, it made a bit more sense actually, it seemed to make sense of why I'd been feeling the way I'd been feeling, and how I could change things and change the way I think about things to make a difference basically, instead of thinking negative all the time"* service user cited in Kahlon et al, 2014:23.

The review identified two factors that appeared to impact on the service user experience of self-discovery and sense making; collaborative development of the formulation and having time to evolve the formulation.

Collaborative development of the formulation

Collaboratively developed formulations supported the service user to actively input into the development of the formulation. This encouraged open discussions with the therapist about potential inaccuracies and disagreements. This was found across 6 papers with 27 references. Active participation in the development of the formulation increased perceived benefits, as the formulation was felt to be owned by the service user rather than the therapist.

> *"I think, retrospectively, I realised it was more of a validation for me because it was coming from me and I was talking through everything myself and coming to my own conclusions. And I think it had more of an impact, and my clinician would affirm what I was saying or nod and I think, because she obviously thought the same things"* service user cited in Kahlon et al, 2014:13.

Developing the formulation collaboratively increased service user's ability to disagree with the therapist, suggesting power dynamics were less noticeable.

> *"Yes there was a lot of debate really actually, there was a lot of discussion and I felt like I could disagree or you know, I would try and take her points on board, erm, I felt like I was able to be very open, you know whether it was something I would consider or just give it a moment or say "it is not for me", or "I don't really agree that that is the case"* service user cited in Kahlon et al, 2014:17.

When the formulation was predominantly therapist led, service users were often unable to share feelings or discuss possible inaccuracies.

> *"I would think that it was something, when I looked at it, it was something that he developed. It wasn't something so much, it wasn't an interactive thing where we said 'oh okay what about this, what about that?', it almost felt like one day he came up with this thing and I was like looking at it going 'oh okay' rather than 'oh shall we change this?' and 'do you feel like this and like this?"* service user cited in Kahlon et al, 2014:14.

Collaborative development of the formulation also appeared to engender a sense of ownership of the tools and therapy in general. Service users subsequently felt empowered and in control.

Having time to evolve the formulation

This factor was found across 6 papers with 25 references. The importance of having time to independently change and test out the formulation was imperative to service users feeling their formulation made sense to them.

> *"Doing the diagram, first with (Therapist) in a session and then coming home and doing my creative bit on it … erm… and just seeing how ingrained this pattern we made a diagram of how it was for me in my childhood, with predominantly the relationship with my mum, and then when I came home I made my own diagram of*

> *what's going on now, and it was exactly the same … but I'm doing it to myself"* service user cited in Shine & Westacott, 2010:169.

When the clinician was perceived as working to the service user's pace, the service user felt more able to openly share feelings and to question aspects of the formulation with which they did not agree. Allowing time to understand the formulation helped service users to recognise harder to see patterns, and practice strategies.

> *"I could practise it, and that's what I did, I went home and I practised my [diagram]. And I would think something, and I'd think 'that's, yeah, of course it is, that's how I've always thought . . . .right, so I've always thought, right, what is another way of doing that"* service user cited in Rayner et al, 2011: 308.

Allowing time to evolve the formulation also helped with some of the initial negative emotions elicited by the formulation.

> *"Oh it was very hard to look at it at the beginning and to think that I had been thinking this way for so long. I wanted to just close my eyes and ignore what was in front of me. Some aspects were completely new to me. But once I started to revisit the formulation I started to realise that not all of the information was new, in fact I already knew some of it. But along the way I had stopped seeing the whole view – like selective vision"* service user cited in Kahlon et al, 2014:16.

Gaining hope through autonomy

This theme was found across 6 papers and 32 references. The findings suggested the formulation process helped to develop feelings of hope and autonomy. Feelings of hope were engendered from developing a sense that things could change, and change was in part in the control of the service user.

> *"I just seem to know myself much better now – I know, erm, why I feel the way I do and this has kind of made me more self-confident. I still feel the same feelings as before, but now I know that the way I feel is no different to other people. And I know the dark feelings will pass and when I feel that way it's like I now know I'll be able to deal with it no matter what life throws my way"* service user cited in Kahlon et al, 2014:20.

The thematic synthesis suggested there were two factors that impacted on service users gaining hope and autonomy from the formulation process: the formulation being linked to a plan, and the impact the development of the formulation had on the service user's identity.

Formulation being linked to a plan

Formulations that were linked to a plan or strategies to help the service user break their maintenance cycle and progress in the recovery journey helped to instil a sense of hope and agency. This was found across 8 papers with 32 references. Service users reported rereading the formulation, sharing it with others, using it as a tool to cope, and referring to it to gauge their progress or manage difficulties by implementing the suggestions.

> *"My problems kind of shrunk for me, after grasping what to do, everything kind of seemed much better for me in myself and people around me. I started to get less anxious and more, I don't know, kind of bouncy instead because you feel low and you feel high, but I suppose you don't shut the lows out – you kind of prevent them instead"* service user cited in Kahlon et al, 2014:22.

Service users also felt having an accurate and meaningful formulation helped to organise the rest of therapy and gave a rationale for the therapeutic work.

> *"We wouldn't have, you know, had the cycles and things like that so, you could go on*

about however many unhelpful thoughts and things that you had, but if you didn't have the pattern . . . we wouldn't really actually see what they then . . . what it turned into" service user cited in Threw & Kronhert, 2015:9.

Impact of formulation on identity

This factor was found across 2 papers with 17 references. The sense of hope and agency experiences through the formulation process was related to the impact formulation had on service user's sense of identity. For those who felt formulation aided in rediscovering their identity this led to hope.

"Erm, day-to-day. I can think clearer. I was always saying 'I'm confused, I can't think straight, I can't work things out, I can't make decisions' and I couldn't. I genuinely thought I couldn't. But I think I'm now starting, you know, at the end of the tunnel sort of thing. I think I'm now starting to be able to think for myself again, which is nice. It's horrible to be, I suppose the best way to describe it is walking around in a fog, and you're lost. You are lost. You don't know which way to go, you don't, you lose your identity even. And to get that back is, it's lovely. To be able to think for yourself again, yeah, that's important" service user cited in Kahlon et al, 2014:21.

However, for others the increased understanding from formulation was incongruent to their identity and caused distress.

"It still eats me. It (his difficulties) ruined a 9 year relationship. And I'm not able to draw a line under it yet. I can't, it still makes me feel really low and depressed, not only about my relationship ending, partly because of it, but about things I've missed 'cause of my excuses" service user cited in Redhead et al, 2015:461.

Discussion

This thematic synthesis aimed to collate research into service user experience of formulation, to understand what factors contribute to this in order to help inform practice. The phased model, derived from the synthesis of studies, described an iterative and non-linear process of developing a formulation. This process is impacted by a range of factors which further affect the service user experience of the formulation process. The model has similarities to the assimilation model of change (Stiles et al., 1990) in psychotherapy whereby service users move progressively along the model from unwanted thoughts to creating problem solutions.

The first process highlights the difficult nature of talking openly about past experiences to a stranger and how dismissive this can feel if this is not managed in a careful and compassionate way. The disclosure of distressing information can have cathartic benefits (Frattaroli, 2006); however, for some it has the opposite outcome. It highlighted the importance of exploring with service users the rationale behind formulation, what they will expect, and being open around the potential for it to be a difficult and distressing time. This active and informed decision making is likely to increase service user experience and their motivation. This is interesting for the process of therapy and shows the need to create a trusting relationship prior to discussing more difficult topics. Trust in the therapist further increases when an accurate and meaningful formulation is developed, this is similar to previous literature around formulation increasing the therapeutic alliance (Shine & Westacott, 2010).

As expected, the therapist skills play an important role in experience of formulation; however, it is only one of many factors that helps the service user feel understood by the therapist. Formulations being accurate and meaningful to the service user were an important factor in the service user experience, highlighting the importance of the formulation being

useful to the service user as well as the therapist or meeting theoretical stance (Johnstone, 2013). Service users who perceived the formulation to be inaccurate did not always feel able to talk to the therapist about this, suggesting clinicians need to be aware of the impact of potential power imbalances (Redhead et al., 2015).

The review identified the importance of the service user developing agency and control over the development of the formulation. This is similar to research into recovery, which has reported agency to be an important factor for recovery (Davidson, 2003), as well as empowering the service user to become the expert in the recovery journey (Perkins & Slade, 2012). Collaboration plays an important role in service user experience of formulation and is essential for any therapeutic process; it is often recognised as a core and important part of the formulation process (Dudley and Kuyken, 2013); findings suggest this is not always happening effectively. The findings in the review are consistent with previous research which suggest service user experience is more positive when the formulation is developed collaboratively (McManus, Peerbhoy, Larkin and Clark, 2010). Collaboration appeared to reduce the impact of power dynamics in the therapist-service user relationship, and empowered service users to openly discuss differences of opinion and potential inaccuracies. Allowing time for service users to consider the formulation outside of the therapy environment, and how it informs daily experiences was another important factor. The time to encompass the formulation into daily lives led to the service user having ownership of the formulation and in turn the mental health difficulties, which engendered a sense of hope.

Another phase of the formulation process involves the service user becoming autonomous in the therapeutic relationship and using the formulation to make changes. Research from the recovery approach reports the importance of moving from professional led care to empowering the service user to become experts in their own recovery process (Perkins & Slade, 2012). The key concepts found to be important in personal recovery are

conceptualised by the CHIME framework (Leamy et al., 2011).: Connectedness, Hope and Optimism, Identity, Meaning and Purpose, and Empowerment. This process is facilitated by the development of a plan linking to the formulation and leaves service users with a sense of hope for the future. This link between hope and having a plan is similar to findings from Snyder et al. (2000) which highlighted for hope to benefit the therapeutic process it needs to be more than just a 'feeling of optimistic advice-giving', it requires 'clear aims and plans to be of full benefit. These elements were identified within the literature.

One interesting finding from the review was the impact formulation has on service users' identity, for some this impact was positive and led to assimilating the mental health experiences into identity and developing identities beyond the mental health diagnosis. However, for those where the information was incongruent to their perception of themselves this caused distress. This is similar to findings by Eells (2007) who found accurate formulations can discourage patient engagement if it resonates with unconscious conflicts at the time.

An exploration of how these findings could inform clinical practice are detailed below.

- Building a trusting and safe relationship prior to developing the formulation may improve service user experience.
- The process of developing a formulation evokes a range of emotions for service users, some positive and some more difficult. Whilst experiencing difficult emotions during the formulation process does not mean the service users overall experience is negative, it may be important to consider strategies to support this within and outside therapy.

- As part of the introduction to therapy, it may be beneficial to discuss the potential emotional impact on service users as well as the possible benefits. This may help to engender a collaborative relationship.
- Throughout the development of the formulation, service users may benefit from open discussions about the perceived accuracy of the formulation, and how it fits with their understanding. Collaborative development should be emphasised throughout.
- When developing the formulation, it may be beneficial to start with a simple formulation, adding complexity as the sessions progress. Including a pictorial version of the formulation, which can be added to outside of therapy sessions, helped increase understanding and ownership
- The development of the formulation should be a collaborative process throughout. Pre-developed formulations shown to the service user appear to negatively impact on the service users experience.
- It may be beneficial to ensure service users are given time to evolve the formulation outside of therapy and link it to current experiences.
- Linking the formulation to a meaningful and achievable plan, made collaboratively, appeared to improve service users experience of the process.
- Clinicians may benefit from considering the potential impact the development of a formulation may have on service user's identity, especially if this is incongruent to currently held beliefs.

Future research

This thematic synthesis has highlighted a number of useful findings that should be considered when undertaking future research into service user experience of formulation with therapists. The findings suggest there is sufficient research using a qualitative approach to identify overall service user experience of developing a formulation. Therefore, future

research should aim to focus more around the therapeutic change processes and/or factors, to understand which processes are related to positive experience of formulation. The model developed within this thematic synthesis could be used to inform this type of process research. Considering the feasibility of formulation may also be a useful avenue to develop this research area further and what defines usefulness for the service user. As suggested by Johnstone (2013), usefulness rather than validity and reliability may allow for a better understanding of the impact of formulation from the service user's perspective.

It is important that the methodological rigor of future research is considered to ensure they add to the literature base and inform clinical practice. The quality review within this thematic synthesis identified there was a limited amount of information available pertaining to the specific details of the study design. For example, the number of formulation sessions, the type of formulation and theoretical underpinning and how the formulation was developed with the service user. Additional information about the analysis was also noted to be missing from many studies including, the length of interviews, the time between formulation and interview, information about the analysis plan and rationale for using the specified analysis. Future research should aim to be more explicit around information in these areas to enable a better critical review of the research conducted and support future systemic reviews.

Limitations

The systematic review used broad inclusion criteria. This meant there was high variability in the papers, including the amount to which service user experience was the primary focus of the research. Even with this broad scope, there was a limited number of papers available. The methodological validity of the current review could have been enhanced through the use of a second reviewer of the themes identified. There is currently no agreed definition of the term formulation and it can vary on the content, approach,

complexity, theoretical foundation, and spectrum of information included in case formulation. This variety hinders the ability to effectively research formulation, as there are individual differences between clinicians that may impact on the findings and overall interpretations. This review also identified the large methodological differences between studies.

Conclusion

This systematic review offers an understanding of the factors influencing service user experience of formulation. The findings proposed in this review have been derived from evidence through a co-produced process of thematic synthesis. Research into this area is in its infancy and further exploration of the identified theoretical phased model and factors could be beneficial. If service user experience of formulation is better understood, the process of formulation can be adapted to increase the usefulness to the service user. It is important to note that the small data set used to inform the model, and individual differences pertaining to the formulation process, should be recognised. These factors could be used by clinicians to inform and potentially enhance the service user's experience of formulation. Formulation is not limited to clinical psychologists and an increase in its use by other disciplines could improve service user experience of mental health services. The findings from the thematic synthesis could be used to inform the training of other professionals.

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Chapter 3: Bridging Chapter

Chapter overview

This chapter aims to summarise the findings from the systematic review and outline how the empirical paper addresses any identified limitations. Consideration of how the empirical paper adds to the evidence base will be discussed.

Systematic review summary

The overall aim of the thesis portfolio was to understand the service user perspective on, and experience of, psychological formulation and operationalise the factors that impact on this, with the hope that this knowledge will help to improve the overall experience of formulation.

The psychological principles and theoretical content which formulation is based on has been researched extensively (DCP, 2011) however, there are many areas of research still missing, particularly incorporating service user perspective. One recommended way of exploring psychological formulation is to consider its usefulness to the service user (Butler, 1998; Johnstone, 2013). Research into service user experience is needed to help inform clinical practice to ensure formulations are developed in a respectful way, collaboratively with service users, to enhance potential benefits and reduce possible negative effects (DCP, 2011).

Service user perspective is missing from the literature and there is no clear understanding around how useful service users perceive formulation or the specific factors that impact upon this. The systematic review hoped to add to the current literature base through identifying and reviewing current research into service user experience of formulation and operationalising the factors that impact upon this. To the researcher's knowledge this was the first systematic review in this area.

The thematic synthesis developed a preliminary theoretical framework detailing the iterative and non-linear process of service user experience of developing a formulation. The framework involved four phases: rawness of telling the story; feeling understood by the therapist; own self-discovery and meaning making; and gaining hope through autonomy. The experience of each phase and overall formulation process were impacted by specific factors; readiness to engage; perception of the benefits of formulation; therapeutic relationship, accuracy and pertinence of the formulation; form of the formulation; being able to see the whole picture; collaborative development; having time to evolve the formulation; being linked to a plan; and the impact of formulation on personal identity. The experience of service users appeared to vary across the formulation process and a range of both negative and positive emotions were evoked. The systematic review supplemented the current literature base by operationalising factors that impact upon service user experience of formulation and considered how these may inform clinical practice.

Empirical study purpose

The empirical paper aimed to develop the theoretical framework proposed in the systematic review, to enhance understanding around service user experience of formulation. The themes from the systematic review were therefore used to develop the topic guide for the empirical paper.

Incorporating psychological formulation across mental health services has been suggested to improve overall experience and outcomes for service users throughout their recovery journey (Bensa & Gregg-Rowbury, 2016). Mental Health Trusts have begun supporting staff members, who have not received extensive psychological training, to develop psychological formulations with service users. Although it has been proposed this could lead to a range of benefits to the service user, to date there is no research exploring this

claim. The theoretical framework developed in the systematic review may serve to inform research into service user experience of formulation developed with mental health staff. The next chapter details the empirical paper which addresses this question by interviewing service users who have developed a formulation, with a member of staff who has not received extensive psychological training, to understand their experience and identify what factors impacted upon this.

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Chapter 4: Empirical Paper

Qualitative Research Paper Prepared for Submission to Psychology and Psychotherapy: Theory Research and Practice

Service user understanding and experience of formulation in the context of a multi-disciplinary team approach: An exploration using Thematic Analysis

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Abstract

Objectives: To explore service user's experience of the formulation process when delivered by a member of the Multi-Disciplinary Team who has not received psychological training, with a focus on understanding factors that impact upon service user experience.

Design: A qualitative study using inductive thematic analysis. The study's underlying epistemology falls within the contextualist methodology and is underpinned by critical realism.

Methods: Six service users who had developed a formulation with a member of the MDT were interviewed individually, using semi-structured interviews, about their experiences of formulating.

Results: Six themes were drawn from the service users data. The themes were: (1) formulation increased service user understanding of their mental health difficulty; (2) nature of the relationship enhanced the formulation process; (3) timing of the formulation in service user pathway; (4) beneficial nature of the formulation; (5) formulation as an evolving process- service users gaining ownership; and (6) formulation impacting on recovery.

Conclusions: To the author's knowledge, this is the first research into this area. The findings suggest implementing a 5 Ps formulation with members of the MDT, can serve to have multiple benefits for service users to enhance and support their recovery journey whilst within mental health services. This is preliminary research into the area and would benefit from being explored further to really understand the factors impacting service user experience and how this can be applied to clinical practice.

Introduction

Formulation is considered a core skill for clinical psychologists (Division of Clinical Psychology, 2010) and is a central component in most therapeutic approaches. There is no universally agreed definition of formulation and the purpose and use varies depending on the theoretical perspective taken. The definition used in the Division of Clinical Psychology Good Practice Guidelines is 'formulation summarises and integrates a broad range of biopsychosocial causal factors. It is based on personal meaning and constructed collaboratively with service users and teams' (DCP, 2011, p. 2).

Formulation can provide a structure for helping the service user understand their experience and how to continue their recovery journey; it can serve multiple purposes. Many of these relate to how the formulation can be used as an aid for the therapist to understand and deliver effective interventions. Additional purposes have been suggested by the DCP (2011, p.8) including: helping the service user to feel understood and contained, encouraging collaborative work, normalising problems, reducing service user self-blame and increasing the service users' sense of agency, meaning and hope.

There remains a paucity of research incorporating service user experience of formulation. The process of developing a formulation has been shown to evoke a range of emotions from positive feelings such as relief, hope, optimism (Chadwick, Williams & Mackenzie, 2003; Pain, Chadwick & Abba, 2008; Redhead , Johnstone & Nightingale, 2015; Rayner, Thompson & Walsh, 2011) to negative emotions including distress, shock and feeling overwhelmed (Chadwick et al., 2003; Evans & Parry, 1996; Halpin, Kugathasan, Hulbert, Alvarez-Jimenez & Bendall, 2016; Pain et al., 2008). Factors proposed to increase a positive experience include the formulation being developed collaboratively (Kahlon, Neal & Patterson, 2014; Rayner et al., 2011; Shine & Westacott, 2010), the formulation being

accurate, according to the service user (Kahlon et al., 2014; Redhead et al., 2015) and the therapist's guidance and accepting stance (Kahlon et al., 2014).

Within the current NHS climate, organisations are having to re-examine how mental health services are delivered. It is recognised that service user involvement should be at the heart of services, and there should be 'no decision about me, without me' (CQC, 2013; Department of Health, 2012). Care planning should be individualised and collaborative with the service user to enhance quality of care and facilitate recovery (Department of Health, 2012). Grundy et al. (2016) investigated service user experience of care planning and identified a lack of focus on recovery and a need for more recovery-based care which is individualised and holistic. There is little research into the use of psychological formulation by adult mental health staff (Bensa & Gregg-Rawbury, 2016). However, it is suggested that the individual and collaborative nature of formulation supports staff to see difficulties as more understandable and increases individualised care planning; which may lead to better outcomes for service users. Additionally, formulation meets many of the NHS values set out in the 6C's approach to care; care, compassion, courage, communication, commitment and competence (Roach, 1984).

Within the Offender Management Services there has been a push to support suitably trained probation officers to complete formulations (Brown, Beeley, Patel & Vollm, 2016). Findings suggest participants showed significant improvement in most areas. However, feedback from staff members identified they had reservations of their role as case formulators as being outside their competency (Brown et al. 2016). A one-day training package on the 5 P's model of formulation, delivered to adult mental health staff, appeared to increase staff knowledge, attitude, confidence and competence in developing formulations (Bensa & Gregg-Rawbury, 2016).

The development of formulation can be a complex skill for psychologists to develop (Dudley, Park, James & Dodgson, 2010) and can evoke difficult emotions within service users (Redhead et al., 2015). Creating an understanding of how service users experience developing a formulation with a member staff, who has not received psychological training, could serve to inform how psychological formulation could be embedded into the service, along with factors that need to be considered to promote a positive, recovery focused experience. Therefore, it would be useful to capture service user experience of formulation delivered by staff who do not have psychological training and investigate whether this appears similar to what the literature says are the central components and functions of formulations delivered by psychologists.

Aim

This study aimed to develop previous research findings of service user experience of formulation. To explore the experience of the formulation process when delivered by a member of the Multi-Disciplinary Team who has not received psychological training, with a focus on understanding factors that impact upon service user experience.

Research Question

The research questions for the current study are:

1. How do service users within adult mental health teams experience the process of the 5 P's formulation template, delivered by a member of the Multi-Disciplinary Team?
2. What factors impact upon this experience?

Methodology

Design

In-depth interviews with service users who had developed a formulation were undertaken. Data comprised transcripts of interviews, which were audio-recorded and transcribed by the researcher. Prior to data collection, approval was obtained from an NHS Research Ethics Committee (Appendix B, C), the Health Research Authority (Appendix B, C) and relevant research and development departments. The Standards for Reporting Qualitative Research: A Synthesis of Recommendations by O'Brien, Harris, Beckman, Reed and Cook (2014) were followed to enhance quality and transparency.

With a lack of research in the area of service user experience of formulation, Thematic Analysis was identified as the most appropriate methodology to answer the research questions (Braun & Clarke, 2006). Thematic Analysis allows theoretical flexibility (Braun & Clarke, 2006). The current study's underlying epistemology falls within the contextualist methodology and is underpinned by critical realism (Willig, 1999). Contextualism purports there is no single reality and acknowledges that knowledge emerges from contexts and is impacted by the researcher's position (Madill, Jordan & Shirley, 2000). However, contextualism assumes a form of 'truth' can be understood in some way (Braun & Clarke, 2014). Critical realism recognises 'the existence of reality, both physical and environmental, as a legitimate field of inquiry, but at the same time recognises that its representations are characterized and mediated by culture, language, and political interests rooted in factors such as race, gender, or social class' (Ussher, 1999, p. 45).

Researcher characteristics and reflexivity

The researcher was a Trainee Clinical Psychologist, undertaking research as part of the doctoral programme. Formulation is promoted as a key component of clinical psychology

and played a central role throughout the researchers' placements. The researcher had a positive view of the benefits formulation can provide for the service user and clinician as well as an understanding of how formulation should be completed. A range of strategies were employed to improve reflexivity throughout the research process including keeping a reflective journal. Reflexivity can enhance the transparency, accountability and general trustworthiness of qualitative research (Coffey & Atkinson, 1996). Additionally, themes were discussed with experts by experience involved in the formulation project as well as within supervision.

Method

Context

A Mental Health NHS Foundation Trust developed a formulation template and training package based on the 5 P's; a framework for CBT formulation that helps link the persons experience to the cognitive model by using the five areas; presenting issue, precipitating factors, perpetuating factors, predisposing factors and protective factors (Dudley & Kukyen, 2013). These were developed collaboratively with experts by experience. The pilot study was based within an Integrated Delivery Team (IDT) consisting of a range of community mental health teams: youth, adult, older adult, eating disorder. The project originated from a review of service user experience and findings from serious untoward incident reports. These identified a lack of clinical curiosity, lack of service user involvement and shared understanding. It was suggested the perceived benefits of formulation could support improvements across these areas. Staff members were encouraged to introduce formulation to new and existing service users.

Participants and recruitment

Participants were recruited across the IDT, provided they met the inclusion criteria. A purposive sampling method was used. A total of six participants were recruited, homogeneity provided by inclusion and exclusion criteria:

Inclusion criteria for service users:

- Aged 18 or over, with a recognised mental health difficulty for which they are receiving support from the specified secondary mental health service,
- Completed the 5 Ps formulation template with a member of the multi-disciplinary team.

Exclusion criteria for service users:

- Not fluent in speaking and understanding English excluded due to the time constraints placed upon the research.
- Lack capacity to consent, lack the cognitive ability to take part, or are functionally impaired to the extent of being unable to take part,
- Participation is deemed unsafe to themselves or others by their care co-ordinator.

Data relating to the formulation process have been included to give context and background to the analysis (Table 3).

Pseudonym	**IDT service**	**Length of time in service**	**No. of formulation sessions**
Becky	Eating Disorder Team	1 month	6
Alice	Eating Disorder Team	3 months	1
David	Adult Mental Health Team	2 ½ years	4

Jade	Adult Mental Health Team	Outset	10
Amy	Adult Mental Health Team	2 months	2
Ben	Adult Mental Health Team	4 years	4

Table 3: Service user information

Procedure

The researcher was invited to join the formulation project steering group to disseminate information about the research, to inform the service development work. The Participant Information Sheet was used by care co-ordinators to share information about the research (Appendix D), service users who showed an interest completed the consent to contact form (Appendix E). Capacity to consent was assessed by the care co-ordinator, as part of routine practice.

Service users were contacted via their preferred contact method. The participant information sheet (Appendix D) was explained in detail and the service user had the opportunity to ask any questions. Interviews took place in person, other than one interview by telephone due to COVID-19 restrictions.

Data collection

Data were collected through semi-structured interviews. The topic guide (Appendix F) was co-produced with the experts by experience and informed by a thematic synthesis of qualitative research on the factors that impact on service user experience of formulation, undertaken by the lead author.

Written consent was obtained for each participant on the day of interview (Appendix G), following discussion to confirm capacity to consent. The formulation definition ‘a formulation is a way of making sense of how mental health difficulties have developed, what

keeps them going and what needs to change to feel better, achieve your goals and live well' used within the formulation project was given to participants to orientate them to the interview. A blank copy of the formulation template was presented to aid memory and help focus the interview (Appendix H). Some participants bought their own formulation to the interview. Participants completed the demographic information form (Appendix I). All interviews were audio-recorded and transcribed by the lead author following the orthographic process. Participants were assigned a pseudonym.

Data analysis

Initial thoughts were noted during the transcription and analysis process to obtain reflections on the data. Analysis was completed using NVivo software.

Interview data were analysed using an inductive method which generates themes from the bottom up. The researcher was an active participant in the generation and organisation of themes and undertook an interpretative rather than purely semantic stance to data analysis. Data analysis was undertaken following the six recursive phases detailed by Braun and Clarke (2006).

A codebook was created (Ando, 2014) detailing the quotes that inform each theme. To enhance trustworthiness, a blank version of this was given to an assistant psychologist to independently code a random selection of 25%. The reliability was calculated, and discrepancies discussed. Four experts by experience were also involved in the analysis process, a portion (25%) of the quotes from each theme were discussed and coded with the experts by experience. Additionally, discussions around the naming and description of the themes were undertaken to improve their pertinence to the intended audience.

Findings

Six themes were drawn from the service users data: formulation increased service user understanding of their mental health difficulty; nature of the relationship enhanced the formulation process; timing of the formulation in service user pathway; beneficial nature of the formulation; formulation as an evolving process - service users gaining ownership; and formulation impacting on recovery. Themes are described and illustrated with quotations from service user interviews.

Formulation increased service user understanding of their mental health difficulty

A common theme across all six service users was the formulation process led to an increased understanding of their mental health difficulties. Four service users, who were introduced to the formulation towards the beginning of care co-ordination, stated their increased understanding derived from noticing factors that impacted upon their mental health. For the other service users, formulation brought previously discussed information together to create a coherent narrative. They explained how the formulation was introduced towards the end of their treatment and described themselves as 'on the road to recovery'. The formulation template enhanced understanding by being in one place. Two service users explained how the formulation template helped to initiate discussions with others, particularly their friends and family.

> *'It definitely felt like I'd kind of had a bit of a journey, you know gone through everything and come out of the end of it in terms of understanding the problem' – Becky*

The formulation process supported service users to talk openly and in detail about their journey. For three service users it was this detail which increased their awareness and helped to positively reframe the mental health difficulty. The level of structure and detail

introduced through the formulation enabled discussions about issues that had not previously been considered or the service user had been trying to avoid. It is possible the formulation template helped the service user to focus on significant issues. For Becky, this detail aided the conversations to feel more containing and purposeful.

> *'Looking at it and seeing that we would actually be exploring things in detail it felt quite comforting that actually we were gunna be looking into things deeply rather than just chatting' – Becky*

All service users discussed how visualising their story enabled them to confront issues they had previously avoided, evoking responses from "relief", "happiness" and "awareness" to "hard", "upsetting", "scary" and "jolting". The process of writing information down helped increase their overall awareness and 'acceptance' of the mental health difficulty. Being able to put thoughts and experiences into writing and sharing these with the staff member was challenging for four of the service users. Having the information written down meant service users couldn't "hide from it" and visualising the information made it more "official" and "final".

> *'It kind of it was a bit jolting, You can't really escape from it then can you it's right in front of your face unless you start ripping it up and throwing it in the bin but otherwise it's there you know and other people have seen it' - Alice*

Amy explained that writing her experiences down involved admitting they were real and something she needed to be aware of to move forward in her recovery journey.

> *'At first it was kinda like upsetting really, it was like oh that's not good and it was hard to admit that and having it written down was admitting that's how I actually felt' - Amy*

Most service users (five out of six) felt the benefits of talking in detail outweighed the associated difficult emotions. However, the experiences highlight the possible difficulties in exploring both past and current experiences; the timing and therapeutic relationship were important factors to support this.

Nature of the relationship enhanced the formulation process

The relationship and support offered by the staff member was an integral part of the formulation process. All service users described the importance of having built a relationship with staff prior to the formulation. This relationship was built upon staff qualities such as showing they were "non-judgemental", "listening", "normalising" and being "easy to talk to". The service users described needing to feel "safe" and "comfortable" within the relationship.

> *'I think it was definitely good that we had quite a few appointments before to build that kind of comforting relationship and then at that point when doing this I was comfortable to write it all down ….so I think it's important to have that relationship before doing it' – Amy*

Service users reported the formulation process helped staff members to understand their story and thus offer more person-centred support. All positively described a collaborative relationship with staff. The importance of support being flexible, and person-centred was identified as helping to increase a feeling of collaboration. This was particularly around the level of active guidance used by staff.

> *'I definitely felt like it was something we were doing together as opposed to her just saying this is what you need to do, you need to put this here, this there' – Becky*

Staff skills and knowledge were essential to support the service user to engage in the formulation. This was more important at the beginning of the formulation process, when service users reported feeling unsure of what to say and write. Four service users explained

how the curious stance of the staff member helped to explore and to develop their understanding. Alice explained how she felt the balance between staff member "delving into areas" and service user control was well balanced.

Four service users requested the staff member to write the information onto the formulation template and did not feel this impacted upon ownership or control over the formulation process. All felt able to disagree with the staff member and state what they wanted to be included or missed out of their overall formulation. The therapeutic relationship and staff checking prior to adding information supported collaborative development of the formulation.

> *'Oh yes spot on, well [staff member] wouldn't have written it down if it wasn't, before she wrote it down she would tell me what she was writing. It wouldn't have been written down if it didn't apply to me at all, I would have said no that's not right' – David*

Ben completed the formulation independently at home and explained how the lack of staff support significantly impacted upon his overall experience of developing a formulation. He reflected his experience may have been more positive if undertaken with the support of the staff member particularly to discuss his past and felt this would have countered negative thinking.

Timing of the formulation in the service user pathway

All service users discussed when in the service user pathway, the formulation should be introduced. Three service users were introduced to formulation near discharge. They reflected this was less effective and would have preferred the introduction earlier in the pathway. The other service users appeared to gain more from the formulation process, although also reported more negative emotions, suggesting greater emotional impact. All

service users described needing to be ready to fully engage in the formulation process. Both personal readiness and feeling ready within the therapeutic relationship was required. Service users described the importance of being "open" and "transparent", being willing to talk about difficult subjects and being able to put their thoughts and emotions into words.

> *'You need to be comfortable communicating your feelings. Personally … I don't really see how this would work if you weren't prepared to do that because if you hide lots and are not open about it then it might be a bit pointless' – Becky*

Beneficial nature of the formulation

The formulation process helped to increase service user awareness of how the difficulty was maintained; all service users described becoming aware of different strategies and triggers. The formulation made service users more aware of a range of coping skills already known to them and increased motivation to use them. They felt better able to notice when becoming stuck in negative thinking patterns and were able to "pre-prepare" for similar situations. Being able to refer to the formulation meant service users could try and identify what may be causing a difficulty or a change in presentation. Jade described how the formulation changed her perception on which strategies were helpful. She found this aspect particularly helpful, especially after having time to see a beneficial impact.

> *'Like in your eyes it is a protector but in a way it's not it's actually a trigger so by seeing it from somebody else's point of view it's so much easier than seeing it from just yourself' – Jade*

Jade also used the formulation to explain her difficulties to others, especially her friends and work colleagues. She described how having her story written down in one place allowed others to have a better understanding, not only of her difficulty but also how to support her more effectively; the formulation diagram removed some of the barriers to

sharing with others. Becky and Alice however, reported they would be unlikely to share their formulation; one due to feeling she was independent, the other due to worries about how it would be perceived.

Formulation as an evolving process – service user gaining ownership

Five service users described the importance of the formulation being an evolving process. All service users felt they would add to their formulation to continue supporting the recovery journey. Developing the formulation slowly "*helped move from it being quite scary and overwhelming to it being useful*" (Amy). Adding to the formulation outside of sessions was an important part of the process, it enabled four service users to link the formulation to everyday situations. This increased ownership of the formulation. Jade discussed how taking the formulation template home also allowed others to add to the formulation. It is possible that developing the formulation outside of sessions increased service users awareness and understanding through actively noticing triggers and coping strategies.

> *So it was being used outside of the session as well because if I was doing something and I thought, okay I've just realised that's a trigger, I could write that down, you can't necessarily always think of everything when you're in that 45 minute session - Becky*

Formulation impacting on recovery

The formulation process helped to develop acceptance, normalised difficulties and promoted kindness to self. Service users felt optimistic and empowered in their ability to make changes, feeling more in control rather than being stuck in negative thinking traps. The formulation process appeared to increase service users sense of self and being able to see opportunities to respond differently to difficulties.

'I think the biggest thing would just have been I think this helped me quickly understood me, like where I'm at, so I think maybe it would have been longer of just accepting it whereas having it written down helped me accept it and then move on, like work on getting better, so that could have took a lot longer I think without it' – Amy

In comparison, Ben's experience of the formulation process negatively impacted upon his sense of self. The new realisation left him feeling to blame for his current situation and how he had chosen to respond in the past. Ben's experience of formulation was different to the others because he completed it without the support of a clinician. This could highlight the impact of a less well-developed collaborative formulation when this template is used without a member of staff, however this was not examined as part of the current study.

'Sometimes there's things you don't necessarily want to visualise and you know, just sort of seeing how things had affected me it was like okay, maybe I should have done that, maybe I should have reacted slightly different way you know, there was lots of questioning in that part' – Ben

Amy found the initial formulation evoked difficult emotions, she explained having time away from the formulation and then revisiting it later gave her the most benefit, almost as a way of testing the formulation for accuracy. Revisiting the formulation, and seeing positive changes, also helped Jade process the formulation and motivated her to continue using the skills.

'It was just you could see progress and the differences and it was nice to have that, oh okay I wrote this when I was feeling like this, but now there's actually these little improvements so it gave me kind of drive to keep going and motivation which was nice' - Jade

Discussion

The current study explored service user experience of formulation undertaken with a member of the MDT, and the factors impacting on this experience. The findings identified six themes: formulation increased service user understanding of their mental health difficulty, the nature of the relationship enhanced the formulation process, the timing of the formulation in the service user pathway, the beneficial nature of the formulation, formulation as an evolving process – service users gaining ownership, and formulation impacting on recovery.

Formulation increased service user understanding of their mental health difficulty

This was the most common theme across all six interviews, suggesting formulation did support service users to gain a better understanding and awareness of their mental health difficulties. This has been a prominent theme in other research investigating service user experience of psychological formulation (Redhead et al., 2015; Chadwick et al., 2003; Pain et al., 2014).

The level of understanding appeared different to research into service user experience of formulation with a psychologist. In the current study, understanding was facilitated by noticing triggers and coping skills, with less focus on maintaining factors. One of the core purposes as outlined by the DCP (2011) is linking psychological theory with personal experience. Previous studies found less experienced CBT clinicians struggled to identify components of the formulation that are theory-driven (Dudley et al., 2010). The formulations were completed by non-psychologist members of the MDT and therefore psychological knowledge is likely to have varied between professionals.

The current study found service users valued the opportunity to have detailed and meaningful discussions with their care co-ordinator. The structure of the formulation template may support staff members to move from ‘having a chat’, to creating an understanding that

informed and motivated service user's recovery journey. The formulation template supported staff to talk about areas that are sometimes more difficult to discuss. There can be a tendency to miss or avoid difficult conversations, with more focus on current mental health. The formulation template may support care co-ordinators to have these conversations.

Seeing their story written down evoked difficult emotions, as shown in previous findings (Shine & Westacott, 2010) and was related to becoming more aware. Although most felt this was beneficial to their overall recovery journey it highlights the importance of considering this with the service user when introducing formulation.

Nature of the relationship enhanced the formulation process

Within the current study, the formulation was described as collaborative. Collaboratively developed formulations increase feelings of being understood and participation (Kahlon et al., 2014), suggesting it is imperative that formulations are completed collaboratively, at the service users' pace.

A range of staff qualities were seen to be important in the development of the formulation: listening, trustworthy and being non-judgemental. Research identified similar qualities in the therapist skills underlying better therapeutic relationships (Evans-Jones, Peters & Barker, 2009). The therapeutic relationship supported the collaborative development of the formulation. Service users identified the therapeutic relationship empowered them to challenge and disagree with staff about the content of the formulation. Concerns about the impact of power in the development of formulation have been discussed (Redhead et al., 2015).

Timing of the formulation in the service user pathway

The timing of formulation impacted upon service user experience. Early introduction of the formulation seemed to have greater overall impact on service user understanding,

awareness, acceptance and motivation to engage. Introducing the formulation towards discharge served more of a process of pulling together previously discussed information. Whilst this did enhance service users overall understanding, it did not seem to be as beneficial. Factors which influenced this were lack of time to evolve the formulation and not linking to the overall treatment plan. These findings parallel psychological formulation which is introduced at the beginning of therapy to understand the service user's presentation and inform the intervention (Dudley & Kuyken, 2013).

Beneficial nature of the formulation

The study suggests formulation supported service users to make steps in their recovery journey. The formulation was seen as helpful in relation to identifying triggers and coping strategies. For many it highlighted coping strategies they did not realise they had, which facilitated recollection in difficult situations. Increased preparation and awareness of moving into negative thinking patterns and how to get out of this, were reported as benefits.

In comparison to previous research, there was less discussion about maintenance factors and linking the formulation to learning new strategies. Eells (2007) emphasised three stages of formulation, in which the final stage involved linking the formulation to the treatment plan. Although service users felt more knowledgeable and able to use coping strategies, in general the formulation did not link to a treatment plan. It is possible this was unclear to the care co-ordinators. In comparison, for two of the service user's interviewed, the formulation helped to inform the treatment and support they then received within the service. This would advocate that the formulation template completed with a member of the MDT could help to incorporate the service users' journey into the treatment plan (Five Year Forward View, 2014). However, the formulation process and amount it linked to treatment planning varied

greatly between service users; further consideration is needed to effectively link formulation to care planning.

Formulation as an evolving process – service user gaining ownership

Being able to develop the formulation across several sessions was an important factor; evolving the formulation between sessions supported service users to consider triggers, with increased ownership. Service users described how formulation helped to track and visualise changes, which increased motivation and engagement in formulation and overall treatment process. Pain et al. (2008) also found service users used written formulations as a tool outside the session.

The current study found service user experience of undertaking formulation with a member of the MDT was positive overall. However, as with previous research (Chadwick et al., 2003; Kahlon et al., 2014; Pain et al., 2008; Redhead et al., 2015) service users experienced a mix of emotional reactions from relief, to upsetting and overwhelming. The negative emotions were generally related to the initial process of telling their story and seeing it written down. For most service users, the negative emotions passed and were replaced by feeling hopeful and motivated for their recovery journey, from the understanding and awareness bought about by developing the formulation. Time to process and evolve the formulation independently from the sessions appeared to be an important factor in changing emotional reactions. The difficult emotions were described as part of, and worthwhile, to gain the understanding bought about by the formulation. This was similar to previous findings (Redhead et al., 2015; Shine & Westacott, 2010).

Formulation impacting on recovery

Service users described the formulation process helped to increase a sense of acceptance, optimism and empowerment to make changes. Many of the experiences described by the

service users linked to the CHIME recovery framework. CHIME is a framework of five interrelated recovery processes Connectedness, Hope and optimism about the future, Identity, Meaning in life and Empowerment (Leamy, Bird, Boutillier, Williams & Slade, 2011). It is possible the introduction of formulation across mental health services could facilitate service users recovery journey and has the potential to promote and support many of the CHIME principles. Service user active involvement is promoted in formulation.

Overall, service users described an increased sense of self from the formulation, for example being able to see themselves as separate to the disorder; this made service users feel more in control, empowered and able to make changes and may have reduced their internalized stigma. Kahlon et al. (2014) reported service users described formulation supported them in a 'new journey towards understanding oneself'.

In comparison, for one service user the formulation had a negative impact on his identity and led to self-blame and pessimism about his future. There are many possible reasons for this outcome including the timing of the formulation (completed just before discharge), the lack of a collaborative development (relying on his own skills and not supported by staff). In their research around service user experience of CBT formulation, Redhead et al. (2015) concluded the meaning attributed from the formulation to the service users' sense of identity impacts upon their overall emotional experience of the formulation. This is particularly the case when the inferences about their sense of self is incongruent with their previous perception (Redhead et al., 2015).

Limitations

One limitation of the current study relates to the smaller than anticipated sample size, therefore limiting the transferability of the findings. The coherence of sample was considered using the concept of information power (Malterud, Siersma & Guassora, 2016). Five areas

have been identified which impact upon the information power of a sample: study aim; sample specificity; use of established theory; quality of dialogue; and analysis strategy. The aim of the current study was narrow, the participants held characteristics which were relatively specific for the aim of the study and formulation is based upon a theoretical underpinning meaning sample size can be lower. However, the lead research was a novice at conducting interviews, so although the length of interviews was sufficient the quality of dialogue could have been improved with additional participants. Finally, the aim of the analysis strategy was a thematic cross case, to explore service user experience of formulation.

The formulation training was delivered across the teams within the community mental health service; however, a limited number of staff members undertook formulations. The six interviews from the study were completed by four different members of staff. This led to a homogeneous sample, conclusions should therefore be developed cautiously.

Staff members within the team decided whether to introduce the formulation to a service user, meaning only service users they thought would engage in the process were likely to have been selected. The care co-ordinator chose which service users to invite to participate in the research; in part this related to capacity and mental health presentation. However, it also seemed to link to staff members anxiety. This may have led to a staff-selected biased sample where only service users with a positive experience were approached.

Additionally, the completion of the formulation varied across service users in relation to the number of sessions completed and where in the treatment journey they were. This gave light to some interesting findings however highlighted the variable implementation of the formulation template.

Clinical implications

The findings of this study have several potential clinical implications relating to the introduction of formulation with a member of the MDT. Looking from the wider context of NHS service delivery, formulation offers many potential advantages, particularly around increasing the service users voice in mental health care and linking the formulation to a treatment plan which may support more streamlined and meaningful support for the service user. Staff training and continued support would be needed. Findings suggest a deeper knowledge of the maintenance factors and how to pull the formulation together to create a meaningful narrative is required.

The development of the formulation should to be adapted to reflect the level of support required by the service user whilst being mindful of the potential power dynamics at play within the relationship. Collaboration is a key element of the formulation; care co-ordinators need to allow time to develop the formulation over multiple sessions as well as time to consolidate and process the information between session. Negative emotional responses are common when developing a formulation, staff members need to be able to contain this distress to effectively support service user's progression. Linking the formulation to the treatment and support plan may enable mental health care to be more person centred and focused on the service users' specific needs.

The findings suggested staff members lack of clarity and psychological knowledge impacted on the development of the formulation. Formulation templates such as the 5 Ps can be a useful starting point however, they don't require moving from a list of factors to creating a meaningful narrative through synthesising the factors with theory (DCP, 2011). It is possible further training could support this. One area to develop is whether linking the formulation to psychological theory is required for this purpose and how it impacts upon the

usefulness to service users. The aim of this formulation was for service users' stories to be more explicit in care and treatment and to enhance staff curiosity. This appears to have happened to some degree.

Recommendations for future research

This area of research is in its infancy therefore, care coordinators developing formulations with service users, and their experience of this, would benefit from future exploration. The current study experienced difficulties in participant recruit meaning the number of service users interviewed was lower than expected. Future research replicating this study would benefit from a higher number of participants. In addition, to increase the transferability of findings participants should be recruited across; age ranges, services and staff developing the formulation. It may be helpful to conduct research in services whereby the process of formulating with service users has been embedded into the service rather than at the beginning of this process.

The findings of this study suggest formulation should be explicitly linked to treatment planning. It would be recommended for future research to investigate the impact of linking formulation to treatment plans on service user experience of formulation. In addition, measuring the impact of developing a formulation with care coordinators on specific recovery measures and length of treatment to identified the potential benefits.

In conjunction with understanding service user experience, future research may benefit from understanding the staff perspective of formulating with service users. Focusing on identifying barriers to implementation, service issues and service requirements may support the effective implementation of formulation across a service and increase service user experience.

Conclusions

The overall aim of the study was to explore the experience of service users developing a formulation with members of the MDT and to consider what factors impact this experience. To the author's knowledge, this is the first research into this area, therefore an exploratory understanding at a local context was undertaken to inform clinical practice, service delivery and future research into the area. The findings suggest implementing a 5 P's formulation with members of the MDT, can serve to have multiple benefits for service users to enhance and support their recovery journey whilst within mental health services. This is preliminary research into the area and would benefit from being explored further to really understand the factors impacting service user experience and how this can be applied to clinical practice.

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Chapter 5: Extended Methodology

Chapter overview

This chapter presents a discussion on the difficulties recruiting to the study and the potential impact of a smaller than anticipated sample size. Additionally, it describes the rationale and steps taken to produce research high in quality and trustworthiness despite the small sample size.

Recruitment and sample size

Sample adequacy in qualitative research refers to the appropriateness of sample size and is seen as an important consideration to evaluate the quality and trustworthiness of research (Spencer, Ritchie, Lewis & Dillon, 2003). The current study aimed to recruit between 10 and 12 participants from across the Trust service lines including adult, youth, eating disorder, older adult and physical health. Unfortunately, there have been multiple difficulties with data collection throughout the research process. In the early stages, the service delayed their date for training staff in how to use formulation by four months, reducing the overall data collection period.

Initially the pool of potential service users was identified as sufficient and across a range of services to achieve data saturation whilst offering a breadth of experience (Guest, Bunce & Johnson, 2006). Attending the formulation training and implementing into daily practice was an optional resource offered to staff to begin using with service users. Unfortunately, there was only a select number of staff members using the formulation tool and they were quite careful in who they selected to use the tool with. As a result, the recruitment and data collection period were longer and slower than expected by the research team. A range of strategies were employed to improve the uptake of formulation. I attended the service on regular occasions to meet staff members and talk about the research project, I

emailed the service leads, I attended formulation steering groups and the assistant psychologist who worked across the teams, spoke to staff on a regular basis to keep formulation and the research project in mind.

The COVID-19 situation meant data collection was temporarily stopped whilst a change in ethics approval was sought to allow interviews to be conducted over the telephone or via videocall. The restrictions set during COVID-19 have understandably impacted upon peoples' mental health, as well as many mental health services having to reduce and adapt the support they can offer. During this time, two service users who had expressed an interest in taking part in the research experienced deterioration in their mental health. Their care co-ordinators felt that taking part in an interview could negatively impact on their wellbeing and requested that the service users not be contacted about the research. Unfortunately, due to the time restrictions placed upon the thesis, they were unable to take part in the study. Therefore, a total of 6 interviews was completed.

Potential issues with small sample size

A systematic review undertaken by Vasileiou, Barnett, Thorpe and Young (2018) reviewed qualitative health research over a 15-year period, to collate how studies have characterised and justified sample size sufficiency. They found researchers have alluded to three potential threats to consider when there are concerns that a sample size is insufficient. The first pertained to the construct of generalisability and the reduced potential to draw inferences to the broader study population. The perceived internal validity of findings was the second concern that arose from the literature; researchers stated they could be less confident about the patterns derived from the data due to a smaller sample size. The final concern was around the uncertainty of whether a small sample size would impact upon how much of a

phenomenon was accounted for or may threaten the content validity of the results (Vasileiou et al., 2018).

Rationale for sample size

Research has pertained that sample size in qualitative research is contingent on a range of factors including epistemology, methodology and practical issues (Ando, Cousins & Young, 2014). Data saturation is one method used in qualitative research to identify appropriate sample size and is often seen as the gold standard (Vasileiou et al., 2018). Data saturation is the point at which no further themes are identified when reviewing data (Guest et al., 2006). In thematic analysis, data saturation is often recommended as the approach to justify sample size (Vasileiou et al., 2018). However, the process to which data saturation was met is often poorly detailed in research and even when saturation is said to be met many researchers specify small sample size as a limitation of the study (Vasileiou et al., 2018). Morse (2000) suggested other parameters, such as the scope of the study, the quality of data, study design and the nature of the topic, should be taken into account.

These factors were considered in relation to the current study. The empirical study forms part of a Doctoral thesis which has set parameters and timescales linked to it; therefore, the data collection period could only be extended for a time limited period. A further element relating to the scope of the study is around the study being undertaken within an NHS Trust meaning their timescales, priorities and difficulties implementing organisational change impacted upon the studies data collection. When comparing sample sizes used in similar studies, these ranged from 1 to 13 participants.

The current study investigated the use of a new formulation tool across a range of services in the same NHS Trust, the specific focus on experience of using the formulation tool meant the sample is likely to be homogenous and focused at a local level. The outcomes

of the research were hoped to inform services, add to the sparse existing literature base, and be transferrable to similar services rather generalised to the whole population. This is akin to the idiographic generalisation, which is more aligned with qualitative research, whereby logical and conceptual inferences to other concepts and generating understanding which could potentially advance knowledge are possible from the data (Vasileiou et al., 2018).

The quality of the data derived from the interviews appeared sufficient, quotes were used to keep the themes close to the data. Vasileiou et al. (2018) reports on the importance of qualitative researchers being transparent and thorough in evaluating sample size and data adequacy. Therefore, a rigorous method to code data, as described by Ando et al. (2014) was utilised to allow for a more robust and transparent measure of data saturation and how codes and themes were developed. This follows the Thematic Analysis method described by Braun and Clarke (2006) with an additional focus on saturation. The analysis of themes was also derived from theory collated in the systematic review of service user experience of formulation.

Conclusion

Although it is clear the sample size did not reach the preferred level set out, or fully meet data saturation, a number of strategies have been employed to increase the quality, rigor and transparency of the data and overall interpretations of it. A review of how these methodological issues impacted upon the study findings are discussed within the empirical paper.

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Chapter 6: Reflective Chapter

Overview of the chapter

This chapter explores the reflections made throughout the research journey. It considers how the research process has impacted on me personally, the development of my research skills and the assumptions underpinning the research. This research project initially appealed to me due to my interest in understanding service user experience and the potential improvements that can be made from co-produced research. Psychological formulation has become an important part of my clinical work and I have witnessed and believe in the benefits it can have for service users when done in a meaningful and collaborative way. The epistemological stance taken throughout the research process has been that of critical realism which accepts there are objective realities however these realities are socially, historically and culturally situated. To consider my own influence on the research process a reflective journal was kept throughout. A summary of the main reflections are included in this section.

Working with experts by experience

When initially exploring the research project it felt imperative to ensure it was co-produced at every opportunity to enrich quality of the study and findings. Within the steering group I have been working with to deliver this project, there were four experts by experience currently involved in developing the formulation template to implement into routine practice across a NHS mental health trust. Their involvement in the formulation service development project meant they had a good understanding of formulation and how it was being implemented across the trust. Additionally, one of the experts by experience had personal experience of formulating with a psychologist.

All four experts by experience were involved in the systematic review and the empirical paper. They helped develop the interview schedule and during the analysis section

we worked together to see whether the quotes from the interviews linked to the themes and they used their personal experience to help give meaning to the themes generated. Involving experts by experience in the development of themes meant both a theoretical perspective from my own learning and clinical experience and a more personal experience were combined to create meaningful themes, derived from the data. Co-production with experts by experience is recognised as a vital component of conducting good quality research (Beresford, 2013), having this experience whilst on training has developed my skills. It has also shown me first-hand the importance of making time to meaningfully incorporate experts by experience across the research process and is something I will continue to do in future research projects.

Conducting research within an NHS Trust

The current research project formed part of a larger, trust wide initiative to improve service user experience of mental health care and treatment. This included making organisational level changes to how assessment and treatment is delivered with service users. Conducting research within a service trying to implement organisational change led to a range of difficulties throughout the research process. The implementation of formulation across the pilot services was dependent on timescales set by the service, that regularly changed due to competing demands along with changes and additions to the overall formulation project. This was quite frustrating for me, because it was outside of my control, however had significant impact on the ability to recruit participants and collect data for my project.

There were a number of areas where I felt I had a lack of control in; for example, how many staff attended the training, how many staff members used the formulation tool, and motivating staff to use the tool with a range of service users. The formulation steering group

aimed to demonstrate a collaborative approach to implementing formulation with the staff team to role model the concepts important in formulation. They decide to use an opt in approach, rather than it being incorporated as a mandatory part of the role, with the view that starting with interested and engaged staff members would then ripple out to other staff as they begin to hear positive feedback. I identified some positives to this rationale; staff felt listened to and feedback suggested they were generally positive about formulation and the approach used to implement it across the service. This approach should have engaged and motivated staff to participate in formulation; however, this was impacted by complex systemic factors. Support relating to how formulation fits into the care co-ordination role may have been beneficial. Similar conclusions were made by Brown, Beeley, Patel & Vollm (2018) who evaluated probation officers' skills and perception of formulating after attending training. Although the findings were promising, feedback suggested reservations about their role as case formulators due to concerns about competency and relevant training. In my opinion, there felt to be a lack of supervision and leadership to support staff in the implementation of formulation. I found this frustrating and noticed it was a frequent interpretation when analysing the interviews. To try and bracket this from impacting the analysis process I included them in my reflective journal and discussed them with my supervisory team.

I feel this experience has highlighted some important learning points that I will take with me. It highlighted the complexity and longer timescales involved in organisational change and how this can impact upon conducting research. The role of the assistant psychologist within the service was shown to be imperative in the research. Having someone in the team keeping the project in the front of peoples' minds, problem solving with staff and motivating them to use the tool was imperative. I reflected that without this support, my research would have been even further impeded.

Personal reflections from reflexive research diary

The unexpected impact of the COVID-19 pandemic added additional pressures to my research project and further delayed data collection period. It caused increased worry for me about the level of recruitment and whether it would be enough to sufficiently identify meaningful themes. Although two service users were no longer able to participate in the study, one service user was still happy to undertake an interview over the telephone. The interview went well and was a similar length to the others, completing the interview over the telephone did not appear to overly hinder the service user's ability to talk openly and reflect about their experience of formulation.

I was aware that I had mixed feelings about other professions implementing formulation, on the one hand, teaching and upskilling staff members is part of the role of a clinical psychologist and widening the application of formulation could serve to improve service user experience of mental health services. However, linking personal meaning to theory is an important part of formulation and I think part of me did not want to relinquish all of that knowledge. I tried to be mindful of these judgements throughout the research process and how they might be influencing how I was interpreting information.

At times I have felt downhearted about the research due to its lack of progress and the many obstacles. The research process has been full of challenges; often, as I overcame one and regained momentum and passion, another challenge appeared. It has tested my strength and perseverance and am grateful to the support of supervisors, the assistant psychologist and my family throughout this process to discuss, problem solve and empathise. These challenges have however taught me many skills along with how to justify the decisions I made.

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Chapter 7: Critical reflections and conclusions

Overview of the chapter

This chapter aims to summarise and critically evaluate the findings from the systematic review and the empirical paper. It will consider how these findings may relate to one another and how they may contribute to the research literature and clinical practice

Summary of findings

The overall aim of the thesis portfolio was to understand the service user perspective on, and experience of, psychological formulation, and operationalise the factors that impact on this, with the hope that this knowledge will help to improve the overall experience of formulation and make recommendations for services rolling-out the use of psychological formulation with staff who do not have specialist psychological training. Service user voice is significantly missing from the current evidence base. Researching service user experience is one way of answering the question around whether formulation is perceived as useful to the service user (Johnstone, 2013). It has been proposed that evaluating formulation in terms of usefulness may be more appropriate than focusing on the reliability and validity of formulation (Johnstone, 2013). Within this thesis portfolio, service user experience has been explored from two standpoints. The systematic review explored service user experience of formulation developed with a psychologist as part of the therapy process. The empirical paper explored formulation developed with member of the Multi-disciplinary Team (MDT), who has not been psychologically trained, as part of the care co-ordination role, within a community mental health service.

The systematic review aimed to identify and review current research into service user experience of psychological formulation and understand what factors impact upon this experience. To the researcher's knowledge, this was the first systematic review in the area.

There was a relative paucity of research identified and the research varied in design and methodology employed; this is a similar finding to other systematic reviews relating to formulation (Flinn, Braham & das Nair, 2014). A narrative synthesis (Thomas & Harden, 2008) was the approach used to develop descriptive and analytical themes which go beyond initial coding. The aim of using this method was to generate new interpretive constructs and explanations to answer the research question (Thomas & Harden, 2008).

The thematic synthesis developed an initial four phased process of formulation that service users progress through iteratively and in a non-linear fashion. The formulation process involves: the rawness of telling the story; feeling understood by the therapist; own self-discovery and meaning making; and gaining hope through autonomy. The experience of each phase and overall formulation process were impacted by specific factors: readiness to engage; perception of the benefits of formulation; therapeutic relationship, accuracy and pertinence of the formulation; form of the formulation; being able to see the whole picture; collaborative development; having time to evolve the formulation; being linked to a care plan; and, the impact of formulation on personal identity. The experience of service users appeared to vary across the formulation process and a range of both negative and positive emotions were evoked. The systematic review supplemented the current literature base by operationalising factors that impact upon service user experience of formulation and considered how these may inform clinical practice.

The empirical paper aimed to develop the findings from the systematic review and consider the experience of the formulation process when delivered by a member of the MDT who has not received psychological training. As with the systematic review, there was a focus on understanding factors that impact upon service user experience. The cohesion of operationalised factors developed from the systematic review allowed for a better understanding of service user experience of formulation and what impacts upon it. Therefore,

the themes identified within the systematic review were used to inform the topic guide for the empirical paper. This allowed for a comparison between service user experience of a formulation as part of the therapy process and formulation forming part of the care co-ordination role.

The empirical paper presented in this thesis portfolio provides rich and detailed accounts of service user experience of psychological formulation developed collaboratively with a member of the MDT, as part of the care co-ordination role. To the researcher's knowledge it is the first of its kind and contributes to the research base, not only about service user experience of formulation but also highlighting potential factors a service may find beneficial to take into consideration when implementing formulation into service delivery.

One of the key points of interest from the research was that although the formulation was developed with a non-psychologically trained member of staff, similar experiences were described along with many of the same factors as identified in the systematic review. The development of the formulation increased service user understanding of the mental health difficulty (Chadwick, Williams & Mackenzie, 2003; Evans & Parry, 1996; Rayner, Thompson & Walsh, 2011; Halpin, Kugathasan, Hulbert, Alvarez-Jimenez & Bendall, 2016) and their experience of this was impacted by the collaborative nature (Kahlon, Neal & Patterson, 2014; Rayner et al., 2011; Shine & Westacott, 2010), the therapeutic relationship (Redhead, Johnstone & Nightingale, 2015) and having time to evolve and integrate the formulation into daily life. One of the main reasons for integrating formulation into service delivery is to enhance service users recovery journey and to increase the service user voice into the care and treatment received. The findings from the empirical paper suggest incorporating formulation into the role of care co-ordination could lead to a number of benefits set out by the 6Cs (Roach, 1984) along with making difficulties more understandable and developing more individualised care plans, which in turn could lead to better outcomes

for service users (Bensa & Gregg-Rowbury, 2016). Policy documents informing mental health care emphasise the importance of involving service users in treatment and care planning to improve the culture and responsiveness of services, enhance the quality of care service users receive, and facilitate recovery (Department of Health, 2011). The themes from the empirical paper suggest that formulation may support this, if delivered in a manner seen as useful by the service user. Further research into the impact of formulation when linked to treatment and support plans may be beneficial.

There were some noticeable differences in the development of the formulation between psychologists and other members of the MDT. The Division of Clinical Psychology 'Good practice guidelines on the use of psychological formulation' (DCP, 2011) defines the main purpose of formulation in any setting is to identify the best way forward and to inform the intervention. Although the formulation identified coping skills service users could use to support the recovery journey, the formulation did not appear to be used with service users to inform the treatment and support plan. It was unclear from the interviews why this was the case; however, it may be that staff were unclear on how to move from the understanding developed from the formulation to establish a person centred and collaborative treatment and support plan. To gain the most from the formulation this is likely to be an area that requires further development and staff training. The formulation did however appear to meet some of the other purposes suggested by the DCP (2011, p.8) including: helping the service user to feel understood and contained; encouraging collaborative work; emphasising strengths; normalising problems and increasing the service user's sense of agency, meaning and hope.

A second interesting difference related to the extent the formulation was linked to psychological theory. Although this varied across service users; two areas were notable, the maintenance factors were often not expanded upon and psychological theory was not used to inform the meaning, development and maintenance of the mental health difficulty. When

considering the key principles of psychological formulation, these findings suggest some of these are missing when completed with a non-psychologically trained member of staff (DCP, 2011). This is understandable given the level of training required to develop these skills within clinical psychology and the varying results shown on the quality of formulations completed by qualified psychologists (Dudley, Park, James & Dodgson, 2010). Training in formulation has been shown to increase staff member's knowledge, competence and confidence in formulation (Bensa & Gregg-Rowbury, 2016). It is possible that formulation developed with staff as part of care co-ordination can serve as a starting point (DCP, 2011) and may be complex enough for the desired use to increase service user voice and inform support and treatment offered by the community mental health team. A more integrative formulation could then be developed if and when psychological intervention was deemed as appropriate. This would be a useful area for further research.

The level of collaboration in the development of formulation appeared greater in the empirical paper compared to the systematic review. It is possible that as staff members feel less confident in developing a formulation, they are more likely to develop it solely in the sessions with the service users, as opposed to psychologists who may pre-prepare a draft formulation prior to the session. This serves to increase service user experience as collaboration is a key component to the completion of formulation (Dudley & Kuyken, 2013).

Critical Evaluation of systematic review

The systematic review presented in this portfolio contributes to the literature on service user understanding of psychological formulation. To the researcher's knowledge it was the first of its kind and therefore provides a novel addition to the literature base. The systematic review yielded a limited number of papers meeting the inclusion criteria,

identifying the limited research into the area of service user experience. To assess the quality of the papers selected for review, the CASP checklist was chosen because it maps onto the domains recommended by the Cochrane Qualitative and Implementation Methods Group guidance Series: paper 3 (Noyes et al., 2018). In addition, the four areas identified by GRADE-CERQual (Lewin et al., 2015) were used to provide a transparent method for assessing the level of confidence to place in the findings. It is based on four areas: methodological limitations, relevance, coherence and adequacy. The limited number of papers yielded in the systematic review mean conclusions generated from the findings should be viewed tentatively.

The review was structured using the PRISMA guidelines (Moher, Liberati, Tetzlaff, Altman & The PRISMA Group, 2009) and the Enhancing Transparency in Reporting the Synthesis of Qualitative Research: ENTREQ guidelines (Tong, Flemming, McInnes, Oliver & Craig, 2012). The search strategy used within the systematic reviewed yielded a large number of studies that were unrelated to the research question; this was partly due to the many different uses of the term ‘formulation’ along with the different terms used across psychology for defining formulation. Previous research into psychological formulation was used to develop the search terms however, if this review was conducted again it may benefit from further exploration and refinement of the search terms used to conduct a more targeted search.

It is often considered best practice for more than one person to assess the quality of studies included in the systematic review and to come to a consensus around the study strength and limitations (Noyes et al., 2018). A similar view is taken about the codes identified within the synthesis of data (Noyes et al., 2018). This would be recommended if the review was undertaken again.

Critical Evaluation of empirical paper

Sample adequacy in qualitative research refers to the appropriateness of sample size and is seen as an important consideration to evaluate the quality and trustworthiness of research (Spencer, Ritchie, Lewis & Dillon, 2003). The empirical paper aimed to recruit between ten and twelve participants to the study because data saturation has been seen to be achieved after twelve interviews (Guest, Bunce, & Johnson, 2006). Initially the pool of potential service users was identified as sufficient and across a range of services to achieve data saturation whilst offering a breadth of experience (Guest et al. 2006). Unfortunately, due to a number of issues, the number of service users recruited to the study only reached 6, meaning data saturation was not reached. With this is mind, care was taken to follow the protocol set out by (Ando, Cousins & Young, 2014) to create a codebook and ensure transparency in the theme development. Conclusions within the empirical paper are made tentatively given these limitations.

The implementation of psychological formulation as part of the care co-ordination process formed part of an overarching service development project to improve service user experience of mental health services. The research was undertaken in the early stages in the implementation process therefore, any teething problems had not yet been identified or amended. Conducting research within this stage of a service development project impacted on the study in many ways, particularly relating to the number of service users who had developed a formulation, the number of staff undertaking formulation, along with the breadth of services engaging in the formulation process. Staff appeared hesitant around developing formulations with service users seen as more ‘complex’. It is possible these factors impacted upon the experiences explored with service users and the transferability of the themes. However, despite this, rich and meaningful data were derived, and similar themes were seen

across service users. It would be interesting to undertake similar research when the formulation process has become more embedded into the service pathway.

Interviewing service users and undertaking Thematic Analysis were both new to me and I found it took time to develop skills in both areas. In relation to interviews, I noticed when listening back, I often slipped into a therapist stance rather than researcher. This may have impacted on the quality of data collected from the interviews. To support with this, I listened back to each interview and made reflections to learn from, I feel this process helped to improve my interviewing abilities. As explained by Braun and Clarke (2013) themes do not passively emerge from the data, theming is an active process impacted on by the choices made by the researcher. This skill developed as the analysis progressed. During the analysis process, the reflective journal and supervision were used to explore decisions made.

Conclusion

The papers within this thesis portfolio have added to the limited literature base around service user experience of psychological formulation. The small sample size means findings should be considered tentatively and may not be transferable to other populations. However, they provide new and enhanced understanding of the process of formulation and factors impacting upon this.

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List of Appendix

Appendix A: CASP quality review

	Was there a clear statement of the aims of the research	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the study?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research	Quality rating
Halpin et al (2016)	Yes clear aim and rationale	Yes – looking at service user experience	Yes – but briefly and question use of IPA	No - only 3 ppts recruited and varied time from completion of formulation	Yes	No	Yes	Yes – discussion about the analysis plan and reflexivity	Yes	Yes - ish as very small sample but more in-depth analysis	8
Kahlon, Neal & Patterson (2014)	Yes – linked to previous research	Yes - looking at service user experience	Yes	Yes – detailed explanation	Yes	Yes	Yes	Yes – clear and detailed analysis plan	Yes	Yes	10
McManus et al (2010)	Yes – linked to gaps in previous research	Yes – looking at service user experience	Yes	Yes - detailed explanation	Yes	No	Yes	Yes – credibility also considered	Yes	Yes	9

Pain, Chadwick & Abba (2008)	Yes – linked to previous research	Yes – looking at service user experience	Yes	Yes – additional information given	Yes – additional information given	No	Yes	Yes – clear explanation of data analysis	Yes	Yes	9
Rayner et al (2011)	Yes	Yes – explains why qualitative was used	Yes – rationale given	Yes – brief information	Yes	Yes – reflexivity discussed	Yes	Yes – detailed description	Yes	Yes	10
Redhead, Johnstone & Nightingale (2015)	Yes – linked to previous research	Yes	Yes – although brief	Yes – information given about participants	Yes – information given about the interview	No	Yes	Yes – validity considered	Yes	Yes	9
Shine and Westacott (2010)	No - Aim not written clearly although is linked to previous research	Yes	Yes – detailed rationale	Yes – information given about recruitment/ participants	Yes	Yes	Yes	Yes – rationale given	Yes	Yes	9
Small et al (2018)	Yes – clear statement	Yes – looking at experience	No – limited information about the design used	Yes	Yes – clear description given	Yes	Yes	Yes – detailed description	Yes	Yes	9
Threw and Krohnert (2015)	No clear aim given	Yes	No – limited information about the design used	Yes	Yes – description of interview given	No	Yes	No – limited information given	Yes	Yes	6
Tyrer & Masterson (2018)	Yes – clear aims given	Yes	No – limited information about the design used	No – limited information about recruitment	No- limited information given	No	Yes	No – limited information given	Yes	Yes	5

Evans and Parry (1996)	Yes	No – aims did not link to use of interview	No – no information given about qualitative design	Yes – information about participants/ recruitment	Yes – description of interview	No	Yes	No – limited information given	No – limited use of quotes	Yes	5

Appendix B: Research and Ethics Approval

Miss Carys Evans
Department of Clinical Psychology
University of East Anglia
Norwich Research Park, Norwich
NR4 7TJ

Email: hra.approval@nhs.net
Research.commissioning@wales.nhs.uk

23 May 2019

Dear Miss Evans

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Service user understanding and experience of formulation in the context of a multi-disciplinary team approach: An exploration using Thematic Analysis.**
IRAS project ID:	**248362**
Protocol number:	**N/A**
REC reference:	**19/YH/0055**
Sponsor	**University of East Anglia**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

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

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **248362**. Please quote this on all correspondence.

Yours sincerely,
Lucy Roberts

Approvals Specialist

Email: hra.approval@nhs.net

Copy to: *Graham Horne*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional negligence insurance]	1	07 May 2018
HRA Schedule of Events [Copy of hra-schedule-events-new template- v1 15.02.19]	1	15 February 2019
HRA Statement of Activities [statement-activities - new template- v1 15.02.19statement-activities - new template- v1 15.02.19]	1	15 February 2019
Interview schedules or topic guides for participants [Draft topic guide]	1	18 April 2019
IRAS Application Form [IRAS_Form_08022019]		08 February 2019
Letter from sponsor [Letter from sponsor]	1	05 February 2019
Other [Consent to contact participants form]	1	02 January 2019
Other [Letter of introduction to gatekeeper]	1	02 January 2019
Other [Insurance document]	1	07 May 2018
Other [Lay summary]	2	18 April 2019
Other [Proposal independent review]	1	06 July 2018
Other [Response letter]	1	18 April 2019
Participant consent form [Consent form]	2	18 April 2019
Participant information sheet (PIS) [Participant Information Sheet]	2	18 April 2019
Research protocol or project proposal [Research proposal]	2	18 April 2019
Summary CV for Chief Investigator (CI) [CV for chief investigator]		
Summary CV for student [CV for chief investigator]		
Summary CV for supervisor (student research) [CV for supervisor - Gillian Bowden]	Jan 2018	

Appendix C: Updated Ethical Approval

From: sheffield.rec@hra.nhs.uk <noreply@harp.org.uk>
Sent: Friday, April 3, 2020 12:54:16 PM
To: Carys Evans (MED - Postgraduate Researcher) <Carys.Evans@uea.ac.uk>; Graham Horne (RIN - Staff) <G.Horne@uea.ac.uk>
Subject: IRAS 248362. Amendment categorisation and implementation information

Amendment Categorisation and Implementation Information

Dear Miss Evans,

IRAS Project ID:	248362
Short Study Title:	Service user experience of formulation
Date complete amendment submission received:	18 March 2020
Amendment No./ Sponsor Ref:	NSA1
Amendment Date:	17 March 2020
Amendment Type:	Non-substantial
Outcome of HRA and HCRW Assessment	**This email also constitutes HRA and HCRW Approval for the amendment,** and you should not expect anything further.
For NHS/HSC R&D Office information	
Amendment Category	**C**

Thank you for submitting an amendment to your project. We have now categorised your amendment and please find this, as well as other relevant information, in the table above.

What should I do next?

If you have participating NHS/HSC organisations in any other UK nations that are affected by this amendment **we will** forward the information to the relevant national coordinating function(s).

You should now inform participating NHS/HSC organisations of the amendment.

For NHS organisations in England and/or Wales, this notification should include the NHS R&D Office, LCRN (where applicable) as well as the local research team.

When can I implement this amendment?

You may implement this amendment **immediately**. Please note that you may only implement changes described in the amendment notice.

Who should I contact if I have further questions about this amendment?

If you have any questions about this amendment please contact the relevant national coordinating centre for advice:

- England – amendments@hra.nhs.uk
- Northern Ireland – research.gateway@hscni.net
- Scotland – nhsg.NRSPCC@nhs.net
- Wales – HCRW.amendments@wales.nhs.uk

Additional information on the management of amendments can be found in the IRAS guidance.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

Please do not hesitate to contact me if you require further information.

Kind regards

Matthew Mills

Health Research Authority

Ground Floor | Skipton House | 80 London Road | London | SE1 6LH

E.amendments@hra.nhs.uk

W. www.hra.nhs.uk

Sign up to receive our newsletter HRA Latest.

Appendix D: Participant Information Sheet

Norfolk and Suffolk NHS
NHS Foundation Trust

University of East Anglia

Service user understanding and experience of formulation in the context of a multi-disciplinary team approach: An exploration using Thematic Analysis

I'd like to invite you to take part in my research study. Joining the study is up to you, before you decide I would like to tell you why the research is being done and what you would need to do. This information sheet will tell you; why I am doing the study, what will happen if you take part and other important information. If you have any questions please ask.

Short summary

Why – To find out what it was like for you to tell your story to a member of staff, using the formulation template.
What – You would talk to me about; how you found doing the formulation, how the professional helped you put your information together, what was helpful and what was more difficult. The interview will take about 60 minutes and be audio recorded.
Who – To take part you need to be:

1) Over the age of 18.
2) Getting support from your local mental health team.
3) Have done a formulation with one of your team.

Where – We will do the interview at Walker Close or over the telephone/Skype. I will try and find a time and date which is best for you.
How & when – We hope to start the study in November

In this guide

Contact details

If you have any questions please contact Carys Evans, Trainee Clinical Psychologist.
Email: carys.evans@uea.ac.uk

Explanation of the study?

We are trying to make it so that everyone who uses a mental health service in Norfolk and Suffolk Foundation Trust is able to tell their story so that they get the right help and support. Understanding and telling our story, using formulation, can help improve the mental health care people receive. A formulation is when the person and their team make sense of the difficulties they may be experiencing. It includes an understanding of, why the difficulties started and what is keeping them going, and can be used to make a plan. One way of doing this is called a 5 Ps formulation. The 5 Ps formulation is used in Cognitive Behavioural Therapy (CBT) and looks at five areas: what is happening now, what happened in the past, what triggers it, what keeps it going and what helps to protect you.

This is a new thing and I would like to understand what it was like for you to complete a formulation. Some areas we may talk about are; how you found the process, what was helpful and what was more difficult. We would like to learn from your experiences to help us understand what it was like and how we could improve it.

What would taking part involve?
If you would like to know more, I will contact you and sort a time to talk about the study. If you decide you would like to take part, I will ask you to sign a consent form and we will pick when you would like to do the interview. We will do the interview at Walker Close or over the phone/ using Skype.
I would like to talk to 10 people. The type of interview I am doing will mean that it should feel like a conversation rather than questions and answers. We can do the interview at a time that is most comfortable for you and it will take about 60 minutes.

To help me study what was said I will be audio recording the interview and will type it up. Some quotes from your interview will be included in the final report, but all information will be anonymous. If you would like, you can read the transcript and let me know if you are happy with it, you can also say if there are any bits you would like me to take out.

What are the possible benefits?
Staff completing formulations with service users is a new process and the information from the interviews will be used to understand what it was like and what changes the service can make so this is better for service users. The findings from the study will also increase the current understanding of service user experience of formulation.

What are the possible disadvantages and risks?
For some people telling their story for a formulation can be a positive experience but others find it difficult and sometimes upsetting. Talking through this process in the interview may bring back some of these emotions and memories. If something we talk about causes you distress, I will offer you support at the time. You can choose to stop the interview and either withdraw from the study or we can book a different time to meet. If I am worried about you, I may stop the interview and offer support. I will talk to your Lead Care Professional afterwards to offer you further support.

The information that you talk about in the interview will be kept on an encrypted Dictaphone and moved to my laptop as soon as possible, this is to make sure your information is kept safe. There should be no information that identifies you on the audio recording. Your contact details will be kept in a locked room and only accessed to contact you. This will make sure that your information is kept safe and secure.

The information during the interview will be kept confidential. However, if I think you or others are at risk of harm then this will need to be broken. I will follow the Norfolk and Suffolk Foundation Trust (NSFT) policy around safeguarding and breach of confidentiality. I will speak to your Lead Care Professional or the duty worker if a worry about risk happens. If this needs to happen, I will tell you before I do this and let you know who to contact to talk about this more.

You are able to stop the interview at any time and decide that you no longer want to take part in the study. This is okay and will not affect any support or care you receive. I will let your Lead Care Professional know.

Supporting Info

What if something goes wrong - If you are worried about anything we have done in the study, you should ask to speak to me (see contact details above) or the researcher supervisor (Dr Gillian Bowden, gillian.bowden@uea.ac.uk) and we will do our best to answer any questions. If you are still unhappy and wish to complain formally, you can do this by contacting Professor Sian Coker (Deputy Programme Director, University of East Anglia, sian.coker@uea.ac.uk).

What if I don't want to carry on? If you decide you don't want to take part anymore that is OK and will not affect your normal support from your team. You can choose to stop the interview at any time and can opt out of the study for up to 1 month after. If you decide you don't want to take part during this time, I will delete the interview recording and it will not be in the study. After one month, I will already have analysed the data so I will not be able to remove the information.

Will my information be kept confidential? Your identifiable information will be kept on a separate, password protected database that will be kept safe with the research supervisor. I will only access it when needed. Your contact information will be put into a mobile phone, only used for this study, before I come to meet you and deleted straight afterwards. The mobile phone will be password protected. After the interview you will be given a pseudonym (a pretend name) so that your information is anonymous.

The University of East Anglia is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of East Anglia will keep identifiable information about you for 10 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information at https://portal.uea.ac.uk or by contacting dataprotection@uea.ac.uk.

Norfolk and Suffolk NHS Foundation will collect information from you for this research study in accordance with our instructions.

Norfolk and Suffolk NHS Foundation Trust will use your name, NHS number and contact details to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Individuals from the University of East Anglia and regulatory organisations may look at your medical and research records to check the accuracy of the research study. Norfolk and Suffolk NHS Foundation Trust will pass these details to the University of East Anglia along with the information collected from you. The only people in the University of East Anglia who will have access to information that identifies you will be people who need to contact you to discuss the research or audit the data collection process. The people who analyse the information will not be able to identify you and will not be able to find out your name, NHS number or contact details.
The University of East Anglia will keep identifiable information about you from this study for 10 years after the study has finished.

What will happen to the results? It is hoped that this study will be published in a journal article. The study findings can be fed back to you in a number of different ways including; having a copy of the final paper, having an overview of the main findings or attending a feedback group.

Who is organising and funding this study? This study is part of my Doctorate in Clinical Psychology and is organised in partnership with the University of East Anglia.

How have patients and the public been involved in this study? There will be service user involvement throughout the study including; creating the interview guide and analysing the information. A service user will take a co-researcher role. The study will also go through a steering group which has expert by experience involvement.

Who has reviewed this study? All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study will go through this process.

Appendix E: Consent to Contact Form

Norfolk and Suffolk NHS
NHS Foundation Trust

University of East Anglia

Service user understanding and experience of formulation in the context of a multi-disciplinary team approach: An exploration using Thematic Analysis

By: Carys Evans, Trainee Clinical Psychologist.
Email: carys.evans@uea.ac.uk

Please initial box if you agree:

I confirm I am potentially interested in taking part in the above study and give consent for the researchers to contact me using the following details to discuss further: ☐

Name: _____

Preferred method of contact (please tick):

☐ Tel. Number: _____

☐ Email: _____

_____ _____

Signature Date

Appendix F: Interview Topic Guide

Norfolk and Suffolk NHS
NHS Foundation Trust

University of East Anglia

Draft Topic Guide

This interview schedule is in draft form and gives a brief outline of the topics that the interview aims to explore. The interview schedule will be discussed with the Formulation Steering Group to develop and refine the specific questions and as the research process is iterative the schedule will further develop during the data collection and analysis stage.

1) A brief introduction to the purpose of the interview and to go through the formulation definition.
2) To discuss how the formulation was developed during the session.
3) To discuss whether the formulation process impacted on the therapeutic relationship and joint understanding of the participants difficulties.
4) To discuss participant's views and responses to the formulation process
5) To discuss whether the participants views and responses changed as the session went on and their reflections looking back.
6) To discuss to what extent the formulation process was helpful to them.
7) To discuss whether any difficulties arose during the process, how these were managed and how they impacted on the participants views and reactions to the process.

Appendix G: Consent to Participate Form

Norfolk and Suffolk NHS Foundation Trust

University of East Anglia

IRAS ID: 248362

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: Service user understanding and experience of formulation in the context of a multi-disciplinary team approach: An exploration using Thematic Analysis.

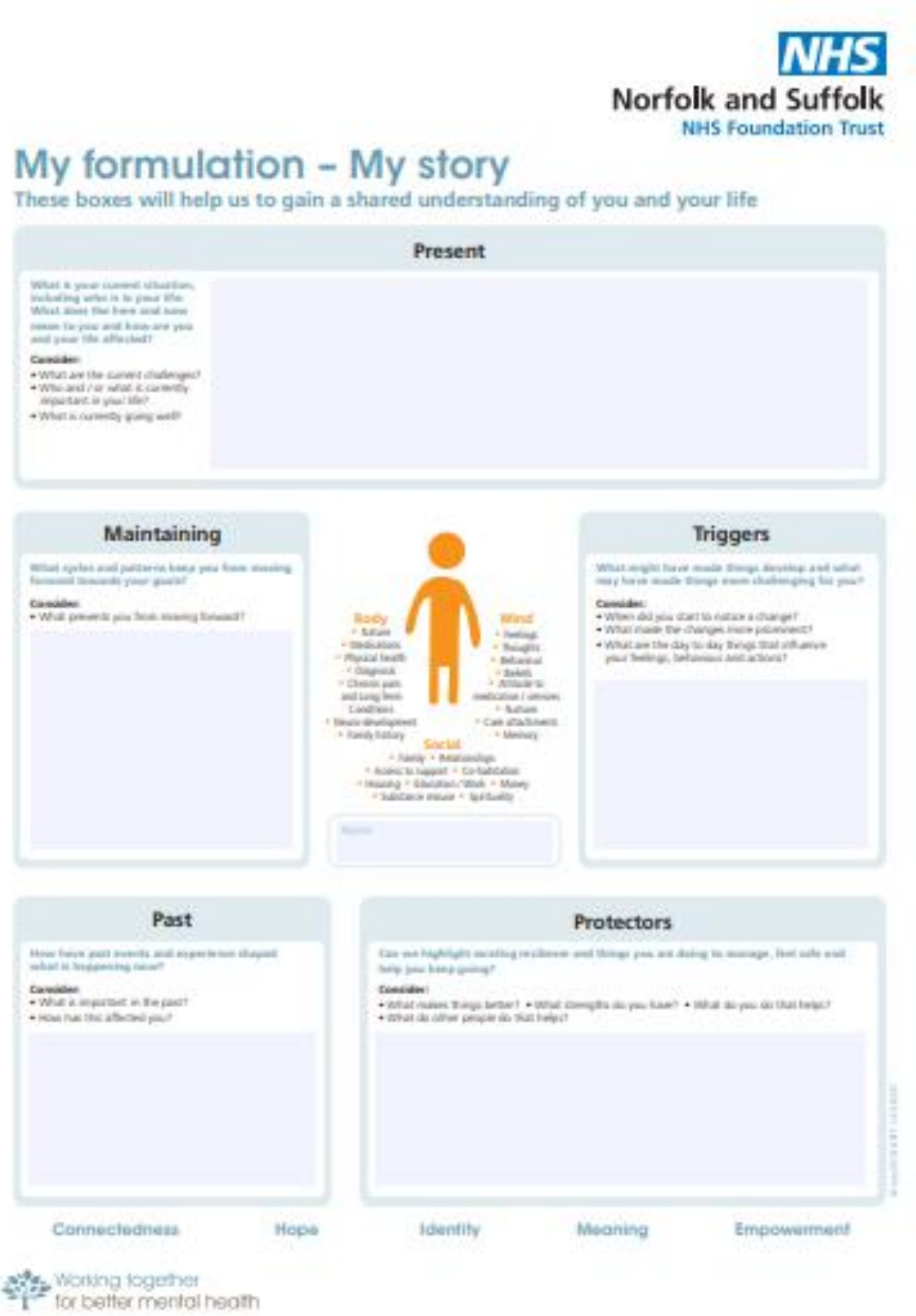
Name of Researcher: Carys Evans

	Please initial box
1. I confirm that I have read the information sheet dated..... (version.....) 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 care or legal rights being affected.	☐
3. I understand that the information held and maintained by _____ [*(enter name of organisation(s) that will be providing you with data, including any NHS/HSC organisations)*] may be used to help contact me or provide information about my health status.	☐
4. I understand that the interview will be audio recorded	☐
5. I agree to take part in the above study.	☐

Name of Participant	Date	Signature

Name of Person taking consent	Date	Signature

Appendix H: Formulation template



Appendix I: Demographic Questions

Gender	
Age	
Occupation	
Nationality	
Presenting difficulty	
Team	
Time in service	
Time it took before formulation	
No of formulation sessions	
Who completed the formulation with you	
Previous experience of formulation	

Appendix J: Contribution of experts by experience

Collaboration with experts by experience was felt to be imperative throughout the thesis portfolio, from ethical approval to the systematic review and empirical paper. Four experts by experience were involved with the development and implementation of the formulation template across the NHS trust. It was felt that their prior knowledge of the formulation tool and the implementation process would be valuable. Additionally, one of the experts by experience had personal experience of formulating with a psychologist. Together we met a total of four times, the initial meetings took place in person however, due to the restrictions implemented due to the COVID-19 pandemic, later meetings were facilitated using Microsoft Teams, email, or via the telephone.

Within the systematic review we collaboratively developed the initial themes through discussion using quotes from the included papers and their own individual experiences. During this process we merged related themes, added meaning and developed the theme names. After the model was developed, we met again to discuss the overall model and again changes were made to names of themes and to consider how the themes interlinked. In terms of the empirical paper the experts by experience reviewed the Participant Information Sheet and lay summary prior to them being submitted for ethical approval. The themes from the systematic review were used to develop the topic guide collaboratively as well as to consider appropriate ways to conduct the interviews to support participants to be able to tell their story whilst collecting data related to the topic guide. As with the systematic review, the experts by experience were involved in two rounds of discussions relating to coding data. A discussion using the quotes from the interviews and initial coding table to consider the initial themes. Once themes were more developed the information about the themes and a sample of quotes were emailed to the experts by experience to look at and comment on their fit with the quotes and the naming of the themes. This was undertaken via email and telephone conversations.

Appendix K: Author Guidelines for Psychology and Psychotherapy: Theory, Research and Practice

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at http://www.editorialmanager.com/paptrap

Click here for more details on how to use Editorial Manager.

All papers published in the Psychology and Psychotherapy: Theory Research and Practice are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

Data protection:

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at https://authorservices.wiley.com/statements/data-protection-policy.html.

Preprint policy:

This journal will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

Psychology and Psychotherapy: Theory Research and Practice is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies and Registered Reports. The Journal thus aims to promote theoretical and research

developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

All papers published in Psychology and Psychotherapy: Theory, Research and Practice are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

- Articles should adhere to the stated word limit for the particular article type. The word limit excludes the abstract, reference list, tables and figures, but includes appendices.

Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 6000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Please refer to the separate guidelines for Registered Reports.

All systematic reviews must be pre-registered.

Brief-Report COVID-19

Until the end of July 2020, the Psychology and Psychotherapy: Theory, Research and Practice are accepting brief-reports on the topic of Novel Coronavirus (COVID-19) in line with the journal's main aims and scope (outlined above). Brief reports should not exceed 2000 words and should have no more than two tables or figures. Abstracts can be either structured (according to standard journal guidance) or unstructured but should not exceed 200 words. Any papers that are over the word limits will be returned to the authors. Appendices are included in the word limit; however online supporting information is not included.

4. PREPARING THE SUBMISSION

Free Format Submission

Psychology and Psychotherapy: Theory, Research and Practice now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.

- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. (Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.) You may like to use this template for your title page.

Important: the journal operates a double-blind peer review policy. Please anonymise your manuscript and prepare a separate title page containing author details. (Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)

- An ORCID ID, freely available at https://orcid.org. (Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)

To submit, login at https://www.editorialmanager.com/paptrap/default.aspx and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page

You may like to use this template for your title page. The title page should contain:

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author’s present address if different from where the work was conducted;
- Abstract;
- Keywords;
- Data availability statement (see Data Sharing and Data Accessibility Policy);
- Acknowledgments.

Authorship

Please refer to the journal’s Authorship policy in the Editorial Policies and Ethical Considerations section for details on author listing eligibility. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the Project CRediT website for a list of roles.

Abstract

Please provide an abstract of up to 250 words. Articles containing original scientific research should include the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use the headings: Purpose, Methods, Results, Conclusions.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet point with the heading ‘Practitioner Points’. They should briefly and clearly outline the relevance of your research to professional practice. (The Practitioner Points should be submitted in a separate file.)

Main Text File

As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

- Title
- Main text
- References
- Tables and figures (each complete with title and footnotes)
- Appendices (if relevant)

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the authors' names or affiliations and always refer to any previous work in the third person.

- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

References should be prepared according to the Publication Manual of the American Psychological Association (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

For more information about APA referencing style, please refer to the APA FAQ.

Reference examples follow:

Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. The American Journal of Psychiatry, 159, 483–486. doi:10.1176/appi.ajp.159.3.483

Book

Bradley-Johnson, S. (1994). Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school (2nd ed.). Austin, TX: Pro-ed.

Internet Document

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from http://www.youtube.com/watch?v=Vja83KLQXZs

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Colour figures. Figures submitted in colour may be reproduced in colour online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. If an author would prefer to have figures printed in colour in hard copies of the journal, a fee will be charged by the Publisher.

Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Click here for Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

General Style Points

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association. The following points provide general advice on formatting and style.

- Language: Authors must avoid the use of sexist or any other discriminatory language.

- Abbreviations: In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.

- Units of measurement: Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.

- Effect size: In normal circumstances, effect size should be incorporated.

- Numbers: numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

Wiley Author Resources

Manuscript Preparation Tips: Wiley has a range of resources for authors preparing manuscripts for submission available here. In particular, we encourage authors to consult Wiley's best practice tips on Writing for Search Engine Optimization.

Article Preparation Support: Wiley Editing Services offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence.

Also, check out our resources for Preparing Your Article for general guidance and the BPS Publish with Impact infographic for advice on optimizing your article for search engines.

5. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Peer Review and Acceptance

Except where otherwise stated, the journal operates a policy of anonymous (double blind) peer review. Please ensure that any information which may reveal author identity is blinded in your submission, such as institutional affiliations, geographical location or references to unpublished research. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review. Before submitting, please read the terms and conditions of submission and the declaration of competing interests.

We aim to provide authors with a first decision within 90 days of submission.

Further information about the process of peer review and production can be found in 'What happens to my paper?' Appeals are handled according to the procedure recommended by COPE. Wiley's policy on the confidentiality of the review process is available here.

Clinical Trial Registration

The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers should be included in all papers that report their results. Authors are asked to include the name of the trial register and the clinical trial registration number at the end of the abstract. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

Research Reporting Guidelines

Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are encouraged to adhere to recognised research reporting standards.

We also encourage authors to refer to and follow guidelines from:

- Future of Research Communications and e-Scholarship (FORCE11)
- The Gold Standard Publication Checklist from Hooijmans and colleagues
- FAIRsharing website

Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

Funding

Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: https://www.crossref.org/services/funder-registry/

Authorship

All listed authors should have contributed to the manuscript substantially and have agreed to the final submitted version. Authorship is defined by the criteria set out in the APA Publication Manual:

"Individuals should only take authorship credit for work they have actually performed or to which they have substantially contributed (APA Ethics Code Standard 8.12a, Publication Credit). Authorship encompasses, therefore, not only those who do the actual writing but also those who have made substantial scientific contributions to a study. Substantial professional contributions may include formulating the problem or hypothesis, structuring the experimental design, organizing and conducting the statistical analysis, interpreting the results, or writing a major portion of the paper. Those who so contribute are listed in the byline." (p.18)

Data Sharing and Data Accessibility Policy

Psychology and Psychotherapy: Theory, Research and Practice recognizes the many benefits of archiving data for scientific progress. Archived data provides an indispensable resource for the scientific community, making possible future replications and secondary analyses, in addition to the importance of verifying the dependability of published research findings.

The journal expects that where possible all data supporting the results in papers published are archived in an appropriate public archive offering open access and guaranteed preservation. The archived data must allow each result in the published paper to be recreated and the analyses reported in the paper to be replicated in full to support the conclusions made. Authors are welcome to archive more than this, but not less.

All papers need to be supported by a data archiving statement and the data set must be cited in the Methods section. The paper must include a link to the repository in order that the statement can be published.

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Author Guidelines updated 28th August 2019

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