Service user experiences of the Sequential Diagrammatic Reformulation (SDR) in Cognitive Analytical Therapy (CAT): An Interpretative Phenomenological Analysis.

Kimberley Taplin

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Supervised by:

Dr Beth Greenhill

Dr Claire Seddon

Professor James McGuire

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University of Liverpool
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I would also like to thank my parents and friends for always believing in me and for providing me with a secure base to explore and develop, both personally and professionally. Finally, I would like to thank my fellow trainees, Rebecca Stephenson and Susannah McNulty, for their support, reflections and countless car share discussions across the three years of training. I dedicate this thesis to my late Grandparents for their unconditional love and kindness; without whom this would not have been possible.
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THESIS OVERVIEW

This thesis is organised into two chapters: a systematic review; an empirical research paper; and relevant appendices. Each chapter is presented as a standalone component adding to current gaps in the literature.

Chapter 1 presents a systematic literature review of all current research aiming to understand service-users’ views of psychological formulation. A total of 297 studies were initially retrieved. 11 papers were included in the final review. A narrative synthesis of their findings is presented. The literature suggests several common themes include: responses to formulation; biopsychosocial understanding; practicable and tangible; collaboration; therapeutic relationship; process; communication; change and diagnostic symptoms. Clinical implications, gaps in knowledge and the need for further research are discussed.

Chapter 2 extends the research discussed in the systematic review with a qualitative empirical paper exploring service-users experiences of the SDR. Interpretative Phenomenological Analysis (IPA) was used to explore/analyse the data. Four superordinate themes emerged from the data: ‘Chaos to clarity (a process of meaning making)’; ‘The change process’; ‘Relational dynamics’; and ‘Focus on treatment context/options’. Findings are consistent with, and extend, the current literature on CAT and formulation. Strengths and weaknesses of this research, future research ideas and clinical implications at an individual therapy and service/organisational level are discussed.
CHAPTER 1: SYSTEMATIC LITERATURE REVIEW

What are service-users’ views of psychological formulation? A systematic review

Abstract

Purpose: Formulation is a unique skill of psychologically-based clinical professions. There has been recent interest in the quality of formulation and what formulation has to offer. Despite practice-based evidence promoting the usefulness of formulation within individual therapeutic work, teams and risk assessments - there is a lack of empirical research evidencing its quality, effectiveness, or usefulness, particularly from a service-user perspective. Therefore, the aim of this systematic review is to investigate service-user views of helpful and unhelpful aspects of psychological formulation.

Method: Key search terms identified in the research protocol were entered into electronic databases, and reference lists of relevant papers were hand searched to identify additional studies. Experts in the area and the Association of Cognitive Analytic Therapy (ACAT) were also consulted. Eleven eligible papers were included and quality appraised. Key findings are presented in a narrative summary.

Results: Key papers identified views and experiences of formulation are complex, diverse, and multifaceted. Key themes from the data are explored; including: responses to formulation; biopsychosocial understanding; practical and tangible; collaboration; therapeutic relationship; process; communication; change; and diagnostic symptoms. Gaps in knowledge, the need for further research, and clinical implications are also discussed.

Conclusion: More qualitative research is needed to develop the evidence base, appraise the synthesis/analysis of results, and inform clinical practice.
Keywords: psychological formulation, case conceptualisation, reformulation, service-user
Introduction

Types and attributes of formulation

Clinical psychologists consider formulation to be an essential skill across the range of applied clinical professions. Kinderman (2001) suggests the success of clinical psychology is, in fact, the success of formulation. Formulation can be traced back to the 1950s with clinical psychologists embracing the scientist-practitioner model, and engaging collaboratively with service-users to generate hypotheses about their presenting problems (Kennedy & Llewelyn, 2001). Literature exploring formulation as a process within therapy has often focussed on a Cognitive Behavioural Therapy (CBT) perspective (Bruch & Bond, 1998; Johnstone & Dallos, 2013. However, recent literature has focussed on formulation across a variety of psychological models such as psychodynamic (Leiper, 2006), social constructionist (Harper & Spellman, 2006), systemic/integrative (Dallos, Wright, Stedmon & Johnstone, 2006) and Cognitive Analytic Therapy (CAT; Dallos, 2006).

The Division of Clinical Psychology’s (DCP) guidelines promote the use of formulation as a process (DCP, 2011). The concept of psychological formulation can be difficult to convey. Essentially, it is a hypothesis about the causes, precipitants, and maintaining influences of a person’s psychological, interpersonal, and behavioural problems (Eels, 1997). Formulations are often presented as a diagram that can be understood as hypotheses to be tested, offering the essential link between theory and intervention (Butler, 1998). The DCP (2011) define formulation as a way of constructing personal meaning out of psychological distress.
Table 1: Essential features of psychological formulations

<table>
<thead>
<tr>
<th>Essential features</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Summarises the service-user’s core problems</td>
</tr>
<tr>
<td>2 Suggests how the service-user’s difficulties may relate to one another</td>
</tr>
<tr>
<td>3 Draws on psychological theories and principles</td>
</tr>
<tr>
<td>4 Aims to explain, on the basis of psychological theory, the development and maintenance of the service-user’s difficulties, at this time and in these situations</td>
</tr>
<tr>
<td>5 Indicates a plan of intervention which is based in the psychological processes and principles already identified</td>
</tr>
<tr>
<td>6 Is open to revision and re-formulation</td>
</tr>
</tbody>
</table>

Ways of conceptualising and researching formulation

Psychiatric diagnostic systems (Diagnostic and Statistical Manual-fifth edition, DSM-V; International Classification of Diseases-tenth edition, ICD-10) are currently the dominant method of conceptualising mental health difficulties. Formulation offers an alternative/complementary framework. DSM-V is often presented as more scientific (i.e. testable, valid and reliable), despite a growing body of research challenging this viewpoint (Read & Bentall, 2012; Kinderman, Read, Moncrieff & Bentall, 2013).

The author of this review is not aware of any research exploring the accuracy of formulations, particularly from a service-user perspective. Constructing formulation objectively, and the focus on quantitative research methodology, may be reasons for the lack of qualitative research exploring service-users’ experiences of formulation.

Formulation may be described as a process of clinical activity that can be an intervention itself. It is almost impossible for a service-user, clinician or researcher to separate formulation and therapy as they are part of the same process. Clinical psychologists argue formulation is inherently different to the psychiatric diagnostic system, due to its emphasis on collaboratively summarising meanings (Harper & Moss, 2003) and negotiating shared understandings (Butler, 1998). Unlike a diagnostic label, a formulation focuses on multiple realities, rather than one truth or
fact. Therefore, the *usefulness* of formulation from a service-user’s perspective should be the focus of formulation research, instead of the search for a universal truth or diagnostic label.

**Service-user involvement**

Collaboration with service-users is pertinent to clinical psychologists both during training (HCPC, 2014) and post qualification (Department of Health User Group, 2001; NHS England, 2014). It is imperative services work together with service-users in developing services, due to the expertise service-users can offer from their own experiences. Specifically in relation to clinical psychology, service-user involvement should be part of the formulation process.

**Rationale and aim of this review**

Formulation is central to clinical psychology as a profession. Key frameworks state the importance of formulations being accessible to service-users, and ideally developed collaboratively (Hart & Logan, 2011; DCP, 2011). However, there is little evidence for this within the literature. The DCP’s guidelines on psychological formulation (DCP, 2011) were devised by professionals who consulted a service-user and carer liaison committee. However, we need to know more about what service-users think about formulation, how it makes them feel, and what they find more or less useful. Service-users’ subjective accounts of what they find helpful about formulation are likely to produce the outcomes that service-users and professionals want (i.e. recovery). Service-user perspectives will be essential in evaluating the therapeutic usefulness of formulation. A systematic review was conducted to explore this area further, to establish service-users’ views and experiences of psychological formulation.
Method

The Preferred Reporting Item for Systematic Reviews and Meta-Analyses (PRISMA) statement was used to inform this review (Moher, Liberati, Tetzlaff, & Altman, 2009).

Inclusion and exclusion criteria

A systematic review protocol was developed (Appendix A) and a number of inclusion and exclusion criteria were defined (Table 2).

Table 2: Inclusion and exclusion criteria

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papers focusing on individualised formulation.</td>
<td>Team consultation/formulation papers</td>
</tr>
<tr>
<td>The DCP’s guidelines which detail the characteristics of psychological formulation (DCP, 2011) were used to decide if a study was looking at formulation or other process/phenomena.</td>
<td></td>
</tr>
<tr>
<td>Service-user's views/opinions/experiences (not professionals) of therapy/therapeutic relationship/psychological formulation</td>
<td>Professional views only (e.g. service-users not asked as part of the methodology). A main focus on therapeutic models/psychiatric medication (not psychological formulation)</td>
</tr>
<tr>
<td>English language</td>
<td>Non-English language</td>
</tr>
<tr>
<td>All publication types (except professional opinion pieces)</td>
<td>Professional opinion pieces, books and book reviews</td>
</tr>
<tr>
<td>Peer reviewed publications and clinical psychology doctoral theses</td>
<td></td>
</tr>
<tr>
<td>Male or female participants of any age</td>
<td></td>
</tr>
<tr>
<td>Time period: any date regarding start date or publication date</td>
<td></td>
</tr>
<tr>
<td>No psychiatric diagnosis to be considered as an exclusion criterion</td>
<td></td>
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</tbody>
</table>

Risk of bias

In an attempt to minimise publication bias (Müller et al., 2013) the reviewer searched for unpublished research such as doctoral theses. The reviewer is confident that all
relevant studies were identified and none were excluded on the basis of the reviewer’s pre-judgements. Two studies could not be obtained; these were doctoral thesis for which the reviewers had not given permission for their work to be disseminated. The reviewer utilised critical appraisal tools recommended by the International Centre for Allied Health Evidence (ICAHE) in an attempt to minimise bias during data extraction and analysis.

**Search strategy**

A scoping search was conducted in August 2014 to explore literature reporting service-users’ views about psychological formulation. The reviewer found no similar reviews were registered via the Cochrane Database of Systematic Reviews (Wiley Online Library 1996 to current) or on PROSPERO (Centre for Reviews and Dissemination’s international prospective register of systematic reviews). It was concluded that the current review was feasible, would add value to the evidence base, and may have useful implications for clinical psychology.

An expert in the area of formulation, Dr Lucy Johnstone, was contacted (Appendix B) identifying four papers. The main author of the Leeming, Boyle and Macdonald (2009) paper was contacted due to the paper reporting that it does not explore all of their research findings. Following clarification, it was concluded formulation was not the initial focus of this study as it was a research project looking at managing the potential for stigma in accessing mental health services. Findings of the paper, however, do relate to the review question, with participant responses providing insight into their experiences of psychological formulation, therefore it was included in this review.
The reviewer was aware that cognitive analytical therapists often report details of ‘research in the pipeline’ on their website (www.acatme.uk). The reviewer consulted this webpage to ensure they were aware of any very recent research and identified one further paper for inclusion in the review.

Searches commenced on 3rd October 2014 (Appendix C). The following electronic databases were searched, dating back to: PsychINFO 1887; MEDLINE 1948; MEDLINE with Full Text 1949; and CINAHL Plus 1937. Searches terminated on 11th April 2015. Reference lists were also hand searched to identify further studies and duplicate citations were deleted.

**Search terms for electronic databases**

formulation or re-formulation or reformulation or “case conceptualisation” or “case formulation” or “SDR” or “sequential diagrammatic reformulation” or “sequential diagrammatic re-formulation” or letter AND “service-user” or “service-user” or client or patient AND experien* or perspective or understanding or feedback or view or opinion or satisfaction or impact AND "cognitive behavioural therapy" OR "CBT" OR "cognitive behavioural formulation" OR "cognitive analytic therapy" OR "CAT" OR "cognitive analytic formulation" OR "psychodynamic therapy" OR "psychodynamic formulation" OR "systemic therapy" OR "systemic formulation" OR "integrative therapy" OR "integrative formulation"

OR

formulation or re-formulation or reformulation or “case conceptualisation” or “case formulation” or “SDR” or “sequential diagrammatic reformulation” or “sequential
diagrammatic re-formulation" or letter AND experien* or perspective or understanding or feedback or view or opinion or satisfaction or impact AND "cognitive behavioural therapy" OR "CBT" OR "cognitive behavioural formulation" OR "cognitive analytic therapy" OR "CAT" OR "cognitive analytic formulation" OR "psychodynamic therapy" OR "psychodynamic formulation" OR "systemic therapy" OR "systemic formulation" OR "integrative therapy" OR "integrative formulation"

**Study selection**

Figure 1 details a flowchart of the search strategy. The reviewer applied the inclusion and exclusion criteria to screen titles and abstracts for all retrieved references (stage one). Full texts were obtained and screened for papers meeting these criteria (stage two). Eleven papers were included in the final review.
Figure 1: Flowchart of Search Strategy

Citations identified via electronic database searches (psychINFO, psychARTICLES, Medline, Medline with Full Text and CINAHL Plus) n=297

Stage One - Titles and abstracts screened for inclusion n=8

Excluded n=289
- Papers were reviews of other papers or books n=29
- Focussed on team consultation or CAT as a contextual model n=4
- Included professional opinion or use of psychological formulation not service-user experiences n=54
- Main focus was not psychological formulation n=202

Stage Two - Full texts obtained and screened with the CASP and EBLIP quality assessment tools n=6

Excluded n=2
- Full text irretrievable n=1
- Focus on experience of therapy not formulation n=1

Additional citations from other sources n=7
- Suggested by expert in the area n=4
- Reference list of included articles n=2
- ACAT Website n=1

Citations included from all search strategies n=11

Excluded n=2
- Duplicate article n=1
- Unable to obtain n=1
Quality assessment

The Critical Appraisal Skills Programme (CASP, 2014) is a methodological checklist providing key criteria relevant to qualitative research. The CASP ten-question appraisal tool was used to assess the quality of the qualitative studies included in this review. The EBLIP Critical Appraisal Checklist provides a thorough, generic list of questions which would determine validity, applicability and appropriateness of a study. The EBLIP Critical Appraisal Checklist was used to assess the quality of the quantitative studies included in this review. One of the papers included in this review utilised a mixed methodology (Shine & Westacott, 2010). The CASP tool was used to quality assess the qualitative aspects of the mixed method paper, and the EBLIP checklist was used to quality assess the quantitative aspects of the mixed method paper. These tools were chosen because the questions related well to the included papers (for example the main focus of the tools was not on intervention and/or comparator studies), and because the tools (Appendix D) are also recommended by the ICAHE (International Centre for Allied Health Evidence).

The reviewer did not assign numerical ratings to the overall quality of each study due to the heterogeneity of methodologies. Studies were not excluded on the basis of quality assessment, as the function of the appraisal was to develop the reviewer’s understanding of the studies in this review, to ascertain credibility of the results, and enhance the likelihood of drawing meaningful conclusions from the data, not to further inform inclusion/exclusion for this review (Boland, Cherry & Dickson, 2014). Tables 3 and 4 summarise the quality appraisals. A selection of papers were independently quality assessed by supervisors as a validity check; the level of agreement was high, but where this was lower, caution was applied when interpreting the studies.
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<tbody>
<tr>
<td>1. Clarity of research aims?</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>++</td>
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<td>2. Qualitative methodology appropriate?</td>
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<tr>
<td>3. Appropriate research design for research aims?</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>4. Appropriate recruitment strategy for research aims?</td>
<td>++</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>++</td>
<td>++</td>
<td>+</td>
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<tr>
<td>5. Appropriate research collection for research issue?</td>
<td>++</td>
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<td>++</td>
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<td>++</td>
<td>++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>6. Appropriate consideration of relationship between researcher and participants?</td>
<td>++</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td>+</td>
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<td>-</td>
<td>-</td>
</tr>
<tr>
<td>7. Consideration of ethical issues?</td>
<td>++</td>
<td>++</td>
<td>++</td>
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<td>++</td>
<td>-</td>
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<tr>
<td>8. Was the data analysis sufficiently rigorous?</td>
<td>++</td>
<td>++</td>
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<td>+</td>
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<tr>
<td>9. Is there a clear statement of findings?</td>
<td>++</td>
<td>++</td>
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<td>10. How valuable is the research?</td>
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</table>

Key: ++ yes/high quality/adequate information provided to fully answer the question  
+ Can’t tell/medium quality/information provided but additional detail would have more adequately addressed the question  
- No/low quality/information was not provided or suggested a negative response.
Table 4: Summary of quality assessment of quantitative papers using EBLIP Critical Appraisal Checklist

<table>
<thead>
<tr>
<th>EBLIP Critical Appraisal Checklist questions summary</th>
<th>Papers assessed (first reviewer, year)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Chadwick, 2003</td>
</tr>
<tr>
<td><strong>Section A: Population</strong></td>
<td></td>
</tr>
<tr>
<td>Is the study population representative of all users, actual and eligible, who might be included in the study?</td>
<td>Y</td>
</tr>
<tr>
<td>Are inclusion and exclusion criteria definitively outlined?</td>
<td>Y</td>
</tr>
<tr>
<td>Is the sample size large enough for sufficiently precise estimates?</td>
<td>N</td>
</tr>
<tr>
<td>Is the response rate large enough for sufficiently precise estimates?</td>
<td>Y</td>
</tr>
<tr>
<td>Is the choice of population bias-free?</td>
<td>Y</td>
</tr>
<tr>
<td>If a comparative study: Were participants randomized into groups?</td>
<td>NA</td>
</tr>
<tr>
<td>Were the groups comparable at baseline? If groups were not comparable at baseline, was incomparability addressed by the reviewers in the analysis?</td>
<td></td>
</tr>
<tr>
<td>Was informed consent obtained?</td>
<td>Y</td>
</tr>
<tr>
<td><strong>Section B: Data Collection</strong></td>
<td></td>
</tr>
<tr>
<td>Are data collection methods clearly described?</td>
<td>Y</td>
</tr>
<tr>
<td>If a face-to-face survey, were inter-observer and intra-observer bias reduced?</td>
<td>NA</td>
</tr>
<tr>
<td>Is the data collection instrument validated?</td>
<td>Y</td>
</tr>
<tr>
<td>If based on regularly collected statistics, are the statistics free from subjectivity?</td>
<td>NA</td>
</tr>
<tr>
<td>Section C: Study Design</td>
<td>Is the study type / methodology utilised appropriate?</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Is there face validity?</td>
</tr>
<tr>
<td></td>
<td>Is the research methodology clearly stated at a level of detail that would allow its replication?</td>
</tr>
<tr>
<td></td>
<td>Was ethics approval obtained?</td>
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<tr>
<td></td>
<td>Are the outcomes clearly stated and discussed in relation to the data collection?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section D: Results</th>
<th>Are all the results clearly outlined?</th>
<th>Y</th>
<th>Y</th>
<th>Y</th>
<th>Y</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Are confounding variables accounted for?</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Do the conclusions accurately reflect the analysis?</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Is subset analysis a minor, rather than a major, focus of the article?</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Are suggestions provided for further areas to research?</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td></td>
<td>Is there external validity?</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Section A validity calculation:</td>
<td>Valid</td>
<td>Validity questionable</td>
<td>Validity questionable</td>
<td>Validity questionable</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------</td>
<td>-----------------------</td>
<td>-----------------------</td>
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<td></td>
</tr>
<tr>
<td>Section B validity calculation:</td>
<td>Valid</td>
<td>Valid</td>
<td>Valid</td>
<td>Valid</td>
<td></td>
</tr>
<tr>
<td>Section C validity calculation:</td>
<td>Valid</td>
<td>Valid</td>
<td>Valid</td>
<td>Validity questionable</td>
<td></td>
</tr>
<tr>
<td>Section D validity calculation:</td>
<td>Valid</td>
<td>Valid</td>
<td>Valid</td>
<td>Valid</td>
<td></td>
</tr>
<tr>
<td>Overall validity calculation:</td>
<td>Valid</td>
<td>Valid</td>
<td>Valid</td>
<td>Validity questionable</td>
<td></td>
</tr>
</tbody>
</table>

**Key:**
- **Y** - Yes/high quality/adequate information provided to fully answer the question.
- **N** - No/low quality/information provided suggested a negative response.
- **U** - Unknown/medium quality/information not provided, or additional detail would have more adequately addressed the question.
- **NA** - Not applicable
Data synthesis and appraisal

Due to the heterogeneous nature of the papers covered in this review, particularly in relation to the range of methodologies, meta-analysis was not possible. A narrative discussion of papers follows, summarising current evidence relevant to the review question. Table 5 summarises key data.
Table 5: Key characteristics of included studies

<table>
<thead>
<tr>
<th>First author</th>
<th>Year</th>
<th>Research aims</th>
<th>Methodology</th>
<th>Data collection</th>
<th>Sample size</th>
<th>Study population</th>
<th>Main presenting difficulties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualitative papers</td>
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<tr>
<td>Hamill</td>
<td>2008</td>
<td>Patient perspectives on how therapeutic letters contributed to their experience of CAT</td>
<td>Grounded thematic analysis</td>
<td>Semi-structured interviews</td>
<td>8</td>
<td>20-85</td>
<td>5 females, 3 males</td>
</tr>
<tr>
<td>Osbourne</td>
<td>2011</td>
<td>To explore client and therapist experiences of sequential diagrammatic reformulations in CAT.</td>
<td>Interpretative Phenomenological Analysis (IPA)</td>
<td>Semi-structured interviews</td>
<td>7</td>
<td>29-39 (mean age, 34)</td>
<td>4 client-therapist dyads; 4 clients (2 females, 2 males) and 3 therapists (1 female, 2 males)</td>
</tr>
<tr>
<td>Redhead</td>
<td>2015</td>
<td>To explore clients’ experiences of formulation in CBT for depression and/or anxiety, as reported after the end of therapy</td>
<td>Thematic Analysis</td>
<td>Semi-structured interviews</td>
<td>10</td>
<td>24-76</td>
<td>8 females, 2 males</td>
</tr>
<tr>
<td>Rayner</td>
<td>2011</td>
<td>To explore clients experiences of CAT and gain better understanding of CAT tools (e.g. reformulation letters and diagrams) and how they relate to the clients’ understanding of change</td>
<td>Grounded theory</td>
<td>Semi-structured interviews</td>
<td>9</td>
<td>25-60 (mean age, 42)</td>
<td>8 females, 1 males</td>
</tr>
<tr>
<td>Kahlon</td>
<td>2014</td>
<td>To explore experiences of CBT formulation in clients with depression</td>
<td>Thematic analysis</td>
<td>Semi-structured interviews</td>
<td>7</td>
<td>19-54 (mean age, 33)</td>
<td>Not specified</td>
</tr>
<tr>
<td>Pain</td>
<td>2008</td>
<td>To explore clients’ experience of case formulation in CBT for psychosis</td>
<td>Content analysis</td>
<td>Semi-structured interviews</td>
<td>13</td>
<td>21-64 (mean age, 32)</td>
<td>5 females, 8 males</td>
</tr>
<tr>
<td>Leeming</td>
<td>2009</td>
<td>How participants managed the</td>
<td>Thematic analysis</td>
<td>Semi-structured interviews</td>
<td>22</td>
<td>15-89</td>
<td>Not specified</td>
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potential for shame that can arise from experiencing difficulties which are often viewed pejoratively

was from a CAMHS, two CMHTs for older adults and a user group who campaigned against issues around stigma

<table>
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<tr>
<th>Quantitative papers</th>
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<tr>
<td>Chadwick 2003</td>
<td>Two experiments (E1 and E2) to explore the impact of case formulation in CBT for psychosis on both therapeutic relationship and psychosis symptoms (including delusional and self-evaluative beliefs, anxiety and depression)</td>
<td>E1: Within-subjects repeated measures design</td>
<td>Psychometric questionnaires and semi-structured interviews</td>
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<td>E2: Multiple baseline design</td>
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<tr>
<td>Evans-Jones 2009</td>
<td>To investigate which factors are associated with the therapeutic relationship in CBT for psychosis</td>
<td>Cross-sectional correlational design</td>
<td>Questionnaires</td>
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<td></td>
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<td>24 client-therapist dyads</td>
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<td>Evans 1996</td>
<td>To evaluate the impact of reformulation in CAT with difficult to help clients</td>
<td>Multiple baseline design</td>
<td>Psychometric questionnaires and semi-structured interviews</td>
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<th>Mixed method</th>
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<tr>
<td>Shine 2010</td>
<td>To investigate if the reformulation process in CAT had an impact on working alliance, and explore the client’s perspective of the reformulation process</td>
<td>Time series analysis and template analysis</td>
<td>Questionnaires and a semi-structured interview</td>
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<td></td>
<td>Time series analysis and template analysis</td>
<td>Questionnaires and a semi-structured interview</td>
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<td>5</td>
<td>22-63 (mean age, 42)</td>
<td>4 females, 1 male</td>
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<td>Axis I disorders</td>
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Results

A total of eleven studies were included in the review. Five of the studies were related to CAT, five were related to CBT, and one of the studies was not linked to a specific theoretical model. The quality assessment of included studies is summarised in Table 3 and Table 4. The quality of the qualitative papers varied but were considered good quality with the exception of one paper (Leeming et al., 2009). The quality of the quantitative papers varied but indicated an overall validity, with the exception of one paper (Evans & Parry, 1996). Consequently, the two papers with questionable validity (Leeming et al., 2009; Evans & Parry, 1996) should be interpreted with more caution. Key study characteristics are summarised in Table 5, grouped by their research methodology, and then presented in order of descending quality appraisal.

Key themes and findings from the qualitative papers

Data relevant to the review question were extracted (Table 6) for each study including primary outcomes and conclusions of the research studies. Data were organised primarily by research methodology, and then presented in order of descending quality appraisal. Key findings are discussed below as a narrative synthesis, organised by methodology and prevalence across the papers. The qualitative and quantitative aspects of the mixed method paper have been reviewed separately.

For the qualitative papers, the reviewer adapted Braun and Clarke’s (2006) thematic analysis approach to finding patterns of meaning across the studies. This approach was chosen because thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data. It is a flexible approach that organises,
describes and interprets the data set in rich detail (Boyatzis, 1998). It is acknowledged that the researcher plays an active role when identifying themes (Taylor & Ussher, 2001). The reviewer reflected on her own values, previous experiences and potential biases in relation to the data. Themes were selected based on their representation of meaning within the data, with similar findings being grouped together under one thematic label and applied in terms of frequency across the data set. Less prominent considerations arising from the data are also discussed. The quantitative papers also included semi-structured interview data. This qualitative material was explored alongside other qualitative data.
<table>
<thead>
<tr>
<th><strong>Author and year</strong></th>
<th><strong>Research aims</strong></th>
<th><strong>Primary outcome/conclusions</strong></th>
</tr>
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<tbody>
<tr>
<td>Hamill, Reid &amp; Reynolds (2008)</td>
<td>Patient perspectives on how therapeutic letters contributed to their experience of CAT</td>
<td>CAT letters helped participants make connections within themselves (developing self-understanding and awareness over time), with their therapist (therapeutic relationship), and therapeutic processes (structure of therapy), and with decisions regarding communicating about themselves to others (using letters to communicate self with others)</td>
</tr>
<tr>
<td>Redhead, Johnstone &amp; Nightingale (2015)</td>
<td>To explore clients’ experiences of formulation in CBT for depression and/or anxiety, as reported after the end of therapy</td>
<td>Four overarching themes: 1. Formulation helps me to understand my problems 2. Formulation leads to feeling understood and accepted 3. Formulation leads to an emotional shift 4. Formulation enables me to move forward</td>
</tr>
<tr>
<td>Pain, Chadwick &amp; Abba (2008)</td>
<td>To explore clients’ experience of case formulation in CBT for psychosis</td>
<td>Seven themes: 1. Reaction to formulation (mixed responses – negative, positive, and difficult to process) 2. Therapeutic value (level of change or helpfulness varied – mainly reflected positive responses to formulation) 3. Behaviour in relation to formulation (re-reading, coping strategy, sharing formulation with others) 4. Reflects experience/understanding</td>
</tr>
<tr>
<td>Study</td>
<td>Research Question</td>
<td>Key Themes</td>
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<td>-------------------------------------------</td>
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| Kahlon, Neal & Patterson (2014)           | To explore experiences of CBT formulation in clients with depression              | Four superordinate themes: 1. Feeling trapped or restricted by depression 2. The development of the formulation – from coming to my own conclusions to something the therapist developed 3. From negative to mixed feelings regarding the reac
ting to the formulation during the therapeutic process 4. A new journey towards making a new sense of self |
| Leeming, Boyle & Macdonald (2009)         | How participants managed the potential for shame that can arise from experiencing difficulties which are often viewed pejoratively | Two themes discussed: 1. Difficulties in using psychosocial explanations 2. Diagnosis as both salvation and damnation |
| Chadwick, Williams & Mackenzie (2003)     | Two experiments (E1 and E2) to explore the impact of case formulation in CBT for psychosis on both therapeutic relationship and psychosis symptoms (including delusional and self-evaluative beliefs, anxiety and depression) | E1: Formulation in CBT for psychosis does not have a significant impact on alliance for clients, but may have a significant impact for therapists Semi-structured interviews suggest clients found formulation helpful by enhancing their understanding of their own problems and showed them that the therapist understood them. They also reported positive emotions - feeling reassured, encouraged and more optimistic. Some clients reported a negative emotional response to the formulation, describing the experience as saddening, upsetting and worrying. Some clients reported positive and negative responses, indicating ambivalence about formulation. Some clients reported no emotional impact of the formulation, and some found them complicated. For therapists, formulation had a number of positive effects: powerful, validating, hopeful about therapy, enhanced alliance, understanding, collaboration and confidence in the model E2: Formulation delivered over four separate sessions did not have a significant impact on strength of delusions, or negative self-evaluations. Formulation alone does not reduce belief strength for delusions or negative person evaluations. Changes are attributed jointly to cognitive restructuring and formulation |
| Evans-Jones & Peters (2009)               | To investigate which factors are associated with the therapeutic relationship in CBT for psychosis | The presentation of a formulation was linked to a better therapeutic relationship |
| Shine & Westacott (2010)                  | To investigate whether the reformulation process in CAT had an impact upon a measure of working alliance, and to explore the client’s perspective of the reformulation process | No significant impact of the reformulation process on measure of working alliance, either as a step-change or slope-change |
| Evans & Parry (1996)                      | To evaluate the impact of reformulation in CAT with difficult to help clients       | Reformulation did not have a systematic short term impact upon measures of the client’s perceived helpfulness of the sessions, the therapeutic alliance or individual problems. |
However, in semi-structured interviews clients reported that the reformulation had considerable impact upon them, including providing a better understanding of their problems, enhanced trust in the therapist, and providing a focus for therapy.
Response to the formulation

All eight studies reported responses relevant to this theme. Participants’ responses to formulation were complex and multifaceted. Reactions were often contradictory within and between participants. Some reactions included finding the formulation unhelpful, complex, and emotionally difficult to engage with (Kahlon, Neale & Patterson, 2014; Rayner, Thompson & Walsh, 2011), leaving participants ‘feeling sad’ (Pain, Chadwick & Abba, 2008) or ‘distressed’ (Redhead, Johnstone & Nightingale, 2015). Other responses to formulation included feeling understood and accepted (Shine & Westacott, 2010; Redhead et al., 2015), providing relief (Pain et al., 2008; Redhead et al., 2015) and being on a new journey and finding a ‘new me’ (Kahlon et al., 2014).

Some participants’ responses highlighted the importance of considering ways formulation may support or hinder service-users in communicating their strengths and weaknesses to others. Some participants reported feeling exposed, and a sense of shame and failure (Leeming et al., 2009; Shine & Westacott, 2010) following the development and discussion of their formulation.

Biopsychosocial understanding

All eight studies reported responses relevant to this theme. Participants frequently reported formulation helped normalise psychological difficulties and simplify complex information supporting them to develop self-understanding regarding the development and maintenance of their difficulties (Osbourne, 2011; Shine & Westacott, 2010; Rayner et al, 2010; Redhead et al., 2015) and their own contribution to their mood state and problematic behaviours (Kahlon, Neale &
Patterson, 2014), while emphasising the potential for therapeutic change. In one study, formulations helped participants reduce their tendency to blame oneself while developing self-compassion and empathy (Rayner et al., 2010).

**Practical and tangible**

Six of the eight studies reported responses relevant to this theme. Participants found the visual element of formulation helpful. Having a visual representation provided something tangible that could be utilised and reflected on inside and outside of therapy (Hamill, Reid & Reynolds, 2008; Rayner, Thomspson & Walsh, 2010; Shine & Westacott, 2010). Participants referred to formulations as something you ‘do’ and ‘more than just talking’. Participants appreciated practical aspects of formulating, ‘real life’ metaphors and practising new skills. Diagrammatic formulations (compared to formulation letters) play a role in re-emphasising learning and reminding service-users of novel adaptive coping strategies (Kahlon et al., 2014; Rayner et al., 2010).

**Collaboration**

Five of the eight studies reported responses relevant to this theme. There was a strong sense of collaboration during the development of the formulation. This gave participants a sense of transparency, ownership, teamwork and empowerment (Osbourne, 2011; Shine & Westacott, 2010). The act of ‘doing with’ the therapist and actively working together impacted positively upon the therapeutic relationship (Hamil, Reid & Reynolds, 2008; Rayner, Thomspson & Walsh, 2010).
In one of the studies participants’ responses regarding the level of collaboration varied. Most participants reported exploring thoughts, feelings, behaviours and experiences with their therapist; however, responses varied regarding who was perceived to be more responsible for the development of the formulation, the participant or the therapist (Kahlon, Neal & Patterson, 2014).

**Therapeutic relationship**

Four of the eight studies where this emerged, reported responses relevant to this theme. Analysis across studies highlights the importance of formulation in developing a therapeutic relationship. Participants reported feeling heard, listened to and understood across the formulation process (Shine & Westacott, 2010). Formulations also conveyed the therapists’ respect, competence and a level of collaboration (Hamil, Reid & Reynolds, 2008). Some authors proposed that formulation can be represented as a tangible object which supports the service user to maintain a connection with the therapist and the therapeutic process (Hamil, Reid & Reynolds, 2008; Shine & Westacott, 2010).

**Process**

Four of the eight studies reported responses relevant to this theme. The impact of formulation is an ongoing process transcending therapeutic sessions. Formulation offers a lasting, tangible document that facilitates ongoing assimilation and awareness (Hamil, Reid & Reynolds, 2008; Osbourne, 2011). Participants explained needing to go through discomfort when acknowledging difficult and complex emotions to aid self-understanding (Rayner et al., 2011) as they engage in a process of revelation, empowerment and relief (Kahlon et al., 2014).
Communication

Four of the eight studies reported responses relevant to this theme. Participants reported formulation facilitated communication promoting a space to talk within therapy, particularly focusing conversations within therapy (Osbourne, 2011; Pain et al., 2008; Shine & Westacott, 2010), and presenting the opportunity to share formulation with others (Hamil, Reid & Reynolds, 2008).

Change

Four of the eight studies reported responses relevant to this theme. Participants reflected on whether formulation is designed to influence change at a diagnostic symptom level, or holistic level. Some participants conceptualised the impact formulation had on therapeutic change as a continuous process, rather than a cure (Rayner, Thompson & Wales, 2011). These changes were more person centred/holistic than symptom/diagnosis specific, including reduced self-criticism, enhanced levels of confidence, assertiveness and self-esteem.

Pain et al., (2008) reported participants found formulation provided clinical improvement (symptom related) and general helpfulness (holistic/quality of life factors). Osbourne (2011) reported formulation influences change on multiple levels, including speeding up the process of change, and providing a foundation for hope. Redhead et al., (2015) found formulation enabled people to move forward and provided a sense of empowerment and control linked to a better understanding of their problems and an ability to move forwards. However, some participants
wondered if the enhanced understanding provided by formulation was enough to facilitate change at an emotional and behavioural level.

Key findings from the quantitative papers

Therapeutic relationship

All four studies reported responses relevant to this theme. Findings from quantitative research assessing the impact of formulation on the therapeutic relationship are inconsistent. Some research reported no statistically significant impact of formulation on therapeutic relationship from the service-user perspective (Evans & Parry, 1996; Shine & Westacott, 2010). However, data suggested formulation impacts the therapeutic relationship from the therapists' perspective (Chadwick, Williams & Mackenzie, 2003). Paradoxically, Evans-Jones, Peters and Barker (2009) reported formulation was linked to a better therapeutic relationship from the participants' perspectives. There are mixed outcomes in relation to effects of formulation and working alliance, consequently these findings should be reviewed cautiously.

Diagnostic symptomatology

Three of the four studies reported responses relevant to this theme. Participants reported no significant impact of formulation on specific diagnostic symptomatology, including anxiety and depressive symptoms as measured by the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983) and psychosis symptoms following four sessions (strength of delusions or negative self-evaluations; Chadwick et al., 2003).
Discussion

The review aimed to summarise service-users’ views about formulation, with a focus on what is helpful and unhelpful about it. Findings provide insight into the under-researched area of formulation from service-user perspectives. At times the review findings were clear and consistent, and at other times, contradictory and complex.

Findings that were consistent across the qualitative papers were that formulation helped participants to synthesise complex information, develop an understanding of their problems, reduce self-blame and enhance self-compassion and empathy. Participants described formulation as a communication tool across settings and relationships. Participants also found formulation helpful in providing ‘real life’, personalised metaphors and practical management strategies, with an emphasis on ‘doing with’ and ‘not just talking’. Most of the qualitative papers found a visual and physical representation of a psychological formulation acts as a transitional object (Winnicott, 1953) and assists internalisation (Ryle, 2004) representing the therapeutic relationship beyond therapy itself.

The concept of ‘change’ is complex; research often focusses on diagnostic symptoms as an indicator of change. However, the majority of the results from the qualitative studies on formulation reported a higher prevalence of holistic change on client-centred measures such as quality of life and recovery orientated goals and values. Kinderman, Read, Moncrieff and Bentall (2013) highlight the serious scientific, philosophical, practical and humanitarian inadequacies in DSM-V, and discuss the weaknesses of mutually exclusive categories based on rules of a hierarchical medical model of human distress. Given that psychometric outcome measures are based on this system, it is important to consider the appropriateness and usefulness of these tools.
Contradictory findings across the qualitative papers include participants’ responses to formulation, which were complex and multifaceted. Some participants experienced formulation as unhelpful, complex, emotionally difficult, and experienced a sense of shame and failure (when considering communicating it to others). Other participants found it reduced shame and provided a sense of control, empowerment and relief. For most participants, formulation evoked some painful emotions while also promoting hope. The role of formulation in promoting a sense of collaboration and ownership over formulation through transparency, teamwork and empowerment was mentioned across most papers. The extent to which participants felt it was a collaborative process varied. This was associated with perceived levels of collaboration in relation to the formulation. It is not clear if this varied due to the participant’s ability to understand and engage with psychological thinking or individual therapist style and training.

Findings from quantitative data were less detailed. Results revealed two topic themes: therapeutic relationship and diagnostic symptomatology. Findings were inconsistent, with some research suggesting formulation has no impact on the therapeutic relationship, and others suggesting it impacts positively. In relation to clinical symptoms, quantitative results suggested formulation did not make a significant impact upon symptoms of anxiety and depression as measured by the Hospital Anxiety and Depression Scale.

The lack of research exploring service-user views and experiences of formulation, and the range of research methodologies across the current studies, suggests there is not an established method for conducting research on formulation. The lack of research regarding formulation may be reflective of the challenges in conducting such research, for example difficulties in operationalising what formulation is (DCP,
2011); what makes a 'good' formulation; and what methodology would be most appropriate to approach such questions. The lack of research into this area may also reflect the assumptions of clinical psychologists that formulation is a positive and helpful tool enhancing the therapeutic relationship and therapeutic change (Osbourne, 2011). It is not surprising qualitative methodologies are used most during these early stages of researching service-users’ views of formulation.

**Strengths of this review**

This review followed scoping searches and employed a comprehensive search strategy. Doctoral theses and peer reviewed journals were included in the review. Due to the paucity of research in the area, and the papers most relevant to the research question being a doctoral theses it was thought important to include these studies. The reviewer consulted regularly with research supervisors and an expert in the topic area to ensure quality of the review and an awareness of up to date literature. A systematic review methodology was chosen to provide a transparent and replicable review. The narrative summaries add a richer synthesis and analysis of the results. The review included both qualitative and quantitative literature, separated out for the purposes of quality assessment and data synthesis. This is a relative strength because it allowed the review to be inclusive. The reviewer recognised her own position in regards to this review question, particularly in relation to her professional role as a trainee clinical psychologist. The reviewer was aware of their own pre-understandings due to her own professional training and clinical experiences which provided positive attributions to both formulation and CAT. The reviewer was mindful to remain open to new findings that may have been inconsistent with her own thoughts and beliefs about the value of CAT formulation to allow for new understandings and an unbiased review. The process of conducting the review highlighted the reviewer’s preconceptions and challenged these at times.
Limitations of this review

It was difficult to analyse and synthesise the included papers comprehensively due to the variation in research methodologies within, and across, the qualitative (grounded theory, IPA, thematic analysis, content analysis and template analysis) and quantitative (multiple baseline design and cross sectional correlational design) papers. The reviewer was aware of the range of psychiatric diagnoses upon which some of the research papers were based (e.g. anxiety, depression, personality disorder and psychosis) and the different therapeutic models (e.g. CAT and CBT) informing psychological formulation, adding to the heterogeneity of the data. Non-English language papers were excluded from the review. The screening of references, full text articles, quality assessment and data extraction were completed by the main reviewer. The quality assessment process is a subjective task, and despite the reviewer using standardised tools, this is a limitation relevant to all quality assessments. However, papers were not excluded on the basis of quality assessment. Two independent reviewers quality appraised a selection of the studies as a validity check. Additional validity checks at the data extraction phase would have strengthened this review. Due to the diversity in participant population, therapeutic modality and research methodology, it is difficult to generalise findings across the studies.

Clinical and professional implications

Response to formulation

Findings from this review could enhance service-user experiences of formulation. Results suggest service-users can find the process leaves them feeling sad and distressed (Pain et al., 2009; Rayner et al., 2011). Clinical psychologists could ensure they provide their service-users with space and encouragement to reflect on their experience of the formulation process, and on the formulation itself. It may be important to support service-users through the process of engaging with potentially
distressing emotions as the formulation is being developed, with an acknowledgement of the learning process and promotion of hope. An area not reflected in the review findings is the potential importance of protective factors and promotion of resilience within formulation. Perhaps this is because formulations are often problem focussed. A number of participants mentioned formulations being difficult to experience at times due to their distressing content; including an individual’s strengths within a formulation may support service-users to engage with it.

**Biopsychosocial understanding**

Results emphasise how clinical psychologists can use formulation to support service-users to develop a holistic understanding of the self, including the attribution of meaning to distressing experiences which reduces self-blame and supports individuals to reflect on their own contribution to their mood states and maintenance of their difficulties (Osbourne, 2011; Shine & Westacott, 2010; Rayner et al., 2010). It is important that we continue to promote this framework of understanding as an alternative to the prevailing medical model. Findings from this review suggest formulation can be used to challenge the mad/bad dichotomy, and to promote understanding of the biopsychosocial model of distress. Furthermore, it emphasises the leadership role of clinical psychologists, including media and political influence at a public health and awareness raising level.

**Practical and tangible**

Service-users found it helpful to have a visual representation of discussions in therapy (Hamill et al., 2008; Rayner, Thomspoon & Walsh, 2010; Shine & Westacott, 2010). A diagrammatic formulation could be used as a visual aid across sessions. Drawings could also support therapeutic learning and reflection. It would be helpful if service-users kept a copy to refer to between sessions to support any homework
tasks. The use of ‘real life’, person-centred metaphors was indicated as a useful strategy when exploring abstract or complex concepts within a tangible framework (Kahlon, Neal & Patterson, 2014; Rayner et al., 2010).

**Collaboration**

There are no guidelines for the development and sharing of formulation letters; this is an area for development. Results suggest those who gained more had an active role in constructing a diagrammatic formulation and an experience of ‘doing with’ the therapist which seemed to translate to a feeling of being actively engaged in their own process of change (Osbourne, 2011; Shine & Westacott, 2010; Redhead et al., 2015). Findings from this review suggest a variation in levels of collaboration with regards to development of formulation. It may be helpful for clinical psychologists to reflect on factors affecting their ability to work collaboratively and ways this can be enhanced to avoid a hierarchical and ‘expert role’ within the therapeutic relationship. Therapeutic training and individual therapist factors are likely to influence the style and level of collaboration. It is important to consider the purpose of formulations, who they are developed for, and who takes ownership of the formulation (the service-user, therapist, and/or the service).

**Therapeutic relationship**

Key themes from this review complement earlier findings from Elliott and James’ review of clients’ experience of therapy generally (Elliott & James, 1989), particularly the role of the therapeutic relationship in supporting service-users to feel comfortable to challenge the therapist/formulation. This suggests there is an opportunity to reflect collaboratively about challenges that may arise within the therapeutic relationship through development of a formulation which identifies problematic relational patterns. Findings from this review also suggest formulation acts as a tangible object which maintains a connection with the therapist and the
therapeutic process/relationship (Hamil, Reid & Reynolds, 2008; Shine & Westacott, 2010). It may be helpful to explore other opportunities to meet this need within therapy, such as developing other means of providing transitional/attachment objects.

**Process**

Results suggest formulation is a process that continues outside therapy sessions and after therapy has ended (Hamil, Reid & Reynolds, 2008; Osbourne, 2011). An awareness of formulation as an ongoing process may provide an opportunity to support change through the provision of follow-up sessions to review progress and support any lapses. Time between sessions could also support service-users to reflect on discussions within therapy and promote the application of learning to other environments.

**Communication**

Service-users could be supported to use the formulation as a communication tool with key people in their life (Hamil, Reid & Reynolds, 2008). It is important that professionals ask service-users what they do, and do not, want to be shared with other professionals involved in their care and support them to share information either directly or indirectly in a way that decreases the feelings of shame and failure reported by Leeming, Boyle and Macdonald (2009).

**Change**

Results suggest formulation influences changes on multiple levels (i.e. clinically, holistically and statistically; Osbourne, 2011; Pain et al., 2008). There is a need for a broader range of client-centred, idiosyncratic outcome measures to capture these
effects of psychological interventions. Service level and commissioning agreements may dictate the outcome measures that a service routinely uses. It is important that clinical psychologists also use individualised means of capturing holistic and meaningful client-centred change. This information should be shared with commissioners to ensure outcomes are captured and valued, in comparison to numerical changes on a symptom checklist, or worse still, change being quantified by a diagnostic checklist that is invalid and unreliable (Read & Bentall, 2012; Kinderman, Read, Moncrieff & Bentall, 2013).

**Future research**

Clinical and professional implications highlighted in this review reflect the value of involving service-users in research and service development. Research into formulation, particularly from a service-user perspective is limited. This may be due to difficulties defining formulation and separating formulation from therapy. Future research should aim to define formulation consistently across studies. The DCP’s definition of the essential features of psychological formulations (DCP, 2011) would offer a useful framework to promote a scientific exploration of formulation that ensures different studies are exploring the same concept. Initially, high quality qualitative research using qualitative methods is needed. Perhaps, once the research base starts to develop, more long term quantitative research methods could be employed. Researchers should be mindful of the timing of data collection, and the methods used to measure change. Future research focusing on how service-users engage with, use and are affected by their formulations would be valuable. It would also be interesting to research service-user perspectives (of specific details) of more or less useful aspects of diagrammatic formulations and/or formulation letters. This could be extended to different therapeutic models of formulation where adherence to the model is controlled for. It would be useful to
research different time points after receiving a formulation, and to explore experiences of where therapy was not helpful. It will be valuable to operationalise what is ‘useful’ and to explore this further to establish both what is helpful and how. There is a lack of research regarding formulation generally; consequently it would be interesting to conduct a systematic review exploring professionals’ views of formulation. There is growing emphasis on psychology and leadership, therefore it would also be valuable to explore what MDTs think about formulation and if/how it influences their clinical practice.

**Conclusion**

Essentially psychological formulation is not a panacea; however, idiosyncratically supporting individuals to formulate their strengths and difficulties within a normalising and empowering framework while promoting hope and the potential for change has considerable implications for clinical practice. More research in this area is needed to contribute to and develop both the evidence-base and clinical practice.
References


CHAPTER 2: EMPIRICAL RESEARCH

Abstract

Objectives: Formulation is an essential tool in psychological therapy. However, there is a paucity of research evidencing the efficacy and credibility of formulation. CAT uses a model specific formulation tool (the Sequential Diagrammatic Reformulation (SDR/map). The evidence base for CAT is developing, however there is little evidence exploring how service-users experience the SDR. Published research suggests service-users have very often not been asked about their experiences of psychological formulation. This research aims to address a gap in the evidence base by exploring service-user experiences of the SDR.

Design: This research is a practice based study exploring service user experiences of the SDR.

Method: Seven participants who had an SDR and completed therapy within three to twelve months were interviewed using a semi-structured interview/topic guide. Data was analysed using Interpretative Phenomenological Analysis (IPA).

Results: Four superordinate themes emerged from the data: ‘Chaos to clarity (a process of meaning making)’; ‘The change process’; ‘Relational dynamics’; and ‘Focus on treatment context/options’.

Conclusion: Results suggests the SDR facilitates understanding and reduces blame. Participants advocated for CAT as an early intervention. The visual and physical aspects of the SDR were important in developing a sense of ownership of the formulation. Collaboration was crucial to the development of the therapeutic relationship and promotes a sense of empowerment, hope and meaningful person-centred change. CAT was regarded as a preferable treatment compared to CBT and medical frameworks of understanding human distress for participants in this
study. Study strengths and limitations, clinical implications and future research ideas are discussed.

**Keywords:** Cognitive Analytical Therapy, Sequential Diagrammatic Reformulation, service-user
Introduction

Formulation offers an alternative or complementary framework to the prevailing medical model of human distress, and although the psychiatric classification system is often presented as scientific, a growing body of research challenges this viewpoint (Read & Dillon, 2004; Kinderman, Read, Moncrieff & Bentall, 2013). Whilst clinical psychology has a critique of the medical model, the evidence base for formulation itself needs to be developed, particularly from a service-user perspective.

Defining formulation

Formulation is an idiosyncratic tool for service-users. It is a theoretically based hypothesis about the cause and nature of presenting problems (Westmeyer, 2003; Kuyken, Fothergill, Musa, & Chadwick, 2005; Persons, 1989). Formulation is also described as a ‘crucible’ bringing together a range of psychological theories, research and idiosyncratic service-user factors (Dudley & Kuyken, 2013) to make sense of complex information and guide intervention (Butler, 1998). The Division of Clinical Psychology (DCP) define formulation as a process constructing personal meaning out of psychological distress (DCP, 2011). Essential features of formulations across therapeutic modalities are summarised in Table 1 (Johnstone & Dallos, 2006). A more thorough list of key characteristics of formulation is included in Appendix E (DCP, 2011).
Table 1: Essential features of the psychological formulation

<table>
<thead>
<tr>
<th>Essential features</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Summarises the service-user’s core problems.</td>
</tr>
<tr>
<td>2 Suggests how the service-user’s difficulties may relate to one another.</td>
</tr>
<tr>
<td>3 Draws on psychological theories and principles.</td>
</tr>
<tr>
<td>4 Aims to explain, on the basis of psychological theory, the development and maintenance of the service-user’s difficulties, at this time and in these situations.</td>
</tr>
<tr>
<td>5 Indicates a plan of intervention based on the psychological processes and principles identified.</td>
</tr>
<tr>
<td>6 Is open to revision and re-formulation.</td>
</tr>
</tbody>
</table>

The evidence-base for formulation

It is challenging to research formulation due to its complex, idiosyncratic nature and difficulties applying formulation to an RCT study, alongside risks in standardising approaches to formulation. Despite formulation being valued within psychology there is a lack of research exploring the development, use, and effectiveness of formulation, (Aston, 2009; Rainforth & Laurenson, 2014).

Formulation has been shown to increase service-user’s understanding of their problems (Persons, 1989) and reduce emotional distress (Horowitz, 1997). Zuber (2000) reported service-users’ understanding of their problems is a stronger predictor of therapeutic outcome than psychiatric diagnosis. Formulation has also been reported to enhance the therapeutic relationship (Needleman, 1999).

Research exploring formulation compares groups and discusses professionals’ views, while lacking empirical data assessing its validity (Mumma & Mooney, 2007), reliability and efficacy (Rainforth & Laurenson, 2014). Bieling and Kuyken’s review of cognitive case formulation found limited research suggesting formulations lead to better therapeutic outcomes. A review exploring the efficacy of formulations in
clinical practice (Aston, 2009) discussed the need for research to explore service-user’s understanding and experience of formulations. A recent review of case formulation (Rainforth & Laurenson, 2014) suggests further research is needed to explore the efficacy, process and function of formulation.

**CAT theory and practice**

CAT was developed in 1979 as a time-limited, integrated approach to meet service-user’s needs within NHS settings. The model incorporates ideas from Vygotsky, Winnicott and Bakhtin (Ryle, 1991; Leiman, 1992). CAT integrates psychoanalytic and developmental theories, and is informed by attachment theory (Bowlby, 1969) personal construct theory (Kelly, 1955) and object relations theory.

CAT emphasises a collaborative approach. CAT aims to identify and revise repetitive maladaptive patterns of thought and behaviour. These patterns are known as reciprocal role procedures (RRPs). A reciprocal role (RR) is a way of relating which is learned and developed through our early experiences of relationships. A RR can be helpful (appropriately caring-appropriately cared for) or unhelpful (neglecting-neglected). Through exploration of service-user’s early experiences of receiving care a selection of RRs and RRPs are identified. The client and therapist develop a list of therapeutic goals (target problems (TPs)). Unhelpful patterns (target problem procedures (TPPs)) are identified in terms of: ‘snags’ (barriers to change such as feeling guilty when happy), ‘traps’ (thoughts or behaviours exacerbating the problem) and ‘dilemmas’ (polarised ‘either/or’ and ‘if/then’ choices). The SDR is drafted collaboratively to support service-users to develop their awareness of maladaptive patterns, and their ability to revise them (refer to Appendix F for an example SDR). The SDR is reflected on and can be revised.
The SDR is also used to explore any transference and counter-transference reactions within the therapeutic relationship.

**Service-user experiences of formulation**

There is a paucity of research exploring service-user experiences of formulation. Research suggests a range of complex reactions subject to change across (and beyond) therapy. Table 2 summarises key research findings exploring service-user experiences of formulation in CBT and CAT. There is currently no outcome research exploring service-user experiences of formulation from other psychological models. Data has been organised by research methodology, and presented in order of descending quality appraisal.
<table>
<thead>
<tr>
<th>Author and year</th>
<th>Research aims</th>
<th>Primary outcome/conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hamill, Reid &amp; Reynolds (2008)</td>
<td>Patient perspectives on how therapeutic letters contributed to their experience of CAT</td>
<td>CAT letters helped participants make connections within themselves (developing self-understanding and awareness over time), with their therapist (therapeutic relationship), and therapeutic processes (structure of therapy), and with decisions regarding communicating about themselves to others (using letters to communicate self with others)</td>
</tr>
</tbody>
</table>
| Osbourne (2011) | To explore client and therapist experiences of sequential diagrammatic reformulations in CAT | Six master themes:  
7. Increases understanding  
8. Facilitates conversations  
9. Collaboration  
10. Facilitates change  
11. Impact of sequential diagrammatic re-formulation beyond therapy  
12. Doing it right |
| Redhead, Johnstone & Nightingale (2015) | To explore clients’ experiences of formulation in CBT for depression and/or anxiety, as reported after the end of therapy. | Four overarching themes were identified:  
1. Formulation helped me to understand my problems  
2. Formulation leads to feeling understood and accepted  
3. Formulation leads to an emotional shift  
4. Formulation enables me to move forward |
| Rayner, Thompson & Walsh (2011) | To explore clients experiences of CAT and gain better understanding of CAT tools (e.g. reformulation letters and diagrams) and how they relate to the clients’ understanding of change | A core conceptual framework of ‘doing with’ appeared in all interviews. Within this theoretical model there were four main interrelated themes: being with the therapist, understanding the feeling, keeping it real, and CAT tools |
| Pain, Chadwick & Abba (2008) | To explore clients’ experience of collaborative case formulation in CBT for psychosis | Seven themes:  
8. Reaction to formulation (mixed responses – negative, positive, and difficult to process)  
9. Therapeutic value (level of change or helpfulness varied – mainly reflected positive responses to formulation)  
10. Behaviour in relation to formulation (re-reading, coping strategy, sharing formulation with others)  
11. Reflects experience/understanding  
12. Optimism/pessimism  
13. Change in relation to formulation over time  
14. Therapeutic relationship (positive reaction to therapist or therapeutic relationship) |
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Title</th>
<th>Summary</th>
</tr>
</thead>
</table>
| Kahlon, Neal & Patterson (2014) | To explore experiences of CBT formulation in clients with depression during the process of therapy | Responses were varied within the key themes and highlight the complexity of formulation research.
| Leeming, Boyle & Macdonald (2009) | How participants managed the potential for shame that can arise from experiencing difficulties which are often viewed pejoratively | Four superordinate themes:
5. Feeling trapped or restricted by depression
6. The development of the formulation – from coming to my own conclusions to something the therapist developed
7. From negative to mixed feelings regarding the reacting to the formulation during the therapeutic process
8. A new journey towards making a new sense of self
| Chadwick, Williams & Mackenzie (2003) | Two experiments (E1 and E2) to explore the impact of case formulation (developed by the therapist) in CBT for psychosis on both therapeutic relationship and psychosis symptoms (including delusional and self-evaluative beliefs, anxiety and depression) | Two themes discussed:
3. Difficulties in using psychosocial explanations
4. Diagnosis as both salvation and damnation
| Evans-Jones & Peters (2009) | To investigate which factors are associated with the therapeutic relationship in CBT for psychosis | Semi-structured interviews suggest clients found formulation helpful by enhancing their understanding of their own problems and showed them that the therapist understood them. They also reported positive emotions - feeling reassured, encouraged and more optimistic. Some clients reported a negative emotional response to the formulation, describing the experience as saddening, upsetting and worrying. Some clients reported positive and negative responses, indicating ambivalence about formulation. Some clients reported no emotional impact of the formulation, and some found them complicated. For therapists, formulation had a number of positive effects: powerful, validating, hopeful about therapy, enhanced alliance, understanding, collaboration and confidence in the model.
| Evans & Parry (1996) | To evaluate the impact of reformulation in CAT with difficult to help clients | E1: Formulation in CBT for psychosis does not have a significant impact on alliance for clients, but may have a significant impact for therapists.
| | | E2: Formulation delivered over four separate sessions did not have a significant impact on strength of delusions, or negative self-evaluations. Formulation alone does not reduce belief strength for delusions or negative person evaluations. Changes are attributed jointly to cognitive restructuring and formulation. The presentation of a formulation was linked to a better therapeutic relationship.
| Shine & | To investigate whether the reformulation process in CAT had an impact on the client’s perceived helpfulness of the sessions, the therapeutic alliance or individual problems. | Reformulation did not have a systematic short term impact upon measures of the client’s perceived helpfulness of the sessions, the therapeutic alliance or individual problems.
| | | However, in semi-structured interviews clients reported that the reformulation had considerable impact upon them, including providing a better understanding of their problems, enhanced trust in the therapist, and providing a focus for therapy.

Qualitative findings:
Westacott (2010) impact upon a measure of working alliance, and to explore the client’s perspective of the reformulation process

Seven themes:
8. Feeling heard
9. Understanding patterns
10. Space to talk
11. Feeling accepted
12. Having something tangible
13. Working together
14. Feeling exposed

Quantitative findings: No significant impact of the reformulation process on measure of working alliance, either as a step-change or slope-change
Research aims

Formulation is an essential tool in Clinical Psychology; however there is a paucity of research evidencing the efficacy and credibility of formulation. Clinical psychology as a profession often criticises psychiatry for its hierarchical model and lack of collaboration with service-users; however, published research suggests service-users have not been asked very often about their experiences of psychological formulation. CAT prides itself on its focus on collaboration, however, even within collaborative therapies there is little evidence exploring how service-users experience CAT tools and approaches. This research aims to address a gap in the evidence-base by exploring service-user experiences of the CAT SDR.
Method

Interpretative Phenomenological Analysis (IPA)

IPA is a flexible, systematic and thorough qualitative research approach examining how people make sense of life experiences (Smith, Flowers & Larkin, 2009). IPA has three theoretical underpinnings: phenomenology, hermeneutics and idiography (Appendix G). There is “no clear right or wrong way of conducting IPA” (Smith, Flowers & Larkin, 2009, p. 80). However, Smith, Flowers & Larkin (2009) provide guidelines for IPA involving the process of moving from the descriptive to the interpretative (Smith, 2004; Finlay, 2008; Larkin, Watts & Clifton, 2006). Appendix G includes information on epistemology and the researcher’s perspective.

Rationale for IPA methodology

The research aim was to gain an in-depth understanding of how service-users experience and make meaning from SDRs. IPA provides a framework to develop an analytic interpretation of participants’ accounts which is clearly grounded in each participant’s sense-making (Larkin, Watts and Clifton, 2006; Smith, 2004). IPA allows the researcher to acknowledge the service-user’s position as an expert in their experience, while providing in-depth analysis and interpretation. IPA also complements the researcher’s ‘contextual constructivist’ epistemological position. Appendix H explores key similarities and differences between IPA and other qualitative methodologies. Appendix I contains an excerpt from the researcher’s reflective journal.

Ethical approval

The researcher met with a service-user research group to discuss this research. Ethical approval was obtained from the ethics committee in April 2014. Approval for
site specific recruitment was granted from four NHS Trust Research and Development departments and ‘sponsor approval to proceed’ was granted in May 2014 (Appendix J).

Procedures

Recruitment

CAT therapists were emailed about the research (Appendix K). The researcher was aware of ongoing research exploring this area within a forensic population; consequently, this research excluded forensic services to ensure the research was novel and contributed to the evidence-base. Therapists were provided with information packs containing a participant information sheet (Appendix L), consent form (Appendix M), and cover letter/opt-in sheet (Appendix N), which they posted to potential participants. Following discussion with experienced CAT practitioners and consultation with CAT literature (Parkinson, 2008; Ryle & Kerr, 2002), a list of features were developed to summarise expectations for an SDR possessing integrity in terms of CAT (Table 3). To ensure the research remained faithful to the model therapists were asked to ensure service-users who were contacted had engaged with an SDR meeting these criteria. Participants were provided with a £20 high-street voucher to thank them for their time.
Table 3: Essential features of a CAT SDR/formulation (versus a diagram or generic formulation)

<table>
<thead>
<tr>
<th>Essential features</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Includes a core state or core pain that encompasses undesirable/unmanageable distress.</td>
</tr>
<tr>
<td>2. Procedures must feed in and out of the core pain (TPPs take them back into it).</td>
</tr>
<tr>
<td>3. Must include a relational focus.</td>
</tr>
<tr>
<td>4. High predictive component.</td>
</tr>
<tr>
<td>5. Includes reciprocal roles or procedures that explain the client-therapist relationship.</td>
</tr>
<tr>
<td>7. Explains what goes on within the therapeutic space and outside of therapy.</td>
</tr>
<tr>
<td>8. Persistent, chronic and pervasive procedures that are played out in more than one domain.</td>
</tr>
<tr>
<td>9. Universal procedures – broad themes around managing emotions and interpersonal concerns (e.g. feeling ‘put down’).</td>
</tr>
<tr>
<td>10. All procedures should capture the transference during therapy.</td>
</tr>
<tr>
<td>11. Should go beyond the presenting difficulties (e.g. does not just look at what’s causing low mood).</td>
</tr>
</tbody>
</table>

Participants

A homogenous sample meeting inclusion criteria of having a SDR, and ending therapy within three to twelve months of the research interview was obtained. Timescales were selected following previous research recommendations suggesting focussing on sessions immediately after the reformulation is too soon to measure its impact (Evans & Parry, 1996; Hamill, Reid and Reynolds, 2008). Seven participants were included in this study. The sample size recommended by Smith, Flowers and Larkin (2009) is between four and ten (for a professional doctorate), to ensure rich quality data. Demographics for those included in the sample are outlined in Table 4.
Table 4: Sample demographics

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Diagnosis/clinical history</th>
<th>Access to other therapies</th>
<th>Time since therapy</th>
<th>Number of CAT sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laura</td>
<td>48</td>
<td>White</td>
<td>Depression and suicide attempts</td>
<td>8 week mindfulness course</td>
<td>19 weeks</td>
<td>16</td>
</tr>
<tr>
<td>Ben</td>
<td>39</td>
<td>White</td>
<td>Borderline personality disorder, heroin user</td>
<td>Multiple therapies (unable to remember the models)</td>
<td>22 weeks</td>
<td>24</td>
</tr>
<tr>
<td>Scott</td>
<td>40</td>
<td>White</td>
<td>PTSD regarding childhood sexual abuse</td>
<td>None</td>
<td>22 weeks</td>
<td>16</td>
</tr>
<tr>
<td>Lisa</td>
<td>37</td>
<td>White</td>
<td>Bi-polar disorder and psychosis</td>
<td>Counselling and 6 sessions of CBT</td>
<td>20 weeks</td>
<td>24</td>
</tr>
<tr>
<td>Tom</td>
<td>52</td>
<td>White</td>
<td>Anxiety, depression, personality disorder</td>
<td>None</td>
<td>22 weeks</td>
<td>24</td>
</tr>
<tr>
<td>Sunita</td>
<td>43</td>
<td>Pakistani</td>
<td>None</td>
<td>Counselling and CBT</td>
<td>35 weeks</td>
<td>24</td>
</tr>
<tr>
<td>Janine</td>
<td>56</td>
<td>White</td>
<td>Bi-polar disorder, depression, and manic depression</td>
<td>6 sessions of CBT and 9 sessions of ECT</td>
<td>20 weeks</td>
<td>16</td>
</tr>
</tbody>
</table>

Data collection

A semi-structured interview/topic guide (Appendix O) with open ended questions was developed through discussions with research supervisors. Probe/prompt questions were used if participants found it difficult to verbalise their thoughts, or if they gave responses that were too succinct. The researcher attempted to collect less biased data by providing the opportunity for participants to voice their own opinions before being led by the researcher’s questions. The topic guide used a funnelling technique (Smith, Flowers and Larkin, 2009) starting with a general
question before asking more specific questions. The schedule was piloted with one research supervisor.

Interviews took place at a local NHS building or in the participant’s home. Interviews lasted between 24 minutes and 44 minutes, with a mean length of 38 minutes. The researcher completed a reflective log following each interview. Interviews were recorded and then transcribed by a NHS approved transcription service. The researcher checked each transcript for accuracy while making minor corrections to correct typographical errors and removing any identifiable information.

*Risk of bias*

The researcher implemented a number of strategies to reduce potential selection bias. For example, therapists were instructed *not* to select participants on the basis of completing CAT, having a positive experience of CAT, or achieving positive change. The researcher welcomed a range of experiences of the mapping process including difficult and exposing experiences, as evidenced by participant responses. Participants were also informed that the researcher was keen to capture an honest account of their experiences of mapping, and made aware that their responses would be anonymised. The researcher was also keen to reduce bias across the IPA; one supervisor was chosen who does not advocate for CAT to minimise positive bias when analysing the transcripts and all supervisors validated themes emerging from the data. Despite the steps outlined above, the researcher acknowledges the possibility of selection bias.
Data analysis and interpretation

Data was analysed according to the recommended steps outlined by Smith, Flowers and Larkin (2009; Appendix P). Appendix Q contains a transcript extract from ‘Janine’. Appendix R contains a cluster themes table for ‘Laura’, and Appendix S contains a master themes table for the group. Table 5 also includes a transcript extract to illustrate the analytic process.

Table 5: Transcript extract to illustrate the analytic process (Lisa)

<table>
<thead>
<tr>
<th>Quote</th>
<th>Exploratory coding</th>
<th>Emergent theme</th>
<th>Theme</th>
<th>Subordinate theme</th>
<th>Superordinate theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>“So it demystified why, it was a complete mystery to me why sometimes in the face of a distressing event I would be super human and I would get praised for everything that I did or I would hide and then I would not even be able to have a conversation with someone because they might ask me what I did today and I couldn’t say that. So that was the demystifying bit”</td>
<td>“Demystified” - word used again – importance of clarification, normalising, self-reflection and understanding</td>
<td>“Mystery”</td>
<td>Self-reflection and understanding</td>
<td>“Demystifying bit, the normalising” – used again</td>
<td>Developing understanding and self-reflection</td>
</tr>
</tbody>
</table>

Quality in IPA

Quality guidelines have been produced for qualitative approaches which can be applied to IPA (Elliott, Fisher, & Rennie, 1999; Yardley, 2000). Appendix T details these criteria and the researcher’s attempts to meet them.
Results

Analysis of seven interviews developed four superordinate themes and nine subordinate themes demonstrating how participants made sense of their experience of the SDR (Table 6). Themes are presented in order of prevalence across transcripts and supported with representative quotes from across the data. Despite individual themes looking at different aspects, some were often not distinctly separate from one another and appear on one level to be inextricably linked. Consequently, it was often difficult to tease them apart during the analytical process. This may reflect the challenges separating common and specific factors of therapy.

Table 6: Superordinate themes and constituent subordinate themes (Taplin, 2015)

<table>
<thead>
<tr>
<th>Superordinate themes</th>
<th>Constituent subordinate themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chaos to clarity (a process of meaning making)</td>
<td>• Understanding the self</td>
</tr>
<tr>
<td></td>
<td>• “Having it on paper”</td>
</tr>
<tr>
<td>The change process</td>
<td>• “Stepping forward”</td>
</tr>
<tr>
<td></td>
<td>• Emotional outcomes of mapping as a process</td>
</tr>
<tr>
<td></td>
<td>• Outside the therapy room</td>
</tr>
<tr>
<td>Relational dynamics</td>
<td>• Dynamics within the therapeutic relationship</td>
</tr>
<tr>
<td></td>
<td>• Emotional responses to the endings in CAT</td>
</tr>
<tr>
<td>Focus on treatment context/options</td>
<td>• What I had to go through to get CAT</td>
</tr>
<tr>
<td></td>
<td>• Medical model</td>
</tr>
</tbody>
</table>

Superordinate theme one: Chaos to clarity (a process of meaning making)

For all participants, the experience of mapping facilitated a process of self-reflection and sense making. Participants conveyed a need to understand past experiences and how these influence current functioning. Developing self-understanding was more important to participants than focusing on symptoms.
Understanding the self

This subordinate theme was present in all seven accounts. Participants often used visual language and analogies of reflection and light when describing mapping as a process of developing self-understanding. Laura describes mapping as “an eye opener”; “a light bulb moment” which “brought clarity and credence to [her] thoughts”. Scott describes a process of self-reflection and subsequent changes in his self-perception: “looking at myself in a different light, err (pause) I was getting to understand myself”. Lisa conveys the link between developing an understanding of the self through mapping and the consequential process of normalising human distress: “it (pause) demystified them, normalised them”.

“Having it on paper”

This subordinate theme was present in all seven accounts. Participants described a process of visualisation involving looking at the map on paper. The process of converting it into a visual object validated the emotions attached to it. Thus facilitating the externalisation of thoughts, emotions, memories and experiences so they could be acknowledged and reprocessed to allow the participant to take ownership of them and internalise them in a helpful/meaningful way. The physicality of the map was central to this process: “Being a visual person for me was good so if I didn't have that I probably wouldn't have taken it is as well” (Scott). Participant’s language describes a process of printing. Tom emphasised the role of the map being a visual tool and how “sometimes we're as well to see things in cold print you know erm (pause) yeah because it acknowledges that it actually happened or whatever or how you're thinking”. Ben describes a process of internalisation of the map: “I have er a good picture of it inside my head; it imprints it you know”. Laura conveys her sense of ownership of the map: “I've still got my moments and I will do I can't break 48 years of life, and life experiences overnight, but I now feel that I've
got the tools because I've got the map”. Janine uses visual language and the metaphor of a tube station map to convey the internalisation of the SDR:

The map's up here up here it's in my head... the map is like a map of a tube station and you know where all the tubes are and you don't need to erm go and have a look and see which line you need to go on or whatever because I know and that's why I don't need to look at the map anymore.

Participants also discussed the importance of the map looking aesthetically pleasing: it was kind of done like you know on scraps of bits of paper and it wasn't very clear or easy on the eye (Sunita); and how adding colour to the map “made it much easier to refer to” (Janine).

Superordinate theme two: The change process

Participants experienced the map as a symbol for hope and a vehicle for change. It was described as a tool evolving as a process both outside of therapy sessions, and beyond the therapeutic contract.

“Stepping forward”

This subordinate theme was present within all seven accounts. Developing and engaging with the map enabled participants to contemplate change and put this into action: “It was stepping forward rather than being always in the past we were moving on to the future” (Laura); “That label was an excuse to, to hide. This treatment was a reason not to” (Ben). Scott discusses how CAT empowered him to make changes in his life:

What I can do is change the future. So that's what the mapping has done for me...it's one of the best therapies ever, it's (pause) it's changed my life, well it's helped me to change my life
Emotional outcomes of mapping as a process

This subordinate theme was present within all seven accounts. Developing and engaging with the map generated a range of positive and negative emotional experiences for participants evidencing their emotional connection to the map and the mapping process. It was important for the participants in this study to not be blamed for their difficulties: “So it was quite a revelation really and quite cathartic because as we started mapping I kind of realised that all these things weren’t my fault” (Laura). Ben describes his experience of mapping as a difficult process to engage with: “You know it’s hard to accept that that was the person I am you know that is me written down on that paper”.

Participant’s experiences of mapping contain a range of complex responses both within and between participants: “well I found it all a bit difficult on one level you know… to a certain extent because it’s very exposing” (Tom). Participants also conveyed inconsistent attachments to the map: “Sometimes it was an elephant in the room… sometimes I wanted the map and sometimes I just didn’t” (Laura). Some participants link the map to a place of safety: “It’s like a, what do you call it (pause) a safeguard kind of thing, it helps me” (Scott). Lisa suggests she sometimes felt a sense of invalidation through the map’s process of simplification: “to have it made into an A4 document there was an edge there about not minimising it”. Scott describes experiencing a range of emotions in response to the map: “it was a range of emotions (pause) it was upsetting, it was (pause) as I said it was daunting, it was scary.

At times participant’s use of language and its content seems clearly interrelated. This allowed the researcher to analyse the transcripts linguistically (as well as
descriptively and conceptually). Participants represent the role of the map as a concrete, tangible attachment object providing psychological and physical support/security. Tom describes the map as “something tangible… that you can sort of hold onto (pause) in between visits you know erm which I think is very important”. Conversely, Sunita describes a lack of ownership or attachment to the map highlighting the importance of collaboration: “No purpose it was just his writing and you know you were just kind of looking at it” suggesting it is the therapist’s tool (not the service-user): “A useful tool for him…an important part of his work”.

Outside the therapy room

This subordinate theme was present within all seven accounts. Participants described the map as a tool which changed/developed over time, within and between therapy sessions. Participants described engaging with the map after therapy had ended: “I keep the map in my bedroom behind a wardrobe door because it’s my wardrobe, it’s my map” (Laura). The map evolved within and across the sessions and became a metaphorical map for the journey of life: “the map evolves and it evolved, it is like a journey, you need a map for every journey don’t you (laughs)” (Laura). The map acted as a tool which supported participants to achieve cognitive, behavioural and emotional change outside of therapy: “The whole, the whole diagram itself I've still got it at home you know its helpful” (Ben). Sunita discusses the importance of looking at the map and adding to it between sessions: “So continually to add things on… I think you wouldn’t of really seen it you’d of just turned up you know to the appointments without really giving it a second thought during the week”.

Superordinate theme three: Relational dynamics

Participants talked about dynamics of the therapeutic relationship and how the map encompassed a relational focus in a varied way; some comments were positive and others were negative.

Dynamics within the therapeutic relationship

This subordinate theme was present within all seven accounts. Participants experienced the map as an embodiment of common therapeutic factors (for example: validation; empowerment; control; and acknowledgement). A range of common factors were activated through the development and use of the map. Key themes within this subordinate theme include trust and collaboration. The therapeutic relationship was often described as a process of empowerment and collaboration. Lisa described the importance of collaborative goal setting and ‘doing with’ the therapist: “to have a shared goal right from the start is brilliant”. Janine discussed the value of a collaborative approach: “It was individual it was me erm so I was leading it so that is very useful” and the role of the therapeutic relationship in supporting people to feel heard: “made me feel at least this time I’m being listened to and it’s going to help so erm yeah it was definitely different from anything I’ve had before and erm well I just feel like a normal person now”. The impact of validation through therapeutic reflection and writing was also acknowledged: “It allows the therapist to acknowledge that they understand your problem and that they’re honouring what you’re saying er and your feelings and erm experiences” (Tom). Conversely, some participants reported an ambivalent therapeutic relationship, a lack of bonding with the therapist and an unhelpful power dynamic:

Other treatment I’ve had in the past I’ve kind of built up a trust relationship you know… where I can, I feel as if I can tell you these things what are going on in my mind… and I didn’t feel that with with my therapist, I didn’t feel it at all… I felt as if he was the enemy and I was fighting that enemy.
Emotional responses to the endings in CAT

This subordinate theme was present within three of the seven accounts. Participants wanted to continue with CAT post discharge: “So yeah I just think it’s a shame because I think with [therapist’s name] I would of liked to have you know continued and I was willing to pay that private” (Sunita). In contrast Lisa suggested the collaborative goals developed at the start of CAT provide a planned ending that was more containing than her experience of counselling: “I think it’s a really good structure to undergo counselling with, yes it kind of scaffolds and gives both of you an exit”.

Superordinate theme four: Focus on treatment context/options

Participants discussed the treatment context in which CAT is available and different frameworks for conceptualising mental health difficulties, while considering potential strengths and weaknesses of different models. Participants recounted their emotional reactions to the lack of access to psychological interventions in the NHS and conveyed a sense of feeling lucky and grateful to have been offered CAT. Participants shared the experiences they had to go through before CAT was provided as a treatment option.

What I had to go through to get CAT

This subordinate theme was present within four of the seven accounts. Participants experienced difficulties in accessing CAT in the NHS particularly as an early intervention. Laura describes the personal consequences this had for her:

It’s a pity I didn’t have it a long, long time ago I didn’t have children because I was scared, of, being my father and treating them the way that he treated me
(pause) with control, so it stopped me having children, whereas if I’d have had CAT therapy years ago erm like I said before it is a crutch is the map.

Participants described being offered CAT after experiencing difficulties for some time and often following a crisis: “I got locked up for 5 months and it was, so it was anything prior to the episode that caused the distress that enabled me to access those kind of services” (Lisa). Participants also reported a lack of choice regarding the model of therapy they engaged with. They describe uncertainly and inconsistency regarding psychological provision across geographical areas and wonder if provision of a psychological intervention would have negated any ‘need’ for medical interventions:

To think that I might not have needed to have those at all if I’d have been offered this therapy all that way back and the only reason I’ve been offered this therapy is because that’s what they happen to do here.

(Janine)

Some participants compared their experiences of CAT to other psychological treatments they had been ‘forced’ to engage in before being offered CAT:

Because I was at a bit of crisis point they said right we’ll give you these six sessions [of CBT] and then we’ll put you on the waiting list [for CAT] erm but I couldn’t be put on the waiting list til I’ve been for the six sessions, it was particularly ridiculous.

(Janine)
Medical model

This subordinate theme was present within five of the seven accounts. Several quotes within this theme focus on psychiatric diagnosis; however other medical model treatments such as electroconvulsive therapy (ECT) and medication were also discussed. Participants discussed the dilemma regarding the potential value and/or damage of receiving a diagnosis. Participants described experiencing ambivalence regarding diagnostic labels: “Sometimes I think would it of been nice to have a diagnosis” (Sunita); “I do feel that if I’d if I’d got something that was more of a diagnosis I would be less inclined to blame myself in a way” (Tom). Some participants voiced their experiences of diagnosis as unhelpful: “I was a heroin addict for 16 years (sighs) I was a right mess and er just having that label just enabled me to be in a mess” (Ben);

One time… I was very thank goodness I’ve got a diagnosis… that means well I can look it up I can look it up, I can research… also diagnosis allows you to get benefits a map doesn’t…but as soon as you realise a diagnosis is for one moment in time and completely irrelevant and out of date as soon as it given, the map is useful the diagnosis is not.

(Lisa)

Participants also discussed their experience of psychiatric medication, particularly its side effects:

I have been on lots of different antidepressants and erm side effect wise they go from making you feel sick to er erm making you feel like you’re on another planet to or or not just not working.

(Janine)
Biological treatments (such as ECT) were experienced as frightening, disempowering and unnecessary in the context of developing self-understanding:

“That was something being done to me in it felt to me like somebody was trying to wipe my memories…. perhaps I could have done without all those nasty things that I’ve had by just having sat there and understood my life.

(Janine)
**Discussion**

This study explored seven participants’ experiences of the SDR. Despite many of the themes being interwoven, four superordinate themes emerged from the data: (1) Chaos to clarity (a process of meaning making) (2) The change process (3) Relational dynamics (4) Focus on treatment context/options. Participants emphasised the value of the SDR in developing self-understanding and how the visual tool supported them to understand, take ownership, and internalise their formulation. Participants discussed how common factors of therapy (Asay and Lambert, 1999) are activated through the SDR (such as the therapeutic relationship, collaboration, empowerment, trust and validation) and the complex relational interplay between participant, therapist and SDR. Participants’ emotional responses to endings in CAT emerged from the narratives. At times the SDR was considered a concrete, tangible attachment object. Participants reflected on the SDRs role in promoting hope for, and achievement of, therapeutic change both within and beyond therapy. Challenges in accessing CAT and a range of negative experiences some participants endured before being offered CAT were also explored. Overall, participant’s embraced the biopsychosocial model of human distress as an alternative to the prevailing medical model.

**Findings in relation to the literature**

*Chaos to clarity (a process of meaning making)*

The SDR supported participants to self-reflect and gain self-understanding while developing insight into how previous life experiences may be associated with current functioning. Normalising distress in the context of challenging experiences was important for participants. Findings are consistent with aims of CAT (Ryle & Kerr, 2002) and empirical research (Pain, Chadwick & Abba, 2008; Shine & Westacott, 2008).
2010). Results from the current study also provide novel information regarding the process of visualisation during the mapping process. The presence of a visual and tangible formulation facilitated ownership and internalisation.

The change process

The SDR and mapping process were experienced by participants as inseparable. Participants described the SDR as a self-management tool, and a symbol of hope and empowerment. The mapping process was described as an enabler of client-centered meaningful change (cognitive, emotional, behavioural, and interpersonal). Participants discussed the value of client-centred outcomes such as returning to work, having children, or being in a relationship, in contrast to standardised outcome measures focusing on a restricted definition of recovery reliant upon symptom lists (Hemmings, 2012).

Participants acknowledged their emotional responses to the SDR and the mapping process including: a cathartic release of guilt and distress; feeling heard and validated; a sense of exposure; and engagement with raw/challenging emotions. This is consistent with research exploring service users’ mixed responses to CBT formulation (Pain et al., 2008; Kahlon, Neale & Patterson, 2014).

Participants highlighted the use of the SDR as a tangible object which could provide psychological comfort across contexts, both between therapy sessions and after therapy has ended (Winnicott, 1974). These findings echo other empirical research (Shine & Westacott, 2010). Participants’ responses suggested ambivalent attachments (Ainsworth, 1964) to the SDR characterised by periods of relying on the SDR for safety and security alongside periods of not wanting (or finding it difficult) to engage with the SDR. Resistant, anxious and ambivalent attachment styles to the
SDR were highlighted, for example, when participants discussed wanting to avoid the SDR but feeling like they needed it. One participant reported taking control of these difficult emotions by destroying the SDR. However, she subsequently requested another copy. Participants found it challenging to engage with the SDR and described it as difficult to look at, exposing and distressing, yet helpful. Interestingly, despite these challenges participants wanted more CAT sessions when therapy was ending. Some participants talked about the usefulness of the SDR despite a difficult and challenging therapeutic relationship. Participants conveyed a sense of sometimes wanting the SDR and sometimes not wanting the SDR. These experiences were present both within and across participants. Participants who took ownership of the SDR felt it had been developed collaboratively conveying stronger attachments to the SDR. This is consistent with research exploring service user’s responses to CBT formulation (Pain et al., 2008).

Participants described the process of change as an evolving journey within sessions, between sessions and after therapy had ended. This is consistent with findings from Rombach (2003) exploring the role of ‘homework’ in enhancing outcomes.

Relational dynamics

Common factors highlighted in patient narratives include: collaboration, trust, validation, empowerment, control and acknowledgement. Results suggest a range of common factors are activated through the mapping process. There is a plethora of research debating relative contributions of common and model specific factors (Duncan, 2010; Hampson, Killaspy, Mynors-Wallis & Meier, 2011; Hatcher & Barends, 2006; Wampold, 2001). The evidence base corroborates findings from this study suggesting a range of common factors are associated with clinical outcomes, with a particular focus on the role of the therapeutic alliance (Grencavage
& Norcross, 1990; Martin, Garske & Davis, 2000). Participants’ narratives suggest the SDR plays a role in developing therapeutic relationships by promoting collaboration and providing a tool to validate the participant’s experiences through therapeutic reflection.

Findings are consistent with Rayner, Thompson and Walsh (2011) highlighting the value of ‘doing with’ the therapist and a collaborative conceptual framework. Findings from the current study considered a range of dynamics within the therapeutic relationship including some participants describing it as a safe base to practice exit strategies from the SDR. This is consistent with findings by Hamill, et al., (2008) who reported CAT letters enhanced the therapeutic relationship. In contrast, quantitative research exploring the effect of the reformulation process in CAT on working alliance (Shine & Westacott, 2010) and the impact of CAT with difficult to help clients (Evans & Parry, 1996) suggests the SDR has a little impact on the therapeutic relationship. However, qualitative data collected alongside one of these studies (Shine & Westacott, 2010) suggests the SDR enhances the therapeutic alliance.

Focus on treatment context/outcomes

Participants’ accounts detailed a range of negative experiences prior to being offered CAT. Participants associated these experiences with a range of emotional and physical side effects and a lack of change. Participants reported being offered CAT if CBT did not resolve their difficulties. These experiences result in delayed access to CAT. The accounts highlight the lack of access to a range of psychological therapies within the NHS, and the need for therapies to be informed by idiosyncratic formulations and patient choice. From a health economics viewpoint, CAT could be offered as an early intervention instead of being reserved for crisis resolution or service-users deemed ‘difficult to help’.
Participants discussed their experiences of psychiatric diagnosis. Narratives suggest participants wondered if a diagnosis would be helpful in reducing self-blame. However, concerns were raised that diagnosis reduces one’s sense of hope and agency over difficulties and decreases motivation and potential for change and personal recovery. This is consistent with literature exploring how service-users manage the potential for shame that can arise from receiving a diagnosis (Leeming, Boyle & Macdonald, 2009).

Read and Harre (2001) replicated previous findings that people reject biological explanations of mental health problems in favour of psychosocial explanations focused on negative life events. Their study reported biological causal beliefs are related to negative attitudes, including perceptions that ‘mental patients’ are dangerous, antisocial and unpredictable. This research extends to service-users’ beliefs about their own difficulties and the likelihood a diagnosis would reduce hope and motivation. Other research exploring service-user experiences of psychiatric diagnosis suggests it often leads to a range of negative consequences such as: feeling labelled and unfavourably judged by others (Nehls, 1999); a reduced sense of self with the diagnosis becoming their whole personhood (Rose and Thornicroft, 2010); questioning one’s sense of self and a lack of control. Others experienced diagnosis as destructive, exposing (Hayne, 2003) and promoting a sense of uncertainty and rejection (Horn, Johnstone & Brooke, 2007).

**Strengths and weaknesses of this study**

Treatment fidelity was controlled for by ensuring therapists were CAT trained and participants were referred to the study if their SDR met criteria in table 3. Timing of data collection followed recommendations from previous research (Evans & Parry, 1996; Hamill et al., 2008). The researcher asked therapists not to select participants
on the basis of their level of success in therapy, to reduce potential sampling bias. The varied responses provided across participant narratives suggest the sample was not biased.

A reflective log (Appendix E) was completed across the research process to develop an awareness of the researcher’s pre-understandings and to help with ‘bracketing’ during analysis. The researcher attended an IPA training course to enhance her competence and confidence in IPA. Themes from all transcripts were checked by three independent reviewers enhancing the validity of the analysis (Elliott, Fisher & Rennie, 1999). Tables evidencing each level of themes/analysis are included in Appendix P, Q, R and S to promote transparency. The researcher sought to meet quality criteria for qualitative research methodology (Elliott, Fisher & Rennie, 1999; Yardley, 2000). Appendix T lists these recommendations and the researcher’s attempt to apply them.

At times it was difficult to tease apart the impact of the SDR from common factors due to the SDR being imbedded in the therapeutic process. Although this is not ideal from a research perspective it needs to be balanced against the need for naturalistic and clinically valid/meaningful research. This research adds to gaps in the literature. See Appendix U for details regarding dissemination.

**Clinical implications**

Results from this study indicate the value of the SDR across a variety of presenting difficulties. It is our role to liaise with commissioners to promote early access to a range of psychological therapies as an alternative to costly inpatient stays or long-term use of psychiatric medication. We should use our research, teaching and consultation skills to promote client-centred outcomes and personal recovery in the context of health economics and patient choice.
It would be useful to pilot access to CAT in primary care services. CAT provides a time-limited treatment framework aimed at making meaning and developing an understanding of interpersonal difficulties. Results from this study suggest CAT formulation enhances self-understanding, reduces blame, and despite focusing less specifically on controlling and eradicating symptoms, provides client-centred meaningful outcomes.

On discussing the political role of clinical psychologists in promoting the biopsychosocial model and challenging the medical model, Newnes (2004) suggests clinical psychologists should debate this more rigorously and use our status as scientists to address the medicalisation of human distress.

It is important clinicians reflect on the level of collaboration involved in developing the SDR and scaffold this learning process for service-users to strengthen the therapeutic alliance and the patient’s relationship with the SDR. Participants found aspects of the formulation letter focusing on strengths, empowering and validating; the SDR may benefit from a section acknowledging resilience, strengths, goals, healthy attachments and behaviours.

**Future research**

Following this study there are a range of future research suggestions which would add to the evidence-base and provide clinically meaningful implications:

- An exploration of the visual formulation process in CAT and CBT to ascertain if there is anything specific to the SDR/mapping process that is more/less beneficial than a CBT formulation diagram.
• A quantitative or survey study establishing what service-users want regarding access to a range of psychological therapies.
• An exploration of how service-users perceive, avoid and manage blame in relation to diagnosis and psychological therapies.
• An exploration of the usefulness of client-centred outcomes as an alternative (or comparison) to symptom based checklists.

**Conclusion**

In conclusion, this research addresses gaps in the literature exploring service-users’ experiences of CAT formulation. Findings suggest service-users in this study engaged well with treatment aimed at facilitating understanding and reducing blame. Service-users advocated strongly for access to CAT as an early intervention and suggested this provides client-centred meaningful change, and reduces iatrogenic distress. Findings suggest the SDR supported the service-users to self-reflect and develop self-understanding while normalising distress in the context of difficult experiences. The visual and physical aspects of the map were important in developing a sense of ownership of the SDR. The SDR provided psychological comfort across settings, and was a self-management tool used beyond the process of therapy. A range of common factors appear to have been activated through the SDR and the mapping process in addition to the model specific strategies. Collaboration was found to be crucial to the development of the therapeutic relationship and appeared to promote a sense of empowerment, hope and meaningful person-centred changes. CAT appears to be a preferable treatment when compared to CBT and medical frameworks of understanding human distress for the participants in this study.

Rich narratives were produced in this qualitative study, however due to the idiographic commitment of IPA the findings do not provide empirical generalizability.
Consequently, the theoretical transferability of the links between the analysis, the position of the researcher and the existing literature should be considered (Smith, Flowers & Larkin, 2009). This process enables the reader to evaluate its transferability to individuals in similar contexts (Smith, Flowers & Larkin, 2009).

In addition to the recommendations for future research mentioned above, this study raises other key questions which could be addressed in future research, such as:

- Is CAT an effective intervention in primary care settings?
- Does CAT provide more effective person centred, holistic, outcomes in comparison to CBT or psychiatric medication?
- Does the SDR enhance self-reflection and understanding more or less than other psychological formulation methods?

These questions could be addressed with the use of pilot projects, randomised control trials and practice-based studies of effectiveness.


