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# **Accounting for psychological problems: How user-friendly are psychosocial formulations?**

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# **Accounting for psychological problems: How user-friendly are psychosocial formulations?**

*Formulation, with its use of psychosocial explanations for psychological problems, has the potential to normalise and destigmatise clients' difficulties. However, we present findings from a recent study which suggest that for mental health service users, using psychosocial explanations is not a straightforward process.*

## **Introduction**

In spite of its prominence in clinical psychology, and the extensive literature associated with it, formulation is still largely discussed from the perspective of researchers and clinicians rather than clients. As Butler (2006) notes, formulation has been seen as an important means by which clinicians can ensure that their practice is informed by theory. By contrast, there has been very little investigation of the impact of formulations on clients (Johnstone, 2006) and virtually no discussion of the value of such psychological explanations as a resource for clients to draw on in accounting for themselves to others. Yet the need to account for oneself to others may be central to service users' experiences, given that their thoughts and feelings may be seen as irrational or even taboo and their behaviour considered unhelpful, unreasonable, a sign of weakness or otherwise shameful. As such, service users often struggle to find ways of making sense of their difficulties as reasonable and understandable (Casey & Long, 2003; Lewis, 1995) and to convince others of this in a cultural context where experiencing psychological problems can be highly stigmatising (Davidson, 2005; Herman, 1993). By offering an account of how the client's difficulties have arisen in a particular context, psychosocial formulations may not only make something

apparently chaotic appear more comprehensible and manageable to the client (Butler, 2006), but also normalise and therefore destigmatise psychological difficulties. If particular thoughts or behaviours make sense as a consequence of the person's history and current set of circumstances then there is perhaps less reason for them to appear shameful or to confer a deviant identity. In support of this suggestion, several recent research studies have indicated that where members of the general public focus on psychosocial rather than biomedical explanations for mental health difficulties they are less likely to view users of mental health services as dangerous, unpredictable or different and are less likely to view problems as chronic (see Read et al., 2006 for a review). Although of course some psychological formulations can be shaming by emphasising personal deficits (Boyle, 2001; Gilbert, 1998), psychosocial formulations have the potential to challenge assumptions which unquestioningly locate psychological problems within individuals, marking them out as in some way different. Instead, the possibility is raised that many people, given similar circumstances, might experience similar difficulties. However, data from our recent research (Leeming, 2008) have suggested that using psychosocial explanations of one's difficulties to account for oneself to others in a way that produces a positive identity is not a straightforward process. The next section of the paper briefly describes the research project and outlines some of our findings in relation to this issue.

### **Background to the study**

We do not aim to give a full account of the study here, but to outline the aims and methods and briefly present some of the findings relevant to the present discussion. Twenty-two mental health service users ranging in age from 15-89 were interviewed

as one part of a larger qualitative research project on managing shame. As such the study was not a direct investigation of receiving and using a specific psychosocial formulation but, as will be seen, the data provide potentially valuable information about how the kinds of psychosocial explanations contained in many formulations might or might not be taken up by service users. The participants were recruited via a child and adolescent mental health service, two community mental health teams for older adults and a user group which campaigned around issues of stigma. The focus of the semi-structured interviews was on how the participants managed the potential for shame that can arise from using services and from experiencing difficulties which are often viewed pejoratively. This included discussion of the disclosure of psychological difficulties to others and of participants', and others', understandings of the nature and causes of their difficulties. A thematic analysis of meaning-making was then carried out which drew on both contextual constructionist and discursive approaches to data analysis, approaching 'meaning-making' as the participants' attempts to construct meaning from the events in their lives, interpreted within a particular local, cultural and discursive context. As such the analytic themes were developed from (and assumed a link between) the participants' attempts to account for their difficulties to the interviewer and their reports of trying to make sense of their difficulties for themselves and others, outside of the interview.

## **Results**

Several themes were drawn from the analysis. Here we will discuss the theme of '*difficulties in using psychosocial explanations*' and then briefly contrast this with another theme – '*diagnosis as both salvation and damnation*'.

## **Difficulties in using psychosocial explanations**

All but three of the participants mentioned psychosocial causes for their distress, and many of them had developed this understanding through discussions with mental health professionals, including psychologists. They talked about the personal relevance of early physical and sexual abuse, persistent bullying, domestic violence, war trauma, loss of key attachment figures and otherwise unsatisfactory relationships. Although this seemed to enable several of the participants to make some sense of their difficulties as reasonable and understandable, they were often much more tentative in accounting for their difficulties in this way than they were when using medical diagnoses to account for their problems. For example:

*I was only 4 when my mother died erm...<sup>1</sup> if it does have any influence on you know, leading to depression, I don't know (Heidi, OP)*

Psychosocial explanations were also used far less than medical explanations for resisting alternative potentially shameful interpretations of their behaviour – for example, that they were weak, deliberately antisocial or malingering. In fact, where adverse circumstances were referred to, several of the participants spoke as if these would only be a sufficient justification for their psychological difficulties if they were able to demonstrate that the circumstances were extreme. They often told lengthy stories emphasising the severity of the trauma and explaining the impact of the experience as if this was necessary to warrant the profound effect of the events. For example Chloe, who connected the onset of her restricted eating and purging with an experience of bullying by other teenagers, emphasised the impact of this on her:

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<sup>1</sup> Notation within quotations is as follows: '...' material omitted; '[ ]' encloses material added for clarification; '(.)' brief pause; '(..)' longer pause; 'OP' older participant from older adult services; 'YP' younger participant from child & adolescent services; 'UG' participant from user group.

*I mean I'd been bullied so much before but that night when he rang me up [and mocked her for being overweight]...it was it was like dying...it hurt so much.*

Similarly, several participants took pains to emphasise the magnitude of the difficult circumstances they faced. For example Gabrielle, a teenage girl who had struggled with the consequences of domestic violence, answered as follows:

*I Do you have any thoughts on why...things got suddenly so bad for you in January...?*

*G I don't really know...everything bad came at once, all in one week...and it just, I couldn't handle it, I don't know why...and like I wouldn't normally be like that. Like if something happened I'd brush it over my head. But this time all of it came, I just couldn't handle it.*

The participants' emphasising of the severity and impact of the events can perhaps be read in the context of what Yardley (1997) refers to as a discourse of coping. As she argues, the notion of coping may obscure the reality of what is being coped with and imply that often we *can* overcome adversity, whether or not we do so being determined by some inner quality that we supposedly possess. For the participants, discussing life events as causes of their difficulties opened up the possibility of their being judged negatively with regard to what they *ought* to be able to cope with:

*...lots of people think that losing a leg, getting your neck broken (.) or it shouldn't affect you as a man, you should be stronger than that, (Frank, OP)*

*... it's that sense of failure, of not being able to cope, of being a lesser person, not **not** a whole person, having bits missing...(Michelle, UG)*

Without recourse to mutually agreed criteria for determining that they had in fact suffered enough adverse circumstances to warrant severe psychological difficulties, the participants could be positioned as weak or incapable for not being able to cope.

There were also a number of other ways in which psychosocial explanations seemed to cause difficulty. Some explanations seemed too exposing, for example relating to abusive and humiliating events. One of the older participants, Bob, said that he was unable to tell the interviewer about the events which he saw as leading to his depression because, as he put it, *'they're very personal...and very embarrassing'*. Therefore, although embarrassed about using psychiatric services, he felt unable to account for this in any way other than by using the term 'depression' with his friends:

*...they know nothing about my personal difficulties. All they know that I was very, very depressed and I've never told them why, where or how.*

Citing psychosocial causes could also mean to the participants that they were blaming others. This was difficult not only because it meant challenging significant relationships but also because it seemed to mean to one or two of the participants that they were unreasonably shedding responsibility for their problems. For example Victoria, who related her diagnosis of bi-polar disorder to earlier sexual abuse as a child, appeared uncomfortable about externalising blame in this way:

*I'd got the issue of abuse to deal with...I thought well maybe that caused it...I certainly wasn't forced to work to a resolution and a forgiveness but I did get there in the end, but...of course I was blaming the person that perpetuated the abuse um for my mental health problems as well. I mean I understand now that it can actually be a trigger but it's actually a trigger for something that's already there (Victoria, UG).*

Victoria's apparent reluctance to blame others and her implicit use of a generic vulnerability-stress model could be seen as reflecting a similar reluctance in professional discourse to 'blame' families for mental health difficulties (Johnstone, 1999). Although there is not the space to explore this in detail here we would suggest that this also relates partly to a discourse of 'personal responsibility' connected to the

modern autonomous western self, which as Smail (1996) suggests, is the idea that individuals are necessarily more likely to achieve improved well-being by 'recognising' that they are 'responsible' for their behaviour. This therefore makes it more difficult for clients to think about how other people are implicated in their difficulties.

### **Diagnosis as both salvation and damnation**

The participants' tentative use of psychosocial explanations can be contrasted with their more confident use of medical diagnoses to account for their difficulties. Many of the participants seemed to feel that psychiatric diagnoses offered a stronger justification for and validation of their difficulties and, like Michelle, talked about a sense of relief in being given a diagnosis:

*I was relieved to get a diagnosis ['complex post-traumatic stress disorder'] because it (..) it made me feel less of a lesser person,...that there's a reason for my difficulties. Validated – I felt validated, um (.)...I wasn't on my own...if you have trauma when...you're growing up as a child then it's inevitable that you're going to have difficulties. So I didn't feel so (.) weak if you like...*

Adding a disorder to the causal chain in this way suggested there was a risk that life events alone would not be seen as sufficient for her difficulties to be considered reasonable. Despite her statement '*it's inevitable that you're going to have difficulties*', the validation of the impact of her early experiences by a diagnostic label seemed vital.

Through using psychiatric diagnoses the participants were able to resist blame by positioning themselves as victims of biological processes and to challenge the notion that they were malingering:

*...what a lot of people don't know about depression is that it's as though somebody's borrowed your brain... a little thing like vacuuming is a big chore. (Clive, OP)*

*I was very big on blaming myself for having bi-polar, because I thought I'd given it myself by drinking. I didn't think of that as being a symptom (Victoria, UG)*

Several of the participants also expressed a confidence in the ability of diagnostic concepts to make sense of the physicality of their difficulties:

*Because you don't only have these depression and anxiety it also causes physical pain all over the body. I used to have bad earaches...headaches, sleeplessness, no appetite, you know there's so much involved in it this mental health. (Heidi, OP)*

In contrast, psychosocial explanations were not generally used to try and account for troubling bodily experiences. Moreover, a double standard was noticeable throughout the data in that the burden of proof when accounting for oneself using diagnostic concepts seemed much less than when using purely psychosocial explanations. The participants seemed to feel less need to justify a claim that 'depression' or another such disorder had caused particular difficulties than they did to justify a claim that adverse circumstances had done so.

However, although psychiatric diagnoses seemed in some ways to provide a stronger warrant for puzzling behaviour than psychosocial explanations did, many participants also experienced their diagnosis as implying something profoundly negative about themselves. They talked of the many negative attributes associated with their various diagnoses including dangerousness, aggression, incapability, instability, lack of reliability, lack of social skills, deceitfulness, irrationality, vanity, and intellectual disability or decline. The diagnostic categories therefore had many of the same

associations for the participants that they have for the general public (e.g. Crisp et al., 2000; Read & Harré, 2001). Chloe, who was quite ambivalent about the value of diagnosis, said:

*...I like feel bad enough about myself anyway, why do I need to feel bad about being anorexic now? (Chloe, YP)*

Therefore, although citing a psychiatric diagnosis could be a useful way of accounting for one's changed behaviour, the participants then had to manage what was often an even more problematic identity as someone who was 'mentally ill'.

## **Conclusions**

As Harper and Moss (2003) note it is important to consider the purpose of formulations and other theoretical explanations of clients' difficulties and to ask for whom they are developed. Although formulation may indeed be of value to clinicians in informing practice, we have perhaps previously paid too little attention to the ways in which psychological and psychosocial explanations may help or hinder clients in accounting for themselves to others and in managing a potentially problematic identity. Indeed we were struck throughout the research by the pressure felt by service users to account for their problematic behaviour and emotions to friends, family, employers, neighbours etc and by the moral judgements implicit in this process.

While further direct research is therefore needed into how clients engage with, use and are affected by formulations and other explanations of their difficulties given by mental health professionals, our present findings suggest several issues worthy of consideration. First, it may be useful for psychologists to work with clients not just in

developing a coherent self narrative but also in looking at how this works as an accounting device within their particular social niche. We can actively help clients to develop better resources for accounting for their difficulties to others, bearing in mind dilemmas such as whether or how to expose shameful past events which could make current difficulties understandable or how to give due weight to adverse circumstances without feeling that they are unfairly blaming others or inappropriately abdicating all personal responsibility. This process might include using systemic ideas to counter the notion that people must blame either their families or deficient selves for their difficulties.

Second, although many formulations refer to bodily processes, we have perhaps tended to under estimate the importance of the embodied nature of emotional distress. Several of our participants used psychiatric diagnoses as if these were the only recognised means of conveying to others that their bodies were implicated in their difficulties in ways over which they had little control. Third, the participants talked as if psychosocial accounts were likely to be subjected to more critical scrutiny than diagnostic explanations partly because of doubts over what constituted sufficient adversity to justify current psychological difficulties.

All of these points suggest that we need to be more active in placing more sophisticated explanations of psychological problems within the public domain. These could focus on, for example, challenging the normal/abnormal and mad/bad dichotomies; documenting the range and complex inter-dependence of psychological, behavioural and physiological responses to adverse circumstances and emphasising both the cumulative effect of stressors and the importance of the presence or absence

of protective factors such as social support in accounting for individual differences in response to adversity. If we do not do this, then service users may face an unacceptably heavy burden in trying to explain their problematic behaviour and emotions to themselves and others.

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