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Psychological Formulation as an Alternative to Psychiatric Diagnosis

Lucy Johnstone[1]

Abstract

The article gives an overview of psychological formulation, a rapidly expanding practice in the United Kingdom that is supported by the British Psychological Society. It is argued that formulation can provide a credible alternative to psychiatric diagnosis in the context of public admissions about lack of reliability and validity of current diagnostic systems. However, vigilance and best-practice principles are essential to ensure that this approach is not assimilated back into the status quo.

Keywords

formulation, team formulation, psychiatric diagnosis, *DSM-5*

Psychiatric diagnosis has been criticized on many grounds over many years—lack of reliability and validity, excluding social contexts, causing stigma, and so on (see, e.g., Bentall, 2009; Boyle, 2002; Kirk & Kutchins, 1997). Rather than repeat these arguments here, I will note that the fundamental reason they are so long-standing, heated, and inconclusive is because "diagnosis is the Holy Grail of psychiatry and the key to its legitimation" (Kovel, 1981, p. 86). In the psychiatric system, diagnosis supports the idea that psychiatry is a branch of medicine—just like neurology, oncology, pediatrics, and so on—in

[1]Consultant Clinical Psychologist, Bristol, UK

Corresponding Author:
Lucy Johnstone, Bristol, UK.
Email: Lucyjohnstone16@blueyonder.co.uk

which the main cause of a person's difficulties is thought to be something that has gone wrong with the functioning of the body or brain. Medicine, like every branch of science, has to be based on a reliable way of describing and grouping its basic elements so that general laws and theories can be developed. Therefore, the lack of a reliable and valid way of drawing up diagnoses, in other words, the lack of a proper classification system, raises very fundamental questions about whether psychiatry really is a legitimate branch of medicine, and specifically, whether these particular forms of human suffering are best understood as disease processes (Boyle & Johnstone, 2014). In other words, we might be in the very strange position of admitting, as one psychiatrist has pointed out, that psychiatry is "something very hard to justify or defend—a medical specialty that does not treat medical illnesses" (Breggin, 1993, p. 505).

Psychiatric diagnosis has also been extensively criticized for its real-life impact on the service user. While some people find it helpful to be offered a name for their distress—however unsupported it is by theory or evidence—many others report feelings of stigma, shame, worthlessness, and hopelessness (Johnstone, 2014). A consistent theme of leading members of the survivor movement—people who have left psychiatry behind and now campaign for change—is abandoning diagnosis in order to "take back authorship of their own stories" (Dillon & May, 2003, p. 16).

In this article, I will argue that the single most damaging effect of psychiatric diagnosis is *loss of meaning*. By divesting people's experiences of their personal, social, and cultural significance, diagnosis turns "people with problems" into "patients with illnesses." Stories of trauma, abuse, discrimination, and deprivation are sealed off behind a label as the individual is launched on what is often a lifelong journey of disability, exclusion, and despair.

It follows from this that the most important function of any alternative to psychiatric diagnosis is to *restore the meaning in madness.* It also follows that genuine alternatives, because of the threat they pose to the many vested interests in the status quo, will face the twin dangers of opposition and discrediting, or of being stripped of their most challenging aspects and absorbed into the existing system. This is certainly true of psychological formulation, which is one, although not the only, current alternative to psychiatric diagnosis. It is, however, a mainstream U.K. practice that is supported by the British Psychological Society (BPS). Formulation is considered to be the core skill of the profession of clinical psychology, and also appears in the regulatory requirements for counseling, health, and forensic psychologists (Health Professions Council, 2009). It is included in the current Core Mental Health Skills Education and Training Framework, which applies to all mental health and related professions in England. A description of psychological

formulation in the United Kingdom, its strengths and limitations, and current practice developments and evaluations is outlined below. I also describe the political contexts and controversies that are shaping the emergence of this rapidly developing field.

What Is Psychological Formulation?

In the United Kingdom, formulation has the advantage of a degree of familiarity, acceptability, and credibility within existing psychiatric settings. It is also a key competence in U.K. psychiatrists' training curriculum, although as discussed below, psychiatrists have a slightly different perspective on it. Formulation is the subject of a growing number of books and articles (see Johnstone & Dallos, 2013). The BPS Division of Clinical Psychology (DCP), with about 10,000 members, is the largest subdivision of the BPS and has published the first set of *Good Practice Guidelines* on the use of psychological formulation (DCP, 2011).

Formulation can be defined as the process of co-constructing a hypothesis or "best guess" about the origins of a person's difficulties in the context of their relationships, social circumstances, life events, and the sense that they have made of them. It provides a structure for thinking together with the client or service user about how to understand their experiences and how to move forward. Formulation draws on two equally important sources of evidence: the clinician brings knowledge derived from theory, research, and clinical experience, while the service user brings expertise about their own life and the meaning and impact of their relationships and circumstances. In this way, formulation is "the tool used by clinicians to relate theory to practice" (Butler, 1998, p. 2). The development of this personal story or narrative has been described by clinical psychologists as "a way of summarising meanings, and of negotiating for shared ways of understanding and communicating about them" (Butler, 1998, p. 4). This provides the basis for an intervention plan tailored to the individual and their needs.

Unlike diagnosis, formulation is not about making an expert judgement, nor is it based on deficits. Instead, a best-practice formulation draws attention to the service user's resources and strengths in surviving what are nearly always very challenging life situations. Most important, and in contrast to psychiatric diagnosis, psychological formulation approaches all expressions of distress with the assumption that "at some level it all makes sense" (Butler, 1998, p. 2). From a formulation-based perspective, the work of every mental health professional, whatever their training, should be based on this principle: that however unusual, confusing, risky, destructive, overwhelming, or frightening someone's thoughts, feelings, and behaviors are, *there is a way of*

making sense of them. The central task of all mental health professionals is to work alongside service users to create meaning out of chaos and despair. Formulation is a powerful and effective way of doing this.

Here is a hypothetical example.

Jane is 20 years old and has started to hear critical and hostile voices. The diagnosis is likely to be "psychosis" or "schizophrenia." In contrast, a written formulation shared and developed with Jane over a few weeks or months might look something like this:

> You have told me that you had a happy childhood until your father died when you were aged 8. We have also discussed how, as a child, you felt very responsible for your mother's happiness and pushed your own grief away. Later, your mother remarried and when your stepfather started to abuse you, you did not feel able to confide in anyone without risking the break-up of the marriage. The only escape was to leave home as soon as you could, and you found an apartment and a job in a store. However, you found it increasingly hard to deal with your boss, whose bullying and controlling ways reminded you of your stepfather. You gave up the job, but long days at home in your apartment made it hard to push your buried feelings aside any more. One day, after your stepfather made some threatening comments on the phone, you started to hear a hostile male voice telling you that you were "dirty" and "evil." This seemed to express how the abuse had made you feel, and it also reminded you of things that your stepfather had said to you when you were a child. You found day-to-day life increasingly difficult as past events caught up with you and many feelings came to the surface. Eventually, your mother persuaded you to contact the mental health services, and for the first time you have been able to tell someone what you went through as a child. Despite your difficult experiences, you have many strengths, including intelligence, determination, and self-awareness, all of which have helped you to survive. You recognize the need to revisit some of the unresolved feelings from the past, and we have started to do this work together.

We can see that the formulation is personal to Jane, and it helps make sense of her experiences in terms of recent evidence about trauma and voice-hearing (Read, 2013). It suggests an individual pathway forward, which will probably include developing a trusting relationship with a mental health worker or therapist, acquiring information about the impact of trauma, learning practical ways of managing and coping with her voices, perhaps gaining support from others with similar experiences, and processing the feelings from the past. We would hope that the formulation helps Jane feel that her experiences are understandable, that she has many strengths, and that she can take steps, with support, to overcome her difficulties. The meta-message of a formulation is, "You are having a normal response to an abnormal situation.

Anyone else who had been through the same experiences might well end up feeling the same. You too can recover." This contrasts with the messages of shame, deficit, and despair often conveyed by a psychiatric diagnosis.

The example shows that although training courses and some textbooks tend to describe formulation as if it is an event or "thing," it is perhaps more accurate to see it as a process, an aspect of a shared exploration that has no definite end point. This is captured in the definition "a process of ongoing collaborative sense-making" (Harper & Moss, 2003, p. 8). However, there are times and purposes for which a summary—a formulation-as-an-event—may be useful, such as at the start and end of contact with mental health services. Appropriately adapted versions can be used for communication with other professionals, in letters to referrers, and so on.

The *Good Practice Guidelines* (DCP, 2011) suggest that formulation can have many other uses and benefits, including: clarifying hypotheses and questions, providing an overall picture or map, noticing what is missing, prioritizing issues and problems, selecting and planning interventions, minimizing bias by making choices and decisions explicit, framing medical interventions, predicting responses to interventions, thinking about lack of progress, ensuring that a cultural perspective in incorporated, helping the service user to feel understood and contained, and strengthening the therapeutic alliance.

Of course, there is no guarantee that a formulation will avoid some of the same traps as diagnosis, such as being individualizing, pathologizing, excluding social contexts, or perhaps simply imposing a view with which the service user disagrees (Johnstone, 2013a). Like any intervention, it depends how it is done. Feedback from service users suggests that formulation is often experienced as increasing understanding and trust, as empowering, as a relief, and as enabling them to move forward ("It just all made sense. I got it because . . . it was true"; "It was bang on, so I trusted that she understood"; "I just felt empowered that I could do something about [the problems]"; Redhead, Johnstone, & Nightingale, 2014). However, it can also be experienced as saddening, frightening, or overwhelming (Chadwick, Williams, & Mackenzie, 2003; Morberg Pain,). It is not clear whether these reactions are, in the longer term, succeeded by a sense of relief and increased understanding; regardless, they highlight the need for working sensitively.

For these reasons, the DCP *Good Practice Guidelines* (2011) specify a number of principles in formulating, including that the process should be collaborative, respectful of service users' views about accuracy and helpfulness, expressed in ordinary and accessible language, culturally sensitive, nonjudgmental, and inclusive of strengths and achievements (DCP, 2011, pp. 29-30). Psychologists are expected to take a reflective stance that reduces the risk of

using formulation in insensitive, nonconsenting, or disempowering ways (DCP, 2011, p. 21).

Three additional best-practice criteria from the Guidelines (DCP, 2011) deserve attention. The first is that formulation should consider "the possible role of trauma and abuse" (DCP, 2011, p. 29). This acknowledges the large and growing body of research that indicates a causal role for these events in many or most mental health presentations (Read & Bentall, 2012; Varese et al., 2012). A trauma-informed formulation can be a powerful way of integrating this knowledge into our interventions. The second is, "[C]onsiders possible role of services in compounding the difficulties" (DCP, 2011, p. 29). A trauma-informed approach recognizes that services may be not only unhelpful but retraumatizing through disempowering and coercive practices (Fallot & Harris, 2009). The third is the requirement to include "a critical awareness of the wider societal context within which formulation takes place" (DCP, 2011, p. 20). The intention is to minimize the individualizing tendency of both medical and (some) psychotherapeutic models, which, by locating the difficulties within the person, implicitly convey a message of blame and deficit.

Using Formulation in Teams

A recent development in the United Kingdom is team formulation, or the process of facilitating a group or team of staff to develop a shared formulation about a service user (Johnstone, 2013b). This is now common practice in mental health services and, to a lesser extent, in older adult (Dexter-Smith, 2015), learning difficulty (Ingham, 2015), child and adolescent (Milson & Phillips, 2015), and health (Cole, 2013) settings. Some services have integrated individual and team formulation into all parts of the care pathway, with associated staff training and documentation (Clarke, 2015; Dexter-Smith, 2015) while other projects are still evolving (e.g., Johnstone et al., 2015; Roycroft et al., 2015).

Team formulation meetings take place as a regular part of the weekly timetable, usually facilitated by a psychologist, although there are some examples of psychiatrists taking this role (e.g., Martindale, 2007; Summers, 2006). The facilitator's role is to reflect, summarize, clarify, and encourage creativity and free-thinking about the service user under discussion, not to provide "solutions." In this way, the team can develop a shared formulation about the service user's difficulties and any "stuck points" in their work with them. Much of the team formulation might look like the hypothetical one for "Jane" (as mentioned above), but the team version would also include staff reactions (such as "Staff find themselves wanting to care for the frightened

young girl part of Jane, and it is important to balance this with recognition of her strengths") and frustrations (such as "Staff found Jane's anger outbursts difficult to manage, but we can now understand these as expressions of fear in the presence of male nurses").

There are various ways of involving the service user in this process. It should be noted that in team formulation the main client is, in effect, the team, whose counter-transference feelings of stuckness, hopelessness, anger, or despair are likely to have prompted the request for a discussion. While these staff reactions urgently need formulating, for obvious reasons it may not be appropriate or helpful to share them directly with the service user (Johnstone, 2013b). One of the advantages of this format is that even if the service user is not currently able to participate (perhaps because they are in acute crisis or "psychosis"), the team can be encouraged not to revert to a default position of simple diagnosis-and-medication, but can start the process of thinking and planning from a more psychologically sophisticated perspective. However, good practice suggests that as soon as possible, a parallel individual formulation should be developed with the service user, which will inform and feed back into the team version in an ongoing process of dialogue, revision, and reformulation.

Practitioners have suggested that team formulation can have the following benefits in addition to those claimed for individual formulation: achieving a consistent team approach to intervention; helping team, service users, and caregivers to work together; gathering key information in one place; generating new ways of thinking; dealing with core issues (not just crisis management); supporting each other with service users who are perceived as complex and challenging; drawing on and valuing the expertise of all team members; challenging unfounded "myths" or beliefs about service users; reducing negative staff perceptions of service users; processing staff counter-transference reactions; helping staff to manage risk; minimizing disagreement and blame within the team; increasing team understanding, empathy, and reflectiveness; raising staff morale; and conveying meta-messages to staff about hope for positive change (DCP, 2011, p. 9).

In my experience, this simple but novel approach makes intuitive sense to and is widely welcomed by staff (Hollingworth & Johnstone, 2014). It can be a powerful and effective means of harnessing the team's clinical experience and intuitions, promoting psychosocial understandings, and encouraging all staff to take an active and valued part in care planning. In fact, staff members often perceived as lower in status (health care assistants, support workers) often have more to contribute than the psychiatrists, whose views typically dominate treatment discussions because of the former's more intimate knowledge of service users' lives and circumstances.

It is also true that tact and persistence are necessary to get everyone on board; the dynamics of multidisciplinary meetings can be tricky; it is hard to preserve the time in busy teams where other crises take priority; and the facilitator will be required to do quite a bit of chasing up and ensuring that the formulation does not simply get lost in the day-to-day pressures and crises of mental health work. Others have described the challenges of embedding team formulation into the system and of getting all professionals on board (Casares & Johnstone, 2015; Dexter-Smith, 2015). Facilitating a meeting that integrates, sensitively and collaboratively, a wide range of theory and evidence with complex staff views and dynamics—and then writing it up in a way that is accessible and helpful—is a sophisticated and time-demanding activity. However, I have found that over time, a pro-formulation stance can, without directly challenging the diagnostic model, lead to a gradual erosion of narrow medical thinking, as trauma becomes a subject that can be discussed more openly, the impact of medication and coercive interventions starts to be recognized, and the team becomes increasingly sophisticated at translating "symptoms" and "illnesses" into understandable responses to life circumstances (Johnstone et al., 2015). "Taking formulation into a wider setting can be a powerful way of shifting team cultures" (BPS, 2007, p. 23).

Research and Evaluation

Formulation is an emerging, practice-based field. To date, its evidence base as a specific intervention is limited (Cole, Wood, & Spendelow, 2015), although there is extensive research into the theoretical content and psychological principles on which it is typically based (e.g., attachment theory, developmental psychology, cognitive-behavioral therapy, etc.). Some critics have seized on the fact that reliability and validity have not been consistently demonstrated in formulation (Kuyken, Fothergill, Musa, & Chadwick, 2005). Aside from the fact that these psychometric qualities are certainly lacking in psychiatric diagnosis (Kirk & Kutchins, 1997), it is, in my view, a mistake to evaluate formulation in the same terms (Johnstone, 2013a). If professionals are essentially dealing with people with problems rather than patients with illnesses—survivors of trauma, abuse, and deprivation rather than victims of disease processes—then a categorical system based on the natural sciences is not an appropriate starting point. Human emotional suffering does not come in neat parcels, and it is not clear in what sense a shared narrative can be said to be "true" or "accurate." It may be more sensible to assess the practice of formulation in terms of its usefulness in promoting the benefits listed above (Butler, 1998; DCP, 2011).

While some critics have objected to formulation in principle, this sits oddly with the fact that it is essentially a structure for developing a hypothesis, which is the heart of evidence-based practice (Sackett, 2002). The validity of any particular formulation is, like any other hypothesis, tested out in practice and amended accordingly. This is not to deny that there are legitimate questions about whether this particular framework for applying theory to practice is effective and acceptable. The most consistent finding so far is the enthusiastic welcome given to formulation by many professionals (e.g., Hollingworth & Johnstone, 2014). We need to know much more about its acceptability to service users, along with its possible impact on measures such as use of medication, number of admissions, recovery rates, and so on (Cole et al., 2015). The first randomized controlled trial comparing teams that do and do not use a team formulation approach is being planned, after a promising pilot study showed improvements in staff–patient relationships and reduced staff burnout (Berry, Barrowclough, & Wearden, 2009).

Psychiatric Diagnosis and Psychological Formulation

In many settings, clinical psychologists use formulation to provide a holistic context to medical diagnoses such as cancer, learning disability, stroke, dementia, and so on. The issue of diagnosis is more controversial in psychiatry, where it raises the question of whether formulation is used as an addition to, or an alternative to, psychiatric diagnosis. This is currently an active and contentious debate in the United Kingdom.

The term "formulation" appears in several places in the U.K. training curriculum for psychiatrists, who are required to "demonstrate the ability to construct formulations of patients' problems that include appropriate differential diagnoses" (Royal College of Psychiatrists, 2010, p. 25). At one level, this is to be welcomed, as any attempt at widening the gaze of diagnosis is likely to be an improvement. The danger is that a psychiatrist who followed these training guidelines might produce a formulation for Jane (see above), which looked something like this: "Schizophrenia/psychosis triggered by the stress of job loss." This is simply a slightly more elaborate version of the basic biomedical model, as opposed to the psychological formulation which could be summarized as "Hearing hostile voices as a response to the abuse you experienced."

It was for this reason that the *Good Practice Guidelines* (DCP, 2011) drew a clear distinction between psychiatric formulation and psychological formulation—the former being an *addition* to diagnosis, and the latter being an *alternative*. The Guidelines (DCP, 2011) state that "best practice formulations . . . are not premised on psychiatric diagnosis. Rather, the experiences that may have led

to a psychiatric diagnosis (low mood, unusual beliefs, etc.) are themselves formulated" (p. 17)—in other words, explained in psychological terms. The argument is that if a psychosocial formulation can provide a reasonably complete explanation for the experiences that have led to a psychiatric diagnosis, whatever they may be, then there is no place or need for a competing hypothesis that says "and by the way, it is also because she has schizophrenia." The diagnosis becomes redundant. In the words of clinical psychologist Richard Bentall, "Once these complaints have been explained, there is no ghostly disease remaining that also requires an explanation" (as quoted in DCP, 2011, p. 17).

Best-practice psychological formulation (DCP, 2011) is, therefore, based on fundamentally different principles from psychiatric diagnosis. It is the difference between the message "you have a medical illness with primarily biological causes" and "your problems are an understandable emotional response to your life circumstances." Clearly, these explanations cannot both be true. They are not only different; they are contradictory. People who are offered both models simultaneously, as happens when we try to dilute biomedical approaches with psychosocial ones or add formulations to diagnoses, become deeply entangled in this confusion. The overall message to service users comes across as follows: "You have an illness which is not your fault, *but* you retain responsibility for it and must make an effort to get better, *but* you must do it our way because we are the experts in your illness." Muddled thinking leads to muddled practice, and both staff and service users can become trapped, frustrated, and demoralized in the resulting confusion.

Despite the contrasting official positions taken by professional bodies in the United Kingdom, this is best understood as a battle of ideas, not professions. The Critical Psychiatry Network (2013), representing 200 U.K. psychiatrists, issued this statement in May 2013 in relation to the publication of *DSM-5* (American Psychiatric Association [APA], 2013):

> A number of reports have described the storm of criticism around *DSM-5* as a guild dispute driven by professional rivalries between psychologists and psychiatrists. However, many psychiatrists are deeply concerned about the limitations and failings of diagnosis in psychiatry and equally, many psychologists take an uncritical view of diagnostic based approaches. . . . The view of the Critical Psychiatry Network is that a *DSM* diagnosis is incapable of capturing the full range of experiences of distress in the way that a more comprehensive formulation can.

Psychological Formulation: The Wider Context

In the United Kingdom, the BPS and DCP have been promoting psychosocial models as alternatives to the biomedical one and formulation as an alternative

to diagnosis in a series of documents over the past 15 years or so. In 2000, an influential report "Recent Advances in Understanding Mental Illness and Psychotic Experiences" (BPS DCP, 2000) argued that "[g]iven the problems of diagnosis . . . clinical psychologists have suggested alternative approaches" (p. 19). In 2010, another report, "Understanding Bipolar Disorder" (BPS DCP, 2010) noted that "[n]ot all mental health professionals accept the idea that these experiences are caused by an underlying illness" (p. 4) and recommended that "[s]ervices should not insist that all service users see their problems as an 'illness' and take medication" (p. 8). The influential and widely cited report "Understanding Psychosis and Schizophrenia" (BPS, 2014) states,

> [H]earing voices or feeling paranoid are common experiences which can often be a reaction to trauma, abuse or deprivation. Calling them symptoms of mental illness, psychosis or schizophrenia is only one way of thinking about them, with advantages and disadvantages. (p. 6)

The DCP, via the BPS (2011), also made a robust response to the consultation on *DSM-5* (APA, 2013):

> Clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation. . . . The putative diagnoses presented in DSM-V are clearly based largely on social norms, with 'symptoms' that all rely on subjective judgments, with few confirmatory physical 'signs' or evidence of biological causation. The criteria are not value-free, but rather reflect current normative social expectations. (BPS, 2011)

The DCP's (2013) position statement on "Classification of Behaviour and Experience in Relation to Functional Psychiatric Diagnosis: Time for a Paradigm Shift" was therefore a logical progression in this series of official reports. The key paragraph states,

> The DCP is of the view that it is timely and appropriate to affirm publicly that the current classification system as outlined in DSM and ICD, in respect of the functional psychiatric diagnoses, has significant conceptual and empirical limitations. Consequently, there is a need for a paradigm shift in relation to the experiences that these diagnoses refer to, towards a conceptual system not based on a "disease" model. (p. 1)

This led to a great deal of national media coverage and debate (e.g., Doward, 2013) with strong feelings expressed in all quarters. One of the

recommendations in the statement was, "For the DCP to continue to promote the use of psychological formulation as one response to the concerns identified in this statement" (DCP, 2013, p. 9).

The larger context is the controversy about psychiatric diagnosis that was precipitated by the publication of *DSM-5* (APA, 2013). The DCP Position Statement led directly to the Society of Humanistic Psychology's online petition and open letter about the proposed revisions to *DSM-5* (http://www.ipetitions.com/petition/dsm5/), which gathered over 15,000 signatures and the support of over 50 professional organizations. While psychiatric diagnosis has been the subject of criticism since its inception, the unique aspect of the most recent events is that the most outspoken attacks have come from within establishment psychiatry—indeed, in some cases from the chairs of previous *DSM* committees. Frances (2014), Chair of *DSM-IV* committee, claimed that "*DSM-5* will radically and recklessly expand the boundaries of psychiatry. . . . There is no reason to believe that *DSM-5* is safe or scientifically sound." Hyman (2013), former National Institute of Mental Health director, described *DSM-5* as "totally wrong, an absolute scientific nightmare' while another former director admitted: 'Patients deserve better. . . . The weakness is its lack of validity" (Insel, 2013).

It is no coincidence that this controversy has been paralleled by an increasingly high profile for formulation. In the face of this threat to the foundation of psychiatric theory and practice, formulation—psychiatric formulation, that is—is increasingly being promoted as an answer to the shortcomings of diagnosis. If diagnosis is accused of obscuring social factors and personal meanings, formulation can be co-opted to fill the gaps. Indeed, formulation makes an appearance in *DSM-5* (APA, 2013): "Case formulation . . . must involve careful clinical history and concise summation of social, psychological and biological factors that may have contributed to developing a given mental disorder" (p. 19). In a recent editorial in the *British Journal of Psychiatry* defending the use of diagnosis ("Psychiatric diagnosis: imperfect and important"), Craddock and Mynors-Wallis (2014) contended: "[D]iagnosis is insufficient in conceptualising psychopathology in any individual patient. Diagnosis should be part of a formulation that brings together aetiology, severity and functioning and should lead to a management plan" (p. 93). This is always the danger with challenges to biomedical psychiatry: they might be stripped of their potentially radical aspects and assimilated into the status quo. As noted above, these positions do not align in any simple way with professional background or discipline, and members of the Critical Psychiatry Network have joined with clinical psychologists to urge "drop the language of disorder" in favor of a narrative or formulation-based approach (e.g., Kinderman, Read, Moncrieff, & Bentall, 2013).

Conclusion

A parallel, nonmedical discourse that is primarily concerned with understanding people's distress within their life contexts has always existed, right back to the inception of biomedical model psychiatry, and it has resurfaced at various points—most notoriously in the so-called "anti-psychiatry" movement of the 1960s. The Moral Treatment of the 19th century is an example from the past (Scull, 1979), and the tradition continues today in the work of the Open Dialogue model in Finland (Seikkula & Olsen, 2003) and survivor movements like the Hearing Voices Network (www.hearing-voices.org). Psychological formulation is only one of several current examples of this trend. It is also important to emphasize that many peoples of the world already have their alternatives to diagnosis, which do not need replacing in an act of psychiatric or psychological colonization (Watters, 2011). However, as described above, in the United Kingdom, formulation has the advantage of familiarity within services, several professions who claim it as a core skill, and a small but growing amount of research and evaluation supporting its benefits. Vigilance is needed to promote, protect, and develop those aspects that run counter to biomedical model psychiatry. Of these, the most important is the emphasis on personal meaning—the core principle that distress and madness are, ultimately, understandable human responses to unbearable situations.

From one perspective, formulation is simply a more formal and structured way of making explicit what we all do already, as professionals, as service users, and indeed as human beings—we develop theories to explain what is happening to us. It is important that formulation does not become reified into a special skill owned and delivered solely by professionals. My book *A Straight-Talking Introduction to Psychiatric Diagnosis* (Johnstone, 2014) is an attempt to offer people informed choice about whether they wish to take on a diagnostic understanding, and if they do not, to find ways of constructing and validating their own narratives.

From another perspective, formulation has the potential to be not just an alternative, but an antidote, to psychiatric diagnosis and its potentially damaging effects. Psychiatry is facing a fundamental challenge to its theory and practice with the crumbling of its cornerstone, psychiatric diagnosis. Best-practice formulation is a radical act that restores agency, meaning, and hope. It provides a framework for witnessing people's stories, hearing their suffering, and making a space for their voices.

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Author Biography

Lucy Johnstone is a UK consultant clinical psychologist, author of *Users and Abusers of Psychiatry* (Routledge, 2000), coeditor of *Formulation in Psychology and Psychotherapy* (Routledge, 2013), and author of *A Straight-Talking Guide to Psychiatric Diagnosis* (PCCS Books, 2014). She is former director of the Bristol Clinical Psychology Doctorate and was lead author of the *Good Practice Guidelines on the Use of Psychological Formulation* (Division of Clinical Psychology, 2011). She has many years clinical experience in adult mental health settings.