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OPI03

Using formulation in general psychiatric care: good practice

OCCASIONAL PAPER

Occasional Paper 103

January 2017

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This report was prepared on behalf of the Faculty of Medical Psychotherapy of the Royal College of Psychiatrists.

Acknowledgements

The authors are indebted to the Division of Clinical Psychology of the British Psychological Society and in particular Lucy Johnstone for the publication *Good Practice Guidelines on the Use of Psychological Formulation* (British Psychological Society, 2011). Although this document was designed for clinical psychologists, it served as a helpful starting point for the current document and was a particularly useful source for the sections 'Why formulate?' and 'Good practice'.

Thanks also to Lucy Johnstone, Nick Kosky, Rosemary Lethem, Sue Mizen, Mary Rose Roe and Phil Thomas for comments on earlier versions of the paper.

Introduction

This paper is concerned with the use of formulation by psychiatrists in the context of general psychiatric care. Formulation is essential to a biopsychosocial approach. It is recognised within the psychiatry curriculum as a core competence for all psychiatrists (Royal College of Psychiatrists, 2013).

There has been little consensus among psychiatrists about what constitutes good practice in formulation (Hollyman & Hemsi, 1983*a,b*) and trainees often identify it as an area of difficulty. The current format of the MRPsych examination does not allow for an adequate assessment of formulation skills and these may or may not be fully covered in workplace-based assessments. In these circumstances, it is a particular challenge to ensure that formulation is taken seriously as a crucial part of psychiatric practice and remains a core skill for all psychiatrists.

At the same time, a major criticism of psychiatry at present is that there is a reductionist overemphasis on diagnosis and biology. Psychological care is sometimes seen as the domain of psychologists, with psychiatrists' roles becoming increasingly confined to prescribing and managing psychiatric problems that have a physical basis. A less limited view of what it is to be a good psychiatrist depends on psychiatrists being able to offer psychologically minded care. Formulation is a key part of this, and of making psychiatric practice more therapeutic.

This paper focuses specifically on the role of psychiatrists, and the use of formulation in everyday psychiatric practice. It is not concerned with the use of formulation within therapies.

The aim of the paper is to:

- explain the rationale for formulation in psychiatric practice
- outline indicators of good practice in this context
- support psychiatrists in using formulation effectively.

The paper is intended primarily as guidance for psychiatrists. A separate document, intended primarily for patients, carers and families, will provide briefer information with the aim of helping people make the best use of opportunities for formulation and collaboration and recognise good practice.

Definition

The term ‘formulation’ is used in many different ways (Hollyman & Hemsi, 1983*a,b*). Sometimes it denotes a summing up, sometimes an interpretation, and there is wide variation in what may be included. It can be used to describe either an end product of a process (formulation as product) or the process itself (formulation as process) (British Psychological Society, 2011).

Here, we define formulation as an attempt to explain how a situation is developed, maintained or resolved, or an attempt to make sense of what has happened. This is clearly distinct from diagnosis, which in psychiatry is generally descriptive rather than explanatory in nature.

In a given situation, there will always be a range of possible formulations. Formulations can vary greatly, along the following dimensions.

Focus

Formulations can be used to explain many different situations (e.g. individual complaints, psychiatric conditions, difficulty in treatment, relationship issues, problems in a team or organisation, or recovery from a problem).

Explicitness

Formulations can be made consciously and deliberately, or there might be a more implicit process whereby an assumption is made about the explanation for something.

Comprehensiveness

All formulations are partial, in that none can attend to every possible aspect of a situation, every possible contributory factor, and every possible explanatory framework. But some will be more comprehensive than others.

Process

Formulations are developed in different ways in psychiatry (e.g. in discussion within a team, in discussion with a patient, or in an individual practitioner’s mind). They can be developed with or without a patient’s input, and with or without a practitioner’s input.

Degree of sharing

Formulations can be written and included in the case record, discussed in the team, or never go beyond the mind of the individual.

A framework for formulation

A formulation can be seen has having four steps (Fig. 1).

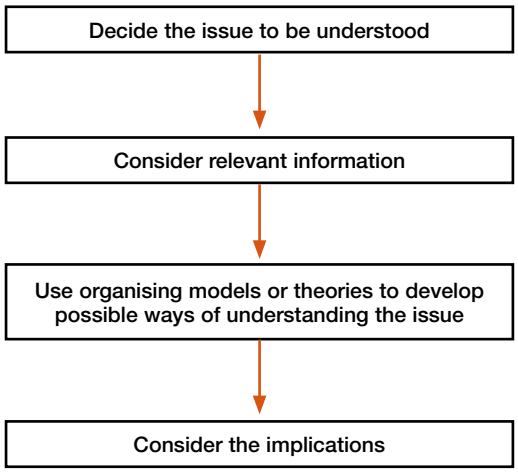

Fig. 1 Four steps of a formulation

In a clinical context, the following points are widely considered as important (British Psychological Society, 2011).

- Formulation depends on assessment information, and on the theory or model used to organise it.
- A formulation is always provisional and open to revision, especially in response to new information or a different organising model.
- Formulations are narratives that are constructed rather than discovered (Lewis, 2011), and need to be judged against criteria of usefulness rather than proof. There will always be more than one way of understanding an issue.

Why formulate?

If formulation does not happen explicitly, it is very likely to be happening implicitly. In that case, it will probably be less comprehensive and more affected by unintended bias and heuristic thinking.

Twelve potential benefits of formulation

1. Bridging biological, psychological and social understandings of experiences and psychiatric diagnoses and encouraging fluidity and comfort in working with more than one approach to understanding these experiences.
2. Providing a language and framework for dialogue that provides an alternative to the language and framework of diagnosis.
3. Supporting a holistic approach to people with complex difficulties. Using an approach that considers the developmental and relational context within which difficulties develop enables recognition of the links between different symptoms and between symptoms and history. This is a very important aspect of work with patients whose difficulties are complex.
4. Improving assessments. Being clear about the question being addressed, and the kind of information needed to address it may help guide information gathering, and help identify gaps in information.
5. Encouraging awareness of areas of uncertainty. This includes awareness of gaps in information and in understanding. This may help guide further enquiry or avoid premature discouragement.
6. Making the rationale for decision-making explicit. One aspect of this can be having key information gathered together in one place. Another can be being explicit about the underlying theory being used. Having an explicit formulation might help support collaborative working with patients, families and other team members and also means the formulation is more open to challenge and revision.
7. Guiding intervention. A formulation can help psychiatrists identify and prioritise possible actions, predict potential problems in treatment, or identify that a specific approach is not appropriate. It can support a focus on core problems rather than an over-emphasis on crisis management. It can encourage a creative and flexible approach, support trials of interventions that may not be otherwise be considered, and help avoid over-reliance on medication.

8 Psychological benefits to patients. These benefits are particularly likely to arise from a formulation that attends to psychological and social factors. Such formulations can support an approach to care that feels human. They can help patients and families feel understood. They can support patients in making sense of their problems in a way that reduces self-blame and stigma, support self-esteem in situations where this is challenged, and help people find meaning in their experience, maintain a sense of agency and develop coherent life narratives. 'Psychological formulation's meta-messages about personal meaning, agency and hope can act as a helpful corrective to some of the well-documented negative consequences of receiving a psychiatric diagnosis, such as increasing a service user's sense of powerlessness and worthlessness' and can guard against 'meta-messages of blame and individual deficiency' (British Psychological Society, 2011). There is evidence that patients find formulations helpful but also at times upsetting or worrying (British Psychological Society, 2011).

9 Strengthening therapeutic relationships, and supporting collaboration. This may happen through patients and families feeling understood, having a better understanding of the rationale for decision-making and feeling they have more choices and more control, and through practitioners and teams feeling better supported. The involvement of families in developing formulations may be a step to more effective family involvement. In an era of fundamental shifts in relationships between practitioners, patients and family members, formulation may be a valuable tool in navigating the complexity of this. Better therapeutic relationships are in turn associated with better outcomes (McKay *et al*, 2006)

10 Supporting practitioners. Developing formulation practice can encourage an understanding and compassionate approach to care, improve morale and reduce depersonalisation and burnout. This is particularly likely when formulations pay attention to the difficult past and present life experiences that might underlie behaviours that staff find challenging, and to difficult aspects of working relationships with patients and other practitioners.

11 Strengthening team working. When teams work together to develop formulations, this can enable them to be more consistent in their approach and to support each other with clients they find challenging. It can help team members feel valued and reduce blame.

12 Supporting reflective practice. Formulation is central to reflective clinical practice. The process of formulation is likely to help develop team members' skills in thinking psychologically and working in a reflective way, and to support a culture of 'mentalising'. Development of psychologically minded reflective practice is increasingly recognised as important for learning, self-awareness and supporting compassionate practice (Ballatt & Campling, 2011).

Almost all these benefits (except point 6) are a result of the process of formulation as much as the final formulation itself. In other words, developing a formulation can be a powerful intervention in itself for the patient, family, team or organisation (British Psychological Society, 2011).

Evidence

There is a large and growing body of evidence about the biological, psychological and social factors that affect mental illness and interpersonal relationships. For example, the past few years have seen increasing evidence of the role of attachment relationships, trauma and social justice in the genesis of psychotic illnesses.

There are several small, practice-based studies of using formulation in teams that have found positive views about formulation among patients and staff, including perceived benefits to care planning, therapeutic relationships, staff satisfaction, team working and staff confidence, and changes in staff views of patients (Berry *et al*, 2009, 2015; Kennedy, 2009; Summers, 2006; Lake, 2008; Wainwright & Bergin, 2010).

However, in general there is limited evidence on the specific effect of formulation as an intervention in its own right as part of general psychiatric care, including how it compares with other approaches to decision-making. More research is needed in this area, including on choice of models and on patient perspectives.

Choosing a model

Many of the benefits of formulation depend on the approach used. Appendices 1 and 2 outline some organising models and theories. Points to bear in mind when selecting an approach include the following.

- Using a model based on a clear theoretical approach makes explicit the assumptions that are being made about how different aspects of the formulation link together. Some 'atheoretical' formulations list relevant factors rather than linking them, but can still include theoretical assumptions (with these being implicit rather than explicit).
- Formulation models differ in the extent to which they are grounded in explanatory theory, in the richness of that theory and in its ability to consider important factors in adequate depth.
- As important factors are often unconscious, psychodynamic approaches have a particular contribution to offer.
- Approaches that do not take adequate account of organisational and societal factors risk inappropriately assuming that primary causes lie within individuals.
- Several of the expected benefits are specifically associated with formulations that attend to psychological and social elements.
- In particular, if formulation is to support a holistic approach to complex difficulties, it is essential to use an approach that adequately considers the developmental and relational context and the link between this and the individual's personality development, and their relationships and attachment patterns with practitioners. Psychodynamic or attachment approaches can achieve this, in contrast to approaches based on single problems or symptom complexes (e.g. formulating 'the anxiety'), which would not. Drawing on a range of approaches increases the chance of selecting an approach that is helpful.
- Using a model that is familiar to other professionals might allow easier communication, and avoid confusion, but this may be at the cost of the benefits that more complex theoretical models can provide.

Good practice

We believe that formulation in psychiatric practice should ideally have the following characteristics.

1. Developed within a good-enough relationship

The quality of formulation in psychiatric practice depends above all on how the clinician engages as a person with the patient (and others involved). Anxiety, mistrust, time pressure and lack of continuity in relationships will all limit the ability of those involved to explore difficulties openly.

2. Tentative

A formulation is a hypothesis, not fact. It is provisional and likely to need revision. There is always more than one way of formulating a particular issue. Formulations will always be partial, with gaps and uncertainties in what is understood.

3. Specific to the individual person or situation

Formulations in psychiatric practice should be specific to the individual person or situation, not simply a generic formulation for a problem.

4. Based on adequate participation

Including a range of perspectives can enrich a formulation. Considerable effort may be needed to ensure that all voices are heard. If a formulation is for an individual patient or family, it should be developed jointly or shared to an appropriate extent, considering the potential effect on those involved, particularly the patient.

5. Based on adequate information

The content of a formulation depends on the information that is considered: including biological, psychological and social aspects. The personal meaning of events, circumstances, relationships and biology need to be considered, rather than simply seeing them as objective events.

In gathering information for formulation, aspects that are often overlooked include:

- the strengths and resources that the patient can draw on; emphasis on strengths and abilities may support self-esteem at a time when this is challenged, and may strengthen hope of recovery

- asking about loss, trauma, abuse, and relationships; this is commonly overlooked in individuals with psychotic illnesses and learning disabilities
- the perspectives of family members
- transference and countertransference and the information that can be gleaned from the clinicians' experience of being with the patient
- the meaning to the patient of mental health services, relationships with practitioners, interventions such as medication, and being a patient.

6. Developed with an adequate theoretical model

A formulation should be consistent with relevant biological, psychological and social research. It should be developed with access to adequate theoretical frameworks. It should make theoretical sense, if possible linking rather than listing relevant factors. It should provide an adequate response to the question addressed.

Psychiatric diagnoses generally do not provide explanation, as most are descriptive rather than explanatory. For functional disorders, it cannot be assumed that the primary cause is biological. Even where there is a clear-cut primary organic cause for a problem (e.g. dementia), the person's experience, distress and coping will still be influenced by psychological and social factors, and formulation remains relevant. Different aspects of a person's experiences might have different explanations (e.g. hallucinatory voices, mood, distress).

In developing a formulation, aspects often overlooked include:

- the value of attachment and psychodynamic perspectives in considering the relationship with services
- the influence of unconscious factors, including psychological defences
- the impact of organisational and societal factors, including social inequality and social justice.

7. Clear about the context

Clarity about the context of a particular formulation will help others to evaluate it. Clarity is needed about the formulation's focus (i.e. what is being formulated), who developed the formulation and who it is for (e.g. patient, family, practitioner, team).

8. Respectful of different perspectives

An individual's own formulation of a problem is crucial, and a good starting point for discussion. However, people differ in their motivation and ability to explore their problems. There needs to be acknowledgement of different perspectives among stakeholders; for example,

differences between the practitioner, patient and family, or between colleagues, or between formulations made from different points of view.

The viewpoints and interests of different stakeholders may not coincide. The clinician might want a formulation that provides a shorthand reminder of potentially relevant issues. The patient might benefit most from a formulation that they find acceptable. Patients and families have varying degrees of interest in exploring the origin of their difficulties. For example, a patient might hope for a biological explanation that is straightforward to address with medication, and a patient's family might not welcome the reframing of a clinical explanation as a family issue.

9. Attentive to issues of power

The language used (verbal and written) needs to be accessible to all stakeholders. Patients and families need an explanation of the purpose of formulation. Patients and families might find it hard to disagree with clinicians' views or to express their disagreement with the formulation, or with treatments stemming from it. They might not feel their views have been heard, particularly when treatment proceeds based on the clinician's formulation.

Formulation can sometimes be seen as the province of clinical psychologists. There might need to be negotiation regarding the different roles of different mental healthcare professionals.

10. Reflective

Ideally, developing a formulation will include reflection about choices made in focus, assessment and theorising. Reflection can encourage the unpicking of implicit, off-the-cuff formulations and can be a safeguard against biases and unconsidered assumptions (Colombo *et al*, 2003).

Capacities and skills for formulation

The nature and quality of a formulation will depend on:

- the quality of the relationships in which the formulation is developed
- the quality of assessment on which it is based (e.g. What information has been sought? What lines of enquiry have been dominant? Has the patient had an opportunity to tell their story in their own way, or has the account already been shaped by professionals' priorities and assumptions?)
- the organising theories, models and evidence used
- sensitivity and judgements of those formulating (eg. What is noticed? What is felt to be important to the clinician? What is felt to be important to others involved? Where should the formulation focus? How much attention and time and comprehensiveness are appropriate? How should different theoretical ideas be integrated? Has a helpful formulation been reached?)
- where and how formulation is used.

Thus, key capacities and skills for formulation include the following.

- Personal capacities for reflection and psychologically minded practice.
- Interpersonal skills to establish relationships in which helpful formulations can be developed.
- Assessment skills, including ability to listen, to reflect on countertransference responses and to observe team responses.
- Knowledge of the evidence base about how biology, psychological and social experience interrelate. Knowledge of relevant models and theories for organising ideas, and skill in applying these. In particular, it will be important to have adequate understanding of attachment and psychodynamic approaches.
- Understanding of values-based practice (Fulford, 2008).
- Ability to make judgements about what will be helpful and proportionate in a given setting.
- Leadership skills to use formulation effectively to inform clinical work in teams and to foster reflective practice in teams.

Appendix 1
Atheoretical models

These are models that might be helpful for organising information. They do not necessarily include or imply a coherent narrative to link the different factors, though one may be present implicitly.

PPPP model

This is an easy-to-use model that does not offer suggestions of how the different factors may be linked.

- Predisposing factors
- Precipitating factors
- Perpetuating factors
- Protective factors

Weerasekera model

The Weerasekera model is an expanded version of PPPP model, with similar advantages and disadvantages. Predisposing, precipitating, perpetuating and protective factors are each considered in terms of factors that relate to the individual (e.g. biological, behavioural, cognitive, psychodynamic) and those that relate to systems (e.g. couple, family, occupation, social).

Why this person, why now?

This can be a list-based approach, as with the previous models, or can incorporate a theory linking the different factors.

Malan's triangle of person

Malan's triangle of person is a way of conceptualising information about patterns in relationships (Fig. 2). It is often a starting point in psychodynamic formulation, but is also useful in any formulation where relationship patterns need considering.

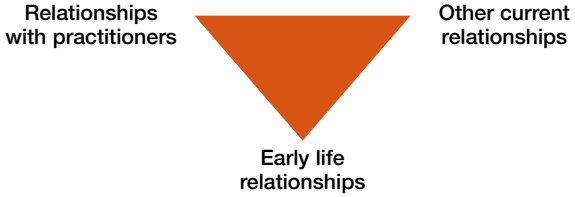

Fig. 2 Malan's triangle of person

Appendix 2
Theoretical frameworks

Below are listed formulation models and theories that include theorising about how causal factors are linked (Cabaniss *et al*, 2013; Johnstone & Dallos, 2014).

Biopsychosocial model

Key points:

- 'Every aspect of our human existence is simultaneously biological, personal, social and historical' (Rose, 2001).
- There are two-way interactions between mind, body, and social environment.

All the psychological theoretical models listed below can be considered to be biopsychosocial when they include the assumption that biology is also involved.

Stress–diathesis or stress–vulnerability model

The key point of this model is that mental illness is precipitated by events that overwhelm because of pre-existing vulnerability. Some versions of this model assume vulnerability to be purely biological, though it is increasingly recognised that early life experiences influence vulnerability, including through their effects on biology (e.g. when trauma affects the hypothalamic–pituitary–adrenal axis).

Attachment theory

Through early attachment relationships, infants develop lasting internal working models of self in relation to others, and capacities to regulate emotion and to mentalise.

Trauma theory

Traumatic experiences may affect integration of experience, and particularly with relationship trauma may affect sense of self, ability to trust others and capacity to regulate emotion.

Psychodynamic theory

Unconscious factors affect conscious experience and behaviour, including through psychological defences. Patterns in relationships are an important source of clues to this internal world. The internal world develops through biology and through life experiences, particularly

experiences early in life. This theory can be used to consider problems in families, groups and organisations as well as individuals.

Cognitive–behavioural theory

Behaviour, thoughts, feelings, bodily experience, and environment affect each other. Dysfunctional patterns of thinking develop as a result of earlier experience, which can give rise to unhelpful models (schema) of self and others.

Cognitive analytic theory

Procedural sequences explain how a target problem is established and maintained. Reciprocal role procedures identify problems occurring between and within people.

Systemic theory

Individual experience and problems are embedded in a multi-layered systemic context with circular interactions of problems and attempted solutions.

Narrative and dialogical theories

Experience is shaped by the stories we tell about ourselves, which in turn are shaped by social and political context. Power relationships determine which stories are dominant and which subordinated.

Appendix 3
Formulation use examples

Table 1 Using formulation in individual patient care

Context	Use of formulation	Comment
Initial assessment appointment	In the course of taking the history, the psychiatrist: • explains that background factors such as personal history and trauma are being asked about to help clarify what might be contributing to the problem, and thus what may be helpful • asks about how the patient has made sense of their problems • summarises his/her impression of what might be contributing, and looks for areas of consensus • gives weight to formulation, not just diagnosis, and clarifies how management plans relate to formulation.	Using formulation makes it clear that the patient's life experience and views are relevant to understanding and addressing their problems. Involving family members in this process can communicate that they are also important in understanding and addressing problems.
Relapse prevention plan, or at discharge from services	During a routine appointment, a formulation is made of how recovery has happened, who and what has helped, what have been the barriers.	–
Progress is stalled and the differential diagnosis needs to be reviewed	In addition to reviewing the diagnosis, the formulation is revisited, other team members or family members may be involved, and a further conversation about formulation is held with the patient.	May introduce new perspectives about possible treatment plans that might help, or are not worth pursuing.
Interventions are accumulating but not working	As part of reviewing the formulation, consideration is given to the meaning of interventions (e.g. medication) for the individual and for practitioners.	–
Risk to self is a major concern	A specific formulation is made of the person's hopelessness.	Supports an empathic response to the person's distress as well as potentially identifying useful interventions.

Table 2 Using formulation in teams		
Context	**Use of formulation**	**Comment**
Practitioners are finding a patient difficult to work with	The team meets to discuss a formulation for a particular individual.	Practitioners in difficulty might feel supported rather than guilty about failure, and ideas might be generated to move the situation forward, particularly if a range of perspectives is brought to the formulation.
Disagreement within the team about what needs to happen for a particular individual	The team meets to discuss the disagreement, considering all points of view as likely to be carrying a valid and useful part of the story, and explicitly agree the basis for the treatment plan.	Can reduce blame and tensions among staff and provide a more coherent and consistent response to the individual. This can be particularly helpful when people provoke split responses in the team.
Attempting to develop a more compassionate team culture	The team meets regularly for individual practitioners to take turns bringing up aspects of the work they are finding challenging.	Regular practice is likely to help develop a culture of 'mentalisation' (i.e. trying to understand underlying thoughts and feelings and the reasons for them) and enable staff to feel that attention is given to their own needs. This in turn is likely to help them be more open to the needs of others.

Table 3 Using formulation in professional development		
Context	**Use of formulation**	**Comment**
Practitioners want to develop skills in thinking psychologically about patients	Balint groups for junior doctors.	Regular practice aims to develop habits of thinking about symptoms and behaviours as complex products of social and psychological circumstances as well as of biology, and to develop reflectiveness about the effects of relationships with staff and services.
Psychiatrists' case-based discussion	Balint groups for consultants.	Opportunity to think in more depth with colleagues about factors underlying complex situations might help mitigate everyday pressure to opt for quick, easy understandings and solutions.
Practitioners want to develop skills in combining insights from different theoretical perspectives	Formulation discussions between practitioners with high skill levels in different evidence bases and theoretical models.	Encourages creative solutions to problems and can be valuable to ongoing professional development.

References

Ballatt J, Campling P (2011) *Intelligent Kindness*. RCPsych Press.

Berry K, Barrowclough C, Wearden A (2009) A pilot study investigating the use of psychological formulations to modify psychiatric staff perceptions of service users with psychosis. *Behavioural and Cognitive Psychotherapy*, **37**: 39–48.

Berry K, Haddock G, Kellett S, *et al* (2015) Feasibility of a ward-based psychological intervention to improve staff and patient relationships in psychiatric rehabilitation settings. *British Journal of Clinical Psychology*, **55**: 236–52.

British Psychological Society (2011) *Good Practice Guidelines on the Use of Psychological Formulation*. BPS.

Cabaniss DL, Cherry S, Douglas CJ, *et al* (2013) *Psychodynamic Formulation*. Wiley–Blackwell.

Colombo A, Bendelow G, Fulford B, *et al* (2003) Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multi-disciplinary teams. *Social Science and Medicine*, **56**: 1557–70.

Fulford KWM (2008) Values-based practice: a new partner to evidence-based practice and a first for psychiatry? *Mens Sana Monographs*, **6**: 10–21.

Hollyman JA, Hemsi L (1983*a*) What do the examiners understand by formulation? A survey of the members of the College's board of examiners. *Psychiatric Bulletin*, **7**: 165–6.

Hollyman JA, Hemsi L (1983*b*) What do psychiatrists understand by formulation? A survey of the clinicians in a group of hospitals in London. *Psychiatric Bulletin*, **7**: 140–3.

Kennedy F (2009) The use of formulation in inpatient settings. In *Cognitive Behaviour Therapy for Acute Inpatient Mental Health Units: Working with Clients, Staff and the Milieu* (I Clarke, H Wilson, eds). Routledge.

Johnstone L, Dallos R (2014) *Formulation in Psychology and Psychotherapy: Making Sense of People's Problems*. Routledge.

Lake N (2008) Developing skills in consultation 2: a team formulation approach. *Clinical Psychology Forum*, **186**: 18–24.

Lewis B (2011) *Narrative Psychiatry: How Stories can Shape Clinical Practice*. Johns Hopkins University Press.

McKay KM, Imel ZE, Wampold BE (2006) Psychiatric effects in the pharmacological treatment of depression. *Journal of Affective Disorders*, **92**: 287–90.

Rose S (2001) Moving on from old dichotomies: beyond nature-nurture towards a lifeline perspective. *British Journal of Psychiatry*, **178 (Suppl 40)**: S3–S7.

Royal College of Psychiatrists (2013) *A Competency Based Curriculum for Specialist Core Training in Psychiatry*. Royal College of Psychiatrists.

Summers A (2006) Psychological formulations in psychiatric care: staff views on their impact. *Psychiatric Bulletin*, **30**: 341–3.

Wainwright N, Bergin L (2010) Introducing psychological formulations in an acute older people's inpatient mental health ward: a service evaluation of staff views. *PSIGE Newsletter*, **112**: 38–45.