

FORMULATION, A CRITICAL VIEWPOINT

In press. Journal of Humanistic Psychology

Psychological formulation, a critical viewpoint: Illness ideology in disguise

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**Abstract**

Recent years has seen a surge of interest by clinical psychologists in the idea of psychological formulation. Interest in this idea has also been shown from humanistic psychologists as evidenced by a recent issue of this journal, in which formulation is offered as a possible antidote to diagnosis. In this paper I examine the idea of formulation from the viewpoint of client-centered therapy, offering a critical perspective, and concluding that as formulation is ultimately about identifying a specific pathway for a specific problem, it continues to subtly promote a medical ideology, incompatible with client-centered therapy.

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**Introduction**

The medicalization of human distress remains a contentious topic in psychology. From the outset, humanistic psychology has challenged the traditionally accepted parameters in psychology, including the model of a practitioner taken from medicine and the idea that diagnosis is basic to treatment (Bugental, 1963). Today, humanistic psychologists continue to support non-medicalized alternatives, but now alongside their voices are many other individuals and organizations that also challenge the diagnostic approach (Robbins, Kamens, & Elkins, 2017). Among those voices are clinical psychologists. Recent years has seen a surge of interest by many clinical psychologists in the idea of psychological formulation as an alternative to diagnosis. Interest in formulation has also been shown from humanistic psychologists as evidenced by a recent issue of this journal in which one of the leading clinical psychology proponents of formulation argues that it ‘...has the potential to be not just an alternative, but an antidote, to psychiatric diagnosis and its potentially damaging effects.’ (Johnstone, 2018, p. 42). For many clinical psychologists the idea of formulation may seem innovative and original and there is much to welcome in how it promises to offer an alternative and more humanistic approach to clinical psychology. While I agree with the concerns about the damaging effects of psychiatric diagnosis and the need for alternative ways of working, it is questionable whether formulation can truly offer an antidote, especially one that would be palatable to humanistic psychologists with their history of radical, client-centered, and non-medical ways of working.

In this article I will discuss formulation as discussed by Johnstone (2018) from the perspective of client-centered therapy, and how, when seen through this lens it seems to inadvertently condone and promote a medical ideology. First, it is necessary to explain the

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medical ideology, and how a defining feature is the idea of providing a specific treatment for a specific problem. Having done this, I will go on to briefly describe the essential points of client-centered therapy, before discussing the idea of formulation. I conclude that as it is ultimately still about identifying a specific way of working for a specific problem, formulation simply serves the same function as diagnosis, and thus continues to promote the medical ideology.

### **Illness ideology in Clinical Psychology**

The heart of the medical approach is that the experiences of distress and dysfunction are seen as symptoms of illnesses, and that those illnesses in some way reflect biological or psychological pathologies. It is understandable that psychiatry, as part of the medical profession, developed to view the problems that people have in this way. Clinical psychology as a profession followed in the footsteps of psychiatry, in adopting the use of psychiatric terminology and with it an implicit if not explicit medical ideology. One of the consequences of the medical ideology is that the physician takes an expert stance over the patient.

There is reason for the expert stance in the medical ideology. To fully describe the medical ideology it is helpful to imagine our own experiences when for example we go to see the medical practitioner with an ailment such as stomach pains. We are likely to be uncertain what the cause of our pain is and anxious for our practitioner to accurately identify the problem and quickly provide the correct solution. To do this, the practitioner needs to be an expert diagnostician. They need to examine us in order to identify our specific symptoms in order to diagnose the most likely cause. As such they need to have knowledge of the likely conditions we may be suffering from and the symptoms of each. They will ask us questions about the nature of our pain, its location, duration, and physically examine us for bruises, swelling and so on. Having reached a diagnosis, they are in a position to prescribe the correct

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treatment. The treatment will depend on what condition they think we are suffering from. The diagnostician is a scientist practitioner in the sense that the diagnosis is a hypothesis. Only the right treatment will make a difference. As such, our practitioner will need to monitor us for a period of time to see if our symptoms abate. If our symptoms do abate this would seem to confirm their initial hypothesis. If our symptoms do not abate then they will develop a new hypothesis that explains our continued symptoms and provide a new prescription. This process continues until we are symptom free. An incorrect diagnosis could be the difference between life and death for us. As such, the more skilled the practitioner is, the better a diagnostician they are. Because of the need for diagnosis, the physician does have a genuine stance as an expert.

By adopting the medical ideology within clinical psychology (Albee, 2000), the assumption is that psychological problems are like medical problems; they too require expert diagnosis in order to prescribe the right treatment. Such a way of thinking is illustrated when one looks through many of the standard textbooks (e.g., Kring, Johnson, Davidson, & Neale, 2015). Typically, the chapters of such books are structured by disorder as described by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013). Each chapter introduces the reader to the research on, for example, anxiety disorders, somatoform and dissociative disorders, mood disorders, schizophrenia, substance-related disorders, sexual disorders, personality disorders, and so on. The assumption is that a range of discrete conditions exist and, as with medical conditions, it is necessary to identify each of them with the purpose of conducting research and identifying their appropriate treatments. Diagnostic categories provide a common language for researchers to examine the causes, correlates, and most effective treatments for each disorder. The implication of the diagnostic system is that each client is treated as representative of the category to which they are assigned by diagnosis. For many psychologists, the medical model

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is the paradigmatic lens through which they view human experience. It is taken for granted assumption that this is the best way to advance knowledge into psychological suffering and how to provide help. In sum, the purpose of diagnosis is to identify the right treatment. When understood in the way described above, it is clear that for any approach to be an antidote to diagnosis it must disavow the medical model in its entirety.

### **Client-Centered Psychology**

The client-centered school of thought was developed by Carl Rogers (1951), one of the founders of humanistic psychology. The history of client-centered therapy is one of radical theory and practice (Kirschenbaum, 2007) which put the client the centre of the healing process, recognizing that they were the best expert on what was wrong and what was needed. The use of diagnosis has long been a topic of debate among person-centered theorists. In general it is thought that it has no place in client-centered therapy (see, Wilkins, 2017a, b) and that those who adopt the medical model damage their clients, and impede their potential for optimal functioning (Sanders, 2005). To that extent, client-centered therapists are in agreement with the proponents of formulation, but their reasons are different.

In client-centered theory, psychological distress and dysfunction has a single cause, which is incongruence in the total personality between self-structure and the lived experience of the person (Rogers, 1951, 1959). As stated in the fourteenth of Rogers (1951) nineteen propositions:

‘Psychological maladjustment exists when the organism denies to awareness significant sensory and visceral experiences, which consequently are not symbolized and organized into the gestalt of the self-structure. When this situation exists, there is a basic or potential psychological tension.’ (pp. 483–522).

As such, the theory of client-centered therapy effectively posits a unitary cause of distress, but varied expressions of that distress will arise according to the uniqueness of each individual and their lives. Client-centered therapy is therefore incompatible with models of diagnosis as all the manifestations of distress and dysfunction are viewed, not as symptoms of illnesses that reflect biological or psychological pathologies, but as ways of relating to the world that arise from incongruence (Sanders & Joseph, 2016). Thus, peoples' presentations of distress differ, and they differ in many of the ways described by psychiatric diagnosis, but there is no need for diagnosis as incongruence has a single cause and as a result a single therapeutic method. In this way, client-centered therapy can be said to be an original transdiagnostic therapy, as it posits common psychological mechanisms for the different expressions of psychological distress.

My argument is not that genuine psychiatric disorders don't exist; some expressions of distress and dysfunction may be the result of an illness, but alongside other critics of the psychiatric establishment, I recognize that much of what is currently labelled as a psychiatric disorder is unlikely to be so in any meaningful way consistent with the medical ideology (Bentall, 2003). More likely, most of the problems of distress that people experience can be understood as expressions of incongruence. Thus, regardless of their presentation, what is required is a therapeutic relationship in which the person can learn to be themselves. Through a genuine, empathic, and accepting relationship, the client will be able to drop their defenses and engage in a process of reintegrating self with experience.

Rogers originally referred to his approach as *non-directive therapy*. He described it as non-directive therapy because it was the therapist's task to follow the client's lead, thus challenging the then dominant therapist-directed approach of psychiatry and psychoanalysis. Rather than the therapist directing the course of therapy by using interpretative methods to

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derive solutions for the patient, Rogers turned the notion of the therapist as the expert upside down, such that the therapist followed the client, helping them to uncover their own solutions (Rogers, 1951). As such, whereas the medical model requires the therapist to be expert over the client in knowing what questions to ask in order to determine what is best for the client, the client-centered therapist aims to help clients understand for themselves what they need and how to move forward. For this reason, Shlien (1989) sees diagnosis as having no role in client-centred therapy. He writes:

‘Client-centered therapy has only one treatment for all cases. That fact makes diagnosis entirely useless. If you have no specific treatment to relate to it, what possible purpose could there be to specific diagnosis? Nothing remains but the detrimental effects.’ (p. 402).

The same argument applies to formulation. Client-centered therapy was once seen as the radical, humanistic, evidence-based practice that was the antidote to diagnosis and the medicalization of distress. For those of us working in this way today, it remains an alternative paradigmatic lens through which to view human experience, and in this case to examine the use of formulation.

### **A Critical View of Formulation**

As a profession, clinical psychology can be viewed as one of the forces in society that has promoted a medicalized approach to psychological distress (Maddux & Lopez, 2015).

However, as already mentioned, some contemporary clinical psychologists do now question the reliance of their profession on the medical ideology and the language of disorder and deficit (e.g., Division of Clinical Psychology, 2015; Maddux & Lopez, 2015; Proctor, 2017;

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Read, 2019). Unfortunately, few of the contemporary scholars critical of the medicalisation of distress seem to be aware of the history of client-centered therapy and the details of its theory and practice. This seems to be the case for those writing about formulation. Johnstone describes formulation 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.’ (Johnstone, 2018, p. 32).

While there are no citations to Rogers’ work or the client-centered approach in Johnstone’s paper, there are clear echoes of his work throughout, in its move towards putting the client more center stage in their own healing process, and allowing them to be part of a conversation on what is the origin of the problem and what is needed. How this is put into practice, however, inevitably varies according to the therapist. How a conversation takes shape between a therapist and a client will inevitably be a function of the type of person the therapist is, their training, and their beliefs about the nature of psychological health.

In this sense of it being a conversation initiated by the therapist, and influenced by their own views and way of being, formulation may best be considered as existing on a continuum. At one extreme is the medical model practice in which the therapist takes the lead in formulating the problem and offering the solution. At the other extreme the client takes the lead in understanding their situation and drives the therapeutic process forward. It could be said that at one end of this continuum formulations are ‘done to’ the client, moving toward the middle of the continuum where it is about ‘being with’ the client, to the other extreme,

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where formulation is ‘done by’ the client. In this sense, formulation seems to take place in the space between the two extremes, around how to be ‘with’ the client; as Johnstone (2018) describes, it is about thinking together to co-construct a hypothesis about the origin of the client’s difficulties. One’s own positionality within this space will determine how one views the idea of formulation. Looking at the idea of formulation through the lens of the medical model, it is understandable how ‘being with’ looks like a radical alternative to ‘done to’. But when viewed through the lens of client-centered therapy, formulation as ‘being with’ looks less like a radical practice than ‘done by’.

For Rogers, therapy was a process of the client coming to an understanding of themselves. In this sense, the idea of formulation as client led is nothing new, but it is not in this way that contemporary writers such as Johnstone (2018) seem to mean it; they mean it as a collaborative working together, ultimately to find a way forward having reached that understanding. But even the most collaborative process when decided on by the therapist brings direction and an agenda. Consider how the concept of formulation is first introduced, what choice there is for the client, how the conversation is directed by the therapist, how the formulation is used, and most importantly, the attitude of the therapist.

It is a fundamental attitude of the client-centered therapist, because of his or her trust in the agency of the client, that they do not intervene, and have no intention of intervening.

As Bozarth (1998) wrote:

“The therapist goes with the client, goes at the client’s pace, goes with the client in his/her own ways of thinking, of experiencing, or processing. The therapist cannot be up to other things, have other intentions without violating the essence of person-centred therapy. To be up to other things – whatever they might be – is a ‘yes, but’ reaction to the essence of the approach. It must mean that when the therapist has

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intentions of treatment plans, of treatment goals, of interventive strategies to get the client somewhere or for the client to do a certain thing, the therapist violates the essence of person-centred therapy (Bozarth, 1998, pp. 11-12).

As such, formulation as an approach to making sense of the client's distress and mental health difficulties addresses many of the concerns associated with diagnosis but it does not necessarily imply a non-medical approach. The therapist is inevitably 'up to other things' when they introduce formulation, and that is ultimately to find the right pathway forward for the client. This is essentially the same function as diagnosis.

Johnstone (2018) herself notes that "...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." (p. 34). I agree that it depends on how it is done. There will inevitably be differences in the use of formulation between practitioners depending on whether they see themselves or the client as the best expert on what the client is experiencing and what they need. And how it is done depends on one's perspective. From the perspective of the client-centered approach there is never an intention from the therapist to introduce a particular treatment for a particular problem, but with psychological formulation it remains the aim to be able '...to suggest a pathway forward' (Johnstone, 2018, p. 33). In client-centered therapy the pathway forward is always the same, to be present in the moment with the client, in an authentic, empathic, and unconditional way.

In this way, formulation continues to condone the current mental health treatment system in which the focus is on finding the specific treatment for the particular dysfunction. Formulation does this in a more ideographic way than diagnosis, but nonetheless continues to

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promote what is essentially a medical ideology, as least as seen from the vantage point of the client-centered approach. In client-centered therapy, the therapist's task is to always stay with the client's direction. Insofar as formulation requires co-constructing a hypothesis it is never client-centered. In these ways described above, formulation may seem like a non-medical approach and an alternative to diagnosis, and for many clinical psychologists it will offer a new and valuable way of working that seems less damaging than more traditional use of diagnostic methods, but seen from the perspective of the client-centered approach it remains a medicalised ways of working. The therapist may not be using formal psychiatric diagnosis in order to prescribe a specific treatment, but if the therapist sees their task as identifying which form of therapy or treatment technique is best suited to a client's difficulties they are essentially doing the same thing.

Thus far, I have been describing the essential incompatibility between psychiatric diagnosis and client-centered therapy. In contrast, from the client-centered perspective, Schmid (2004) views 'diagnosis as the work of the client'. He writes:

'...psychological diagnosis can only be a phenomenological process diagnosis, unfolded step by step through the joint process of experiencing and reflecting by both client and therapist. Just as therapy does, diagnosis needs both modes and requires both persons involved in the relationship, thus making it a co-diagnosis process.' (p. 47).

In this sense, the concept of formulation seems to echo these ideas about how therapists and clients can work together. In the end, as Johnstone wrote, it depends on how you do it. As such, formulation can mean different things to different therapists. What I hope to have shown is that when done skillfully with the client leading, the idea of formulation

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may be compatible with client-centered therapy, but only in the sense that formulation would not be something additional that the client-centered therapist would actually need to do, because client-centered therapy is already a process of formulation, led by the client who is trying to understand and become themselves. It would not be a tool for the client-centered therapist to develop a plan for a treatment pathway. As Rogers (1951) wrote in relation to diagnosis, but which might also apply to formulation, 'In a very meaningful and accurate sense, therapy is diagnosis, and this diagnosis is a process which goes on in the experience of the client, rather than in the intellect of the clinician' (p. 223).

More often, however, formulation is not meant in any way that would be compatible with client-centered therapy. Rather, it seems that formulation is intended to be used as a tool for the therapist to determine a specific pathway for treatment, thus from the outset assuming a medicalised mindset that such discussion is actually necessary, overriding the possibility of a client-centered therapeutic relationship. In this way, formulation may be an alternative, but it is not an antidote to psychiatric diagnosis. As an alternative to diagnosis, whether formulation is just as damaging, or if it is just less damaging, is a question for new research.

It is important to emphasise that this discussion about formulation has been framed from a person-centered theoretical position. How any therapist approaches the issue of formulation will depend on their own theoretical positionality. For many, medicalization is not an issue of concern. Clinicians from other positions than the client-centered will often want to determine a specific pathway for treatment. For them, formulation may offer a way of working which allows them to do this but with greater involvement of the client, and in a way in which the client feels more involved and respected. The point, however, is that this does not mean it is a non-medicalized approach. In this way, I intend this as a challenge to those who believe themselves not to be medical model practitioners because they are using

formulation instead of diagnosis, and as a warning to humanistic practitioners to be wary of the rhetoric of formulation as non-medicalized practice.

### **Conclusion**

It is welcome to see members of the profession of clinical psychology move away from the psychiatric framework that dominates their profession and toward more humanistic ideas. Diagnosis and prescription are terms that many humanistic psychologists will not identify with and as such are unlikely to perceive themselves as medical model practitioners. The idea of listening to the client and therapy as a process of self-understanding is not new. As a way of working therapeutically this was pioneered by Rogers (1951) and his client-centered approach has offered an 'antidote' to psychiatry and diagnosis for seventy years. Seen from the client-centered viewpoint, formulation seems like one step towards a more humanistic way of working, but with one foot still firmly in the medical model. Any direction from the therapist that the client needs or would benefit from a particular form of intervention would be described as operating within a medical model, even when there is no formal use of psychiatric diagnosis. As the use of diagnosis comes under threat, formulation can be seen as clinical psychology's attempt to maintain its control as a profession over human distress and dysfunction. Formulation still requires us to think about the role of power insofar as the therapist is at least implicitly telling the client what the problem is, and formulations can label and make value judgements just as much as diagnostic models. Thus, while it is a move to a more ideographic way of working which is to be welcomed, formulation is nonetheless a description of medical model practice and not an antidote, and possibly just as dangerous.

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