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# Utilizing Psychiatric Diagnosis and Formulation in the Clinical Process: Meeting the Needs and Expectations of Service Users

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## 1. Introduction

Service users and those who support them, such as family or friends, have an expectation that a clinical or health diagnosis will offer insight into the cause of their symptoms. Diagnosis is expected to allow both prediction of prognosis and determination of treatment options. However, current widely used psychiatric diagnostic systems do not usually provide links to cause or prognosis. This is explicitly stated in the introductions to the two major current systems, the Diagnostic and Statistical Manual of the American Psychiatric Association (APA, 2000) and the 10<sup>th</sup> revision of the International Classification of Diseases (WHO, 1992).

Within a complex field such as mental health, the diversity of causal or pathogenetic contributors means that both aetiology and prognosis are likely to be highly individualised. As a result, there is a gap between mental health service users' expectations and what can be realistically provided by diagnosis alone.

However, when paired with a thorough and reflective formulation, diagnosis is placed in a context that facilitates the ineluctable logical development of a comprehensive management or recovery plan. This dynamic combination of diagnosis and formulation results in a collaboratively developed management plan, agreed to by clinician and consumer, that is better placed to meet both the needs and the expectations of those seeking help.

## 2. The clinical process

People are motivated to go to psychological, counselling or psychiatric services by their discomforts or needs. These needs may relate to various forms of distress or dysphoria and/or to decreases in functionality. Such clients or service users are seeking intervention(s) which will improve the way they feel and/or the way they function. Sometimes it will be family or others who approach services on their behalf.

Together, the trained clinician and the service user will develop a plan of action, perhaps with input from family or supporters, as well as from other clinicians. Indeed, it can be argued that the development of a comprehensive management or recovery plan is the major purpose of the clinician-service user interaction (Mellsop and Banzato, 2006).

In order to develop the plan, an assessment of the individual's difficulties and the context in which they occur is required. The term "assessment" is used to cover a wide variety of ways in which information is obtained. Central to the assessment is the clinical interview. This may be brief or lengthy, but ideally will be comprehensive and supplemented by collateral information such as details from family and other key informants, files written by previous clinicians involved in care or treatment, and sometimes by formal, psychometrically credible, evaluations.

However, sometimes the information available may be very limited. Whatever that information is, a plan of how to proceed will need to be drawn up. Sometimes the central part of that plan may be evidence based therapeutic interventions. By contrast, sometimes the main focus will be on further assessment, data gathering, referral to an alternative service provider, or other intermediate variations or combinations.

A clinician utilizing a recovery approach will expect the service user to be an active participant in this process. Their cognitive, attitudinal and behavioural contribution to the clinician's provisional management plan will be major determinants of the success of the resulting collaboration (Chinman et al., 1999).

Gathering the assessment information is a skill taught, at various depths, to medical students, nurses, psychologists, social workers, occupational therapists, trainee psychiatrists and other clinically active disciplines. It is not usually the ability to collect the information which clearly separates students from practitioners. Rather, the skill lies in making coherent, credible, sense of that assessment information, in formulating it, and in making an accurate diagnosis of the condition with which the individual presents.

The role that diagnosis plays in the process of clinical decision making is sometimes pivotal, but its singular significance can be overemphasised. There are in fact two reasoned conclusions to be drawn from the available assessment information: the diagnosis (or diagnoses), and the formulation. These are distinct and quite different from each other; both, however, are essential to the clinical process. Their contributions to the logic which psychologists and psychiatrists apply need to be clearly understood.

The diagnosis is generally a categorical classification of the disorder the person is presenting with, based on evidence collected from the assessment, determined by utilizing the clinician's judgement. It is the disorder which is receiving the label, not the person.

Classification is categorical in the sense that each diagnostic label is expected to apply to a distinct condition, separable from other conditions, and that the boundaries between disorders can be defined and relied upon. The diagnosis is usually drawn from within an accepted, standardized and reliable classification framework such as the International Classification of Diseases (WHO, 1992) or the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (APA, 2000).

In contrast, the formulation is more subjective, extensive and idiographic. It can encompass a diagnosis, but it also provides a broader narrative, thereby giving an explanatory context to the presenting problem and foreshadowing the management or recovery plan. It is likely to take account of predisposing, precipitating and perpetuating factors as they relate to the person's presenting symptoms and level of functioning. It will include reference to the

person's capacities and strengths, attitudes, values, illness behavior, culture and societal context.

Therefore, it can be argued that formulation is more meaningful and more useful than diagnosis on its own, not just to the clinician, but also to the non-clinical stakeholders in the process, namely the service user and their family or community of support.

The process of the clinical logic of the clinician/service user interaction is displayed diagrammatically below. The link between the assessment information and the management plan is provided by both the diagnosis and the formulation.

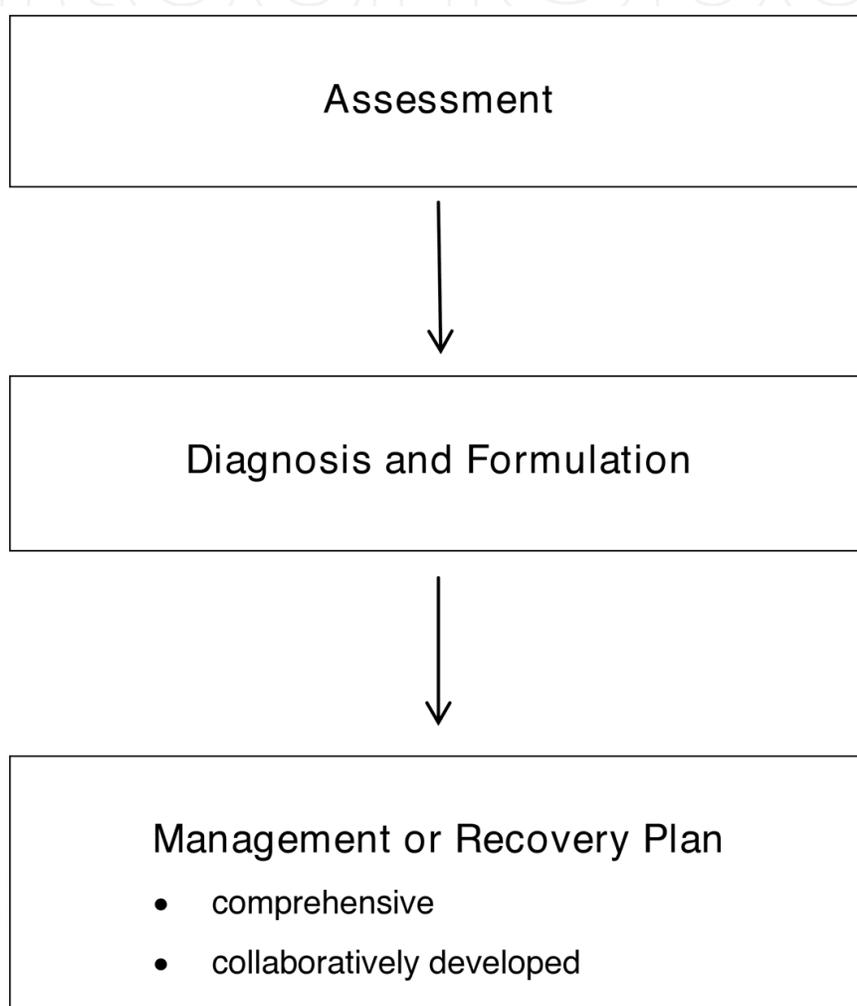


Fig. 1. Diagrammatic display of the essential steps in the clinical process

### 2.1 Diagnosis and the diagnostic system

Assigning a diagnosis to the symptoms or presentation of psychiatric service users is essential to work in mental health and addictions and important also in counseling services. A diagnosis is not purely clinical in its function. It underpins much of the structure of mental health and addictions work. For example, it can serve a statistical purpose, be taken into account in a public health perspective and is often required for funding, including the funding of research (IAG, 2011; Carey & Pilgrim, 2010).

Because they are determined mainly by the symptoms or phenomenology and ignore much of a person's developmental and contextual information, diagnoses tend to be reductionist in nature. This has the potential for being at odds with therapeutic intentions: diagnosis produces descriptive, generalised labels and can invoke stigma that can be argued is therefore, at least partly, iatrogenic (Carey & Pilgrim, 2010; Hanzawa et al., 2009).

Distinct in its role from diagnosis in other branches of health, a psychiatric diagnosis does not usually have a link to aetiology or to prognosis (Maj 2005; APA, 2000; Mellsop et al, 2007; IAG, 2011).

Classification usually requires a process of creating, defining, and confirming boundaries between concepts. In psychiatry for almost half a century, there have been five widely publicised criteria for judging the validity of the diagnostic categories which make up the classificatory systems. As first suggested by Robins and Guze (1970), these are:

- description of clear and consistent clinical features
- the exclusion of other possible disorders
- a uniform clinical course (including prognosis)
- an increased prevalence in close relatives
- an investigatory marker of the disorder (e.g., laboratory test).

However, it has become clear that for many diagnostic labels the current categorical classificatory systems fail to fulfil most of these criteria (Mellsop et al., 2007; Jorm, 2006; IAG 2011, Hyman, 2010). Recognition of this underpins the planned research programme of the (US) National Institute of Mental Health (Insel et al., 2010).

Three psychometric properties are required of a diagnostic system. In addition to reliability and validity, if the system is going to be used and survive, utility is required. Central to utility in clinical psychiatry is the expectation that knowing the diagnosis allows the selection of the most effective treatment (Nice, 2003; APA 2006; Mellsop et al 2007; Frese and Myrick, 2010).

Psychiatric diagnosis on its own, however, is generally of limited use in the choice of optimal treatment for individual service users. In most cases, multiple characteristics of both the service user and the context will influence a clinician's management plans and treatment choices (Mellsop, & Banzato, 2006; Byrne, 2007; Nice, 2003).

Modern pharmacotherapies are often combined and are remarkably non-specific. For example, 'antidepressants', 'antipsychotics' and 'mood stabilisers' are all used in a range of conceptually and categorically distinct disorders. Most of the different classes of treatment appear to have a place in the treatment guidelines issued by bodies such as the American Psychiatric Association for a variety of different disorders (APA, 2006). Moreover, inter-individual variation in response to these same pharmacotherapies can be striking and usually remains unexplained.

While diagnosis tends to be regarded by the medically trained psychiatrists as fundamental to clinical psychiatry, this is not necessarily the case for other mental health clinicians who embrace the broader field of mental health and its disorders. For example, in psychology practice, diagnosis tends to be underemphasised in favour of formulation (Carey & Pilgrim, 2010).

### 2.1.1 Significance of diagnosis to the service user and their community

While it may be tempting for all involved to regard diagnosis as a discrete event in the clinical process, for service users and their family or other community it is just one more step (albeit a significant one) on a much longer journey. The service user, along with those whose lives intersect closely with him or her – their family members, friends, those they live or work with – are often highly invested in the outcome of the diagnostic process.

Service users, for example, report the clinical process and its resulting diagnosis as impacting on their self esteem, their sense of self and identity, and influencing their hopefulness for their future (Frese and Myrick, 2010; Crumlish and Kelly, 2009; Barnett and Lapsley, 2006).

These comments offer an insight into the high expectations these “ultimate stakeholders” can bring to the clinical process. For example, many people think it reasonable to believe that following the assessment they will be given an explanation for what they are experiencing. But more importantly, they are likely to hope that there will be a cure, help will be provided, the problem will be fixed and health will be restored (Moeke-Maxwell et al., 2008; Laird et al. 2010).

Service users and others closely affected report both positive and negative consequences stemming from the process of receiving a diagnosis. Some will experience initially favourable outcomes that are not sustained over time, leading to a more sober, sometimes cynical, appreciation of the process.

In terms of positive consequences, service users talk of a diagnosis providing them with a sense of validation: that their experiences, often frightening or confusing to them and those around them, are normalized by receiving a clinical explanation (Moeke-Maxwell et al., 2008). Family members likewise report a sense of relief, and express hope that the burden of care they experience will now be reduced (Laird et al., 2010; Hanzawa et al., 2009).

This concept of clinical validation may at times also lead to a reduction in stigma, both internal and external, and judgements about a person’s behaviour or the reasons for it. For example, some family members report having more tolerance for behaviour they might have judged negatively before knowing the diagnosis. The service user’s distress may now be explained in terms that are more socially acceptable. As well, having a clinical explanation can mean that others in the wider community are seen as less likely to judge the family as a whole e.g. behaviour is now attributed to a medical condition rather than to “bad parenting” (Laird et al., 2010; Barnett and Lapsley, 2006; Carey and Pilgrim, 2010).

There is often a welcome sense for service users and the others affected of positive action occurring, with the expectation that a diagnosis will go hand-in-hand with some form of treatment, particularly medication (Barnett and Lapsley, 2006; Moeke-Maxwell et al., 2008; Laird et al., 2010).

The diagnosis is also acknowledged as potentially opening doors to specialist (secondary or tertiary) services, as well as to other supports (Carey and Pilgrim, 2010). This has particular significance for family members who often have a “paraprofessional” role in supporting a relative or loved one through illness, and can experience considerable burdens, both objective and subjective, as a result (Laird et al., 2010).

Following a diagnosis family members and supporters report increased understanding of what the service user is experiencing. Many feel more alert to the service users' symptoms, better able to respond and empathize (Laird et al., 2010). Service users can also experience an increased sense of personal competence from working with a new understanding of their experience based on the diagnostic/symptomatic framework.

Some may only experience a downside if treatment turns out to be harder than expected, or not as effective as hoped, or when a relapse or crisis changes their initially favourable perception of the clinical process. For others, however, the negative response to a particular diagnosis is immediate.

The negative stigma associated with mental illness and addiction, and with some diagnoses in particular, is a common theme in service user and family/carer literature (Frese and Myrick, 2010). In particular, psychotic spectrum disorders, such as schizophrenia or some bipolar disorders, as well as personality disorders, tend to come with more unfavourable associations (Hartnell and Lapsley, 2006; Laird et al., 2010).

Families and service users may find themselves struggling with perceptions of "dangerousness" and instability, which can make it difficult for the service user to access meaningful occupation such as employment or study. In some countries such heavily stigmatized associations have been seen as sufficiently important as to require a disorder being renamed, by national fiat (Sato, 2006).

Those affected also have to contend with the limited expectations that can come hand-in-hand with some diagnoses, based on the symptomatic prognosis. Gillian, a young woman diagnosed with an Axis II disorder, sums it up like this:

*"[Being diagnosed with] personality disorder, it's horrible to get because it's just kind of stuck with you and it suggests that there's something intrinsically wrong with you and it's not something you can change."* (Barnett and Lapsley, 2006)

Keith, a forensic service user, comments on the behavioural consequences of diagnosis:

*"I think the labelling that goes on is really limiting. Once you get a person to accept a label you also get them to accept the behaviour which is attached to that label. To be called a schizophrenic or a bipolar...turns you into just that."* (O'Hagan, 2000)

It is not uncommon for the service user to disagree with the diagnosis they are given. Both family members and service users report at times that the diagnosis did not match their interpretation of their experience, and came with too many negative associations to be accepted (Frese and Myrick, 2010; Moeke-Maxwell et al., 2008; Laird et al., 2010). Some felt that clinicians did not communicate with them in a way that allowed hope for the prospect of future health.

It can be seen that psychiatric diagnosis cannot stand on its own in terms of pointing to useful interventions for the service user, or in offering a meaningful explanation for the difficulties with which they present. The subsequent steps or consequences that arise from a diagnosis tend to take on much more importance, particularly over time, than the diagnosis itself.

Formulation therefore, along with diagnosis, forms an essential link between the assessment process and the ongoing management or recovery plan (Carey & Pilgrim, 2010).

## 2.2 Formulation

The process of formulating the assessment information is a fundamental skill required of all trained mental health clinicians. The underlying concept is not particularly contentious. However, there is considerable variation both in creating formulations and in describing the techniques involved (Belz, 1967; Varghese and Mellso, 1983; Nurcombe and Fitzhenry-Coor, 1987; Mellso and Banzato, 2006). Alternative frameworks abound, and these can be at odds with each other (Mace and Binyon, 2005). There is further confusion about the definition of a formulation. Is it a summary of the descriptive information obtained via the assessment; or an integrated bio-psycho-social synthesis of the assessment information; or purely psychodynamic?

In essence, formulation consists of bringing together those parts of the information derived from the assessment which are most central to understanding why this person has presented in this fashion at this time.

In order to support this objective, the formulation will include reference to relevant information about the person's socio-cultural context including illness behaviour, family of origin, their health beliefs, personality style, significant relationships, life event exposure, likely treatment participation and adherence. The resulting "understanding" or narrative is therefore a highly individualistic, explanatory summary of the assessment information.

A useful formulation will do more than summarize or re-arrange assessment information, however. Ideally it will draw inferences from that information and offer a range of hypotheses. It will inform treatment, by extracting from the assessment information everything that will make a difference to the recovery plan (Mellso and Banzato, 2006).

Because the process requires judgements by the clinician, formulations are less standardized, reliable or consistent than diagnoses. However, those aspects which influence the recovery plan are generally agreed; for example, social supports, intellectual ability and style, previous medication adherence, medication tolerance, family support, daily living skills, work and accommodation. The person's susceptibilities and resources are likely to be included. In particular, their personal attributes and strengths which can be drawn upon in the therapeutic alliance and clinical management plan will be delineated.

In practice, most aspects of the plan will be informed by details from the formulation. Much of a service user's contextual information needs to be taken into account by them and the clinician, if they want to produce a successful recovery plan. For example, information about a person's living situation, attitudes, habits and health beliefs is important to include because this will be relevant to the individual's ability and willingness to adhere to the plan.

One of the ways an effective formulation can inform the plan is by predicting the individual's response to treatment, by drawing on the understanding of how the individual perceives and responds to being ill, and their theory of change (Duncan et al, 2010). It can also play a vital role in ongoing evaluation of the effectiveness of treatment and can suggest priorities to address or re-consider, should the initial focus prove ineffective (Mace and Binyon, 2005; Eells et al, 1998).

A thorough formulation will also place importance on the clinician's self-reflection, noting any possible counter-transference issues and utilizing de-biasing strategies to counteract cognitive errors and biases (Crumlish and Kelly, 2009).

Providing as it does a context and narrative for what the service user is experiencing, the formulation offers a more meaningful conclusion to the assessment for the non-clinical stakeholders than does diagnosis alone. It can better encompass factors of significance to the service user and their family or community of support, such as the role trauma may have played.

Read et al. (2005) reviewed the available literature and noted the significance of trauma, including childhood physical and/or sexual abuse, to current presentation. Trauma may not be explicitly reflected in the diagnosis alone, although it is expected that the 11<sup>th</sup> revision of the International Classification of Diseases will have a full section devoted to trauma-consequential disorders.

Relationships between stressors and trauma on one hand, and psychiatric diagnoses on the other, have been debated for 100 years, and still remain contentious (Bebbington, 2011; Sato, 2006). Stressors or trauma can be predisposing, precipitating or perpetuating factors in psychiatric presentations. As such they need to be acknowledged by the clinician, discussed between the clinician and the service user, and above all, be taken into account in the comprehensive recovery plan, the method by which the service user and their supporters will manage their experience day by day.

Culture can also be highly significant to the service user's experience. Much debate about culture has centred on diagnostic issues, for example culture bound syndromes and the pathoplastic effect of culture on disorders (eg Strakowski et al 1993; WHO, 2000; Udomratn, 2009; Mellsop & Smith, 2007). Other literature emphasizes the importance of cultural consistency or safety across the spectrum of psychiatric or psychological clinical activities (McClintock et al., 2011a & 2011b).

However, of more universal relevance is the effect of culture on illness behaviour and on attitudes towards mental health services. These factors cannot be addressed within the, necessarily limited, scope of a diagnostic label; their incorporation into the formulation is essential. Without this context, the chances of developing a recovery plan that will be useful and effective to the service user are much diminished (Sato, 2006; Lim et al, 2011; Elder, 2008; Mellsop et al, 2007; Bhui, 2010).

### **2.2.1 Significance of formulation to the service user and their community**

The major emphasis for the non-clinical diagnostic stakeholders – service users, their families and broader community of support – is on fixing the “problems” posed by symptoms and illness. Those who live with a mental illness and/or addiction experience their “problem” as developing over time, and being contributed to by many psychosocial factors (Barnett and Lapsley, 2006). Therefore clinical assessments tend, for stakeholders, to be too short and not take the psycho-social factors sufficiently into account (Laird et al., 2010; O'Hagan, 2000).

For some the diagnosis is a source of confusion, subject to significant change over time. The conspicuous lack of a definitive “silver bullet” is highlighted by service users and their supporters who comment on the frequency with which a new clinician is assigned to their case. Many experience this as being the cue for an automatic re-assessment of the service user and often a change to their current diagnosis, which flows on to the management plan.

*"... the new psychiatrist wants to prove that he is a better psychiatrist than the last one... Every time [there's] a new doctor, every time a new diagnosis, and therefore different drugs. ... then you are going to have new withdrawal symptoms."* (Moeke-Maxwell et al., 2008)

The mother of a service user comments:

*"They put labels like 'schizophrenic' on to him, but it seemed superficial, they didn't get down to the depth of what it was... I can't put it into words but I just know that they looked at the mental problem, instead of seeing a whole person with a mental problem."* (O'Hagan, 2000)

Frese & Myrick (2010) undertook what they describe as a "quasi-qualitative" survey of United States and some international service users, that yielded some common themes pointing to the significance of formulation to service users.

In general, service users reported that a psychiatric diagnosis could be useful, but its utility to them was limited when the focus of the clinician-service user interaction was mainly on the diagnostic label/s. They expressed a desire to have a wide range of other factors taken into consideration, for example acute medical conditions, physical disorders, psychosocial, environmental and traumatic factors. The primary diagnosis as a stand-alone focus, was described as "not capturing the full picture" and "ignoring the whole person and the world in which we live".

Formulation can offer a particularly useful bridge to the recovery plan, when the diagnosis is highly stigmatized and/or not accepted. In the article cited above, one of the authors documents a personal account of how she worked with clinicians to reframe an unwelcome diagnosis into a construct that was of more use to her.

Keris J. Myrick, who has an MS in Organizational Psychology, received a first diagnosis of depression as a college student while studying in a master's program. She writes of an initial response of relief.

*"...the diagnosis provided me with information about what was going on in my life that I had attributed to defects in my character. Further, the diagnosis consisted of a word used in everyday language - depression."* (Frese and Myrick, 2010)

However, over time Myrick found that more diagnoses were added, and some were changed. As the "labels" shifted towards words that tend to be used derogatorily in the popular media, and were prefaced by descriptors such as "persistent", "life-long" and "devastating", her first response could not be maintained.

*"Stereotypes and stigma impacted my belief that anything in the schizophrenia spectrum was beyond depression, and the change in diagnosis was like a seismic shift moving me into the range of 'crazy'."* (Frese and Myrick, 2010)

The relief and acceptance she had felt on her initial diagnosis were replaced by fear and shame. She describes her rejection of a schizophrenia diagnosis as, "the refusal to be labelled as 'crazy'".

However, unfortunately but perhaps inevitably, her refusal to accept the diagnosis was then viewed as further evidence of symptoms that supported the diagnosis. The resulting "lack of insight" impasse is not untypical, but its effects can be serious. It can lead to a lack of engagement with treatment options on the part of the service user; and/or a lack of

willingness to continue the effort of hopeful engagement on the part of the service provider (Chinman et al, 1999).

This need not be the case. Myrick writes that, from her perspective, “accepting my diagnosis was not related to my recovery, to engaging in treatment, and/or to taking (or not taking) medications”. A clinical partnership between her psychologist and a psychiatrist allowed a broader view to emerge.

*“...the focus [moved] from acceptance and diagnosis to 'call it whatever you want' and 'what would you like to do with your life, how would you like to accomplish your goals/dreams, what is getting in the way of achieving those goals and dreams, and how can we partner together to assist [you] in achieving those goals/dreams?’*

*“Thus, the diagnosis took on less importance and relevance. I used the information about the range of symptoms as a construct (man-made)... that can help me to understand the range of possible treatments that I can choose to help me move forward with my life.” (Frese and Myrick, 2010)*

Myrick’s experience illustrates the importance of a comprehensive consideration of the service user’s contextual factors in applying a recovery approach to clinical work. In order to engage with treatment options and move towards recovery, Myrick needed an approach that considered her as a whole person – one that captured the “full picture”, including the fear and shame that caused her to reject a particular diagnosis. She needed, in essence, to “recover” the personhood and hope for the future that the diagnostic label of schizophrenia – with all its associated stigma and negative stereotypes – denied her.

### **2.3 The comprehensive recovery plan**

The ultimate outcome of the clinical process must be a comprehensive plan for managing and addressing the symptoms causing distress and/or functional difficulties for the service user. The plan should emerge as an ineluctable result of the summarizing of the assessment information into a formulation, along with any diagnostic conclusions that can be drawn.

More than just a management plan, however, the result will ideally be better described as a recovery plan. This approach to treatment should allow for the person to “recover” not just from the distress caused by their symptoms, but also to “recover” or regain lost ground in terms of social inclusion, autonomy and self-efficacy.

Therefore, the plan needs to be oriented around the overarching goal of the individual being able to live a life that has meaning to them; a life worth living (Barnett and Lapsley, 2006; Moeke-Maxwell et al., 2008; Mental Health Commission, 1998). Ideally, it will support the service user in maximizing their ability to live as they wish, and to also enjoy the concomitant responsibilities inherent in the concept of autonomy.

The plan needs to be comprehensive in the sense that it includes all the actions which need to be taken by both the person seeking help and by the clinician.

Technological changes over the last 30 years, such as advances in neuro-imaging and genetics, have influenced the conceptualisation of mental illness. In that period, society’s expectations of mental health care have shifted also, from a focus on biological or medical

treatments, to more encompassing and holistic approaches that take into account the broader contextual and psychosocial factors (Frese and Myrick, 2010).

Parallel with these advances has been the increasing availability of what are essentially psychological treatments or clinical management approaches, that are more and more evidence based. Many of these are founded on empirical research, in contrast to the available psychologically based treatments of the first half of the 20<sup>th</sup> century.

The developments in what is available to be included, and the breadth of service users' expectations, means that a truly comprehensive recovery plan may encompass much more than what is usually thought of under the narrower heading of therapies. For example, it may include referral to other social, personal or health agencies; it may require actions by other individuals within the service users' community of support; it may require further assessments; it may involve immediate actions, and/or a course of action undertaken over a prolonged period of time.

While diagnosis and symptom stabilization may be factors to be addressed, they will seldom be the only aspects of the clinical process that are addressed by the plan, or even its primary focus.

The impact of various diagnostic labels on the ability of the individual to be socially included needs to be carefully considered. Implications can be serious, for the service user and for those who support and care for them (Crumlish and Kelly, 2009; Frese and Myrick, 2010), and need to be taken into account within the plan.

Service users have recommended that clinicians explicitly convey to them the multiple purposes of the diagnostic system used, and encourage them to see beyond any perceived limitations of a diagnosis to how they can work together to help the service user achieve their goals in life. It has been suggested that this could be achieved by ensuring all of the current five DSM axes are considered in treatment and treatment planning (Frese and Myrick, 2010).

At the time of writing, it is not yet clear what axes will operate in the next edition of the American Diagnostic and Statistical Manual (DSM-V). It is clear, however, that the 11<sup>th</sup> revision of the International Classification of Diseases, currently being developed by the World Health Organisation, will retain the separate classificatory systems (their version of axes) in separate publications. The diagnostic labels will remain in a separate publication from that which deals with level of functioning and/or disability. In that sense, it will differ significantly from the American Diagnostic Statistical Manuals, where impairment of functioning is usually a requirement for any individual diagnosis to be allocated (APA, 2000).

One approach that has been endorsed by service users for how to engage diagnostic classifications in ways that are useful to them, is the ADDRESSING framework proposed by Pamela Hays (2006; cited in Frese and Myrick, 2010). This approach would add value to whichever diagnostic system the clinician uses, by including consideration of the individual's age, developmental and acquired disabilities, religion, ethnicity, socioeconomic status, sexual orientation, indigenous heritage, national origin, and gender.

Finally, in order to be both comprehensive and recovery-oriented, the plan must be developed and endorsed collaboratively. This may not be a straightforward part of the process, however.

Service providers and service users have been found to differ greatly in their perceptions of service user interest in collaborative treatment planning. In one study, 60% of service providers believed their clients' lack of interest was a barrier to working collaboratively on treatment planning, whereas only 15% of service users thought this was the case.

As perceived by service users, the principal barriers to working effectively together were a lack of time available within the process, lack of knowledge of how to work collaboratively, and uncertainty that setting treatment goals would help (Chinman et al., 1999).

While a collaborative approach may then require time and effort to achieve, this can be seen as a highly worthwhile investment at the front-end of the process that is likely to ensure better engagement and, ultimately, better outcomes for the service user. It is an essential component of the "recovery" philosophy.

### 3. Conclusion

Diagnosis is an inescapable factor in the clinical process. It carries significance for service users and those who support them, but as a logical conclusion to the clinical assessment it is insufficient, and it cannot stand alone.

The formulation is a summary of the information gathered via the assessment process(es). It provides an extensive, individualistic and idiographic context to aid understanding of what is occurring for this person at this time, and why this may be so. As such, it provides a wealth of information that is not just useful to developing the recovery plan, but essential to it.

Thus, while the diagnosis may suggest a particular course of action, this will be as part of a comprehensive recovery plan underpinned by the narrative provided by the formulation.

By taking care to contextualize the diagnosis with a thorough and reflective formulation, clinicians can better address the gap between what service users expect from a health diagnosis and the limitations of the diagnostic classification system in psychiatry. This process can also ameliorate the effects of stigma and negative media stereotyping that accompany certain diagnoses.

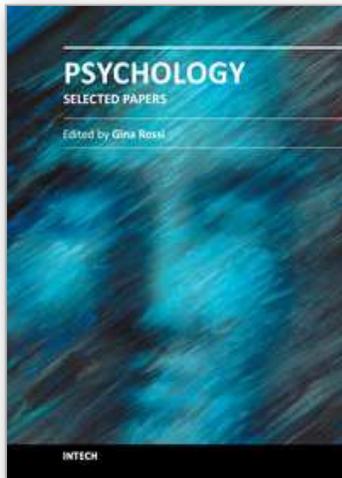
The collaboratively agreed recovery plan that results from this dynamic combination of diagnosis and formulation will then be better placed to effectively meet the service user's needs.

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