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Psychological Formulation

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2. The concept of formulation in psychology

The initial phase of psychological treatment usually involves several steps, including identifying the reason for consultation, analysing the demand for therapy, developing a formulation of the problem, providing feedback, and setting therapeutic goals. However, when understood in this way, the use of the term “formulation” in the title might seem a synecdoche, that is, a part standing for the whole. Nevertheless, formulation can be understood as a specific event that takes shape in the production of a report or is used as a tool for communication with other professionals or in supervision, but also as a collaborative and constantly evolving process throughout therapy (Johnstone & Dallos, 2013). Traditionally, it has been defined according to the first of these options, that is, as something concrete involving a provisional explanation, a hypothesis, or a descriptive framework. In contrast, more modern process-based conceptualisations have been linked to understanding the therapeutic process as a collaborative endeavour between the person and the therapist.

This conceptualisation has had a major influence on the Good Practice Guidelines on Psychological Formulation of the British Psychological Society (BPS[1], Division of Clinical

[1] British Psychological Society.

Psychology, 2011), one of the most comprehensive documents on the topic produced by a professional association to date. The document recognises the value of all types of formulation, while recommending "that clinical psychologists should always formulate from a broad, integrative and multimodal perspective that locates personal meaning within wider systemic, organisational and social contexts." In this way, formulation would encompass all the elements mentioned previously, as well as other aspects related to the selection and implementation of treatments, involving constant readjustments as understanding of the person and their difficulties deepens throughout the process of change.

In this material, we will adopt this second, broader and more recent perspective on psychological formulation, hence the title used. Nevertheless, we will include a specific section (referred to as the problem formulation process) to present the main elements of formulation explicitly related to the operationalisation of the person's difficulties, their history, the stage they are at in relation to making changes, as well as the development and testing of hypotheses about the acquisition and maintenance of the problems that the treatment aims to address. It is therefore important to note the distinction in how both levels of formulation are understood in this material.

In any case, the term "psychological formulation" is widely accepted across different theoretical orientations and recognised by multiple professional associations as a way of summarising the difficulties presented by the person, understanding why they may be occurring, and providing a shared sense of meaning. Despite this fundamental agreement, any formulation also involves, in some way, the application of theory to a case. Therefore, the existence of different theoretical orientations within psychology inherently allows for a certain degree of diversity. In this regard, Johnstone & Dallos (2013) offer an overview of the different perspectives on formulation within each therapeutic school.

For example, within the cognitive behavioural orientation, formulation involves generating a hypothesis through functional analysis. The procedure consists of identifying behavioural variables and their physiological, cognitive, emotional or social correlates, establishing functional relationships between them (the A-B-C model,

standing for antecedent, behaviour and consequence[2], is often used) which serve to select therapeutic targets. In its most purely behavioural form, functional relationships are operationalised almost exclusively through classical and operant reinforcement, although the influence of Beck's cognitive therapy introduced dysfunctional beliefs and, more generally, cognition as a key component in explaining the maintenance of many behaviours.

For the psychoanalytic and psychodynamic schools, formulation should serve to identify why the person's psychological equilibrium has been disturbed, how symptoms have emerged, and how they are maintained. These processes may be either conscious or unconscious. A classic example of an unconscious process is the use of defence mechanisms, such as repression, whereby thoughts related to drives that are incompatible with the social environment are rejected to prevent them from entering conscious awareness[3].

In the constructivist systemic school, the relationships between the members of the family or other systems play a central role. The generation of hypotheses should not be carried out about families but with families (the same principle can be applied in an individual process, although always taking the context into account). The formulation process is not viewed as a search for an objective truth, but rather as a disturbance initiated to bring about change within the family system.

These are some examples but, in summary, the differences between the formulations adopted by each theoretical orientation can be conceptualised as follows (Johnstone & Dallos, 2013):

- **The factors regarded as most relevant**. For example, whereas the cognitive behavioural orientation emphasises behaviours, cognitions and emotions, the sociocognitive approach places particular emphasis on the subjective perception of social conditions.

[2] Antecedent-Behaviour-Consequence.

[3] For a review of the subject, we recommend reviewing Anna Freud's work "The Ego and the Mechanisms of Defence".

- **The explanatory theories that are used**. For example, while the cognitive approach typically employs schemas, psychodynamic tendencies, as we have seen, often appeal to unconscious mechanisms such as defence mechanisms.
- The emphasis placed on **reflexivity, discussion and supervision**.
- The degree to which an **expert stance** is adopted (more typical of directive schools such as classical behaviourism) as opposed to a **collaborative approach** (typical of humanistic and sociocognitive tendencies).
- The stance regarding **diagnosis**. There are schools and professionals in favour of its use, contrasted with those who, as we will see in the diagnosis section, oppose it, arguing that it has little utility for psychological treatment and can produce stigma and discrimination.
- Their stance regarding the **"truth" versus** the **"usefulness"** of the formulation. For more ontologically objectivist schools (e.g., cognitive behavioural), it is important that the formulation comes as close as possible to the actual reasons for the distress, whereas for more subjectivist schools (e.g., sociocognitive), the most important aspect is that it serves to inform and guide the therapeutic process.
- The way in which the **formulation is developed, shared and used during therapy**. We can establish a continuum between psychoanalysis, which does not provide feedback as such (instead it is validated through the person's reception of interpretations during the therapeutic process), and classical behaviourism, in which the functional relationships between behaviours and their causes are explained pedagogically to the person.

3. Identification of the reason for consultation and analysis of the therapeutic demand

As a first step in psychological treatment, it is always necessary to listen to what the person seeking our services is telling us. For this reason, identifying the reason for consultation and analysing the therapeutic demand usually constitute our initial tasks and are essential for laying the foundations of the therapeutic relationship. This step is necessary to understand the person's problem in their own words, clarify what they expect from the consultation, address their questions, adjust expectations, and begin a collaborative process to facilitate therapeutic change. This then leads to the formulation of the problem and the design of a treatment tailored to the needs of the person, thereby enhancing their engagement and involvement throughout the therapeutic process.

Although it is not always distinguished in everyday clinical practice, the literature differentiates between the reason for consultation and the therapeutic demand. The reason for consultation is defined as the description of the problem provided by the person seeking help, whereas the demand refers to the recognition of a subjective need and the resulting appeal for assistance (Martínez Farrero, 2006). In this text, we will preferentially use the term "demand" when referring to the appeal for help, and "reason for consultation" to refer to the factors that have prompted a request for help. Furthermore, we understand that while the reason for consultation is a specific fact made explicit at the beginning of the therapeutic process, the therapeutic demand is dynamic and subject to change.

When analysing the reason for consultation and the therapeutic demand, it is important to consider both their explicit or manifest levels and their implicit or latent levels. Although these levels may sometimes coincide, they can also differ. Some indications of incongruence between these levels can be inferred when the reason for consultation or the explicit demand seems unreasonable, is expressed with little conviction or concern, or refers to a problem that has been experienced over a long period (Martínez Farrero, 2006). In such cases, in-depth exploration is likely to reveal motivations that the person has not made explicit. For example, a person who has been enduring intense psychological distress for a long time may consult without attaching much importance to it and may also suggest that they will not need many sessions.

Following a thorough exploration, it may be concluded that this person has learned to live with their distress. However, their current concern lies with their children, as they worry about the possibility of them experiencing the same distress. While the initial explicit reason was their own distress, the implicit reason that emerges after the initial exploration is the fear that their children may experience it.

Given that there are different models for analysing the reason for consultation and the therapeutic demand, this text has attempted to develop an integrative model, considering aspects common to several therapeutic orientations and prioritising a pedagogical approach. While an effort is made to follow a linear logic in the order of elements, it is important to note that they do not necessarily appear in that specific order during a clinical interview. In fact, some of these elements may emerge spontaneously during conversation, while others will need to be explored deliberately.

3.1. Identification of the person seeking help

First, it is important to determine the role of the person presenting the reason for consultation to identify who is using our services and to analyse their demand. When considering these questions, a variety of possible situations can be encountered:

- A person recognises their own distress, generates a reason for consultation, and makes a demand for help for themselves. This is the ideal situation for initiating a therapeutic process.
- A person may present a reason for consultation upon noticing difficulties in someone else. These types of consultations can arise from another professional's recommendation, the advice of a loved one, obligations imposed by social services to maintain benefits, or a court order related to matters such as child custody or the possibility of parole. For example, it is common for individuals with substance use problems to seek psychological treatment as an alternative to serving a sentence in a correctional facility. These cases are particularly delicate, as, we will see later, motivation for change is a crucial factor in therapy (Ryan et al., 2011). It is reasonable to expect that a person attending therapy under legal mandate will have lower levels of motivation and engagement compared with someone attending voluntarily. In these situations, it is essential to foster a therapeutic demand that is genuinely owned by the person who will ultimately receive the help.

- There are also cases in which a person presents a reason for consultation on behalf of someone who lacks the capacity to do so. This occurs, for example, with minors or individuals experiencing severe psychological distress. In these situations, the person making the demand plays a crucial role. Interventions are often directed towards them in the hope of promoting improvements indirectly. As in the previous situation, when work is carried out directly with the person experiencing the distress, the aim will be to foster their own therapeutic demand.
- A person presents a reason for consultation because they are experiencing the consequences of situations determined by the social context. It is common for psychological distress resulting from socioeconomic, legal, or political problems to be identified as reasons for consultation to psychological services. In these situations, it is necessary to assess whether, beyond the support the person needs to cope with the situation, there is any intervention from which they could benefit, whether it is the appropriate time, and, above all, to work in an interdisciplinary manner with professionals from the social sector.

This typology covers most cases that may be encountered in therapeutic practice. In the section on analysis of the therapeutic demand, we will see how the type of demand is influenced by the person who has generated the reason for consultation.

3.2. Time elapsed between the emergence of the problem and the consultation

Seeking psychological services is often a more complex decision than accessing other health services. People seeking psychological help usually go through a prior process that can vary greatly. In some cases, the time elapsed between the onset of distress and seeking help is short, as the situation overwhelms the person and/or their environment, prompting an urgent request for support. In other cases, distress gradually increases until it reaches the point that generates the reason for consultation. In any case, it is less important to quantify the objective time than to allow the person to express subjectively what they have experienced and how they have managed their distress during that period, the reasons that prevented them from seeking help earlier, and the factors that have led them to seek it now. This information will help us better understand their demand and tailor a future treatment as effectively as possible.

3.3. Theory of the problem that motivates the consultation

During the period between the onset of distress and seeking help, it is common for people to develop their own explanation of what is happening to them, as well as its possible causes. That is, a personal theory of the problem motivating their consultation.

When analysing this theory, it is important to pay particular attention to the attributions the person makes—that is, whether they attribute what is happening to internal or external factors, and consequently their perception of control over the situation (locus of control according to Rotter, 1966). We highlight this point because, to initiate an effective therapeutic process, it is advisable that there is a minimum level of internal attribution—that is, the person recognises that they have some ability to change aspects of their situation to improve it. If the attribution is entirely external, it is necessary to explore the possibility of redirecting this attribution so that the person feels empowered to make changes. Otherwise, it is unlikely that the person will be motivated to take an active role in their recovery process (Ryan et al., 2011). For example, if a person believes that their distress is solely the result of an organic disorder entirely beyond their control and unaffected by their actions, it is unlikely that they will engage in psychological treatment.

3.4. Attempted solutions

People often use various strategies to manage their distress before seeking specialised services. We define “attempted solutions” as all actions undertaken by the person to try to resolve their problem, whether consciously or unconsciously, regardless of whether these actions solve the problem, worsen it, or have no effect. In fact, attempted solutions can help maintain the problem acting as maintaining variables, or they may even exacerbate the situation. A paradigmatic example is found in cases of specific phobias, where the person avoids certain situations or stimuli in an effort to manage their fears. However, this avoidance strategy reinforces the fear, making it more difficult to overcome.

It is important to bear in mind that, in their attempts to resolve the problem, people may have turned to different sources of support, such as friends, family members, primary care physicians, or other therapists. They may also have sought the experiences of others in similar situations. Additionally, it is very likely that they have searched online

for information related to the symptoms they are experiencing, and it is even possible that, with varying degrees of accuracy, they have self-diagnosed and used strategies found through these sources. In this regard, the quality of online resources and information can vary considerably, as can the thoroughness and accuracy of the search conducted by the person. Therefore, each situation will need to be explored specifically.

An illustrative example of an "attempted solution" could be a person who, in order to relieve their sadness, decides to meet with close friends and experiences some relief. In this case, we can infer that the person has a social support network, which is a valid resource that can be utilised on certain occasions and incorporated into the intervention. However, if they have tried this strategy previously without success, it is unlikely that they will be willing to accept it as a proposal within the therapeutic process.

3.5. Previous therapeutic experiences

It is essential to pay particular attention to previous therapeutic experiences, whether in psychological treatment services or mental health services more broadly. Exploring the person's subjective impressions of these consultations can provide valuable information and have a significant impact on understanding their current situation. Furthermore, as will be discussed later, previous experiences with other psychological treatment services play a key role in shaping expectations for the current treatment. These prior experiences can influence the person's beliefs and perceptions about the outcomes they may achieve, as well as their willingness to engage actively in the therapeutic process.

It is possible that there have been previous consultations related to the current problem. In this case, these consultations can be conceptualised as part of the person's coping strategies and, therefore, understood as an attempted solution, as we have seen. In any case, it can be useful to differentiate between the therapeutic experience itself, which can provide information about their expectations, and the role that seeking help has played in their history of coping with the problem.

3.6. Analysis of the therapeutic demand

Once the problem, which can be summarised in the reason for consultation, has been explored, it is time to analyse what the person expects from therapy. As mentioned

earlier, the demand refers to the appeal for help in the present moment, so its analysis places the therapist in the position of considering what they can do for the person seeking help from their professional role. Villegas Besora (1996) proposes two dimensions of analysis. The first is the psychosocial dimension, which involves the context of the consultation. The second is the discursive-pragmatic dimension, that is, the mental representation of the help-seeking situation held by the person. This level of analysis allows us to classify the demand into different modalities, as shown in Table 1.

Table 1

Therapeutic demand modalities according to Villegas Besora

Modality	Origin	Goal	Example
Non-demand	External	Satisfy a third party who generated the reason for consultation.	A person seeks help for a substance use problem and denies having an issue, but states that they came because their partner asked them to.
Delegated	External	Refer a person to another professional.	A person attends therapy following a consultation from primary care for a condition in which no organic cause has been identified.
Collusive	External or own	Harm another person or oneself using the authority of a diagnosis or coercive treatment.	A person demands that a relative be involuntarily admitted to a psychiatric institution. A person seeks confirmation of a self-diagnosis, which would imply adopting the role of a patient and thereby increasing self-stigma.
Vicarious	Own but oriented to another person	Provoke the involvement of a third person in the therapy.	A mother seeks a consultation because her son is confined at home and wants guidance on how to help him.
Confirmatory	Own	Ensure the correctness of one's own criteria or decisions.	A person with a predetermined plan consults and only accepts arguments that confirm the validity of that plan.
Magic	Own	Solve the problem by relying on the therapist's powers, authority, or prestige.	A person consults a therapist recommended by an acquaintance and expresses absolute confidence in his or her abilities.
Symptomatic	Own	Recover from a somatic or psychosomatic illness, or from a psychic discomfort, avoiding any change or internal confrontation.	A person diagnosed with irritable bowel syndrome is referred to therapy but does not identify that their discomfort is amenable to psychological treatment.
Perverse	Own	Satisfy in a direct way one's own needs of attachment, sexuality or power.	A person goes to therapy because they want to develop an affective relationship with the therapist.

Modality	Origin	Goal	Example
Nonspecific	Own	Seek support and guidance to understand and deal with problems without being clear about what they are.	A person tells the therapist that they do not feel happy and that they would like to improve their mood and "get to know themselves a little more".
Specific	Own	Solve previously identified psychological problems.	A person undergoing psycho-pharmacological treatment for panic attacks expresses a desire to discontinue the use of medication by trying a psychological approach.

Modified from Villegas Besora (1996, p. 42).

This classification, while not exhaustive, can be useful for considering ways to reformulate demands that do not facilitate the therapeutic process. This can be achieved by identifying elements that allow the demand to be as specific as possible. In other words, regardless of the initial type of demand, the goal is to analyse whether it is possible to progress towards a reformulation that makes the demand specific.

3.7. Expectations and theory of change

People who seek psychological treatment often have previous conceptions about how therapy works, the role of the therapist, and expectations related to the personal effort required to solve their problems. A related concept is that of "theory of change," which refers specifically to what the person believes is necessary for the problem to be solved (Duncan & Miller, 2000). These conceptions may be influenced by the person's prior knowledge, consultations with other professionals or via the Internet, as well as by previous therapeutic experiences, as discussed in the corresponding section. The importance of exploring the person's expectations and theory of change lies in the extensive literature linking these factors to therapeutic success (Dew & Bickman, 2005). The presence of positive expectations regarding the therapist's professional competence, the belief in the need for active participation in treatment, and previous positive therapeutic experiences are factors that generally indicate a favourable prognosis.

Identifying the reason for consultation and analysing the therapeutic demand involves an initial process of listening and exploration. This includes determining **who** is seeking help, **how much time has passed and what has occurred** since the onset of the problem, **what** the person believes is happening and **why**, **which solutions** they have attempted, their **previous therapeutic experiences**, **what** they are demanding, their **expectations**, and **how** they hope these will be fulfilled.

Below, we present two vignettes illustrating different reasons for consultation and types of demand. In these situations, a therapist explores the points outlined above.

Vignette 1

Therapist: M, tell me what brings you here.

Service User: I've come because I feel really stuck… About a month ago I had problems at work, I didn't know how to handle them, and I just collapsed. In fact, I've been off work for three weeks. Just thinking about going back makes me nervous.

T: What happened at work?

SU: They gave me lots of extra hours and didn't pay me… well, they didn't even thank me, they spoke to me quite harshly, kept asking for more, and I couldn't keep up. I wasn't sleeping, I was very stressed, my hair was falling out, everything annoyed me, anything could make me cry, I lost a lot of weight… until I went to the doctor, and when they saw me, I was signed off.

T: That must have been tough.

SU: Yes, and on top of that, I felt very unfairly treated, I saw that it wasn't the same with my colleagues.

T: And that?

SU: I suppose they know how to say no, so they aren't taken advantage of.

T: They know how to say no…

SU: Yes… I don't know. I've always found it hard to speak up… I'm afraid people will get angry or think badly of me… My friends already tell me that I'm too nice, I'm foolish… People take advantage of me. When people do things I don't like, I put up with it, try to

say something, but I quickly back down… So I keep accumulating it until I explode and either cry… or get really angry, especially at myself.

T: I understand. M, does this happen in other areas of your life?

SU: Everywhere, with my parents, my siblings, my friends… Uf! It's just who I am.

T: You say it's always been like this; however, you are consulting now… how come?

SU: It's just that the work situation was too much… I've realised that this way I end up being a doormat, and honestly, I'm tired of it.

T: And is there ever a time when you manage to set limits or express your opinion?

SU: Well… with people who know me, it's easier, they already see me and ask me.

T: Do you have any strategy to make it easier?

SU: Hum… Sometimes with my parents, I don't dare to say something to my dad, so I tell my mum to tell him for me.

T: I see, you're looking for someone to help you. M, what do you think we can help you with?

SU: I suppose I need to learn to speak up and not keep things to myself… I don't know, I want to learn to face problems before they overwhelm me.

T: That seems like a very good goal. How do you expect me to help you achieve it?

SU: I don't know, I suppose I'll have to start expressing these emotions little by little.

Identification of the reason for consultation and analysis of the therapeutic demand

- **Identification of the person seeking help:** it is the person himself who demands help, the reason for consultation is a work problem that is revealed to be related to interpersonal difficulties.
- **Time elapsed between the emergence of the problem and the consultation**: Refers to a gradual onset, without specifying a date. The generation of the reason for consultation was rushed a month ago, with the labor problem.
- **Theory of the problem that motivates the consultation**: Explains that what happens to her has to do with her difficulties in saying things, the fear of what will be thought about her. Makes internal attribution of its difficulties.
- **Attempted solutions**: Avoid expressing their opinion, avoid problems, avoid setting limits, is passive (lack of assertiveness), looks for a third person to express

themselves for them (mother). Three weeks ago she went to her family doctor and he signed her sick leave.

- **Previous therapeutic experiences**: It has not been explored whether there have been previous consultations in the field of psychology.
- **Analysis of the therapeutic demand**: Specific demand. Ask for help to improve their coping skills.
- **Expectations and theory of change**: Believes that change is possible gradually.

Vignette 2

T: M, tell me what brings you here today.

SU: My life is a mess, I'm sad and tired, but at the same time nervous… my GP had to give me some tablets because I can't even sleep… there's so much going on that I just can't cope.

T: You've got a lot on your plate…

SU: My children make my life impossible, my husband doesn't help at all, and at work they're bullying me.

T: You mentioned feeling sad and tired…

SU: Yes, yes… very tired and fed up.

T: How long have you been feeling like this?

SU: Oh, goodness! I can't even remember anymore… I've had a complicated life, got married young and have had to work hard all my life. My children didn't turn out very well, they only care about themselves, they never help… and at work, my colleagues are awful, they're always gossiping and spend the whole day criticising others. They all get along with each other and with the manager, who's just like them, but I've got nothing to do with that. I end up keeping to myself and, since I'm not part of their group, the manager gives me the worst shifts, and I can't choose my holidays properly…

T: I see. You're dealing with a lot at once.

SU: But don't get me wrong! I'm very strong.

T: M, and how have you managed to stay strong? What things have you tried to help yourself feel better?

SU: But what do you expect me to do? I've got no time… things are the way they are and I must work. If my husband or the children helped a bit more… but you can't say anything

to them, they're so spoiled… and what am I supposed to do? Leave everything undone? So, I keep quiet, put on a brave face, and do everything myself.

T: How did you decide to come and see a psychologist?

SU: Well, when my doctor suggested it, I thought: "Anything that might help is fine by me."

T: Is this the first time you've seen a psychologist or a therapist?

SU: Yes, the first time…

T: How do you think therapy could help you?

SU: Well, I don't know… maybe talking to someone who doesn't know me could help me get things off my chest and maybe give me some advice about what to do with my home and my job. But I don't think there's much of a solution for me.

Identification of the reason for consultation and analysis of the therapeutic demand

- **Identification of the person seeking help:** The request for help comes from another professional (the GP). The reason for consultation is a state of sadness, nervousness, fatigue and insomnia related to family and work issues.
- **Time elapsed between the emergence of the problem and the consultation**: The patient cannot identify a clear starting point for the distress but reports a long-standing struggle. The reason for consultation arises when suggested by the GP.
- **Theory of the problem that motivates the consultation**: Other people are causing her problems: her children, her husband and her workplace.
- **Attempted solutions**: She avoids expressing her distress and carries out her responsibilities, even if she feels dissatisfied. She has consulted her GP and is receiving psychopharmacological treatment.
- **Previous therapeutic experiences**: She has no prior experience with psychological treatment.
- **Analysis of the therapeutic demand**: Non-specific demand. She expects to be able to express herself and receive advice, essentially seeking an external solution.
- **Expectations and theory of change**: She does not expect to find a solution to her problem and does not identify any personal changes that could contribute to it.

In the last vignette, it can be seen that people are not always ready to begin a therapeutic process. In these cases, it is important to reformulate the request for help. It is crucial to learn to identify the difficulties and address them before starting the process, as a poorly executed intervention can be iatrogenic. When we begin a psychological intervention with someone who is not ready and it fails, we reduce the likelihood that they will seek help again when they are better prepared, as their negative expectations about treatment are likely to increase.

4. Problem formulation process

Once the reason for consultation has been identified and the demand analysed, the prerequisite for initiating a psychological intervention is to establish the problem formulation. To do this, all the information gathered during the previous steps should be used, as well as any additional information deemed necessary at this stage to develop the formulation.

In general terms, a problem formulation is expected to be theory-based and hypothetical, and therefore open to modification. It should also be parsimonious, meaning that the simplest explanations among all possible ones are prioritised. The objectives of the problem formulation are (Butler, 1998):

- Clarify the person's hypotheses and questions.
- Understand: to get a "general idea of the map."
- Prioritise problems.
- Plan and select treatment strategies.
- Predict the response to strategies and interventions.
- Anticipate potential difficulties.
- Determine criteria for evaluating whether the process has achieved an appropriate outcome.
- Reflect on the lack of progress if it does not occur.
- Overcome possible prejudices and biases.

We will now have a look at the different elements that make up the problem formulation in order to pursue these objectives.

4.1. Identification of the difficulties experienced by the person

Firstly, following models such as the three-response system (Lang, 1968), it is essential to gather information about what the person does (motor behaviours or autonomic responses), thinks (cognitions, conscious or unconscious) and feels (emotional reactions) in relation to the difficulties identified from the reason for consultation and the demand expressed by the person in their own words.

Some useful strategies for analysing the problem include asking for specific examples to clarify the information, specifying general or ambiguous terms used, describing the most recent situation in which the problem was experienced, or breaking it down into concrete behaviours.

4.2. History of the problem

Once the difficulties experienced by the person have been identified, it is essential to look back in time and examine the moments when psychological distress first arose and began to be perceived as a problem. It is likely that some relevant information has already emerged when exploring the time elapsed between the onset of the problem and the consultation, but it is crucial here to explore the predisposing, precipitating and maintaining factors of psychological distress. It is important to consider that these factors vary greatly between individuals, cultures and forms of psychological distress. Although there are variations, they are generally defined as follows:

- **Predisposing** factors are those elements that increase a person's vulnerability to developing psychological distress. They may include genetic factors, family history, early life experiences including previous trauma, personality characteristics, and cultural, socioeconomic, and political factors.
- **Precipitating** factors are the specific circumstances that trigger the onset or worsening of psychological distress. These factors may include significant life changes (losses, separations, job changes, etc.), interpersonal conflicts, or traumatic events.
- Finally, **maintaining** factors are those that contribute to the persistence of psychological distress. They may include maladaptive coping mechanisms, lack of social support or dysfunctional support networks, stressful or toxic

environments, unfavourable socioeconomic conditions, or difficulties accessing support resources, including psychotherapeutic services.

It is important to consider these factors not only in terms of their dynamic role in the problem, but also from a biopsychosocial perspective on health. The biopsychosocial model (Engel, 1977) is an approach that aims to understand and address health problems from an integrative perspective. This model recognises the complex and bidirectional interaction between biological, psychological and social factors in determining a person's health and well-being.

It is essential to consider that the development of psychological distress, although it may be influenced by a biological vulnerability, occurs within the context of a life narrative and a specific cultural, social and political situation. Given that there are no reliable biological markers for any type of psychological distress, the presence of a family history of similar difficulties should be interpreted in the context of the meaning attributed to these experiences, as well as the material circumstances in which they occurred. Therefore, it is crucial to take into account possible power imbalances and discrimination experienced by the person in the context of their distress. These imbalances may appear as discrimination based on gender, ethnicity, social class, language, or personal beliefs. For example, a child's attentional capacity is partially influenced by biological factors. However, the way the environment responds to a child with below-average attention is likely what determines whether this translates into behaviours considered disruptive and contributes to the child's own distress. Appropriate support and the promotion of compensatory skills can lead to very different outcomes compared with punitive approaches.

4.3. Phase of the change process

Another important element in a problem formulation is identifying the person's motivation to make changes. While some aspects may have been identified when exploring the reason for consultation, attempted solutions, or in the analysis of the demand, further exploration allows us to situate the person at a specific stage of the change process. This provides valuable information for understanding their readiness and facilitating progress towards the desired change. The stages of change model

(Prochaska & DiClemente, 1982) describes the change process in distinct stages. The model is divided into five stages:

1. **Precontemplation**: At this stage, the person does not recognise the need for change and has no intention of doing so in the near future. As therapists, our role would focus on raising awareness of the problem.
2. **Contemplation**: At this stage, the person is aware of the need for change and is considering the possibility of doing so but has not yet taken any concrete action. As therapists, we aim to motivate them and support their decision-making by helping them weigh the advantages and disadvantages of change.
3. **Preparation**: During this stage, the person has made the decision to change and is preparing to take concrete steps in the near future. The therapist therefore focuses on contributing to the search for effective ways to implement such measures.
4. **Action**: In this phase, the person has initiated concrete actions to modify their behavior and is actively working to achieve their change goals. As therapists at this stage, we accompany the person in the changes applied, providing support as needed.
5. **Maintenance**: In the final stage, the person has successfully modified their behaviour and is consolidating the changes made. The aim is to maintain these changes in the long term, so therapeutic work focuses on sustaining the achieved balance and fostering the acquisition of skills to maintain the changes.

This model recognises that change is not a linear process and that people may revert to earlier stages before moving forward again. It also emphasises the importance of motivation, self-efficacy, and social support at each stage of the change process. Therefore, when a person comes to consultation, they are often situated in the contemplation or preparation stages, although depending on the reason for consultation and the demand, they may also be in the precontemplation stage. As has been seen, the therapist's work, either after or even during the formulation, will be to encourage progress towards the action stage and subsequently maintenance, while also addressing any setbacks that may occur throughout the process.

4.4. Development and testing of explanatory hypotheses

Once the person's difficulties have been identified, the history of these problems explored, and their readiness for change assessed, it is common to organise the information according to the therapist's theoretical orientation. As mentioned earlier, all formulations are usually based on a theory. This process can be more or less explicit, beginning as a mental process on the part of the therapist, which may then lead to the preparation of a written report. It is important to bear in mind that, like the formulation as a whole, the development of hypotheses can be understood as an ongoing process rather than a one-off event. In this way, if a hypothesis is refuted, further exploration will be required to formulate new hypotheses (Feixas & Miró, 1993).

The development of an explanatory model of the problem aims to situate both the person and the therapist within a coherent framework, thereby facilitating collaborative work. To achieve this, it is important to test the hypotheses, either to confirm them or to discard them if necessary. Additionally, it is essential to reach an agreement with the person on the relevance of the explanatory model to their own experience.

4.5. Assessment instruments

In problem formulation processes, it is possible to complement the information obtained through interviews by using psychological assessment instruments. In fact, these are often used to test initial hypotheses, although this is not their only purpose. There is a large number and variety of instruments, which far exceed the scope and aim of this text. However, some guidelines can be provided on how to make the most of assessment instruments in the context of psychological treatment, avoiding overuse while optimising the information they provide. Three stages of the therapeutic process can be identified in which instruments may be used: at the beginning, during the process, and at the end.

- **During the initial assessment**, relevant variables are collected to carry out a problem formulation or diagnosis (see the following section). The aim is to determine the nature, complexity, and degree of interference of the distress.
- **During the therapeutic process**, the person's progress can be evaluated, including the evolution of their distress, adherence to assigned tasks, engagement in therapy, and the state of the therapeutic alliance. Standardised instruments exist, although

records or clinical observation are often used. This evaluation is essential for promoting engagement with treatment, preventing and addressing process difficulties, and, if necessary, reformulating the therapeutic demand and renegotiating goals and methods.

- **At the end of the therapeutic process**, the variables assessed at the start can be re-evaluated to determine treatment effectiveness, provide final feedback, and complete closure. Follow-up assessments may also be conducted to evaluate medium- and long-term progress, maintain the achieved balance, and reinforce the strategies learned during the intervention process.

In general, any assessment process begins with an exploratory interview, which can later be complemented by structured interviews or hetero- or self-administered instruments to refine the information obtained or to gather data from other sources (family members, school, workplace, etc.). Therefore, in the assessment process, it is possible to combine elements with different degrees of flexibility and structure.

If the assessment process includes structured elements administered in consultation, the total time required must be carefully calculated, along with the cost of this time for the person, the public health system, or the insurer covering the consultation costs. It is also important to explain to all interested parties (the person, supervisors, funders, etc.) the reasons for administering these instruments. Likewise, if the assessment is being conducted for research purposes, information and informed consent must be provided, and it is considered ethical to offer feedback to the person on all the results obtained. In other words, if an instrument not normally used in clinical assessment is introduced in a research context, the ethical course is to inform the person, seek permission, and provide explanations about the results.

Regardless of whether the use is clinical or clinical-research, the choice of instruments, like any professional decision, requires a clear understanding of the overall goals of the process. For example, using a session to explore anxiety-provoking situations with specific instruments (or a semi-structured interview following an inventory) makes sense in a case of agoraphobia, where it is useful to identify situations that will later be used in treatment. However, the same investment may not be as fruitful in a case of post-traumatic stress disorder. In the latter case, the actual triggers of anxiety may be

traumatic memories, and the specific situations in which they occur can be almost limitless, making targeted evaluation unnecessary.

In addition to their relevance to the problems being assessed, it is important to be clear about the intended scope of application when selecting instruments. There are instruments, generally standardised on the general population, that can be applied regardless of whether a diagnosis exists, allowing us to compare a person's level of functioning with their reference population. Without aiming for an exhaustive review, examples of widely used questionnaires standardised on the general population include the Wechsler intelligence scales for adults (WAIS; Wechsler, 1939) and children (WISC; Wechsler, 1949), the Beck Depression Inventory (BDI; Beck et al., 1961), the State-Trait Anxiety Inventory (STAI; Spielberger et al., 1983), the revised 90-item Symptom Checklist (SCL-90-R, Derogatis, 1988) and the 36-item short form of the Health Survey (SF-36; Ware y Sherbourne, 1992). By contrast, there are highly specific instruments that are only meaningful in a particular context. A clear example is the Hospital Anxiety and Depression Scale (HADS; Zigmond y Snaith, 1983) which is only suitable for hospitalised patients, or instruments intended solely for individuals diagnosed with a specific disorder, such as the various quality of life and psychosocial well-being scales applicable to particular somatic conditions[4]. While the possibility of comparison with the general population is an undeniable advantage, caution is required with general questionnaires. Some people may not understand certain questions or may simply feel that they are not applicable to their situation, which can result in a sense of being treated impersonally. Clear examples include the physical symptom items in the BDI that refer to fatigue (not applicable to people with somatic or psychosomatic illnesses that cause fatigue), weight loss (not applicable to individuals with digestive disorders or eating and intake disorders), or sexual appetite (not applicable to many people taking medications or substances that affect sexual function). In such cases, different strategies can be employed: using a more specific questionnaire (for example, a primary care version of the BDI that accounts for somatic comorbidity by rewording certain items) or excluding those items and scoring the scale based on a reduced number of items. A simple strategy

[4] There are quality of life instruments applicable only to specific underdiagnoses of somatic disorders such as cancer or diabetes.

to make scores comparable with those from the full scale is to use the mean of the items answered (total score divided by the number of items used in the assessment)[5]. However, it should be noted that this approach is only appropriate when a limited number of items are left unanswered; in fact, some instruments specify how many missing responses are acceptable.

Conversely, when using highly specific instruments, difficulties in obtaining norms or the particularities of each case can compromise the validity of the information obtained. For example, imagine using an instrument to assess quality of life in people with diabetes. Once the questionnaire has been administered and the total score obtained, consulting the norms may reveal that, although the somatic illness was considered, the type of diabetes was not considered. There are two types of diabetes: type 1 is an autoimmune disease usually manifesting in childhood, while type 2 typically occurs in adults with overweight. Quality of life measures have very different specificities in each of these groups, and scores obtained using a questionnaire designed for the other type of diabetes are unlikely to provide useful information. Therefore, it is always highly recommended to apply instruments within our areas of expertise, carefully reading the application instructions and even imagining ourselves as the person being assessed to visualise whether all items make sense and cover the characteristics of interest. In short, it is advisable to know any assessment instrument thoroughly before using it.

On the other hand, there are instruments that allow us to measure the therapeutic process and the evolution of common factors. In these cases, the goal is not so much to compare the person with a reference population or the specificity of questions about their particular problems, but to explore how the process is developing and the factors that facilitate it. An example of an instrument for assessing the quality of the therapeutic relationship (positive bond, agreement on goals, and agreement on methods) is the Working Alliance Theory of Change Inventory (WATOCI; Corbella y Botella, 2004).

[5] In our example, the BDI comprises twenty-one items, each scored from 0 to 3 (thus, the total score ranges from 0 to 63). A person for whom all items apply and who obtains a total score of 42 would have a mean item score of 2 (42/21). However, if we are treating someone with a digestive disorder, such as dyspepsia (which involves nausea, a feeling of heaviness and stomach pain, heartburn, and flatulence after meals and may result in weight loss), we might consider removing the weight-loss item, since it may not be related to depression and could artificially inflate the total score. In this case, the scale would comprise twenty items, and a total score of 40 would again correspond to a mean item score of 2 (40/20).

Finally, it should be borne in mind that the validity of an instrument, even if it was very high during its development and validation, may be reduced when applied to socioculturally different populations. A clear example of this is working with migrant populations and ethnic minorities.

5. Diagnosis in clinical practice

5.1. From taxonomies to dimensional and critical perspectives

As you may have observed, psychological formulation in its broad conception, including the identification of the reason for consultation and the analysis of the demand, is a tool that helps us understand the situation of people seeking help while contextualising their problems and distress, enabling us to plan a series of interventions. In cases where the demand relates to the onset of severe psychological distress, the formulation process usually, and sometimes must, for legal and administrative reasons, include a diagnosis.

From a psychological perspective, formulation is considered a more appropriate approach to initiating a therapeutic process than diagnosis. This is because diagnosis does not represent a discrete entity with clear boundaries, meaning that people with the same diagnosis may have experienced very different situations and life events that require distinct interventions (Macneil et al., 2012). Additionally, it is important to consider that individuals who receive a diagnosis may experience stigma and discrimination, or even internalise social prejudices and develop self-stigmatising attitudes (Cromby et al., 2013a). For this reason, organisations led by people with lived experience of psychological distress, such as *Intervoice*[6] within the global Hearing Voices Movement advocate shifting the question from “What’s wrong with you?” to “What has happened to you?”.

This is a controversial issue, and we believe that extreme positions or generalisations are rarely the best option. While it is true that the stigma associated with diagnosis is a real phenomenon, there are also people for whom receiving a diagnosis can be a source of relief. This goes beyond the adequacy of diagnostic systems to the complex reality of

[6] International network dedicated to the study, education, and research of voice hearing, with hundreds of groups in more than twenty-five countries. http://www.intervoiceonline.org

psychological distress. Some people feel relieved when they can put a name to what they are experiencing, when they realise they are not the only ones going through that situation, or when they discover that therapeutic options are available. This can occur regardless of whether it is framed within a diagnostic system or a psychological formulation.

In this regard, some authors point out that formulation has limitations that can be addressed by combining it with diagnosis. In a reflection published in the Clinical Psychology Forum of the British Psychological Society (BPS), Green (2013) reminds us that labels in general, and particularly in healthcare, exist to facilitate interprofessional communication and to justify interventions to public administrations and insurance providers. While diagnostic classifications have often neglected subjectivity, eliminating labels altogether could hinder shared understanding, that is, the ability of different professionals to exchange information within a reasonable timeframe. Green argues that the problem does not lie in the existence of words such as “psychosis”, “depression”, or “anxiety,” which exist beyond their specialised use, but rather in the increasingly refined systems developed with each new edition of diagnostic manuals such as the DSM (Diagnostic and Statistical Manual of Mental Disorders) and the ICD (International Classification of Diseases), which enforce artificial consensus that can reduce the practical usefulness of these labels. The author recommends retaining the use of labels but enriching them with a broad repertoire of shared meanings and enabling people who receive a diagnosis to understand that there is a plurality of interpretations attached to each term. This conceptualisation aligns more closely with the ICD of the World Health Organization (WHO) than with the DSM system of the American Psychiatric Association (APA). Whereas the DSM focuses on specific diagnostic criteria concerning the description and duration of symptoms, the ICD includes a more narrative and interpretative framework for professional judgement.

In any case, both systems have advantages but also entail certain disadvantages. The DSM system facilitates the production of quantitative, multicentre[7], evidence, both experimental and observational, since it allows for theoretically equivalent diagnoses to be made across different professional and sociocultural contexts. This, in turn, enables

[7] Studies conducted in multiple locations.

the generation of epidemiological evidence that supports better planning of resources and services. Moreover, the acceptance of DSM-based diagnoses by public administrations and insurance companies makes it possible to activate services, social and healthcare benefits, and legal processes (such as access to specialised teams or medical leave). However, the rigidity with which diagnostic criteria are applied also leads to unintended consequences. A paradigmatic example is the existence of "diagnostic orphans" (Hasin & Paykin, 1998), a term used in the field of addictions to describe individuals who meet one or two symptoms of dependence but do not fulfil enough criteria to receive a diagnosis of either dependence or abuse under the DSM-IV. Although this issue was corrected in the DSM-5 by merging the categories of abuse and dependence, it caused significant problems for many years, particularly in terms of treatment follow-up and insurance coverage, as numerous individuals with problematic alcohol or substance use were denied access to care.

The ICD model, by contrast, offers a more open conceptual framework that allows for broader consensus within international committees and among professional associations that, to some extent, hold reservations about the exclusive use of diagnostic categories to conceptualise psychological distress. However, conducting epidemiological studies based on ICD criteria has presented several challenges. For instance, a study carried out in primary care (Sartorius, 1993) using the Composite International Diagnostic Interview (CIDI[8]) produced widely varying rates of depression diagnosis ranging from 30% in Santiago, Chile, to 4% in Shanghai, China. While differences between such distinct settings may be partly explained by cultural factors, other discrepancies observed in this study cannot be fully attributed to them. For example, 6.1% of participants in Berlin, Germany, met diagnostic criteria for depression compared with 15.9% in Groningen, the Netherlands. It has been hypothesised that these variations

[8] Composite International Diagnostic Interview. Although diagnosis is often established through unstructured clinical interviews, both the ICD and DSM systems include structured clinical interviews. The Composite International Diagnostic Interview (CIDI), developed by the World Health Organization (2001), based on ICD criteria, does not require clinical specialisation for its administration and is therefore more commonly used in epidemiological contexts. The DSM system, on the other hand, includes two main instruments: the Mini International Neuropsychiatric Interview (MINI), a brief tool used for screening and epidemiological studies, and the Structured Clinical Interview for DSM (SCID), which is more extensive. The latter requires specialised clinical training to administer and is typically used in clinical research projects where consistency in diagnostic application is essential.

might be due to researcher bias during data collection at each site. For example, the data collector in Santiago de Chile was an expert on depression, which could have influenced diagnostic sensitivity. Nonetheless, there is no conclusive evidence to confirm or refute this hypothesis.

Despite their differences, efforts have been made to achieve administrative integration between the two diagnostic systems. For instance, the DSM classification includes ICD codes, allowing any diagnosis to be "translated" between systems. The main purpose of this integration is to enable clinicians who use the DSM to record their diagnoses in a format compatible with international databases, which in turn provide data to the WHO using ICD coding.

In any case, diagnosis is part of the training and usual practice of therapists. In practice, psychiatrists and clinical psychologists working within national health systems are required to diagnose their patients, whereas those practising psychotherapy in the private sector, at least in Spain[9], are not legally obliged to do so. However, as discussed earlier, many therapists question the usefulness of psychiatric diagnoses in the context of psychological treatment. Moreover, within the field of psychology, categorisation is not viewed as a prerequisite for developing a coherent understanding of the individual's difficulties. In this regard, several dimensional proposals have emerged, some of which have been partially incorporated into the DSM-5, that attempt to replace categorical diagnoses of personality disorders with a dimensional model of personality. In this model, every person is situated along a continuum of various personality traits, much like in general personality theory (Caballo, 2013; Esbec y Echeburúa, 2015).

Regarding real alternatives to the entire nosological system, Beutler and Malik (2002) compiled options outside the DSM model, highlighting narrative approaches, the operationalised psychodynamic system[10], the model-based approach applied to child

[9] The requirement to provide a diagnosis outside national health systems varies internationally as much as professional training does. Generally, the existence of private insurers offering psychotherapy as a service usually entails the use of diagnoses. However, in Spain, there is some debate on this issue, since the authority to make a diagnosis is reserved for specialists in Psychiatry and Clinical Psychology. Currently, this is not explicitly recognised for professionals who have completed the Master's in General Health Psychology (Máster en Psicología General Sanitaria), even though diagnosis forms part of their training.

[10] It is important to note that this system introduces some interesting elements, including four novel axes: experience of distress and treatment prerequisites, interpersonal relationships, conflict, and structure. However, the fifth axis, called the "syndromic diagnosis", uses Chapter V (F) of the ICD-10 (Cierpka et al., 2006).

and adolescent psychology, and the prototype-matching approach grounded in cognitive theories. In practice, only the latter has had a widespread impact on clinical practice. Langenbucher (2004) argues that the limited influence, particularly of the narrative and psychodynamic approaches described by Beutler and Malik is because, despite their flaws, the DSM and ICD systems are shared frameworks used by a wide range of professionals who communicate through them. If alternatives are rooted in a highly specific professional or theoretical orientation, they are likely to fail or remain confined to a minority context.

More recently, the idea of creating alternatives to diagnosis has been developed from a genuinely transformative paradigm, grounded in a robust proposal based on the testimonies of people with experiences of extreme psychological distress. In this context, Johnstone and colleagues (2018) have proposed the framework of power, threat, and meaning. While this can be considered a formulation model, its implementation has been strongly shaped by its opposition to traditional diagnoses and its attempt to overcome some of the limitations of formulation models tied to specific theoretical orientations.

This framework proposes that people are constantly embedded in power relationships, and that power is not distributed equally. Power is not only relevant in work or political contexts but is also present in family and intimate relationships. Within these relationships, where there are varying levels of power imbalance, individuals may experience threats when these imbalances cause distress. In response to this distress, a meaning-making process occurs as we need to understand the experience and incorporate it into our framework of understanding. Psychological distress arises when we struggle to assign meaning and respond to the perceived threat through what have been classically conceptualised as symptoms. For implementing a formulation using this system, the following interview framework is proposed (Boyle & Johnstone, 2020):

- What has happened to you? (How is Power operating in your life?).
- How did it affect you? (What kind of Threats does this pose?).
- What sense did you make of it? (What is the Meaning of these experiences to you?).
- What did you have to do to survive? (What kinds of threat response are you using?).

Analysing these questions leads to an understanding of the person's psychological distress through one of the following patterns (provisional and therefore open to future revision):

1. Identities, situated as a foundational pattern as it is proposed that economic and social inequalities and ideological meanings which support the negative operation of power result in increased levels of insecurity, lack of cohesion, fear, mistrust, violence and conflict, prejudice, discrimination, and social and relational adversities across whole societies.
2. Surviving rejection, entrapment and invalidation.
3. Surviving insecure attachments and adversities as a child/young person.
4. Surviving separation and identity confusion.
5. Surviving defeat, entrapment, disconnection and loss.
6. Surviving social exclusions, shame and coercive power.
7. Surviving single threats.

One of the most distinctive features of this new framework is that it defines distress through the lived experience of individuals. In other words, it represents what people "do" in response to threat rather than the "disorders" they have. We believe this constitutes a significant advance in recognising the rights of mental health service users, as it positions them as experts in their own difficulties rather than merely recipients of professionally directed interventions. This approach enables a collaborative development that respects individual preferences, fostering an active role in the recovery process. The use of collaborative approaches not only honours the rights of service users but is also supported by emerging experimental evidence. In this regard, a Cochrane group is dedicated to monitoring the effectiveness of collaborative approaches (versus non-collaborative approaches) in the treatment of severe mental disorders (Reilly et al., 2013).

Currently, there is, therefore, a diversity of options regarding the diagnostic process in clinical practice. In this material, we consider it part of the broad perspective of psychological formulation that we advocate. However, in a university training context, it is important to provide education on the most widely used diagnostic systems, such as the DSM and ICD, as well as to introduce new proposals like the aforementioned Power,

Threat, Meaning Framework, ensuring that students are aware of and understand the different possibilities.

5.2. The Differential Diagnosis Process

In contexts where it is necessary to make diagnoses, with all their limitations but also recognising their communicative value, it is useful to follow differential diagnosis guidelines, including the identification of the primary disorder, often through decision trees. During the development of the DSM-5, its official differential diagnosis manual was reissued (First, 2013) introducing the possibility of carrying out the process via mobile applications. This system provides a decision tree for each diagnosis. Within this framework, the differential diagnosis process is divided into six steps:

1. **Rule out factitious disorder and malingering.** Although work within mental health services relies heavily on a good therapeutic relationship between the service user and professional, sometimes individuals may simulate their symptoms. When the deception provides a secondary "material" gain (such as sick leave, social benefits, or avoidance of civil or criminal responsibilities), it is considered malingering. If there are no obvious external rewards and the behaviour serves to obtain secondary benefits related to presenting oneself as ill, it is considered a factitious disorder[11]. It is important to note that evaluating the truthfulness of symptoms should not be the first step in the intervention process, but caution should be increased when: a) there is a very evident benefit in receiving a diagnosis; b) the symptoms closely match the popular understanding of the disorder; c) the symptoms change radically between sessions; d) the person imitates a "model" (such as another person or a film); or e) there are clear signs that the person is being manipulated or influenced to obtain a potential gain.
2. **Rule out the use of a substance as an aetiology.** Once malingering has been excluded, it is necessary to determine whether a drug affecting the central nervous system could be causing the psychological distress under evaluation. If there has

[11] Criterion B for factitious disorder has changed from the DSM-IV-TR to the DSM-5 due to difficulties in objectifying it:
DSM-IV: The motivation for the behaviour is to assume the sick role.
DSM-5: The individual presents himself or herself to others as ill, impaired, or injured.

been substance use, the etiological relationship should be assessed. There are several possibilities: a) withdrawal syndrome (a state that can mimic a wide range of symptoms), in which case many treatments, both pharmacological and psychological, may be contraindicated; b) effects of the substance; c) attempted self-medication, in which case the symptoms would have preceded the use; d) the two phenomena are completely independent. When a causal relationship is established, it is important to consider whether there has been a close temporal coincidence, whether the pattern of use aligns with the pattern of symptoms, and whether there are alternative explanations.

3. **Rule out medical aetiology.** This step is essential but can be complicated and may require referral to a specialist. The difficulty arises from how similar certain psychological symptoms and somatic illnesses can be, the fact that some medical conditions, such as cancer, may present with psychological symptoms, the complex relationship between both aetiologies (it is not always possible to separate mind and body in a Cartesian manner), and the fact that care for people presenting with psychological symptoms often occurs in settings where there is no expectation of finding somatic disorders. When there is doubt as to whether the observed symptoms are explained by organic or psychological causes, a physician should first rule out organicity. In any case, and despite the evident overlap between the physical and psychological, if there is the slightest doubt that a concomitant somatic disorder may be present alongside the detected symptoms, the person should be referred immediately to a specialist.
4. **Determine the specific primary disorder(s).** The next step is to decide which symptom or symptoms constitute the primary disorder in the case, in other words, to establish a diagnostic orientation. Diagnostic manuals are structured in this way, and the chapter titles themselves suggest symptom clusters that any professional with adequate training in psychopathology should be able to recognise. In the DSM-5 (compatible with ICD codes), the main disorder categories are: neurodevelopmental, schizophrenia spectrum and other psychotic disorders, bipolar, depressive, anxiety, obsessive-compulsive, trauma- and stressor-related, dissociative, somatic symptom, feeding and eating, elimination, sleep-wake, sexual dysfunctions, gender dysphoria, disruptive, impulse-control, and conduct disorders,

substance-related and addictive disorders, neurocognitive, personality, and paraphilic disorders. The manual and the mobile application based on First (2013) provide decision trees to explore each of these categories in depth and select the most precise diagnosis. As noted earlier, there are various alternative conceptualisations that relate more or less closely to this system[12]. These approaches place less emphasis on screening symptoms to assign a specific label and instead focus on describing each of the person's distress experiences in a phenomenological way and collaboratively with them.

5. **Differentiate adjustment disorders from unspecified disorders.** When the symptomatology does not fit a particular pattern or does not meet temporal criteria, but causes clinically significant distress, a differential diagnosis should be made between an adjustment disorder (cases in which the symptoms have appeared in response to a specific and identifiable stressor) and the other specified or unspecified categories. The decision between the latter two depends on whether the therapist wishes to specify the reason why they do not consider the diagnosis to fit within one of the taxonomies defined by the DSM or ICD.
6. **Establish the boundary with the absence of mental disorder.** Although this constitutes the final step, it is highly significant and can sometimes be very complex. In general, the symptomatology included in diagnostic manuals is ubiquitous, and almost the entire population has experienced some symptom at some point in their lives. Deliberately, the DSM-5 has declined to define the term "clinically significant", leaving it to the judgement of the professionals using the diagnostic criteria. The boundary between what is considered clinically significant and what is not is influenced by culture, the clinical context in which the diagnosis is made (for example, whether it is primary care, specialised care, or emergency services), the therapist's biases, the availability of resources, and so on. The conceptualisation of the same problem can vary significantly depending on whether the person sought consultation voluntarily, was referred by someone close to them, or was referred from another social or health resource.

[12] For example, sadness and worry, sexuality and gender, madness, distressing bodies and food, and "deranged personalities?" described by Cromby et al. (2013b).

6. Feedback and goal setting

As with determining the person requesting help, the first decision when providing feedback is to establish who it is directed to. When the individual seeks help for themselves, it is clear that the feedback will be offered to them and to anyone they consider appropriate to share it with. In cases where third parties consult on behalf of minors, the feedback is provided to their family members or legal guardians. Afterwards, an explanation can be given to the minors to the extent that they are able to understand. In cases where individuals are unable to manage the situation themselves due to the impact of their difficulties, feedback can be given to the family and the person separately, adapting explanations and avoiding disclosure of personal or intimate information that is not relevant.

In general terms, feedback includes two fundamental points: the explanatory hypothesis about what is happening with the person and the plan established to address it. However, not all approaches follow the same model. As mentioned earlier, there is a spectrum between the implicit feedback typical of psychodynamic approaches and the fully explicit feedback characteristic of cognitive-behavioural approaches. Between these two styles, there are multiple possibilities. For example, therapists using the solution-focused model place less emphasis on developing an explanatory model and instead focus on solutions, using strategic language in which the goals being pursued are not always disclosed. Despite differences regarding what points feedback should contain, in a psychotherapeutic context it is essential to present an intervention proposal and assess whether the person accepts it.

Regarding the information provided about the hypotheses, it is common to include a useful explanatory model and offer a realistic yet hopeful perspective in terms of prognosis. Concerning treatment, it is usual to propose goals to work on, specify the type of intervention (individual, group, family, etc.), the strategies to be employed (activities, between-session tasks, etc.), and an estimate of the duration and frequency of the intervention. Although there is some debate on this topic, from our perspective it is essential to reach a consensus on goals with the person or at least ensure that they adopt them as their own, in order to foster commitment and engagement from the start of the process.

We also recommend ensuring that goals meet the so-called SMART criteria[13]. This means that goals should be specific (targeting a concrete aspect), measurable (progress or achievement can be assessed), realistic (attainable), relevant (meaningful to the person), and time-bound (a clear timeframe is proposed within which the goal is to be achieved).

Finally, it is important to respect the person's choice regarding the start of the therapeutic process. If the explanation or proposed treatment does not meet their needs, or if they do not see a way to engage with it, guidance can be provided to help them find another therapist or professional from a different discipline who may be better suited to their situation. Likewise, if the professional is aware that they cannot offer the intervention they consider most appropriate, it is equally important to do everything possible to support the person in accessing another service or form of care.

As general recommendations, it is important to maintain an attitude of closeness and use language that is accessible to the person. This helps ensure that the information can be understood and that the person feels free to ask any necessary questions. It is essential to avoid rigid or dogmatic explanations, as there may be alternative explanatory models, changes during the person's difficulties that alter the intervention, or life events that produce broader transformations in the difficulties or the therapeutic process. Honesty is a fundamental attitude. The professional should gauge the person's tolerable limits, providing a realistic yet hopeful perspective. When done in this way, feedback can become a source of relief, as the person feels understood. Additionally, it is important that the person can form a theory of what is happening and feel that the therapist has tools that may help them.

6.1. Feedback as the Foundation of the Therapeutic Alliance

The moment when feedback is provided can be crucial in establishing the therapeutic alliance. It is therefore essential that the person feels welcomed and understood and perceives that a solid hypothesis has been developed regarding the problems they have brought to consultation, along with a plan for their treatment. Likewise, it is vital to

[13] Mnemonic acronym for Specific, Measurable, Attainable, Relevant, and Time-Bound.

maintain a collaborative attitude, remain open to reconsidering the premises of the hypotheses if necessary, and respect the person's preferences.

The characteristics of the therapist that facilitate the proper establishment of the therapeutic alliance in the early stages of treatment include attitudes that can be actively fostered, such as openness, warmth, trust, empathy, flexibility, honesty, respect, and a sense of safety (Ackerman & Hilsenroth, 2003; Corbella & Botella, 2003). Contrary to what one might assume, there is no solid evidence that the therapist's level of experience decisively influences their ability to establish a therapeutic relationship. However, certain personal characteristics of the therapist, such as their comfort in intimate relationships, personality traits like low hostility, and their perception of social support, can implicitly affect the formation of the therapeutic alliance (Dunkle, 1996). Nevertheless, research findings on the profiles of therapists most effective in establishing the therapeutic alliance do not allow for definitive conclusions.

On the other hand, there are characteristics of clients that can influence their engagement with the therapist and their receptivity to therapeutic proposals. For instance, defensiveness, lack of motivation, hostility, and dominance have been linked to difficulties in forming a strong therapeutic alliance (Corbella & Botella, 2003). The concept of attachment style (Bowlby, 1958) refers to the way individuals form and maintain emotional bonds. This style also affects the establishment of the therapeutic alliance, and there is extensive literature examining this influence. While individuals with a secure attachment tend to form alliances characterised by high levels of mutual trust, shared understanding of therapeutic goals, and effective collaboration on treatment tasks, those with insecure attachment often face more challenges in developing the alliance (Castonguay & Beutler, 2005). These difficulties can arise from struggles to agree on or achieve goals, as well as from not obtaining results as quickly as they would like. Therefore, it is important to consider attachment styles when establishing the therapeutic alliance.

Some practical tips for developing the therapeutic alliance are (Ackerman & Hilsenroth, 2003; Beck et al., 1985; Johnstone & Boyle, 2018):

- Build the relationship on a reciprocal basis, avoiding a position of superiority.
- Facilitate the expression of the person's experiences in their own terms.
- Encourage the expression of affect and emotions.

- Provide feedback that reflects your understanding of the person's demand.
- Set objectives based on mutual agreement.
- Avoid hidden agendas; apply techniques openly, explaining their rationale and expected outcomes for each session.
- Design intersession tasks or activities collaboratively to maintain progress.
- Admit mistakes and explore alternatives.
- Maintain a collaborative environment throughout the entire process.

6.2. Feedback examples

Service user: Why do I worry about germs and wash my hands so much?

Therapist: Because you have obsessive-compulsive disorder.

SU: How do you know I have obsessive-compulsive disorder?

T: I know because you worry about germs and wash your hands a lot.

As can be seen in this example, the diagnosis alone does not provide a theory, which is likely necessary to explain to the person to begin treatment. Therefore, comprehensive feedback should be based on a process of psychological formulation. In the following example, we offer feedback given to a person experiencing obsessions and compulsions.

T: In my view, your problem is not that you wash your hands a lot, but that you wash them so much that it bothers you, takes up a lot of your time, and you want to stop but cannot. You probably wash your hands so often because the idea of having dirty hands causes you a lot of distress, and to reduce it you choose to wash your hands. Does this make your problem go away?

SU: At the time, yes… but afterwards everything starts again…

T: What do you mean?

SU: Well, I get the idea again that my hands are dirty.

T: Exactly, washing your hands reduces the distress momentarily, but washing like this is not a good solution because the doubt comes back. If you like, we can leave this topic for when we discuss the treatment. On the other hand, correct me if I am wrong, but it seemed that at some point you thought you were washing your hands too much, tried not to do it, and wanted to force yourself not to think about germs.

SU: Yes, I have tried that already.

T: Then you have already found it is impossible not to think. If I tell you, "I am going to tell you something, but I do not want you to think about it: pink elephant. Above all, do not imagine the pink elephant, do not visualise it…"

SU: I have already thought about it.

T: Exactly, thoughts are not entirely voluntary; they simply come, and if we focus our attention on them, they do not go away.

SU: I do not know how to ignore my thoughts.

T: That is the point. It is very difficult for you not to think a lot about certain issues related to cleanliness and scrupulousness. If it were as simple as telling you to ignore your thoughts, after this explanation you could just ignore them and that would be it. But the truth is it is more complex; you will need training. As all training requires time and consistency, later we will talk about the intervention plan I can offer you. We call these kinds of thoughts that recur so often and cause so much distress "obsessions." The behaviours carried out to reduce the distress caused by obsessions are called "compulsions." Does this explanation fit with what happens to you?

SU: Yes, yes, yes, totally… but why does this happen to me?

T: In mental health, things are rarely explained by a single factor; usually a combination of biological aspects, environmental influences, family, friends, things we have learned,

experiences we have had, all interact. Sometimes some of these factors weigh more than others and are the main explanation. This set of difficulties that occur together is called obsessive-compulsive disorder, commonly known as OCD. This diagnostic label helps professionals identify and name the set of difficulties you experience, as it is a situation shared by many people. Had you heard of this diagnosis before?

(…) [It is important to clarify any doubts that may arise and to allow the person to raise new doubts at a later stage.]

However, you do not change as a person simply because we give this diagnostic label in our reports; you remain the same person you were yesterday and will be tomorrow. With the therapeutic proposal we will offer, we do not aim to change you; you have many values you consider positive. If you agree with the proposal, we will try to help you reduce the difficulties that cause you distress. You will probably continue to be a generally careful, meticulous, and scrupulous person. Nevertheless, we will try to reduce these difficulties so that they do not interfere with your life.

7. Example of psychological formulation

As a conclusion, we provide a complete example of psychological formulation. It is worth clarifying once more that by "psychological formulation" we refer to the full process presented in this material, from identifying the reason for consultation and analysing the presenting problem, to providing feedback and setting goals.

M. is a 35-year-old woman who has experienced considerable distress over the past year due to changes and increased demands in her job, which she feels are limiting her life. Two weeks ago, she decided to seek therapeutic help after several medical specialists ruled out physical problems as the cause of her distress. One of these professionals, her general practitioner, prescribed medication that M. prefers not to start until consulting a therapist, as she does not like "taking things that might affect me." She reports no alcohol consumption, "just a coffee a day."

Initially, M. believed something was physically wrong, but she has now come to the conclusion that something is not right in her mind, which she believes is causing the

"panic episodes" she reports experiencing increasingly often. She therefore thinks that there is something "psychological" not functioning "properly" within her.

To cope with her symptoms, M. has tried to avoid situations where she thinks something catastrophic might happen. For example, she avoids physical exercise and does not leave the house without someone who could help her in the event of a crisis. This has led to social isolation.

M. has no previous therapeutic experience. She communicates that her goal is to overcome the panic attacks she has been experiencing and specifically seeks help in managing them. She appears motivated to find a solution to the problem but states that she does not know what to do and hopes that we can provide a quick solution.

At the start of the assessment, M. reports that during the episodes she experiences palpitations, tachycardia, shortness of breath, a feeling of dizziness, paraesthesia (abnormal skin sensations) and sweating. When asked about her thoughts during these moments, she explains that she fears she will faint and not receive help, or even that she might go mad or have a heart attack. These thoughts increase her fear with each episode, as she feels that "everything is linked in a self-reinforcing cycle."

M. reports that her mother and maternal grandmother were always anxious and worried about everything. She also mentions being very distressed when her uncle, to whom she was very close, was diagnosed with cancer. She recounts that he survived treatment but passed away a few years later. M. also acknowledges that work-related stress and pressure may have contributed to the development of her distress, as "it coincided exactly in time."

7.1. Identification of the reason for consultation and analysis of the therapeutic demand

- **Identification of the person seeking help**: It is the person himself who requests help due to experiencing high anxiety that she feels is limiting her life.
- **Time elapsed between the emergence of the problem and the consultation**: She reports experiencing "panic episodes" for the past year, which have been increasing. She decided to seek help two weeks ago after several specialists ruled out physical causes.

- **Theory of the problem that motivates the consultation**: Initially, she thought something was physically wrong, but she now believes that something is not right in her mind, which is causing her "panic episodes." She feels there is something "psychological" that is not functioning "correctly" within her.
- **Attempted solutions**: In response to the idea that something catastrophic could happen, she avoids physical exercise and does not leave the house without someone who could help in the event of a crisis. She has consulted several medical specialists.
- **Previous therapeutic experiences**: Not reported.
- **Analysis of the therapeutic demand**: Symptomatic demand. She seeks help to overcome panic attacks.
- **Expectations and theory of change**: She expects that, during the session, the therapist will produce a change in it and the symptomatology will disappear. She is motivated to look for a solution to the problem she exposes; however, it seems that she is looking for a solution that comes from outside. It shows capacity for partial introspection, low levels of reactance.

7.2. Difficulties experienced

- **Physical symptoms:** palpitations, tachycardia, dyspnoea, paraesthesia, feeling dizzy and sweating.
- **Cognitive symptoms:** belief that she might faint or harm herself, not receive help, or go mad.
- **Emotional symptoms:** fear that increases with each episode.
- **Relationship between physical, cognitive, and emotional symptoms:** She experiences physical sensations and interprets them catastrophically. The fear of fainting, not receiving help, going mad, or having a heart attack increases her anxiety and physiological arousal, which she again interprets catastrophically, creating a vicious cycle.

7.3. History of the problem

- **Predisposing factors:** Family history of significant distress related to anxiety and worry. Childhood experiences of concern about the illness of a close family member.

- **Precipitating factors:** The onset of the first panic attacks coincided with a period of high work demands.
- **Maintenance factors** (previously explored as attempted solutions): due to the fear that something catastrophic might happen, she avoids physical exercise and does not leave the house without someone who could help her in the event of a crisis, which has led to a marked restriction in her social activity.

7.4. Stage of change

The person is in a precontemplative stage transitioning towards contemplation, as she has decided to seek help.

7.5. Development and testing of explanatory hypotheses

M. presents a pattern of sensitivity to anxiety that has been exacerbated by her work situation, leading to episodes of crisis. The interaction between physical, cognitive, and emotional symptoms creates a negative feedback cycle. She interprets the physical sensations experienced during panic attacks in a catastrophic way, which in turn increases her fear. This pattern, which can be identified with the concept of anticipatory anxiety, further heightens M.'s physiological arousal, reinforcing her negative beliefs and perpetuating the cycle of anxiety.

7.6. Administration of assessment instruments

Given the specific nature of the psychological distress experienced by M., and with the aim of enabling efficient monitoring, it is proposed to administer the Panic and Agoraphobia Scale[14] (Bandelow, 1999) at the start of therapy and then monthly until the end of the process. The person is informed about its purpose and how it is interpreted, and feedback is provided on the results, including their usefulness for monitoring progress throughout the therapeutic process.

[14] The instrument consists of 13 items that are grouped into 5 subscales: panic attacks, agoraphobia, anticipatory anxiety, disability, and health concerns. Each item is scored using a 5-point Likert scale (0 to 4).

7.7. Differential diagnosis process

1. Malingering or factitious disorder is ruled out, as no indications are detected.
2. There is no use of medication or toxic substances.
3. Organic causes have been excluded.
4. The panic episodes are not attributable to another anxiety disorder, as they occur unexpectedly and are not linked to triggers beyond the physical sensations themselves. Affective disorders are ruled out, as the main symptoms are not consistent with their core clinical features. Diagnostic orientation: Panic disorder (F41.00) and agoraphobia (F40.00).
5. Adjustment disorders and unspecified disorders are ruled out based on the symptoms assessed and their duration.
6. The distress causes significant interference in the person's life; therefore, the absence of a mental disorder is ruled out.

7.8. Feedback and treatment goals

- Reformulate the demand so that it is closer to being specific, helping the person understand the importance of her active participation in the therapeutic process.
- Strengthen the therapeutic alliance through the development of a shared understanding of anticipatory anxiety and how to address it.
- Reduce the degree of interference that anxiety has in her daily life.
- Develop the ability to go out independently.
- Return to work.

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