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Experience of Psychosocial Formulation within a Biopsychosocial Model of Care for First- Episode Psychosis

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Abstract

Objectives: A biopsychosocial model of care (integrating biological and psychosocial supoprt) is often applied within Early Intervention for Psychosis services. The current study aims to explore the experience of people engaging with a process of psychosocial formulation whilst also being supported by clinicians representing a biological understanding of psychosis. Design: A qualitative design is used, with data collected through semi-structured interviews. Methods: 9 individuals from Early Intervention services were interviewed regarding their experience of engaging in psychosocial formulation whilst concurrently receiving ongoing support from a medical perspective. Results: 3 common themes were identified across the experience of the participants. These were (i) a joined-up 'package' of support (ii) formulation makes a distinctive contribution to the 'package' (iii) shaping the experience. Conclusions: The biopsychosocial model of care for first episode psychosis was experienced by participants as offering a sense of a coherent support 'package'. This was multi-faceted, of which psychosocial formulation was identified as making a distinctive contribution. Participants also exerted agency upon their experience of the biopsychosocial model of care and were able to shape their support in a way that was most personally meaningful. Suggestion of the existence of a continuum of experience of psychosocial formulation within this context is discussed, in addition to implications for clinical practice regarding the need to enhance the malleable nature of the biopsychosocial model.

Keywords: biopsychosocial, formulation, early intervention, psychosis.

Introduction:

Traditionally, medicine has viewed the mind and body as two distinct entities to be analysed, diagnosed and treated separately (McDaniel, 1995). The complex interaction between biological, psychological and societal experiences, including their bi-influential roles, began to be recognised following an influential article published by George Engel in 1977. This called for a new approach, which Engel (1977) named the 'biopsychosocial model', highlighting a gap to be bridged between the two parallel but differing ideologies of biology and psychology.

The main theory underpinning the biopsychosocial model involves a 'vulnerability-stress' hypothesis, the interaction of environmental stressors and characteristics of vulnerability, which may be genetic in nature or acquired due to adverse life events (Nuechterlein & Dawson, 1984; Zubin & Spring, 1977). This model is now commonplace in a variety of clinical settings (McDaniel, 1995; Main, Sullivan & Watson, 2008; Read, Mosher & Bentall, 2004).

One area of mental health research where a biopsychosocial understanding is often drawn upon is that of first-episode psychosis (FEP; Read et al., 2004). Within this setting the biological component of support is provided through the use of neuroleptic medication, aiming to reduce psychotic symptoms (Kerr, 2003). Alongside this, the biopsychosocial model addresses the role of social factors such as housing and employment (Read, 2004). Additionally, a psychological perspective emphasises the role of adverse life events and pays attention to the sense people make of their experiences (Geekie, 2004; Read & Haslam, 2004). Psychological intervention within the biopsychosocial model for FEP is usually delivered as Cognitive Behaviour Therapy (CBT), consistent with good practice guidance (e.g., International Early Psychosis Association, 2005; McGorry, 2005; National Institute for Health and Clinical Excellence [NICE], 2013; 2014). This approach posits that it is the way that people think about their experiences that causes distress, rather than the (psychotic) experiences themselves (Beck, 1976) and aims to "place the individual's . . .search for meaning at the heart of the process of formulation and therapy" (Chadwick, Birchwood & Trower, 1996, p. 177).

The process of formulation (e.g. BPS; 2008) not only aids care planning, but also provides a tool for meaning making. The meanings people make of their lives and the stories they tell in doing so have been suggested to be a "unique dimension of recovery" that cannot be reduced to simply identifying the presence of symptoms (Roe & Lysaker, 2012). Helpful components of formulation within CBT have been found to include understanding of the onset and coping with psychotic experiences, normalising experiences and considering alternative explanations (Berry & Hayward, 2011; Judge, Estroff, Perkins & Penn, 2008).

Continuum-based CBT perspectives appear to contradict a medical perspective that views psychosis as a chronic, biologically determined illness that prioritises pharmacology and symptom reduction (Heriot-Maitland, 2011), distinguishes normal from abnormal within a diagnostic system (Pilgrim & Bentall, 1999) and considers the content of the experience as having no inherent value or meaning (Jameson, 2003). Furthermore, contrasts exist between the qualitative accounts of individuals who have accessed traditional medically led mental health services and those who have engaged in psychological approaches to support for FEP. In stark contrast to the normalising and validating experience described earlier (Berry & Hayward, 2011; Judge et al., 2008), traditional medically led mental health services in the United Kingdom (UK) and North America have been described as involving "patronizing attitudes and feelings of stigma" (Dinos, Stevens, Serfaty, Weich & King, 2004, p. 176) and provoking feelings of being labelled, invalidated and unheard (Hagen & Nixon, 2011). However, it is proposed that the provision of a therapeutic space within the biopsychosocial model facilitates reflection upon the personal understanding of psychosis, potentially limiting the impact of any perceived discrepancies between the different components to support and allowing improved communication and negotiation of shared goals (Mackler, 2009).

With their provision of a biopsychosocial model of care, Early Intervention (EI) services provide an alternative to traditional medically led community psychiatric services for individuals experiencing FEP (Johannessen, 2004). EI services consider psychotic experiences to be dynamic and reversible in their nature and focus upon recovery rather than management (Johannessen, 2004). EI services have been shown to have effective clinical, social and vocational outcomes (Bird et al., 2010; Craig et al., 2004), though little is known about long-term benefits (Bird et al., 2010).

Within FEP settings, service users have reported EI services as enabling their personal journey towards recovery, citing the importance of developing relationships, increasing a sense of agency and understanding, whilst also helping to reduce perceived stigma (Harris, Collinson & das Nair, 2012). Despite this, opinion on the utility of the biopsychosocial approach remains divided. The model has been criticised for failing to fully address issues related to the relationship between the different natures of its three component elements; biological, psychological, social (Kinderman, 2005). Read et al. (2004) further argue that the biopsychosocial model simply creates an “illusion of balance” (p. 4), focusing on pathology and relegating the role of psychosocial factors to triggers of an “underlying genetic time bomb” (p. 4). For those with personal experience of psychosis however, understanding that environmental factors may have impacted upon a biological predisposition to psychosis has been found to allow sense to be made of personal feelings regarding the interaction between the brain and senses (Kerr, 2003).

Given the apparent conflicts between the biological and psychosocial perspectives on psychosis, the current study has adopted a qualitative approach to understanding the way in which people experience a model of support that attempts to integrate differing theoretical perspectives. This question has been addressed by asking people to reflect upon their experience of simultaneously engaging with psychosocial formulation (as part of a therapeutic process) and support regarding biological treatment whilst accessing an EI service. The guiding research question was, ‘How do people receiving support for psychosis within a biopsychosocial model of care experience the process of psychosocial formulation whilst concurrently engaging with a biological approach to support?’

Method

Sample and Participants

Participant recruitment took place across seven EI for psychosis teams within three NHS providers in the North of England. Participants were eligible for the study if they were under the care of an EI team at the time of recruitment, were within three years of onset of first treated episode of psychosis (as assessed by the service using the Positive and Negative Syndrome Scale [PANSS; Kay, Fiszbein & Oplar, 1987] criteria), were over the age of 18 and had, within the last three years, engaged in a process of longitudinal psychosocial formulation with a clinical psychologist or psychological therapist whilst engaging in regular discussions regarding neuroleptic medication with relevant professionals (e.g., psychiatrist, community psychiatric nurse).

Individuals were not approached if substance misuse, head injury or organic disorder were judged to be the primary cause of psychotic symptoms, if they met ‘at risk’ criteria on the Comprehensive Assessment of At Risk Mental State (CAARMS; Yung et al., 2005) but had not met PANSS (Kay et al., 1987) criteria for a psychotic episode, if doubts existed about the individual’s capacity to consent or they were unable to converse in English.

Approximately 25 potential participants were provided with information about the research. Nine of these chose to take part; these were recruited across five of the seven host teams. Participants were aged between 19 and 36; the majority were of White ethnicity, with one individual of mixed White and Black African ethnicity. All had engaged in a notable amount of individual psychosocial therapy prior to participation (between 3 and 16 months of regular sessions with a psychological therapist) and had concurrently engaged in regular discussions regarding medication with other members of the care team. Table 1 displays this participant demographic information (pseudonyms are used).

Table 1

Participant demographic information.

Participant (pseudonym)	Gender	Age	Ethnicity	Support medication	Contact with psychological therapist
Jason	M	25	White - British	Medication throughout	12 months with psychologist
Simon	M	36	White	Medication throughout	12 months with CBT therapist
Andy	M	26	White	Initially taking meds – stopped after 3 months, ongoing discussion in reviews.	6 months with CBT therapist
Adam	M	19	White – English	Medication throughout.	6 months with CBT therapist
Kenyon	M	20	Mixed ethnic groups – White and Black African	Medication throughout.	3 months with CBT therapist
David	M	30	White- English	Medication throughout	12 months with psychologist

Materials

Demographic information was gathered using a questionnaire based upon categories represented within the national census (Office for National Statistics, 2011). The main research question was approached using a semi-structured interview schedule. This was developed through consideration of extant research literature and consultation with a service user.

Open questions were used to explore the research topic. For example, in reference to seeing a therapist following a psychiatrist: "how did you then find thinking about your personal experience from a psychological angle?" Additional prompt questions were used where necessary to gain further insight into an experience, for example "was there anything helpful/unhelpful about that?"

Procedure

NHS ethical approval and permission was gained from each host NHS trust prior to conducting the research. Potential participants were identified and given information about the research by clinicians within the host teams. Interested persons were asked to respond directly to the researcher, at which point their understanding of the information sheet was confirmed and they were given the opportunity to ask questions. Consent was also gained to contact care-coordinators to discuss any potential risk issues (no concerns were raised) and meetings were then arranged in familiar community locations (e.g., local health centres). Two interviews were conducted by telephone.

Upon meeting, a further opportunity for questions was provided before gaining informed written consent. Where interviews were conducted by telephone, the signed consent form was returned in advance of the interview. Prior to interview participants were asked to complete a demographic information questionnaire. Interviews then commenced (lasting between 22 and 55 minutes). These were audio recorded and followed by a debrief discussion. Each recording was transcribed verbatim.

Data Analysis

Interview transcripts were analysed using Interpretative Phenomenological Analysis (IPA), an approach that aims to understand how participants make sense and construct meaning from experience (Smith & Osborn, 2008). In taking the individual's description of their experience as the object of enquiry (Baker, Wuest & Stern, 1992), IPA was chosen for its consistency with the aims of the research question. IPA also acknowledges the researcher's own conceptions and recognises the role these have to play in interpreting the interview data, creating a "two-stage interpretation process" (Smith & Osborn, 2008, p. 53) whereby the participant tries to make sense of their experience and the researcher tries to makes sense of the participant trying to make sense of their experience.

Analysis was approached following the IPA procedure described by Smith and Osborn (2008). Each trancripst was analysed separately following an iterative process that initially involved the development of themes for each participant. A narrative was written for each of these themes, reflecting a level of abstraction however linked clearly back to the data and supported by indicative quotes. Consistent with the aims of IPA, the researcher took an idiographic approach throughout analysis and attempted to bracket-off thoughts regarding preceding transcript analysis, approaching each from a fresh stance as much as possible (Smith et al., 2009).

The themes from all transcripts constituted the subthemes of the final analysis. The commonalities of these were then compared and merged in order to develop overarching themes, whilst care was taken to ensure that the connections being made were representative of the actual participant accounts. Each final theme was developed to include a narrative that aimed to reflect original participant experience (based upon its subthemes and supported by indicative quotes) and given a name that reflected the experience of the theme.

Ensuring the Credibility of Analysis

A number of measures were taken in order to enhance the rigour and credibility of the analysis (Elliot, Fisher & Rennie, 1999). A service user consultant helped to develop the participant information sheet, interview schedule and consent form, increasing the accessibility of these documents. The researcher completed a reflective diary (Yardley, 2008) which was discussed with the second and third authors to aid reflexivity, acknowledging areas of bias and/or preconceptions and subsequently reducing the influence of these upon the research process (Elliot et al., 1999; Smith, Flowers & Larkin, 2009). Methodological rigour was also ensured by the grounding of themes in examples from transcripts and these being audited by the second and third authors (Elliot et al., 1999). This process ensured that the analysis “is not confined to one perspective, and makes sense to other people” (Yardley, 2008, p. 241).

Results

Analysis resulted in the identification of three themes; (i) a joined-up ‘package’ of support (ii) formulation makes a distinctive contribution (iii) shaping the experience. These are presented in narrative form below, alongside supporting indicative quotes taken from the original data, as recommended by Elliot et al., (1999). Table 2 displays each theme with identified sub-themes.

Table 2. Three major themes with incorporated subthemes (and participant source).

A complete ‘package’ of support	**Formulation makes a distinctive contribution**	**Shaping the experience**
▪ It felt like a complete support package (David) ▪ A joined-up package of support (Kim) ▪ Care coordinator- that supportive middle ground (Kim) ▪ Hearing the same message over and over (Kim) ▪ The impact of support and guidance (Simon) ▪ The importance of support (Kenyon) ▪ The importance of relationships (Adam) ▪ Turning to others (Andy) ▪ Care coordinator as constant (Jess) ▪ The team working as a whole (Simon) ▪ It all helps – hard to say how (Jason)	▪ The experience of therapy within this setting (David). ▪ Therapy offers a new understanding (Adam). ▪ Therapy as different to medication and to be kept separate (Jason). ▪ Keeping things separate (Andy). ▪ Seeking the find the root cause (Jess). ▪ The role of therapy alongside medication (Simon). ▪ Team as a whole with many very separate parts (Adam). ▪ Medication and therapy are totally separate (Steven).	▪ The experience in between (David). ▪ Having both approaches aids understanding and learning (Simon). ▪ Medical understanding potentially part of the deal but not for me (Jess). ▪ Allowing others to take control (Jason). ▪ Taking control for myself (Andy). ▪ The need to practically address distress (Kenyon). ▪ Using the support and understanding in everyday life (Steven). ▪ The role of explanation (Steven). ▪ The more I understand the easier I can cope (Kenyon). ▪ Drawing upon resources in

A Joined-up 'Package' of Support

For all except Steven, the biopsychosocial approach was experienced as a 'package' of support. The experiencing of therapy, medication and social support as different but complimentary components, provided a sense of coherence:
It was easy to let me key worker in on what was going on [in therapy], I could even let me psychiatrist in on what was going on and how things were progressing, because I felt like it was a complete support package. (David)

The different components of support within the biopsychosocial approach were often experienced as having individual roles, but delivering a consistent message. For Simon, this increased a sense of learning and understanding: "I've learnt a lot of that though. . .you pick bits, you do learn bits from your therapist and from your care workers". For some participants these various components appeared fully integrated, with little distinction made between the different aspects of support. This further increased the sense of coherence, demonstrated as Jason attempted to reflect upon his experience of both medical and psychosocial support: "I think they've both helped, but it's hard for me to say oh yeh it's…".

For Kim, the consistency in the message being delivered by different professionals reinforced this sense of coherence, but also created some difficulty. Kim struggled to understand a biopsychosocial formulation of her experience and this impacted upon her ability to engage with the whole team as various members advocated the same message that didn't make sense to her:
Kim – [care coordinator] used to say erm, you need to do the work that [therapist] was giving out and that
Int – and how did you find that, hearing that from [care coordinator] and having conversations about that?
Kim – I found it quite difficult to believe what they were saying. (Kim)

The experience of support being delivered as a 'package' impacted upon the participants' experience in a number of ways. Kenyon reflected upon a sense of security that this provoked: "I knew I weren't on me own". For Adam, this went further as he experienced the two strands of therapy and medication as safety nets for each other: "it felt to me really really good and really supportive, coz it felt like I had something to fall back on if one of them wasn't working".

Additionally, the interaction of the different components of support impacted upon the experience of understanding. A number of participants, e.g., Kenyon, David and Simon, identified the way in which understanding developed through psychosocial formulation was transferred into other areas of support. For example, David experienced formulation as aiding his communication skills when then discussing his experience with his psychiatrist: "I could explain it in words and visions rather than getting confused and muddled up on what I was saying".

Relationships with team members were also experienced as significant within the experience of the 'package' of support. Participants commonly reflected upon these being characterised by a theme of guidance during early contact with the teams, something that many experienced as important at that time: "But if I didn't get the help, erh I think to be honest something else could have gotten worse" (Andy). The care coordinator was often experienced as holding a significant role as someone with whom all aspects of the support 'package' could be discussed. For example, prior to discussing his childhood during formulation in therapy, Kenyon found himself considering this with his care coordinator: "I'd spoke to me CPN about it, erh and she said that it could be a trigger to cause me illness". For Jess, the care coordinator's flexible and supportive presence, alongside more strutcutred sessions with a psychological therapist, appeared to increase her sense of security: she's been such a huge part of me life for like 3 years, even though like she's not there constantly. . . I could go weeks and weeks without seeing her, months, but I know I can ring her, and it's the security. (Jess)

The only participant who did not appear to share this experience was Steven who appeared to experience psychosocial formulation and medical intervention as entirely disconnected aspects of his support. This is reflected in his response when discussing his experience of reviews with the psychiatrist and whether these included any discussion of his developing psychosocial formulation: “he just sees me and like assesses medication and that’s it” (Steven).

The experience of a joined-up ‘package’ of support with different, yet often complimentary parts, represents a sense of coherence within the biopsychosocial model. This was experienced by some as containing distinct but complimentary components, and others as fully integrated with less awareness of difference between various aspects of support. Relationships with clinicians appear key in enhancing this sense of coherence. Whilst participants occasionally reflected upon some unhelpful aspects to experiencing all aspects of support in this joined-up manner, this more often aided understanding and enhanced a sense of security.

Formulation Makes a Distinctive Contribution

Seven of the nine participants (the exceptions being Kenyon and Kim) experienced the role of psychosocial formulation as a distinct feature within the overall ‘package’ of support. The process of psychosocial formulation was frequently described as providing an opportunity to view the experience of psychosis from a unique perspective. This was compounded by participants’ observations of different professionals as being interested in very different aspects of their experience. For Adam for example, psychosocial formulation provided the first opportunity to explore his experience in depth, over being asked to simply quantify his experiencing of ‘symptoms’:

Adam: talking to a psychiatrist erm, it was really only talk of “are you still experiencing hallucinations, yes right we need to up your medication” and that was kind of the jist of every conversation. . .whereas when I spoke to [therapist] about it, even though my psychosis had gone she still sort of counselled me through what I’d experienced. . .

Int: had that been the case with any other members of the team?

Adam: no, noone else had spoke about what I was actually seeing or feeling. (Adam)

Formulation within therapy was consistently described as aiding understanding about the experience of psychosis. This was experienced as a crucial aspect of the recovery process. Exploring childhood experiences appeared key within this helpful experience of formulation:
once we’d worked out that it was me childhood that had started it we could understand why they [voices] were there and what they were doing there coz there was no point in working out where they- like why they were there if I didn’t know where they’d come from in the first place. (Jess)

Developing a new understanding through psychosocial formulation played a distinct role that was also then incorporated within the overall support ‘package’:
Int: before you described to me how you understand erm that a lot of your psychosis has come following a difficult upbringing, how did you find fitting the role of medication in there, into that understanding of psychosis?
David: once I knew what the problem was it made me understand why I was seeing things and why I was hearing things and why I was feeling like everybody was against me and hated me and, so it, it made me understand what I was going through and then having [care coordinator] and [psychiatrist] and [therapist] all going through it with me makes it easier for me to fit along with the medication as well as the sessions I was having with [therapist]. (David)

For some participants however, the psychosocial component to support was experienced as the only setting within which to discuss personal feelings and issues from the past. An example of this includes Jason’s description of his experience of psychosocial formulation as at times upsetting and something he preferred to only share with his therapist:
Int: has that been quite a new experience for you? Talking about that kinda stuff?
Jason: yeh, I didn’t really wanna go into it with anyone else. (Jason)

Some participants were able to engage with the different components of support separately but concurrently: “like the psychiatrist was mainly, like ‘how are your meds, how are you, how’s your psychosis’ and the CBT therapist was like ‘right lets do this today, lets work on these thoughts’ they never really crossed over” (Adam). Similarly, Andy reflected upon the way in which he chose to engage entirely with psychosocial formulation and in doing so, put his experience of medication to one side rather than attempting to integrate these two approaches: “I didn’t fit anything in, it was just a completely new sway”.

Participants did not identify any drawbacks to psychosocial formulation as making a distinctive contribution to the support ‘package’. This was experienced as either integrating well into the overall ‘package’ e.g., David, or working well alongside other parts within this e.g., Jess, Andy, Adam, Jason, Simon. For those whose experience is not represented by this theme i.e., Kenyon and Kim, psychosocial formulation was not recognised as making a distinct contribution. Instead, for these two participants all aspects of the support ‘package’ were experienced as very similar, meaning that psychosocial formulation was not experienced as any different to the support received from other members of the team.

The experience of psychosocial formulation as making a distinctive contribution to the support ‘package’ involves this being very different to other areas of support such as medication. This often involved participants’ first experiences of exploring their early life experiences, a highly valued aspect of the recovery process and often experienced solely within psychosocial formulation. For some this was well incorporated with other areas of support, however others kept this experience very separate although still remaining part of an overall support ‘package’.

Shaping the Experience

The biopsychosocial approach was experienced by seven of the nine participants as something that could be shaped to be used in the most meaningful personal way. This suggests the biopsychosocial approach was sufficiently flexible to engender a sense of personal agency for the participants, Having a variety of components to the biopsychosocial model enabled participants to take learning from various sources and apply this to themselves in a way that felt helpful.

This can be seen within Simon’s reflections over the course of the interview,
you learn from talking to people, getting a better understanding, like psychiatrists, like the way we behave and the way things affect us. . .the therapist has an understanding of certain, your behaviour . . . mainly I’ve just learnt to tell people when I’m feeling stressed. (Simon)

Most participants described benefits of using psychosocial formulation to gain an increased understanding of their personal difficulties:
it was hard to understand but once I understood it was easy to like, at first like, I was in a state over it then once I understood it I was like “oh this is nothing, just go with the flow like”. (Jess)

Int – did therapy have any impact on how you understood the voices?
Steven – yeh it had a big impact…I used to think it was real and it used to get me into trouble…and the fact that they’d said like they explained to me…it made me understand that they are not real…and I’ve got nothing to worry about really coz before I was worrying. (Steven)

Additionally, many participants described developing useful ‘tools’ from formulation. For example, Kenyon discussed taking a thought challenging exercise into his daily life after his formal therapy had ended, and the increased confidence he gained from this:

just before erh my erh time was up we was gonna go to X and do it in X coz it's erh a crowded place, but we didn't have time to do it. . .but it still reassures me coz I can do it myself now, can just go out and think sort of and it reassures meself so its another like tool to understand me illness. (Kenyon)

For some participants, the process of formulation itself was viewed as the useful 'tool' upon which to draw when experiencing difficulties in everyday life: "now and again I go back to that [the formulation] and that helps" (David) and: "I try and think of what I've talked about with [therapist] when I'm having a difficult day" (Jason).
For some, this experience was enhanced by the flexibility of the biopsychosocial model to allow them to draw upon different aspects of biological and psychosocial support in response to their personal need. This was reflected upon by Jason, who discussed the way in which having therapy available helped him address the barriers to the progress he has made by taking medication alone: "generally everything's going quite well…the only thing what's stopping me is erm, delusional thoughts, so that's why I'm having CBT to challenge them".

Despite the range of understandings of psychosis demonstrated by the participants, the flexibility of the biopsychosocial approach supported the most useful application of psychosocial formulation for each individual. For those with a dominant medical perspective of psychosis, aspects of formulation such as education, tools and techniques appeared to increase understanding and help manage distress. Alternatively, other participants engaged more thoroughly in developing a longitudinal psychological formulation and drew heavily upon this understanding during their recovery. Finally, the clinicians supporting these participants appear to have been responsive to the service user's needs, being flexible and allowing therapy to be shaped in the most meaningful manner for each individual.

Discussion

The three identified themes offer insight into the way in which individuals experience concurrently engaging in medical and psychosocial components of support within a biopsychosocial model of care for psychosis.

Existing literature identifies typical differences between medical and psychosocial approaches to understanding psychosis (e.g., Kerr, 2003) and raises concerns in attempting to incorporate these within a biopsychosocial model (Heriot-Maitland, 2011). However, the current findings suggest that service users do not always differentiate between medical and psychosocial components of the biopsychosocial model.

Where discrepancies between the different components were acknowledged by the participants within this study, e.g., diverse styles of interaction with different professionals and practical variations between the differing components to support, these appeared not to present difficulty for the participants. The current research suggests that overall, participants often continued to experience these in a coherent manner (Kerr, 2003).

Although experienced by the majority as a coherent whole, some participants experienced different team members and their roles as separate components within this 'package' i.e., recognising differences between medical and psychosocial approaches to support and viewing these as parallel processes that may be engaged with concurrently. This appeared to be facilitated by a view that it is ok for the psychiatrist to only be interested in 'symptoms' (Jameson, 2003), as the psychological therapist is available for a different understanding, but that the two may be incorporated within the overall support 'package'. Steven's experience provides an exception to this viewing the two elements as entirely separate support systems with a limited acknowledgement of them being part of a 'package'.

The theme 'shaping the experience' offers interesting insights into the way in which participants drew upon psychosocial formulation in many different ways. For example, Jess appeared to make sense of her experience of psychosis drawing predominantly upon psychosocial theory, whilst Jason appeared to understand his experience based upon a biological perspective of psychosis as an illness. Interestingly, both Jess and Jason engaged in psychosocial formulation with clinicians with similar professional backgrounds (both clinical psychologists), however each described drawing upon this in different ways. For Jess, the longitudinal nature to formulation appeared key in helping her make sense of her experience and work towards her goal of improved quality of life, however Jason described formulating his current experience of 'delusional thoughts' the most helpful approach to reaching his goal of 'symptom' reduction.

The above two examples of differing applications of psychosocial formulation highlight stark contrasts in the way in which this component of the biopsychosocial model may be experienced. One potential interpretation of these findings involves viewing the experiences of Jess and Jason as representing two extreme points upon a continuum representing the experience of psychosocial formulation within a biopsychosocial model of care. Jess' experience appears to represent the application of psychosocial formulation grounded predominantly within psychological theory, and Jason's the use of psychosocial formulation to make sense of a biological understanding of psychosis. The varied experiences of participants within the current study could be considered to represent different points upon this continuum. For example, the experiences of David, Kenyon, Andy and Adam could represent a middle point, as these participants often used medical language to describe their 'illness', however described this as being 'caused' by traumatic early experiences. As such, working through these traumas within longitudinal psychosocial formulation, exploring both early childhood experiences and current maintenance cycles, appeared helpful to these participants.

Furthermore, the current findings suggest that the participants in this study were able to move along this proposed continuum throughout their experience of recovery. For example, at times Jess described feeling so distressed by her experience of hearing voices that she would have considered taking medication to be rid of this. This suggests that despite holding a predominantly psychosocial understanding of her experience, the flexibility of the biopsychosocial model enabled Jess to consider a medical perspective alongside this.

Despite variation between participant experiences, commonalities also appear to exist. These also reflect previous literature exploring the experience of CBT for psychosis. One example includes the way in which, similar to Messari & Hallam (2003), the majority of participants experienced psychosocial formulation as a healing and educational process. The ability for participants to gain similar benefits whilst approaching psychosocial formulation from very different angles demonstrates further benefits of the flexible biopsychosocial approach.

The current findings also suggest that the biopsychosocial model manages to overcome previously identified concerns regarding a message of passivity that may potentially accompany the prescription of medication (Ross & Read, 2004). The clear role of formulation discussed within the findings indicates a focus upon active participation in a process of recovery. A number of participants appeared to experience feelings of motivation to engage in psychosocial formulation whilst concurrently holding a perspective of being medically 'unwell' and requiring medication.

These participants appeared to shape their experience of psychosocial formulation in order to reflect a personal understanding that incorporated aspects of both medical and psychosocial perspectives. This seemed to facilitate an assimilation of new understanding developed through formulation, into personal explanatory frameworks (whether these be predominantly medical or psychological in nature), drawing upon psychosocial formulation as a tool for exploration. This supports previous suggestion that the biopsychosocial model is advantageous in providing a therapeutic space within which to explore potential discrepancies between different perspectives to psychosis (Mackler, 2009).

The results also suggest that the biopsychosocial approach provides an experience largely consistent with the positive and helpful features previously identified within psychological approaches to support (Berry & Hayward, 2011; Judge et al., 2008). This includes staff qualities such as a normalising and supportive approach, as highlighted within the attention paid to relationships within the theme 'a joined-up 'package' of support'. These findings show that despite clinicians within a biopsychosocial model of care having various professional backgrounds (i.e. both medical and/or psychosocial), their relational style appears more consistent with that more traditionally represented by psychological approaches to psychosis. This may be as a consequence of the input provided by psychological therapists within the development of guidelines that underpin EI services (e.g., International Early Psychosis Association, 2005).

Clinical Implications

The current findings raise important implications for clinical practice. The seemingly malleable nature of the biopsychosocial model appears to play a role in enabling individuals with differing understandings of psychosis, to engage simultaneously in both medical and psychosocial components of support.

The sense of coherence between different components appeared further facilitated for the current participants, by the use of a language shared between all team members and individual service users. According to the participants, this appeared to often (although not in all cases) include diagnostic labels and descriptors such as 'delusional thoughts'. The consistent use of such medicalised language between all team members, including psychological therapists, was experienced as helpful in enhancing a sense of overall coherence between the different components to support.

In highlighting potential benefits of all team members adopting the use of a shared language, the current research suggests that clinicians adopt a flexible approach to such aspects of their practice when working within a biopsychosocial model of care. However, this may present challenges to those who hold a view that the use of diagnostic labels and language that medicalises distress is unhelpful to service users working towards recovery (e.g., Scott, 2010).

Furthermore, formulating the effects of trauma in the context of 'symptoms' of a medical 'illness', may be considered a retrogressive step by those that view this as misinterpretation of psychosocial theory e.g., Read and Bentall (2012). However, the way in which some participants within the current study described experiencing psychosocial formulation in this manner (and experienced this as helpful) emphasises the need for psychological therapists working within a biopsychosocial model to remain open to formulating with service users in ways that may draw upon both biological and psychosocial perspectives.

Additionally, the current research highlights the influence of the therapeutic relationship upon the sense of coherence experienced between the different elements of support within a biopsychosocial model of care. This builds upon previous findings by Harris et al. (2012) that central to good care are relationships between team members and service users that involve feeling understood (Johansson & Ekland, 2003). Continued attention to the therapeutic relationship, through the adoption of a normalising and valuing approach, is therefore encouraged by the findings of the current study.

Strengths and Limitations

The current study has provided insight into a novel research question within an area of high interest within current research. Although findings from qualitative research are always limited in their generalisability, by recruiting across three NHS trusts the current study has attempted to maximise this as much as possible, though it is acknowledged that the application of a biopsychosocial model of care may vary . Purposive sampling was used in order to recruit a sample that was homogenous in that all participants had experienced concurrently engaging in both medical and psychosocial support for FEP. This approach to sampling is consistent with the aims of IPA research, where researchers "usually try to find a fairly homogeneous sample, for whom the research question will be meaningful" (Smith et al., 2009, p. 49).

Additionally, it is important to acknowledge that the data has been subjected to a process of analysis that is interpretative in nature. This must therefore be recognised as representing the way in which it has been understood and organised by the researcher (although validated by a second researcher as discussed above) and is open to critique and further interpretation by others.

Conclusions and Future Directions

The current study has provided valuable insight into the discrete experience of concurrent engagement in psychosocial and medical approaches to support for first-episode psychosis, as contained within a biopsychosocial model of care. The participants within this study generally experienced this as offering a sense of a coherent support 'package', of which psychosocial formulation was identified as making a distinctive contribution. Participants were also found to shape their experience of the biopsychosocial model of care in a way that was most personally meaningful. The findings additionally suggest the potential existence of a continuum representing a range of experience of psychosocial formulation within this context.

Implications for clinical practice include highlighting the importance of a flexible, client centred application of a biopsychosocial approach through underpinned by the use of a psychosocial formulation. Future research may wish to build further upon the current findings by exploring the experience of clinicians working from a biopsychosocial model of care for psychosis.

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