

THREE

Case Formulation

Making Sense of Complexity

A case formulation, or conceptualization, is a way to make sense of a particular patient's problems. Making a formulation is not "fitting someone to a formula" but using one's knowledge of the theory and employing a wide array of clinical sensitivities and skills to develop a hypothesis, together with the patient, about how a problem developed, how episodes of difficulty are triggered, and how the problem is maintained. In old-fashioned terms, it should address predisposing, precipitating, and perpetuating factors and guide decisions about treatment. The words "formulation" and "conceptualization" are often used interchangeably. The word "formulation" is the one that is used here.

This chapter focuses on the difficulty of producing clear, theoretically sound, and useful formulations when working with atypical or complex cases. These are cases in which there is a high incidence of comorbidity, for example, between different manifestations of anxiety, between anxiety and depression, or between anxiety and one or more of the personality disorders. Such complexity makes it hard to understand and to make sense of presenting problems in terms of the theoretical links between all the relevant factors. Sometimes information may be lacking; often problems appear not to hang together, and it is not usually possible to apply theory to the case in the relatively straightforward way illustrated so well by the specific cognitive-behavioral models for single, specific, anxiety disorders that we outlined in Chapter 1.

In less straightforward and also in unusual cases there is a risk that therapists will construct increasingly complex formulations, and that the end product will then lose some of its potential clinical value. The more complex a formulation, the harder it is for the patient and the therapist to understand, to remember, and to use as a basis for making theoretically sound decisions about what action is likely to help. The two main solutions to this problem suggested in this chapter are closely linked: to keep the formulation as simple as possible and to learn to think about deeper levels of patient cognition, about beliefs as well as about thoughts and assumptions. As we saw in Chapter 2, a thorough assessment is needed so as to understand cognitive factors in depth. In

this chapter we present strategies and tools for helping clinicians to use the products of this assessment in their formulation work.

PRINCIPLES GUIDING CASE FORMULATION

Three central principles guide the case formulation process (for further discussion see Butler, 1998, 1999a; Johnstone, 2006). A clear understanding of these principles, and of their implications, is essential when working with complex cases.

1. A formulation should be *based on a theory*, reflecting an attempt to put the theory into practice. Working this way enhances consistency, allows therapists to draw on the same basic theory irrespective of the specific emotion they are working with (such as anxiety or depression, or mixtures of anxiety anger and shame), and helps them when stuck to think about what the theory would suggest: for example, that this person often feels threatened and vulnerable even though it is as yet difficult to define triggers of specific episodes of anxiety or links between presenting problems.

2. A formulation should be *hypothetical* in nature, so that it can be modified by information gained during the course of treatment—and also so that patients can be invited to contribute, asked for their feedback, and encouraged to collaborate in searching for a way of making sense. (Therapists should avoid making pronouncements: “this is how it is,” etc.). This also recognizes that there may be more than one possibility, and that the interaction between diverse factors, such as genetic predisposition, cultural pressures, and reactions to frightening experiences, may be hard to disentangle.

3. A formulation should be as *parsimonious* as possible—for the sake of simplicity, clarity, and ease of remembering. The more complex the formulation, and the representation of it, the harder it will be to remember, and the harder it will be to use (for the patient as well as for the therapist). This is one of the central points made in this chapter and it is discussed further below (pp. 62–64).

APPLYING THESE PRINCIPLES TO RESOLVE PROBLEMS IN FORMULATION

When applying these principles to resolve problems in formulation it is essential to be able to draw on the generic cognitive model (Beck, 1976). As cognitive therapists we understand a wide range of problems, including anxiety, in terms of general theories about the links between cognition, behavior, physiology, and affect. A standard way of representing this model for the purposes of formulation is shown next. This is represented diagrammatically in the top half of Figure 3.1, and in the bottom half this general model is applied to a patient with complex GAD.

This way of making sense of a particular patient’s concerns continues to have value when working with complex and treatment-resistant cases. There are, however, two other ways of making sense: through diagnosis and through using one of the more specific models described in Chapter 1. These different ways of making sense serve different functions and have different advantages and disadvantages (Butler, 1998). In straightforward cases all three fit well together: A diagnosis of social phobia defines

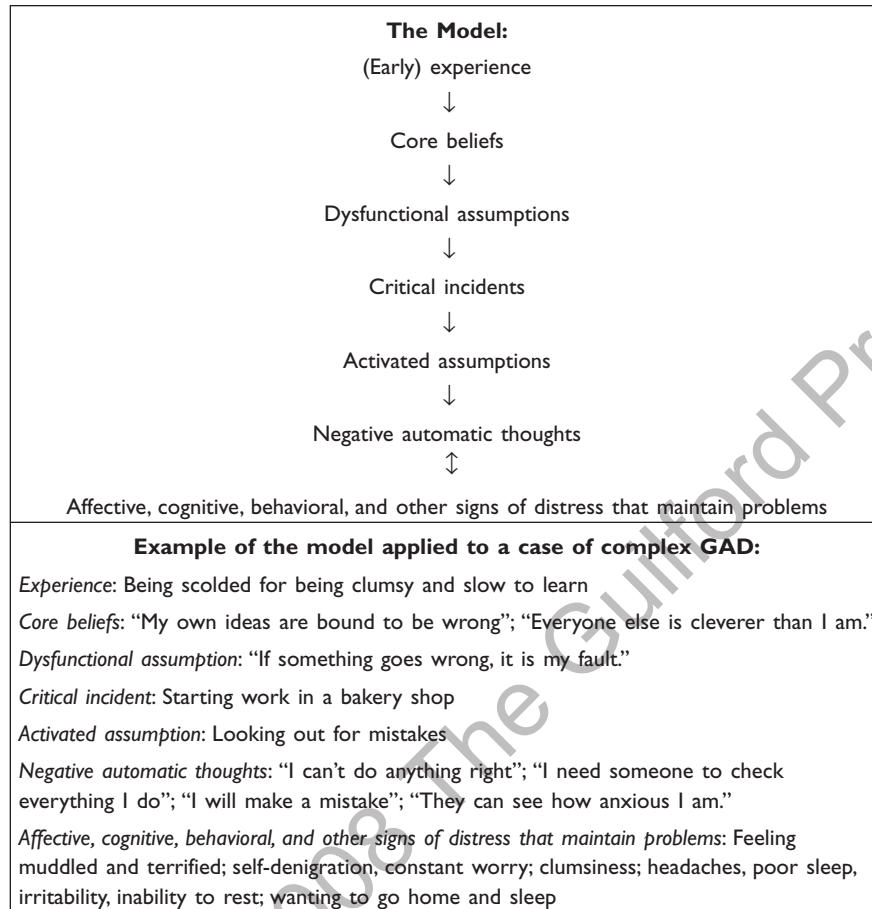


FIGURE 3.1. The cognitive model and its application to a case of complex GAD.

features of the presenting problem; application of the Clark and Wells (1995) model suggests how these fit together and indicates which processes (e.g., self-focused attention, safety behaviors) serve important maintaining functions; and the formulation specifies how the social anxiety is manifested and maintained in the particular case (e.g., through attempting to monitor signs of trembling and shaking, and through speaking quietly in an attempt not to attract attention).

In this book we are considering how to proceed when complexities interfere with the straightforward application of such clearly specified procedures, and this tends to happen when the various ways of making sense no longer fit together so smoothly. For example, more than one diagnosis may apply, or there may be no single diagnosis that fits the particular case; there may be no specific model for the problems presented by the patient, or the anxiety problems may be just one aspect of a complex set of problems following early childhood trauma, and so on. Here the case formulation is the main—or even the only—source of ideas about how, in theory, to understand presenting problems, and how to provide an effective treatment. This gives case formulations,

and the work that goes into developing them, a central role in determining the process of therapy as well as the content (see also TARRIER, 2006).

Even in straightforward cases, making a formulation involves using clinical judgment. In unusual, complex, and comorbid cases, or when information is missing, therapists are increasingly dependent on their clinical judgment. Safeguards are therefore needed to ensure that mistaken ideas are not being imposed on patients. The work needs to be done together—in collaboration, and the style of cognitive therapy plays a crucial role here. Being explicit about how we understand what we have been told provides one kind of check, provided that we have also taken care to ensure that our patients are able to give us honest and detailed feedback. For example, some patients have a strong “need to please.” Others are fearful of offending their therapists and keep their doubts to themselves. Then it is especially important to adopt the Socratic style of questioning, and to use methods to guide discovery. It is important to give people enough time to consider, and to ask questions that help them become genuinely engaged in constructing a (theoretically consistent) way of making sense of their difficulties. We need to find out at each stage, for instance, whether the current formulation seems coherent to them, and whether they can draw on it as a source of ideas about how to change. Some examples of useful questions to assist in making the process of formulation a collaborative enterprise are shown in Figure 3.2.

Patients are the most obvious source of comment on our developing case formulations. Other sounding boards include supervisors and colleagues, and a degree of objectivity can also be found by using behavioral experiments to test specific hypotheses relevant to a formulation (Bennett-Levy, Butler, et al., 2004; Wells, 1997). We discuss the use of behavioral experiments at length in Chapter 6. In addition, there may be results from new research or theoretical developments to take into account, such as Borkovec’s (2007) findings concerning the value of attending to interpersonal and experiential processes during treatment for GAD.

Making links:

“How does that fit together? Could that link up with . . . ?”

Looking for patterns and themes:

“Is there a pattern here? Is that a pattern?”

Exploring meanings:

“How do you make sense of that? How do you understand it?”

“What are the implications of that for you?”

“What does that mean to you?”

“What kind of impact does / did that have on you?”

Clarifying processes and mechanisms:

“What do you think keeps this going?”

“And when that happens, what do you think / feel / do / conclude?”

“When you do that, how do you feel? At the time? Later on?”

“If you think . . . , what do you then do?”

FIGURE 3.2. Examples of formulation-based questions.

ANXIETY DISORDERS AND FORMULATION WORK: MAPPING THE TERRITORY

There is a basic tension in working to formulate particular cases, as it involves bridging the gap between relatively simple, clear theoretical models and the largely unknown, complex, and private world of the person who is anxious. The first essential step is paying close attention to each person's experience of anxiety, and tuning in to that person's particular sense of feeling at risk, under threat, or in danger. To apply the principles concerning the use of theory, hypotheses, and parsimony to resolve problems in formulation it also helps to broaden our understanding of anxiety, and to share that understanding with our patients. Many people can tell us why they become anxious, but there are also many who cannot do so. They may be confused by their experiences and unable to predict when their symptoms will occur. The task of case formulation is harder in such cases and can be helped by drawing on information about anxiety beyond that represented in each of the specific models. Four general points about anxiety that have important implications for the task of formulation are described next.

Anxiety Has Secondary Consequences

Anxiety has secondary consequences, especially if it has been present for a long time. These include depression, impaired confidence, and reduced self-esteem. Making the distinction between primary and secondary features of presenting problems helps to reduce confusion. It also helps make sense of the secondary features and clarifies how to target interventions. It is, after all, not surprising that persistent anxiety "gets people down," undermines their confidence in their own abilities, and reduces their sense of self-worth. The cognitive model of low self-esteem, which takes particular account of comorbid anxiety and depression, can sometimes be helpful here (see Chapter 8).

Different Manifestations of Anxiety Are Often Linked

There are conceptual links among the different kinds of anxiety in the DSM, despite the distinctions. For example, whatever problems your anxiety brings, you can *worry* about them. Worry tends to spread from one thing to another, and aspects of GAD are often present even in the absence of the full clinical version of the problem. Similarly, people are often embarrassed by their anxiety problems and feel *at risk of being judged or rejected by others* because of them. This adds a social dimension to their anxiety. So we need a way of formulating that helps to make sense of the whole picture, including attitudes and reactions to anxiety, rather than just part of it. This should include consideration of a person's relative strengths and assets, as recognizing these early on helps to reverse the effects of low self-confidence and low self-esteem, validates and affirms the person so as to increase motivation, and increases awareness of skills to draw on during treatment. It provides a general, confidence-building framework for treatment based on efforts to construct (or strengthen) adaptive functioning, which is not focused exclusively on reducing (or demolishing) unhelpful thoughts and behaviors.

Some of the accepted wisdom about which problems should be tackled first may be exactly that: (accepted) assumptions rather than the product of research. Common assumptions are that depression should be treated before anxiety, social anxiety before

worry, alcohol misuse before anxiety, and panic (or Axis I disorders generally) before personality disorder (and Axis II disorders generally). Yet in our research on the treatment of GAD we found that treating the GAD also reduced depression scores (from an average BDI [Beck Depression Inventory] score of 21.4 to an average of 7.5 after treatment; Butler, Fennell, Robson, & Gelder, 1991), and clinical observations during this research trial indicated that changes in depression rapidly followed engagement in treatment, possibly reflecting increased hope that the main problem could be alleviated. One possible explanation is that broad understanding of anxiety and of the ways in which problems interrelate, together with skilled case-formulation work that takes assets as well as deficits into account, facilitates change across as well as within problems. What we have come to think of as separate and distinct may not be so separate in practice, and these assumptions can be tested clinically as well as in research.

Earlier Experiences May Explain Specific Triggers of Anxiety

Particular events such as turning aside or snapping a finger may trigger anxiety because of their links with earlier experiences. For example, one patient, Rachel, became anxious if the person she was talking to looked away. This small action triggered an intense fear of being left unacknowledged and abandoned because of her childhood experiences.

Formulating such idiosyncratic meanings is essential and difficult and often involves paying close attention to events within the therapeutic relationship. Small behavior changes can provoke disproportionate reactions, and these small behavioral events often take some time to notice during therapy, and which can be difficult to make sense of. It can be relatively easy to feel and to notice the disruption to the therapy process (Rachel's silence when she felt abandoned), but harder to understand its cause (the therapist looking away). The patient may not find it easy, for many reasons, to explain the process as it affects them, and clinical judgment is needed to decide how and when to explore these observations in order jointly to ascertain their significance. Such explorations will also be more difficult when experiences are stored in implicit memory and are hard to put into words. Then it can be especially useful to use drawings, metaphor, or imagery to represent the "felt sense" (see Chapter 2 for a detailed discussion of this issue).

Three Common Reactions to Anxiety: Control, Rigidity, and Safety-Seeking

Our understanding of anxiety in broad terms suggests there are three common reactions to feeling anxious: a wish to keep control, a tendency to rigidity in responsiveness, and the desire to seek safety or protection. As therapists, our starting point is that anxiety is about feeling threatened or at risk. The danger has not yet occurred, but it could, so there is necessarily a degree of uncertainty about what might happen and/or about how one might cope with it, whether the threat or risk is internal or external (see also Chapter 9). An understandable reaction to this uncertainty is to try to keep control.

There is also a well-documented tendency for people to become increasingly rigid or inflexible in their reactions when anxious (see, e.g., Borkovec & Newman, 1998). A reduced range of responsiveness has been found in autonomic, behavioral and cogni-

tive responses, and also in measures of electroencephalogram (EEG) activity (specifically for people who suffer from GAD—but we have already noted the pervasiveness of worry). The messages that we give our children in many Western cultures as they grow up and encounter alarming situations may also encourage them to “hang in there,” “keep going,” “batten down the hatches,” and generally to persist in the face of fear (to “get a grip,” and maintain a stiff upper lip). These messages may encourage the development of tension and rigidity as responses to anxiety, as if that could assist in getting a handle on the fear and prevent it surging out of control. Finally, seeking safety or protection leads to familiar patterns of avoidance, to safety behaviors, to escape behaviors and thoughts about escape, and sometimes even to dissociation.

Formulation work should therefore start by recognizing that these general reactions make sense. The task is to explore idiosyncratic versions of them in a particular case, and to consider how best to replace them with more functional reactions. Three general aims or themes may guide this work, and help to determine new attitudes to the understanding and treatment of anxiety. These are to encourage curiosity rather than control, to increase flexibility and reduce rigidity, and to learn how to face (and accept) fears and anxiety, rather than seeking (too much) safety and protection. These aims provide a broad context within which to apply the strategies derived from specific models.

The four aspects of anxiety described above provide a way of thinking in terms of commonalities across specific anxiety disorders. In addition, therapists can draw on general psychological principles. For example, we know that novelty triggers anxiety, in humans and animals: As familiarity develops it becomes easier to explore, signs of anxiety diminish, and signs of feeling safe and confident increase. From the point of view of someone with a personality disorder, or with a history of repeatedly being subjected to dangerous or threatening situations, intense anxiety may occur if familiar patterns change, even if the novelty is potentially positive. People may be fearful of abstractions or generalities, such as the sense that things feel unpredictable or out of control, or they may feel anxious if they do not know what to expect, or what to do, or what others expect of them and so on.

It follows that intense anxiety may erupt if something familiar changes, or threatens to change, and that it will be important to help such people to develop a sense of security (or of “safeness” in Gilbert’s [2005a, p. 22] terminology) before or, as well as, encouraging them to confront their fears directly. The arguments above also suggest that a person presenting with comorbidity, when anxiety coexists with affective or with personality disorders, will be more efficiently treated when their problems are formulated in terms of core beliefs that are common to the different presenting problems. Work on changing these beliefs would then, theoretically, be likely to result in a variety of different changes simultaneously. As one patient with numerous anxiety problems, low self-esteem, and a history of abusive relationships put it: “It’s like moving on all fronts at once.”

JUDGING THE QUALITY OF A CASE FORMULATION

If formulation work is to play a central role in solving problems that arise when treating anxiety, then clearly our formulations should be good ones, and we should

double-check the information on which they are based and reformulate when we fail to get the desired or expected results. However, judging the quality of a case formulation is a complex business. An incomplete formulation can still be useful. So can one that is wrong, for example, when it assists in narrowing down the possibilities, or when it prompts patients to clarify misunderstanding and enhances their ability to give honest feedback, or when talking about it prompts recollection of previously undisclosed material. For these reasons case formulations should be judged not only in terms of the qualities of the finished product (internal consistency, accuracy with respect to the facts, predictive power, etc.) but also with respect to the dynamic processes involved in making and using them, and taking account of the success with which helpful metamessages are delivered, for example, about the factors contributing to the development of problems. When reflecting on a piece of formulation work one might consider, for example, whether it engaged a process of exploration, increased pattern-recognition skills, brought order out of confusion, revealed new options, secured a feeling of being understood, and helped to clarify and predict process issues and future problems. The work of developing a formulation is thus different from and potentially more valuable than the end product (the final version), which may be written down and evaluated, but may also live only in the therapists' head, or notes.

Current research on the interrater reliability of case formulations has not yet produced clear-cut results (e.g., Bieling & Kuyken, 2003; Eells, Kendjelic, & Lucas, 1998; Fothergill & Kuyken, 2003; Persons & Bertagnolli, 1999; Persons, Mooney, & Padesky, 1995). This is not surprising given the complex processes involved. If we are to be able to justify our clinical decisions and be held accountable for them, we still need to use our theories, and specific models when they are available, to make sense of the information presented to us. So even if our belief in the value of case formulations and of formulation work, generally, is largely a matter of faith, it remains important that therapists reliably make and use them. Faced with someone's continued anxiety despite one's best efforts to help, we can then reformulate and check that our actions and interventions are based on (theoretically based) hypotheses rather than on hunches and habits. This is especially important when a therapist and a patient make sense of things in different ways. Explicitly phrasing the different views as hypotheses to explore then provides the basis, for example, for further information gathering and experiment. A patient with multiple anxieties following a disrupted and unstable childhood commented: "At first making sense was not a lot of help. Once I started to change I could see it was the key." The process of case formulation is thus essentially dynamic, and the interactive and changing processes involved will have to be taken into account before we can find out more about the value of the work that goes into making sense of someone's difficulties. "Formulation work" may be as important as, or more important than, the end product.

An example of a patient's reflections on the value of formulation work is to be found in P. S. (2006, and discussed in Butler, 2006). The patient told us that "Formulation is a tool that was used in my treatment. I found it enormously helpful. At the beginning I had a mixture of rational and irrational beliefs and assumptions. I could not discriminate between them. They all had equal internal authority in determining my actions. The formulation made the incomprehensible accessible. It explained and imparted insight. I understood myself" (p. 13).

USING METAPHORS, PICTURES, AND DIAGRAMS IN FORMULATION WORK

In atypical cases formulation work is likely to be harder, and its dynamic aspects are especially important. There are also different ways of proceeding with formulation work, and different ways may suit different circumstances. So therapists faced with complicated or unusual manifestations of anxiety need to be flexible in their approach to making and using formulations. Sometimes it is useful to emphasize systemic factors and ideas about patterns of relating to and interacting with other people; at others it may help to start from a problem list, or it may be more helpful to be selective, and to focus solely on the main problems. Often therapists initially base their formulations on a maintaining cycle in the present and work backwards from there, including assumptions and beliefs as required. But sometimes it might be better (or easiest) to gather an overall impression of a patient's particular perspective, and to begin by making a hypothesis about underlying beliefs: This person had a terrible life story and learned early on never to trust people. Therefore therapy needs to start by building trust, and looking at patient behaviors in the present. For example, being unwilling to disclose personal information or defensive can (tentatively) be fitted into the case formulation as making sense in terms of underlying cognitive structures. The cognitive processes involved, for example in mistrust, might also be expected to interfere with the process of gathering the detailed information needed for formulation work based more exclusively on less abstract cognitive processes. This is not to say that other things might not also be going on, nor is it to say that this hypothesis is right, but it provides a (collaborative) starting point, and that is what it is meant to do. We have no information yet to suggest that one starting point is better than another.

Pictures, stories, metaphors, and diagrams can all help in the task of formulating and contribute to making sense, and often our patients provide us with useful tools in the metaphors and images they bring to treatment. A deeply avoidant patient who dreaded talking or thinking about her fears and her current situation described herself as hidden in a huge bramble bush. She felt as if she was surrounded by a thicket that had grown up around her so tightly that she did not dare to open her eyes for fear of the thorns. This made some sense in terms of the dangerous situation that she had endured as a child, and her fear of discovering just how painful it would be to extract herself. However her situation was now different, and her combined safety behaviors and avoidance were preventing her noticing the difference: Metaphorically speaking she could not open her eyes and look around. The metaphor was further elaborated without losing touch with the underlying theory.

Another patient found it hard to understand how, during a setback in her progress, all her old problems reemerged, one by one, until she "ground to a halt." She made sense of this by saying it was like being on an old-fashioned train. When it stopped all the separate carriages bumped one at a time into those in front, giving the passengers a series of jolts. She decided she would no longer be a passenger but restart the train and keep it moving. The metaphor revealed her current perspective, assisted in the reevaluation of this, and helped her to adopt a different attitude that then provided a basis for specific behavioral changes.

These metaphors are listed first to emphasize the point that there is no single way of formulating more complex cases, and no precise model available to ease the thera-

pist's task. Further illustrations are provided in the next two chapters. For some people relatively standard methods may work well (e.g., Butler, 1998; Eells, 1997, 2006; Nezu, Nezu, & Lombardo, 2004; Persons, 1989; Westbrook, Kennerley, & Kirk, 2007). Here we have selected a few of the many possible diagrammatic representations of elements of formulation work and we present them as illustrations of useful tools rather than templates (Figures 3.3–3.8).

The diagram in Figure 3.3 represents a way of formulating a habitual process of interaction between people that reveals its self-defeating effect. This pattern has clear implications for what to do: learn to recognize the pattern, change the old behavior (in this case, being nice to everybody), and find out what happens. It also reveals a common difficulty: When people try to change such patterns they sometimes go to extremes and need to learn more appropriate and flexible ways of behaving that fall in the middle ground between being nice to everyone and saying what you think however offensive that might be.

In Figure 3.4 there is a visual representation of patterns of cognition similar to those described by Padesky (1993a) in her article about self-prejudice. The “Mental Crusher” stands at the entrance to the schematic head and allows information consistent with prevailing ideas readily to be processed and stored (rectangular shapes). It operates so as to force inconsistent information (the other shapes) into the same shape. If the information remains a different shape it will be ignored or forgotten. Only information that naturally fits, or has been distorted to fit, can enter. The whole picture can be used to explain why nothing changes. In practice this will need to be illustrated, amplified, and tested using specific examples. One patient spoke, for instance, about numerous comments and requests made by her boss, reporting them as evidence for his critical view of her work and her abilities. With the Mental Crusher in mind she agreed to pay more careful attention to his actual words. It soon became clear that she had been ignoring appreciative or encouraging remarks, assuming that he was only being nice to her. In her view, he did not really mean them so they meant nothing to her. At the same time his neutral remarks or behaviors, such as accepting her work without comment or ignoring her while she got on with the work, were interpreted by her as criticisms—distorted to fit.

Figure 3.5 provides a schematic representation of the way in which someone's early experience may have led to a particular way of behaving that elicits the kinds of reactions from others that maintain the behavior. For example, someone whose parents always doubted his competence and scolded him for making mistakes developed a habit of apologizing repeatedly, even when nothing had gone wrong. When his therapist noticed this he started counting and calculated that early in treatment the patient

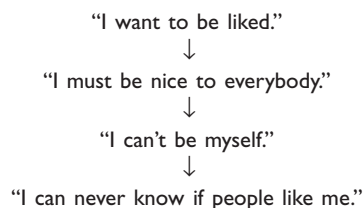


FIGURE 3.3. A self-defeating pattern of interaction.

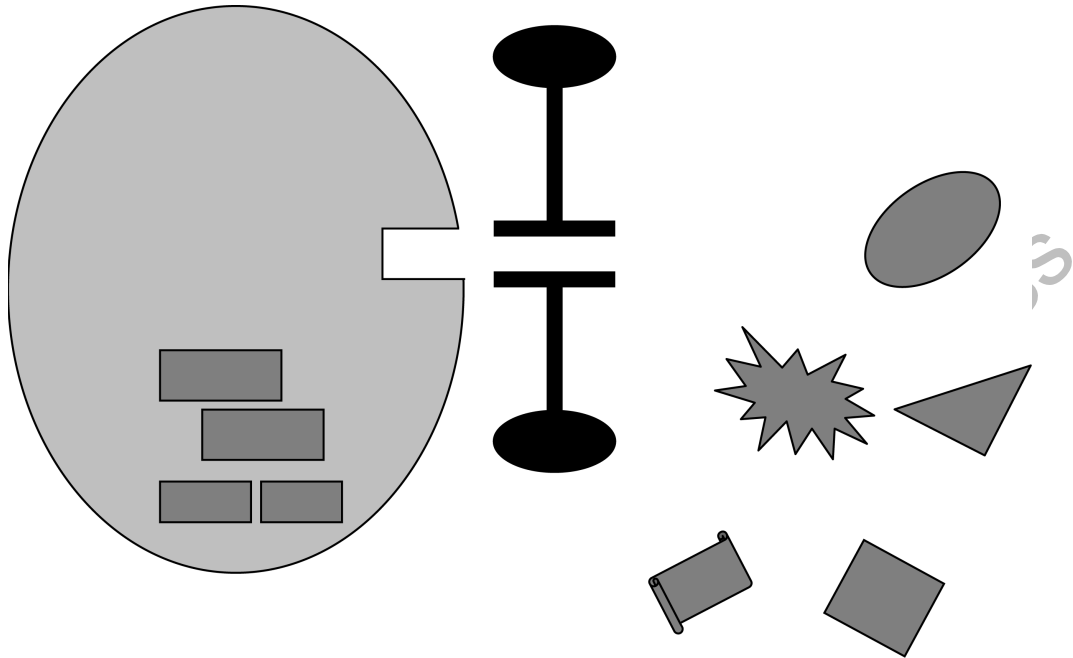


FIGURE 3.4. The Mental Crusher.

said “sorry” 37 times in just under 30 minutes. The diagram suggests that this behavior elicits reactions from others that maintain it: The more he apologized, the more others doubted his competence. The more they doubted him, the more he apologized. When asked if this made sense, this patient provided a specific example. He had borrowed his neighbor’s lawn mower and returned it in good order. A couple of weeks later the mower broke down when the neighbor was using it. The patient (feeling highly anxious) apologized and was accused of having caused the problem. When asked to pay for repairs, he avoided discussion and paid up, assuming he must be responsible (even though he could not think how).

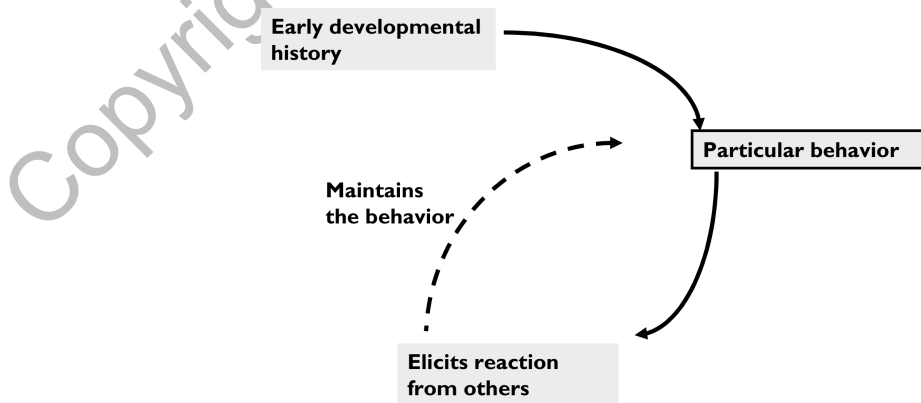


FIGURE 3.5. Schematic representation of a historical process.

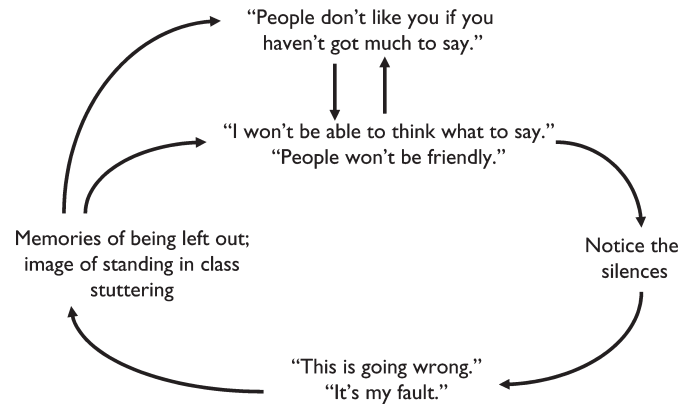


FIGURE 3.6. How to collect a store of information that fits with what you already know.

Figure 3.6 illustrates another way of representing cognitive maintaining processes, based on that described by Fennell (1999, p. 43; see also Chapter 4, p. 80). This draws attention to the ways in which assumptions, perceptions, interpretations, and memory interact. These parsimonious representations of complex interactions can clarify maintaining processes. Further work may be needed to identify relevant thoughts and feelings, but even before this has been done, outline sketches such as these may be sufficient to engage someone in the process of trying out new ways of behaving. The information this provides can then contribute to more detailed formulation work.

The diagram in Figure 3.7 also makes use of the principle of parsimony and illustrates in outline how many different kinds of processes may be generated by an underlying belief and contribute to its maintenance. Last, Figure 3.8 illustrates the value of selecting two levels of cognition so as to illustrate their differences and their interrelatedness. In the example, one of these represents a schema, and the other represents the ways in which this person attempts to prevent the schema being activated. This sketch can also be used to illustrate how the different levels of cognition are associated with different kinds of affect. In the example provided, activating the schema evoked intense sadness. Efforts to prevent the schema being activated were motivated by anxiety. Recognizing these links helped to explain why attempts to change such behaviors felt so alarming.

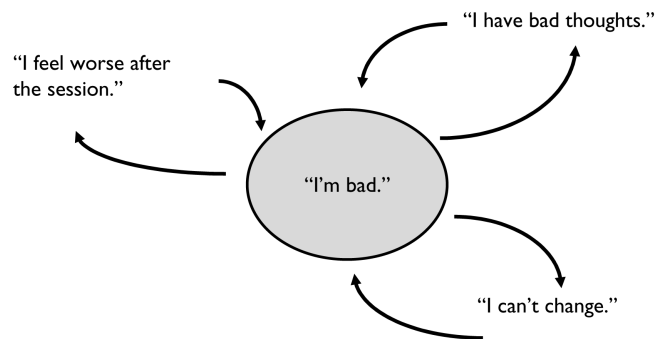


FIGURE 3.7. Making sense of similar processes.

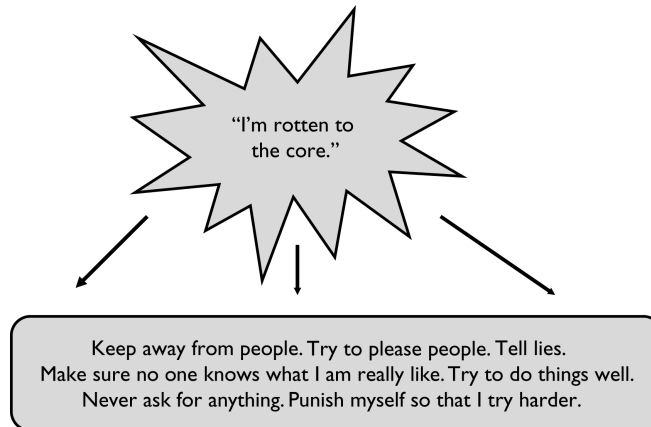


FIGURE 3.8. Illustrating links between two levels of cognition.

Of course verbal descriptions as well as metaphors and diagrams can help in the infinitely various process of making sense. Someone with “borderline features” to her problems, who suffered intensely from anxiety, described having the feeling that she was her own worst enemy, as whenever she started to improve she did something to make things worse again. Unpacking this process of “self-sabotage” provided her with a new hypothesis: making functional changes in her life (providing an organizational framework and structure to her day) put her in unfamiliar territory, which felt strange and alarming. The more novel her situation, the less safe and the more scared she felt. Reestablishing old (familiar) behaviors such as drinking too much alcohol and cutting her legs made her feel safe again. Further work was needed on learning how to comfort herself, and on establishing more functional and enduring ways of providing a sense that she could be safe and secure in this world. Understanding the processes involved also helped her to accept and to tolerate a degree of anxiety, and to accept a slower rate of change.

FORMULATING INTERACTIONS BETWEEN PEOPLE

The principles of formulation work described and illustrated so far apply just as well to the interactions between people as to the individual case. They can help us to understand and make sense of specific difficulties and problems in relationships (including the therapy relationship), and to derive ideas about change from that understanding.

For example, a patient who had very little sense of her own value or worth had found that she could cope well by caring for others instead of herself, and by avoiding discussion of painful issues, especially if these linked to her experience of emotional neglect and criticism during childhood. She became highly anxious in interpersonal situations. Her therapist readily recognized her distress and was concerned to set her at ease during their first encounters. Subsequently she found herself making extra efforts to care for and help this patient, and she hesitated to bring up painful material for discussion. Indeed she apologized to the patient when a behavioral experiment elicited much higher anxiety than expected, and the patient responded with caring and concerned remarks about the therapist.

Supervision and self-reflection (Bennett-Levy & Thwaites, 2007) can help to clarify and to formulate such processes. In this case the therapist and the patient were caught up in parallel needs to care for others that reinforced their joint avoidance of topics that might elicit distress. The pattern was discussed explicitly, using material from a recent therapy session. Recognising the “pull” (see, e.g., Safran & Segal, 1990, p. 74) and resisting it during subsequent sessions enabled the therapist to provide a different interpersonal context within which the patient was able to address the issues that she found distressing, and learn to care better for herself.

FORMULATING COMORBIDITY WITH DIFFERENT KINDS OF ANXIETY

Sometimes it is hard to work out how to apply the principles derived from research, and sometimes doing so fails to bring about the desired—or expected—degree of change. How then should we proceed when a patient has a collection of anxiety symptoms that span specific disorders such as panic attacks, fears of social interactions, and worry? An option discussed by Barlow, Craske, Rapee, and others in a symposium on the topic (Craske, Farchione, Tsao, & Mystkowski, 1998) is to target the anxiety problems successively. For example, to start by focusing on the “main” problem, assessing the degree of change across all relevant anxiety disorders immediately after treatment and after a follow-up interval, and then to target remaining anxiety problems separately, as required. The successive approach illustrates well the influence of thinking predominantly in terms of differentiating features of anxiety states. Similarly, Williams, Watts, MacLeod, and Mathews (1997) explored differentiating features of anxiety and depression that are also often dealt with separately, in research and in the clinic. However, to solve the problem of comorbidity efficiently we may need to think more in terms of commonalities (Hertel, 2002, 2004; Mineka, Walsh, & Clark, 1988; Mogg & Bradley, 1998, 2004).

Formulations have many levels, summarized by Persons (1989) as “overt difficulties” and “underlying mechanisms.” The cognitions involved in these underlying mechanisms are usually represented in a hierarchy by cognitive therapists. At the lowest hierarchical level are the many automatic thoughts, positive, negative, and neutral, that represent the “stream of consciousness.” Higher up come assumptions; above them beliefs, and finally representations of schemas (variously described). An obvious point follows: Changing cognitions at a higher level in the pyramid will affect a broader range of cognitions lower down. So, in cases of comorbidity, working at higher levels of cognition should enable therapists to target related problems simultaneously rather than successively. An example follows.

Paula, age 28, is in a rocky relationship. She is underconfident at work, and her first presenting problem is that she is unable to go into town, or travel beyond her immediate neighborhood on her own. She has panic attacks at home and also when she is out, and manages to work and to cope at home only with considerable support from her mother and partner. It soon becomes clear that there is also a social aspect to Paula’s anxiety: She “knows that others judge and evaluate her”—negatively of course—and is fearful of talking to her boss, of interacting with colleagues, and of socializing in general. In addition, Paula is a worrier. She can

worry about anything and everything (e.g., what to buy from the supermarket, arrangements for meeting up with a friend, tidying up, possible future financial difficulties, etc.). On one occasion, following a minor infection, the worry focused on her stomach, and she interpreted each twinge or grumble as a sign of serious illness. She repeatedly sought reassurance, which irritated her partner and provoked arguments, and further worries about the stability and suitability of her relationship.

Paula suffers from numerous forms of anxiety. The therapist started by focusing on Paula's sense of vulnerability and working to understand (formulate) the idiosyncratic flavor of this vulnerability. To begin with, Paula described this by saying, "I can never be confident," a phrase that suggests some underlying beliefs and assumptions. The therapist helped Paula identify these attitudes and assumptions about how or whether confidence develops. This was done partly through Socratic questioning, asking Paula to think about how she had become confident about her ability to type and to drive. It was also done independently by Paula through homework assignments involving discussions with others and behavioral experiments. Her conclusions following this work were that "confidence is not all of a piece." She meant that you can be confident in one area of life but not in another, that confidence can develop and fluctuate, and that many people appear more confident than they feel. Clearly her therapist could have explained this to her straight away, but it is unlikely that this would have had the emotional impact provided by guided discovery and personal experience. Paula started to improve slowly and later observed that as her beliefs about confidence changed, her panic, her social fears, and her worrying all started to decrease. First she opened her mind to the possibility that she might after all be able to achieve a degree of confidence, then the different aspects of her anxiety started to change together. The treatment strategy derived from using a more general, or higher level formulation. It was designed to ensure that all subsequent work was relevant to changing underlying beliefs whatever the associated feelings, specific triggering incidents, or focus for homework between sessions.

Notice that a case formulation does not have to be complete to be useful. One of Paula's early homework tasks was to ask herself, whenever she felt "bad" (anxious, irritable, miserable, etc.): "How does this fit with not being confident?" At this stage she was testing the relevance to her of one (tentative) way of phrasing her underlying sense of vulnerability. Without the incomplete formulation she would not have had this task to perform, and without this task she would have been much less actively involved in the process of case formulation, and more of a passive recipient of someone else's (possibly mistaken) ideas. She might also have focused "down" onto the specifics of each triggering situation, running the risk of becoming overwhelmed by detail, and thus narrowing the possibilities for generalization.

The Skills of Abstraction and Selection

The value of working on underlying (or higher order) meanings cannot be overemphasized. So therapists need to develop skills for thinking at higher levels of abstraction. As Teasdale (1997) said: "You can't change things by thinking at a single level of cognitive architecture," and "We need to become poets in therapy, as the business is about

changing higher level, implicational meanings [and] to do this we can use parables, stories and metaphors.” The proliferation of multilevel theoretical approaches (e.g., Brewin et al., 1996; Power & Dalgleish, 1997; Teasdale & Barnard, 1993) now provides ways of thinking coherently about the different levels. All of which can contribute to our formulation work—but only if it is seen as a source of (testable) hypotheses rather than as an objectively valid road map. As the example of Paula illustrates, higher level formulation in terms of beliefs about confidence simplified and focused work that might otherwise have become fragmented or overcomplicated.

Consistent with the hierarchical understanding of cognitions generally we would assume that numerous automatic thoughts are influenced by fewer assumptions, which in turn are influenced by fewer beliefs. When formulations provide ideas about higher level, implicational meanings, they will be more likely to assist therapist and patient to achieve lasting change (see also Chapters 2 and 5).

The process of formulation also requires therapists to develop the skill of being able to select from the information available to them. Selection affects every aspect of therapy. Patients select what to focus on, what to talk about in therapy, and what not to disclose. Therapists select what to attend to, what to inquire about, and what to ignore. The therapist’s theoretical understanding provides a rationale for further selection. So if the problem is understood as being primarily one of social anxiety, associated depression, irritation, or low self-esteem might (at first) be ignored. So when the focus is on removing maintaining factors, therapists need to focus on a few target cognitions and behaviors and not diffuse the effort by employing a wide spectrum of techniques directed to a range of target behaviors. Recognizing this process of selectivity, and the need for targeting interventions efficiently when anxiety does not resolve, it is useful to think again about how the various kinds of selectivity may have influenced the current formulation and the subsequent choice of treatment methods.

More often than not, our clients recognize that things are not working in their life but are either unclear as to why or have developed explanations that are erroneous. Metaphorically speaking, they are in the dark about relevant aspects of their functioning (e.g., their emotional reactions) and the functioning of others (e.g., how their emotional reactions impact on others). Our role is to focus a spotlight on those aspects about which we, as their therapists, believe that a better or more accurate awareness would be helpful. Still another way to look at this is that we function as “attention deployers,” in that we help clients to become more aware of those thoughts, actions and desires that are relevant to the problems they are experiencing. (Goldfried, 2004, p. 98)

Clearly theoretical considerations should guide the deployment of that clinical spotlight. However, when focusing it we are often more in the dark than we should like to be; theories do not tell us all we would like to know, yet. Detailed supporting evidence may not be available. Patients may communicate in obscure, allusive, or incomplete ways. Information gathered from the processes that operate between patient and therapist may be crucial (and, e.g., reveal problems with dependency or mistrust that help to make sense of the anxiety), but they may also confound the contributions of patient and therapist. If they are to use the processes of selectivity well, therapists as well as their patients need enhanced reflective and metacognitive abilities. They need to use these abilities to reflect on the processes of selection, and on the various biases and heuristics that may be involved in the process of selection.

The Sandwich Principle: A General Formulation Strategy

A sandwich provides a useful metaphor for a general formulation strategy that can help “when the protocols fail.” The idea is that a formulation, just like a sandwich, will hold together better, and serve its intended function better, if it has two slices of bread to hold it together. With two slices of bread in place the sandwich can be infinitely various: any shape or size, with any of a myriad different types of filling and so on. Without the two slices of bread the sandwich will fall apart. In the case of the formulation, one slice of bread stands for “beliefs,” and the other stands for “behaviors.” With beliefs and behavior in mind, it matters less if the focus of therapy shifts between sessions, and the maximum possible change can be elicited even from small behavioral experiments. The following examples are intended to illustrate more clearly what is meant by this metaphor. One general point is that all formulations should include hypotheses about underlying beliefs and ideas about how behaviors can maintain problems. (These provide the basis for further hypotheses about how changing beliefs could help to resolve the problems.) The sandwich principle can be used to hold treatment together if, whenever focusing on a behavior the therapist asks: “How does this fit with your belief that . . . ?” And conversely, whenever focusing on a belief the therapist asks: “How does this link with what you do; with your behaviors?” The same type of questioning can consolidate and expedite the process of change. Moving from the behaviors to the beliefs one might ask: “Given what you just did, how does that influence your belief that . . . ?” Moving from beliefs to behaviors one might work to crystallize a new, more functional belief about personal adequacy, and ask, “Given your idea that maybe you are not as inadequate as you feel, what might you do to test that out?”

The following example shows how a case formulation that leads to focusing exclusively on behaviors can be mistaken.

Geoffrey, age 23, was a junior member of a sales team. His job involved much travelling, and he had no experience of intimate relationships. He was socially isolated, and an expert worrier, especially about his future and his health. At the time of starting treatment he was also worried about having (a normal degree of) floaters in his left eye. His initial goal was to improve his ability to relate to people. Maintenance cycles were easy to formulate, as they involved readily recognized avoidance and safety behaviors such as refusing invitations, not expressing his feelings or making suggestions, and never talking about himself and his feelings. These safety behaviors served to maintain his social isolation. Geoffrey was highly motivated to change and courageously took many risks involving facing the situations he had feared and avoided, and dropping his safety behaviors. He predicted that others would reject his ideas if he showed more initiative at work, and still attempted to do so. He experimented with being more assertive. All this work was designed specifically to provide opportunities for testing his predictions, and when these proved to be unfounded it was expected that his anxiety would decline. However, despite achieving some of his goals for increased social contact, his anxiety remained as high as ever.

At this stage, his therapist tried to achieve a deeper understanding of his “felt sense” of vulnerability and discovered that reformulating his difficulties in terms of beliefs, instead of in terms of maintenance cycles perpetuated by fear and avoid-

ance, opened up new routes to change. Discussions revealed that Geoffrey held the idiosyncratic belief that the floaters in his eye meant that he had lost his youth. He believed that unless the floaters disappeared his life would be over before it had begun. This understanding led to a shift in the focus of therapy: to thinking about the meaning to Geoffrey of being a young person (his beliefs and assumptions), and about what he wanted to do while he was young; about how he wanted to live his life now so as to be able to expect a different kind of future (his behaviors). This clarified his priorities, and many behavioral changes followed, including seeking a new job that allowed him more free time. The impact on him of the floaters diminished, and he noticed them less. Being clearer about his priorities did not remove his anxiety entirely, but it enabled him to accept and to tolerate the fear better, and to move forward in ways that to him felt significant.

The second example illustrates what may happen if the therapeutic work focuses on beliefs at the expense of behaviors.

Liz was 32, and a single parent with two children. She was fearful of going out to work, but in serious financial need. She had panic attacks at night and a nervous, anxious demeanor. She wanted to talk in treatment about the emotional and practical neglect that she had experienced as a child; about physical abuse at the hands of her former partner, her fear of entering new relationships, and issues concerning mistrust. Her beliefs about herself, about others, and about the world were all highly relevant and easy to talk about. She developed a good relationship with her therapist and started to feel more valued and worthwhile during sessions, a feeling that did not last once she returned home. She made no practical changes at this stage of therapy, and her anxiety remained high—until the behavioral aspects of her difficulties, such as her reluctance to go out on her own, or to seek work, were brought to the fore. As these were linked with her beliefs, for example about the hostility of others and her own inadequacies, she started to explore and to make behavioral changes, and also—slowly but surely—to construct a new and more functional set of beliefs.

It may be worth noting that it can be easy to make this mistake. Liz's belief systems were readily understood, and responses to the distress caused by her experiences of neglect and abuse were readily elicited. At the same time, her reaction to focusing on the behaviors was that it made little difference: just "a drop in the ocean." To her and to her therapist, they seemed at first less important than the underlying beliefs. However, working on beliefs without anchoring the work in behavioral change and experiment may not only be less productive, but also run the risk of losing the way: of getting lost in conceptual hyperspace. In our experience, patients' expectations are often of talking in general about their problems rather than focusing down on details of specific events. Working only at the more abstract level prevents therapists from acquiring the discipline of unpicking and understanding specific mechanisms and sequences that contribute to the persistence of anxiety.

A third example illustrates how some behavioral patterns can produce vicious circles that are especially difficult to break, as if they "get you coming and going." Again it helps to work on the behaviors and on associated underlying beliefs.

Nadim suffered from avoidant personality disorder. He became extremely anxious when interacting with others and went to great lengths to hide what he was really like. He spent hours preparing himself to go out: washing repeatedly, trying on different clothes, combing his hair, and so on. He was unable to answer his doorbell in case people would find him unprepared—and unprotected—and conclude that he was “downright weird.” Sometimes he dressed in a sober and conventional way, hoping that would make him acceptable. On other occasions he dressed flamboyantly, in ways that he thought would be eye-catching and attractive. In either case, the reactions of others to him confirmed his beliefs about being weird and confirmed that he should never be seen “unprepared,” without his protective clothing (or mask). A positive response indicated that his disguises worked and should be continued. A negative response suggested that his disguises were not sufficiently successful, so he needed to work harder on them. Nadim described another situation that demonstrated the pervasiveness of such a process. When travelling to therapy Nadim said he had caught the eye of the bus conductor as he paid for his ticket. Because the bus conductor looked at him, Nadim concluded that the bus conductor must think he was weird. Then the bus conductor looked away, and he came to the same conclusion, this time because the bus conductor (apparently) could no longer look at him.

In such cases it is extremely difficult to achieve any lasting change without working on beliefs and behaviors together. The main strategy was to link all types of dressing-up behaviors preparatory to meeting people to his beliefs about himself and to the assumptions that followed from those beliefs. He believed he was weird and made various assumptions about how he should behave to keep his weirdness hidden from others, hence the protective behaviors. The first useful step for Nadim came from working on his beliefs, and throwing doubt on his criteria for acceptability (not being weird) and for judging weirdness. Until this time these had been largely derived from internal events (his feelings about how he came across to others; his conclusions about the significance of looking, or not looking at him). He found abstract discussions about acceptability, weirdness, being different from others and unique, and about being himself fascinating, and provocative. He began to observe others closely and to take note of the way they responded to each other. He started to doubt his previous beliefs and became curious about trying out ways of “being himself.” Behavioral changes followed and provided the data for more objective judgments about what others find acceptable (or not).

So in cases such as these, when comorbidity and complexity make straightforward methods hard to apply, it helps to have both slices of bread in the sandwich, and to make clear links between them. Keeping the specific behaviors and the more general beliefs in mind helps to make the treatment of complex cases into a coherent whole, and in this way it contributes much to the work of case formulation. Theoretically, given the hierarchical way in which cognitions are represented, the sooner beliefs are included in the formulation, the more efficient the work will be. It is even possible that drawing explicit conclusions in terms of beliefs would expedite treatment in more straightforward cases for which conventional methods currently suggest it is sufficient to focus on more proximal maintaining factors. Explicitly identifying beliefs would help to ensure that specific interventions are linked to general sources of difficulty and thus be more likely to lead to generalization.

Using the Case Formulation

A case formulation that fits with theory provides hypotheses about how to change. It suggests which thoughts, assumptions, and beliefs should be worked on, which reactions serve the purpose of protection or safety seeking and prevent adaptive change, which are the facts and which are the hypotheses. It shows where the gaps are and provides ideas about problems that may arise during treatment, and about how the problems fit together, form patterns of relating to others, link up with past experiences, and so on. The case formulation becomes a source of fruitful questions such as “What does this suggest about how to change? What do you want to do differently? What do you predict would happen if . . . ?”

Engaging the Patient in Teamwork

A formulation that belongs only to the therapist is potentially far less useful than one that is worked on together, drawn up collaboratively, and owned by the patient. It is therefore essential that therapists learn how to use the Socratic method and guided discovery to derive their formulations (using questions such as those listed in Figure 3.2). For example, they should learn how to explain their ideas about formulation simply, in ordinary language; practice explaining the ideas behind cognitive therapy to those who know nothing about them; search for and respond to doubts and reservations; and find out how patients already understand their difficulties. The work of formulation is nearly always a matter of *reformulation*, as few people experience persistent problems and difficulties without trying to make sense of them in their own way. So it is important to explore these ideas and to take account of what is right and what is mistaken about them when developing a new version. It is also important to search for a language that has meaning for a patient, possibly using and adapting the terms already used, and listening carefully for signs of cultural and linguistic variation. Metaphors can be extremely helpful, provided that they work for the patient (see also Chapters 2 and 9). For example, one patient described his anxiety as a product of building a rigid building on a fault line and likened treatment to a way of rebuilding the framework for his life with the flexibility needed to withstand an earthquake. Using the language of increasing flexibility helped him to be more creative in his response to difficulties, and also more relaxed in the face of the unknown. Asking about rigidity helped him to understand his symptoms of high anxiety and to respond more flexibly to them.

Checking Out What Has Been Understood

Understanding of abstract ideas, such as those involved in formulation work, may be more apparent than real, especially for concrete thinkers, who may be more confused than helped by using metaphors. Again it is essential to listen carefully to the language used. This is especially useful when facing obstacles to progress despite having a case formulation that seems (to the therapist) to fit. Asking the person to explain how he or she understands the theory of cognitive therapy, and how it fits for him or her often reveals misunderstandings or reservations that could be interfering with progress, and it may also reveal mistakes the therapist has made concerning theories or facts, for instance, about the weight or relevance to be given to a past event (being teased or bullied), or to a particular past experience (fainting in public).

Including Positive and Functional Factors in the Case Formulation

It is important to formulate positive and functional factors at all levels, including beliefs and assumptions. One option is to draw up functional maintenance circles using material from another aspect of the patient's life. Paula, for example (p. 61), put much energy into keeping in touch with her girlfriends by telephone and by e-mail when she found it hard to travel, and their responses gave her a sense of belonging. She was also a tidy and organized person, and on better days at work could achieve a lot in a short time. Creating a more positive context for the discussion in therapy changes the perspective from which problems are seen and may also enable both parties to identify and draw on sources of strength or resilience that they might otherwise have overlooked during the problem-focused interactions that tend to predominate in the therapy room. Such work also carries metamessages about someone's strength or resilience; about that person's ability to be creative, to solve problems, and to change.

Communicating Your Ideas about Formulation Carefully

On the receiving end of a case formulation (especially if provided as a monologue) a person can feel that he or she has been summed up, or judged, or that his or her defenses have been "seen through," or penetrated. Theoretical underpinnings of cognitive therapy suggest that patterns of thinking, feeling, and behaving develop because they served a purpose. They made sense at the time (not trusting anyone, operating in hypervigilant, self-protective mode, for instance) and the pattern became fixed because—to a degree at least—it worked. Again it helps to make the formulation collaboratively with many pauses for reflection and feedback, so that doubts and reservations can be explored. Presenting the ideas Socratically makes the process interactive and stops therapists "talking in paragraphs" (or even in whole chapters). Use the language of "trying to make sense" rather than of "giving a formulation," or telling someone how their experiences fit with a preconceived model. Ask yourself, "Will I be heard?" Ask patients whether there are aspects of their problem or layers of their diffi-

1. **Consider the relationship.** Can you collaborate? Do you have sufficient mutual trust? Is the patient able to handle relevant feelings? Can you?
2. **Coping.** What support systems are available? Is this person skilled at keeping himself (and others) safe? Is self-harm or suicidality an issue to consider?
3. **Understanding.** Do you have an idea about what links with what? About how the theories might apply? Is this person able to make links? How does he or she currently understand his or her difficulties? Will this interfere with entertaining a different possibility? Can you see how to search for information that might distinguish different possibilities? (e.g., concerning the genetic, physiological, social, and psychological contributions to the problem?)
4. **Level of metacognitive awareness.** Can this person reflect on his or her experiences (including thoughts, feelings, and behaviors) or is the person caught up in subjectivity, without being able to stand back and think about his or her own experiences (and those of others)? Can the person distinguish thoughts and feelings? Can he or she consider the possibility that there are alternative ways of seeing things—different perspectives? (For more on this, see Chapter 4.)

FIGURE 3.9. The question of readiness.

culty that they have not fully described. Consider whether there are things you should not share, or things that a patient may not be ready for. Obviously this too is a matter for clinical judgment, and some of the parameters to consider are listed in Figure 3.9.

Risks to Watch Out For

Perhaps the main risk is that people may “hear” a case formulation as confirmation of their beliefs, rather than as a way of understanding their origins and their contributions to the maintenance of problems. Sharing a (longitudinal) formulation can be risky for someone with a strong habit of self-blame (“I knew it was all my fault”), and sometimes also for people who habitually blame others and find it hard to accept responsibility (“Everything would be alright if only they would pay attention to what I say . . . love me the way I need . . . apologize as if they meant it”). As Padesky (1993a) pointed out, preconceived ideas may operate like a prejudice: People can hear confirmation of their own ideas even when it was not intended, and they can also ignore, deflect, or distort information that is inconsistent with them (as shown in the Mental Crusher, Figure 3.4). Counterschematic information may be screened out (not attended to); it may not be stored or linked with other related information, and it is difficult to recall, or easy to forget. Repetition may help, and wider psychological principles suggest that the more people work with such information, for example, to identify it, search for it, label it, fit it into current understanding, and make meaningful use of it, for example, as a basis for behavioral experiments, the more likely it is that they will be able to recall it when they need to.

Adapting According to the Stage of Treatment

At first the emphasis is on communicating that it is possible to make sense of the patient’s current predicament: on giving information and on seeking a way of understanding problems. This understanding then provides a rationale for the selection of specific interventions. At this stage formulation work can also enhance engagement, collaboration, and motivation and provide a practice ground for giving and getting feedback. It illustrates well the explicit style of cognitive therapy. During the middle phases of treatment the formulation provides a tool to help therapists check and recheck that the work is on track, makes sense, and is likely to assist in reaching the desired ends. The formulation may need fine-tuning or it may need radical change to fit with new findings and observations. It can be used to identify gaps in understanding and to help anticipate and predict difficulties in the therapeutic relationship, process issues, setbacks or future problems, and so on. If the process of change falters or becomes stuck, the formulation can be used as a source of questions to help in the process of troubleshooting. Toward the end of therapy it can serve as a template for making a blueprint, or summary of the ideas learned during treatment (as illustrated in Chapter 10). It can guide future work to be carried on by the patient once therapy has ended and pinpoint future vulnerabilities and ways of dealing with them. It may indicate that some problems have not been solved during therapy and help both parties to consider whether similar methods could potentially help. If so, it is valuable to summarize the cognitive approach parsimoniously, using ordinary language: for example, “First work out how you see things, then search for new perspectives, and test them

out in practice.” This makes sense of the “unfinished business” in familiar terms and clarifies implications that follow from that.

Drawing metaconclusions is another possibility. For instance, the fact that someone has been able to use cognitive therapy, and has changed her behavior, become more confident, become able to understand things differently, and so on, tells that person something about herself. Work out what implications this has for her and for her future, remembering that the metamessage of formulation work is not that there is a solution to every problem, or that cognitive therapy will resolve all difficulties, but that it is possible and useful to understand what is going on—to make sense of it. Formulation work helped Paula draw the conclusion that “It’s not that everything is a problem. There’s one problem and that’s not being confident.” By the end of therapy she knew that that could change, bit by bit. It may be more useful, and consistent with a broad understanding of anxiety problems and the reasons for them, to acknowledge that difficulties, worries, and anxieties will always occur in the future, and that fostering the ability to adapt or roll with the punches may be the best that any of us can expect to do in a world full of uncertainties (see Chapter 9).

CONCLUSION

This chapter has made reference to numerous clinical skills involved in the process of producing clear, theoretically sound, hypothetical, and useful case formulations. In summary, it is argued that these can be held together by using the principle of parsimony to ensure that the formulation is kept as simple as possible, and by paying close attention to each person’s “felt sense” of vulnerability, or belief system. A new strategy for therapists, applying the sandwich principle combines use of these principles with a practical, down-to-earth focus on changing specific behaviors. Using their clinical judgment, and the two essential skills of abstraction and selection, therapists can discover how to use the work of formulation to provide much more than a mere template for treatment. Sensitive formulation work helps people to make sense of complex problems, and it also enables patients to recognize and to build on their strengths, to collaborate, give accurate feedback, reflect anew on their experiences, and to make new plans.

These principles and ideas are intended to help therapists in the task of making sense (in theoretical terms) when faced with unusual, atypical, or complex forms of anxiety, and to use their understanding to build their interventions on reasonable foundations. More detailed ideas about specific aspects of treatment are provided in all of the remaining chapters. It is difficult to help people who suffer from complex anxiety disorders, and therefore problems will continue to arise. One of the best sources of solutions comes from the processes of formulation, and of reformulation. All of the work involved, including the implicit or metamessages delivered on the way, may contribute. Retaining a questioning attitude toward a formulation, to the uses made of it, and to the work surrounding it helps to guide a search for solutions. It also serves as a reminder that, when it comes to formulation work, patients as well as therapists have much to contribute. They may even know best.