

# **Formulation in Psychology and Psychotherapy**

**Making sense of  
people's problems**

**Edited by Lucy Johnstone and Rudi Dallos**



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# Formulation in Psychology and Psychotherapy

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Formulation is attracting an increasing amount of interest in the fields of psychology, psychiatry, psychotherapy and counselling. Drawing on psychological theory, it attempts to examine a client's or family's problems in terms of how they arose and what may currently be holding them in place. It synthesises this information and explanatory ideas into 'working hypotheses', which are then used to suggest appropriate and effective ways of working to relieve the problems. It can also be described as the key way of relating theory to practice in clinical work.

*Formulation in Psychology and Psychotherapy* places this growing interest in formulation in a clinical and historical context. It introduces the reader to the theory and practice of formulation through the discussion of two clients (one adult and one child), whose problems are formulated from the perspective of five different therapeutic traditions: systemic, psychodynamic, community, cognitive-behavioural and social constructionist/narrative. It looks at the growing trend for formulations that draw on two or more therapeutic models and includes two chapters dealing with integrative formulation. It offers some creative suggestions for how this can be carried out in a way that is theoretically coherent and clinically effective. The authors also explore the important issue of formulation as a collaborative activity, and consider the ethics of formulation. The final chapter takes a critical overview of the main research, controversies and debates in the area, and gives a guide for using, developing and researching formulation in a way that maximises its strengths while being aware of its limitations.

The book is unique in including newer therapeutic approaches such as narrative therapy and social inequalities. It critiques and takes forward recent work on integration, and provides a lively and challenging critical evaluation of the area as a whole. It guides

readers through a complex field in a clear, accessible and engaging way. Both experienced and novice clinicians will be able to enhance their clinical skills and theoretical knowledge.

**Lucy Johnstone** is a clinical psychologist and Academic Director of the Bristol Clinical Psychology Doctorate. Her main interests are in Adult Mental Health, and in psychological approaches to the more severe forms of mental distress. She is the author of a number of publications including *Users and Abusers of Psychiatry*, Adult Mental Health (Routledge 2000), and is a regular speaker and guest lecturer at conferences and training courses.

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and Rudi Dallos

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# Introduction to formulation

*Lucy Johnstone and Rudi Dallos*

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### **Formulation in psychology and psychotherapy**

Formulation is a topic that is attracting an increasing amount of attention in psychology, psychotherapy, counselling and psychiatry. Although it is arguably central to the implementation of any psychological intervention, it has until recently been a neglected area of research, training and publication. The most relevant publications to date are Bruch and Bond (1998) *Beyond Diagnosis: Case Formulation Approaches in Cognitive Behaviour Therapy*; Eells (1997) *Handbook of Psychotherapy Case Formulation*; and Weerasekera (1996) *Multiperspective Case Formulation*. All of these are useful texts, but are written by psychiatrists with a medical readership in mind (Eells and Weerasekera); are oriented towards an American audience and healthcare system (Eells and Weerasekera); or are written from a CBT perspective only (Bruch and Bond). None of them covers the newer therapeutic traditions, nor do they give a critical overview of the issues around formulation. This book is an attempt to fill those gaps. We hope it will be useful to trainee and qualified clinicians from a wide range of helping professions and therapeutic orientations.

We have organised the book around a number of central themes, which run through the various chapters and are brought together in Chapters 7 and 8 on Integration and in the final overview and reflection. These themes are as follows:

- *Formulation and collaboration.* Is formulation something that we do to, or with, clients? If formulation is the starting point for the whole process of therapy, this has crucial implications for the whole way in which the therapy proceeds. How

important is it to ensure the client's genuine involvement right from the start, and how can we promote this in the process of formulation?

- *Formulation and reflective practice.* The notion of reflective practice is becoming increasingly important in all therapeutic traditions: that is, the necessity of being aware of one's own thoughts, feelings and reactions as a therapist as well as one's own position in terms of professional status, gender, class, ethnicity and so on, and how these impact upon the therapeutic process. How might these ideas be taken on board in formulation? What kind of biases is formulation open to, and how can we minimise them?
- *Formulation and the therapeutic relationship.* Linked to the above are general questions about power and control in therapy, and in whose interests the therapy (or the formulation) operates. This leads us to ask questions such as how and when we share formulations with clients, and whether it is ethical to do so (or not to do so) in particular clinical situations. It also raises the question of whether formulations can be harmful, as well as simply not helpful, and how we can take steps to avoid this possibility.
- *Formulation and context.* Different therapies take different positions on what is included in the formulation. Do we refer mainly to individual thoughts, feelings and behaviours; do we include family and institutional settings as well; and/or do we also look at much broader social and political contexts? And if the latter, how do we integrate these into our understandings of our clients' difficulties? Where does the 'problem' reside, and how can we come to a shared view about this which will allow constructive work to be carried out?
- *Formulation and integration.* As the following chapters will show, there are as many different approaches to formulation as there are therapies, although there is also a recent trend towards therapeutic integration, with all traditions being more open to borrowing ideas and concepts from each other. Is it possible to combine the strengths of various different approaches in order to produce integrated formulations, and how might this be done?
- *Formulation and diagnosis.* There is an ongoing debate about how formulation differs from psychiatric diagnosis. Is it a replacement for, or an addition to, the more traditional way of

matching clients to treatments? Or is it trying to achieve something rather different, perhaps a more individualised and tentative working hypothesis?

- *Formulation, evaluation and evidence.* This brings us on to some more fundamental debates about the nature and scientific status of formulations. Can they in some sense be described as ‘correct’ or ‘true’, or are they best viewed in terms of their usefulness to the client? In either case, how might we evaluate this, and whose view (therapist or client) counts most? What kind of research has already been carried out and what kind is needed in the future?
- *Do we need formulation at all?* Finally, we should not be afraid to ask fundamental questions about the value and place of formulation. As will be seen in the chapters on social inequalities and social constructionism, not everyone is convinced that formulation is an essential part of therapeutic work. Is it simply rhetoric, politically useful as part of a claim to expertise and professional status? Could any non-professional do as well – or perhaps better? Indeed, is it possible not to formulate – in our work and in our everyday lives? Can we take anything meaningful and valuable from the debates that all parties would be able to agree with, and if so what might that be?

Our themes, then, are threads running throughout the chapters, which are organised around the stories of two clients – Jack, a young man in his mid-twenties, and Janet, a child aged nine. Their difficulties are formulated from a number of different perspectives in turn: CBT, psychodynamic and systemic, which represent mainstream therapeutic approaches; and social inequality and social constructionist viewpoints, which are more recent developments. Readers will be able to gain a clear sense of how to formulate within each tradition, and the respective strengths and limitations of each. There then follows a chapter on the general principles underpinning integrated formulations, followed by a chapter describing two ‘ready-made’ models of multi-perspective formulation. Finally, we present a summary and critical overview of the themes of the book, in order to come to some tentative conclusions about the place of formulation in therapeutic work.

## **What do we mean by formulation?**

A good place to start is by looking at some of the many attempts to define formulation. It may be useful to bear in mind the themes outlined above as we reflect on these definitions:

Formulation is . . . a provisional explanation or hypothesis of how an individual comes to present with a certain disorder or circumstance at a particular point in time.

(Weerasekera 1996: 4)

A formulation is the tool used by clinicians to relate theory to practice . . . Formulations can best be understood as hypotheses to be tested.

(Butler 1998: 2, 4)

A psychotherapy case formulation is essentially a hypothesis about the causes, precipitants and maintaining influences of a person's psychological, interpersonal and behavioural problems.

(Eells 1997: 1)

Formulation is the summation and integration of the knowledge that is acquired by the assessment process (which may involve a number of different procedures). This will draw on psychological theory and data to provide a framework for describing a problem, how it developed and is being maintained.

(Division of Clinical Psychology 2001: 3)

Thus, the common elements are that a formulation provides a *hypothesis about a person's difficulties*, which *draws from psychological theory*. We may wish to note that what seems to be missing from these definitions is the role and viewpoint of the client in developing the formulation.

## **What is the purpose of a formulation?**

Again, there are a number of different but complementary views on this, from the different perspectives that we will be describing in this book.

**Cognitive-behavioural**

A formulation . . . 1. relates all the client's complaints to one another, 2. explains why the individual developed these difficulties, and 3. provides predictions concerning the client's behaviour given any stimulus.

(Meyer and Turkat 1979: 261)

[Case formulation's] purpose is both to provide an accurate overview and explanation of the patient's problems that is open to verification through hypothesis testing, and to arrive collaboratively with the patient at a useful understanding of their problem that is meaningful to them . . . The case formulation is then used to inform treatment or intervention by identifying key targets for change.

(Tarrier and Calam 2002: 312)

**Psychodynamic**

A psychodynamic formulation: makes a statement about the nature of the patient's problems or difficulties, usually in terms of repeated maladaptive patterns occurring in relationships . . . Makes an inference as to how these are related to the patient's internal world, including unconscious conflicts . . . Links the above (if possible) with historical information in an explanatory model.

(McGrath and Margison 2000: 2)

The formulation explains how and why the patient's equilibrium has become disturbed and how the problems or symptoms have arisen and are maintained. From it, a logical course of therapy can be deduced, taking into account the probable consequences of change (losses and gains) and the likelihood of achieving change. The formulation, therefore, serves both as a map for therapy and a guide to which map to choose.

(Aveline 1999: 202)

**Systemic**

By hypothesising we refer to the formulation by the therapist of a hypothesis based upon the information he possesses



regarding the family he is interviewing. The hypothesis establishes a starting point for his investigation as well as his verification of the validity of the hypothesis. If the hypothesis is proved false, the therapist may form a second hypothesis based upon the information gathered during the testing of the first.

(Palazzoli *et al.* 1980: 4)

### **Integrative**

Formulation . . . is defined as a provisional explanation or hypothesis of how an individual comes to present with a certain disorder or circumstances at a particular point in time. A number of factors may be involved in understanding the etiology of the disorder or condition. These include biological, psychological and systemic factors. . . . All these variables interact under certain conditions to produce a specific condition or phenomenon. . . . A comprehensive formulation then needs to examine all three models carefully.

(Weerasekera 1996: 4)

Butler (1998: 9) gives a very full summary of the purposes of formulation:

- Clarifying hypotheses and questions: ‘Therapists should work with a formulation in mind right from the start . . . they guide questioning, and open the therapist’s mind to the kind of understanding from which effective treatment strategies can be derived, applied, and evaluated.’
- Understanding: ‘Providing an overall picture or map: formulations, just like maps, provide an overall view . . . of something that it is not possible to see all at once.’
- Prioritising issues and problems: ‘Formulation . . . helps to differentiate what is essential from what is secondary in a general sense. It also helps in a more particular sense to decide which issues or problems should be prioritised.’
- Planning treatment strategies and selecting specific interventions: ‘The way in which a problem is formulated determines what should be done about it.’
- Predicting responses to strategies and interventions and predicting difficulties: ‘Formulation . . . helps to predict the effect of

the intervention . . . and to predict the stumbling blocks and difficulties that will be encountered during therapy.'

- Determining criteria for successful outcome: 'A formulation provides the basis for hypotheses about what needs to change for someone to feel better, or the goals of therapy in the broad sense of the term.'
- Thinking about lack of progress and troubleshooting: 'When lack of progress lead to frustration, and the reactions of both the patient and the therapist interfere with subsequent progress, including these factors in the reformulation can reveal ways of overcoming them.'
- Overcoming bias: 'Working with a formulation that can be explained to others provides a check on the use of too much speculation and too many far-fetched inferences.'

The essential elements here would seem to be *helping to select and guide the interventions*. Again, this raises the questions of who draws up the formulation and in whose interests it operates. Is formulation something done by the therapist to the client, and how does this fit in with the broader therapeutic relationship? We might also want to ask about the role of reflexivity – the therapist's awareness of their own process and position – and the wider social context within which the client lives and the problem is construed.

Although all formulations share the key features summarised above, they will differ according to the model they draw from. Approaches such as CBT, psychodynamic theory and so on are broad, general sets of explanations that draw on their own characteristic ideas and concepts: for example, negative automatic thoughts in CBT or the unconscious in psychodynamic therapy. A formulation takes these general theories and applies them to a particular individual and their difficulties. The subsequent chapters will illustrate the very different, although sometimes overlapping, formulations that could be relevant to Jack and Janet, depending on which therapeutic perspective is taken. In the case of social constructionist and social inequality perspectives, the distinctive characteristic is a reluctance to engage in a traditional process of psychological formulation and a preference for alternative ways of generating useful ideas or narratives. Further possibilities are introduced by the increasing tendency for therapists to work integratively: that is, to draw from a number of different models in their formulation and intervention. Integration is the subject of Chapters 7 and 8.

## **How did the concept of formulation arise?**

The answer to this question varies according to the therapeutic tradition in question.

### ***Cognitive-behavioural approaches***

Most current writing and research on the subject comes from the cognitive-behavioural tradition, where it is usually referred to as 'case formulation'. Bruch describes how this approach was pioneered at the Maudsley Hospital from the 1950s onwards by clinical psychologists such as Hans Eysenck, Victor Meyer and Ira Turkat (who coined the term 'case formulation') – key figures in the development of the then new approach of behaviour therapy (Bruch 1998). In its earlier form of functional analysis, case formulation was seen as a more useful alternative to psychiatric diagnosis, aiming to describe problem behaviour in terms of environmental stimuli and response contingencies (Hayes and Follette 1992). For example, agoraphobia might serve the purpose, or function, or helping someone to avoid anxiety-provoking situations, or alleviating the possessive jealousy of an insecure partner. This kind of analysis was said to provide a much more useful guide to treatment than psychiatric diagnosis.

Cognitive therapists such as Aaron Beck (1976) have, from the 1970s onwards, made significant additions to early behavioural analysis by including the role of thought processes in the development and maintenance of mental distress, and there is now a very large literature on the subject (see Chapter 2).

The term formulation first appears in the regulations governing the profession of clinical psychology, a profession that traditionally specialises in CBT, in 1969 (Crellin 1998). Crellin has argued that the concept of formulation (and its earlier version, functional analysis) played a crucial political role in establishing the expert status and independence of the fledgling profession, which was at that time both overshadowed by psychiatry and in competition with a number of other professions with a claim to alleviate mental distress (Crellin 1998). In *The Core Purpose and Philosophy of the Profession* (Division of Clinical Psychology 2001) formulation appears as a central defining skill, and it is one of the core competencies that all graduating clinical psychologists are expected to possess.

In CBT, formulation is located firmly within a scientific, experimental framework as ‘a central process in the role of the scientific practitioner’ (Tarrier and Calam 2002: 311). It is ‘an elegant application of science’ (Kinderman 2001: 9). Similarly, the British Psychological Society describes clinical psychologists as using ‘psychological science to solve human problems’ (Division of Clinical Psychology 2001: 4).

### ***Psychodynamic approaches***

The earliest psychotherapy formulations originate from Freud’s case studies, and draw on the psychoanalytic concepts of the unconscious, the transference, defence mechanisms, and the id, ego and superego (Bateman and Holmes 1995). Although Freud did not use the term formulation, this was a way of explaining symptoms in psychological terms as having both a meaning (often symbolic) and a function (classically, meeting instinctual needs).

‘Psychodynamic’ is a general term for approaches that draw on psychoanalytic ideas and assumptions, but the field is a very wide one and includes significant later developments such as object relations theory, self psychology and attachment theory (see Chapter 3). Each of these brings its own characteristic emphasis, which is reflected in the process of formulation.

During the initial assessment interview, which is seen as being of crucial importance, the psychodynamic therapist will be gathering information and looking for the client’s ability to form a good working alliance, to make use of interpretations, and to be in touch with their feelings (Bateman and Holmes 1995). He or she will be looking for important factors in the past, for patterns in relationships, and for the key defences used by the client. From this, a psychodynamic formulation of the client’s difficulties, which would typically be based on Malan’s (1995) ‘triangle of person’ – that is, the links between the client’s current relationships, the relationship with their parents, and the relationship with the therapist – will be developed. Elements of this may be shared with the client at the end of the first meeting in order to assess their response and hence their ability to work psychodynamically.

The scientific status of psychoanalysis and its derivatives has been a subject of heated debate for many years, and was part of the impetus for the emergence of the more experimentally verifiable behavioural schools of therapy. For the purposes of this book,

it is worth noting that a number of recent attempts have been made to evaluate psychodynamic formulations scientifically (see Chapter 9).

### **Systemic approaches**

The concept of working hypotheses has been central to the practice of family therapy from the late 1970s (Palazzoli *et al.* 1980). In the early years of family therapy there was an emphasis on making 'objective' and 'scientific' assessments and formulations of a family 'out there', and mapping their dysfunctions (Dallos and Draper 2005). The 'symptoms' displayed by one member were seen as part of an attempted solution that was serving a function for the whole family. More recently there has been a recognition that the therapist's values and assumptions are inevitably part of the process of formulating, and that there is no such thing as 'the truth' about a given family. This represented a shift from a position of certainty, from which the families were assessed in terms of their 'dysfunctions', to one in which it is recognised that there are multiple realities in any given situation. There is no one way of viewing a family and thus the therapist holds 'working hypotheses' not truths. This frees the therapist to allow new and different ideas to enter their thinking. Later still, the emphasis moved towards the holding of a position of 'curiosity' rather than hypotheses or formulations.

Systemic formulations, or working hypotheses, must therefore retain an 'as if' quality, and be constantly open to revision ('progressive hypothesising'). Their worth is best judged not in terms of 'truth' but by their usefulness in helping to bring about change.

A social constructionist perspective is influential in current systemic thinking, leading to an increasing awareness of the wider socio-cultural context in which therapists and clients exist, and the variety of assumptions that shape our understandings of what, and whose, the problem is. Systemic approaches have always drawn on social and relational, rather than medical, factors for their hypotheses. The process of hypothesising might nowadays include questions about the role of social inequalities; of competing views of the problem that may be held by agencies such as social services, psychiatry, the school and so on; the role of therapists as employees of the state; and the more general cultural assumptions about how families 'should be'.

**Other therapeutic traditions**

As noted above, not all therapeutic approaches use formulation as a starting point. Humanistic therapists have been reluctant to engage in a process that Carl Rogers (1951) saw as an unhelpful imposition of an expert view on the client's experience, a theme that has been taken up in different ways by social constructionist and social inequality writers (see Chapters 5 and 6).

**Summary**

All formulations:

- summarise the client's core problems
- show how the client's difficulties relate to one another, by drawing on psychological theories and principles
- explain, on the basis of psychological theory, why the client has developed these difficulties, at this time and in these situations
- give rise to a plan of intervention which is based in the psychological processes and principles already identified
- are open to revision and re-formulation.

Formulations from the various therapeutic traditions also differ in terms of:

- the factors they see as most relevant (thoughts, feelings, behaviours, social circumstances, etc.)
- the explanatory concepts they draw on (schemas, the unconscious, discourses, etc.)
- the emphasis they place on reflexivity
- the degree to which they adopt an expert as opposed to a collaborative stance
- their position in relation to psychiatric diagnosis
- their position about the 'truth' versus 'usefulness' of the formulation.

Psychological formulation has been used, under various synonyms, for many years, but has recently attained new prominence. The editors of this book see formulation as having many strengths, but at the same time take a constructively critical view of its limitations. Both viewpoints will be explored thoroughly in the following chapters through the stories of our two clients, Jack and Janet.

## **Jack**

Jack is 25 and was referred to a clinical psychology department shortly after his admission to an acute inpatient unit, because nursing staff felt that unresolved issues in his life were contributing to his distress. He was quite 'high' in mood for much of the time, talking non-stop about music, but at other times would lapse into tears and say that he and his life were a hopeless mess.

Jack was born and brought up in Swindon. His father, who came to England in 1979 from Southern Italy, had worked his way up from humble origins to become head of a chain of shops, and the family was well off and comfortably settled as part of the community. His mother stayed at home to bring up the family, consisting of Jack and his three younger sisters. Jack did well at school and was popular and sociable, with a talent for music, and there were strong expectations that as the only son he would carry on the family business.

Jack's father was an alcoholic and violent to his wife and children. Both the drinking and the violence worsened as his business began to run into trouble, when Jack was about 10. When Jack was 14, he took on a Saturday delivery job and was sexually abused on several occasions by the male boss. He felt unable to confide in his family at the time and is still very reluctant to discuss this; no other details are known.

Jack himself started drinking from the age of 15, and failed his GCSEs. Around this time his parents divorced and his father moved back to Italy and has not kept in contact. Jack has very mixed feelings of love and hate towards his father, although his sisters seem to believe they are better off without him. The effect on the family was disastrous. They had to sell their comfortable house, lose contact with the Italian community in Swindon, and move to central Bristol, where Jack's mother tried to make ends meet by various low-paid jobs. The family were harassed and burgled on a number of occasions.

Meanwhile, Jack continued to go off the rails, drinking, taking drugs and becoming involved in petty theft. A pattern developed in which he would hold down a job for a few months, but invariably slip back into drinking. Eventually, after some violent rows at home, his mother threw him out and he slept rough for a few months. At around this time he was first referred to the psychiatric services for outpatient appointments and was diagnosed as

depressed. He was put in touch with a project for the homeless and appeared to settle for a while.

About two years later, Jack's mother developed some serious health problems and finances became even more stretched. At around the same time Jack began to develop the first signs of what was diagnosed variously as 'paranoia' and 'persistent delusional disorder', when he started to complain that Robbie Williams (the pop singer) had stolen his songs and his royalties and that Robbie's friends were out to beat him up or kill him. He also believed that Robbie had raped one of his sisters. He described the frightening experience of looking in the mirror and seeing his father's face reflected back at him.

Eventually Jack was admitted to hospital at his family's request, where he became a little more settled, but still convinced of the truth of his ideas and reluctant to address the problem of how he was going to put his life back on track, because he was anticipating a huge royalty cheque any day. He was compliant with medication and said he found it helpful.

It was hard for the psychologist to get a clear agreement about what to work on, given Jack's tendency to escape into fantasy. Problem areas identified by Jack were:

- He was desperate to get hold of the royalties that were, he believed, due to him.
- He was afraid to go out in case he was attacked by Robbie Williams's minders.
- He was very concerned about and protective of his family, especially the sister who, he believed, had been raped (although the sister said that no such event had taken place).
- He missed his father and was confused about his feelings for him. When he saw his father's face in the mirror he was filled with fear and self-loathing.

## Janet

Janet, aged 9, was referred by a school nurse to the primary care therapy service serving GPs in an inner city locality. Social services had previously been alerted about a number of contacts with the accident and emergency department of the local hospital, although no evidence of abuse had been found. Mary, Janet's mother, had also contacted social services for various reasons including a request



for a wheelchair to help with Janet's mobility problems. She was concerned that Janet was not developing properly and wondered if this was linked to Janet's reluctance to travel or use public transport. In addition, Mary and the school nurse had concerns about Janet's low weight. Janet was already being reviewed at yearly intervals by the paediatric consultant because of worries about her development as an infant. On assessment, no physical problems were evident.

Mary, in her late forties, separated from Janet's father, Colin, when Janet was 3. He still lived nearby, and was until recently having overnight contact with Janet at his home. Janet has recently said she does not want this to continue, although she still sees her father. Colin is a heavy drinker and was violent towards Mary. Colin and Mary's older child, Andrew, aged 12, was doing well at school, both academically and socially. He also lived with Mary and Janet, and hoped to join the police force when he grew up.

Mary said that she found it 'hard to bond' with Janet when she was born, and felt sad and depressed for a long time after the birth. At times she wished Janet could be taken away, although she did not feel this way about her other children. This was hard for her to understand, and made her feel guilty.

Mary had four older children from an earlier relationship, two of whom lived in the same street, and Mary was very involved with her two infant grandchildren. She was particularly proud of the son who had done well educationally and become a schoolteacher. Mary was also close to her sister, Cindy, who lived locally and had no children of her own, but had a special relationship with Janet and took a close interest in her.

The family had always lived in a very socially deprived location in local authority accommodation, alongside some of the most 'difficult' families in the area. The estate was due for demolition and the family had been waiting to be rehoused for the last two years. They are a Romany family and this is a central part of their identity, expressed in a strong interest in spiritualism and clairvoyance. A clairvoyant had told Mary about a 'white car', which Mary connected with Janet's nightmare about a 'white van' and her fear of using any form of transport.

At the time of referral, Mary was awaiting a heart operation, having suffered from angina and arrhythmia for a number of years. That meant that she easily became exhausted.

The referral letter documented Mary's many concerns about

Janet, including her weight loss, behaviour at home, and refusal to use transport, although she would walk to school, town and therapy sessions. This was paralleled by her mother's limited mobility, which resulted in them both becoming more withdrawn and isolated, especially from their extended family. Mary described Janet as being a prisoner in her own home.

Janet was also described as being unable to sleep in her own bed because of night terrors, so that she often ended up sharing Mary's bed; losing her temper (including once setting the dog on her mother); and refusing to eat food prepared for her by Mary, so that she was now seriously underweight. However, she had friends at school, joined in quite enthusiastically, and was achieving adequately for her age.

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# **Formulation in cognitive-behavioural therapy**

**‘There is nothing either good or bad, but thinking makes it so’**

*Robert Dudley and Willem Kuyken*

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### **What is a cognitive-behavioural approach?**

At the heart of any CBT approach lies a deceptively simple idea. Perceptions of ourselves, the world and the future shape our emotions and behaviours. As Shakespeare’s Hamlet put it: ‘There is nothing either good or bad, but thinking makes it so.’ People are thought to develop emotional disorders when they are locked into unhelpful patterns of interpretation and behaviours. From this comes the idea that if we evaluate and modify dysfunctional thinking, we can profoundly affect our emotional well-being. Enduring changes occur when people are able to modify dysfunctional beliefs and learn healthier and more adaptive beliefs. This central feature of CBT is based on two broader assumptions. First, a biopsychosocial context is implicated in the development and maintenance of emotional disorders. Biological and social theories of emotional disorders (e.g. Beck 1999) are not seen as competing theories, but rather as complementary theories operating at different levels of analysis with different points of focus. Second, even though a client’s presenting problems arise in a biopsychosocial context, the client’s perspective and agency are seen as the main focus in CBT. Cognitive theory takes into account the broadest range of factors that can help understand why a client presents with a particular set of problems, and then focuses on how the client has shaped this through a process of making sense of their lives. A powerful illustration is the work of Victor Frankl, a survivor of Auschwitz who went on to describe how he was able to draw meaning from his experience and how this process enabled him to survive Auschwitz and its aftermath (Frankl 1963). It is beyond the scope of this chapter to describe the breadth and depth of CBT approaches but interested

readers are referred to the work of Beck (1995) and Padesky (1996; Greenberger and Padesky 1995).

### **Formulating within a CBT approach**

While often taken to be a single entity, cognitive-behavioural therapy (CBT) actually encompasses a broad church of approaches that are unified by several underlying principles (see Beck 1995). Cognitive therapy is identifiable by the presence of these principles in effective action. While excellent cognitive therapy protocols for a range of problems exist, what is of primary importance is enacting these principles in practice with clients. In our view the first and most important principle is that CBT draws on cognitive and behavioural theory to inform our understanding of clients' presenting issues.

A second principle driving CBT formulation is that it is built on 'collaborative empiricism' (Beck 1995): an emerging and shared description of the problem and understanding of what caused and maintains it. When this collaboration is successfully established, the therapist and client work like a partnership, approaching the client's problems together as a scientist approaches a scientific problem.

The third principle arises directly out of 'collaborative empiricism' and mirrors CBT itself: CBT formulations are always evolving and are therefore always provisional. Formulations are usually built up layer upon layer over the course of therapy (Kinderman and Lobban 2001). Whilst theories and clinical experience may lead us to hypothesise that factors which affect a group will be relevant to a particular person, we do not know this unless or until the person tells us that they think it is relevant.

A fourth principle driving CBT formulation is that it is a framework for intervention planning. By identifying cognitive and behavioural mechanisms the CBT formulation provides not only understanding, but also leads to the use of appropriate intervention techniques. The CBT formulation provides a rationale for selecting from the large and complex array of interventions (Needleman 1999).

A fifth principle driving CBT formulation is that a good therapeutic relationship is a necessary, but not sufficient, condition for collaborative formulation. Cognitive therapists, like other therapists, aim to provide an empathic, warm, genuine and respectful

context in which to work. Given the focus of CBT, they should be particularly skilled at seeing the world from their client's viewpoint while holding a realistic perspective in the face of what may be quite distorted thinking. With clients with significant interpersonal problems, which are often manifest in the therapeutic relationship, therapists might work with the client to examine the beliefs and behaviours that underpin the relationship difficulties through collaborative formulation.

A sixth principle driving CBT formulation is its focus on *current* problems and mutually agreed goals. This problem/goal orientation enables cognitive therapists to use formulation to work strategically, planning several steps ahead, anticipating the stages of change that will enable a client to achieve his or her goals and the likely obstacles. A CBT formulation is categorically not an attempt to understand the whole client or his or her life. Instead, formulations are of a scope and at a depth appropriate to the problems, goals and progress in therapy.

Finally, CBT formulation is complementary to psychiatric diagnosis. Most of the literature or evidence base is derived from studies of diagnostic categories such as major depression, panic disorder and schizophrenia. The relative merits and limitations of diagnosis have been the subject of debate for decades (e.g. Johnstone 2000). The definition and function of formulation are different to diagnosis. Diagnoses are descriptive and atheoretical, historically providing nosologically discrete clusters of symptoms used to develop theories of and interventions for emotional disorders. CBT formulation, on the other hand, provides a psychological description and explanation of a particular individual's presenting issues at a given point in time. Diagnosis may be a reason to consider a hypothesis or intervention strategy, but the diagnosis will probably only have marginal bearing on the process of formulation.

## **The empirical basis of CBT**

From its inception CBT was established as a system of psychotherapy that (a) is based on a cognitive theory of personality and psychopathology with solid empirical foundations for its basic tenets; (b) has been subjected to outcome studies that attest to its efficacy and effectiveness with a broad range of disorders and populations. The process of formulation is the crucible where the particularities of a case and the evidence base come together.

A generation of researchers has empirically examined cognitive theories of emotional disorders. The benefit of this theoretical research is that CBT formulation draws on models, primarily based on diagnostic categories (see principle seven above), that are empirically based. The model tells us what themes to look for and what relationships to expect between cognitions, emotions and behaviour. The process of formulation is the synthesis of the generalised model with a particular person's presentation. For example, the cognitive model of panic disorder proposes that people with panic catastrophically misinterpret their bodily sensations (Clark 1986). Hence, for one person the signs of a racing heart may be appraised as a heart attack, for another person, dizziness is a sign of a stroke. The formulation is unique as it reflects the idiosyncratic differences, but is based on a common process stated in the model, in this case the catastrophic misinterpretation of bodily sensations. Even though excellent models have been developed and continue to evolve, a word of caution is warranted. Although we know that CBT works, we are less sure about for whom it is best suited and what are the active ingredients. Hence, there is a great deal that we do not know.

While there is a large body of CBT outcome research indicating its value with a variety of psychological problems (Roth and Fonagy 1996), there is a much more limited body of CBT process–outcome research, and surprisingly almost no research examining CBT case formulation (Bieling and Kuyken 2003; Kuyken 2005). This leaves us advocating the value of formulation on the basis of emergent CBT ‘established good practice’ rather than on the basis of any evidence base. However, a body of relevant research is beginning to emerge (see Kuyken 2005).

### **The process of CBT formulation: the five Ps**

We now turn to the formulation process. We suggest a framework for CBT formulation that refers to the levels and process of formulation in terms of the five Ps: presenting issues, precipitating, perpetuating, predisposing and protective factors. This framework structures the process of formulation and helps achieve formulation's goals. Each involves different levels of description and inference and relates to intervention planning differently. We examine the Ps in turn, outlining how each relates to therapy (Table 2.1). They are presented as we might typically expect them to unfold in the

Table 2.1 The five Ps of CBT formulation

<i>The five Ps</i>	<i>Relationship to therapy</i>
<b>1 Presenting issues</b> Statement of the client's presenting problems in terms of emotions, thoughts and behaviours.	This process goes beyond diagnosis in that we begin to define the current problems which the person faces. This introduces specificity and individualisation. We also define short, medium and long-term goals that can help identify the likely end point of therapy. This process helps to develop the therapeutic relationship, clarifies problems and instils hope.
<b>2 Precipitating factors</b> The proximal external and internal factors that triggered the current presenting issues.	Introduces the cognitive model and provides initial focus for CBT interventions. If successful builds clients' confidence in themselves, therapy and therapist.
<b>3 Perpetuating factors</b> The internal and external factors that maintain the current problems.	Provides a focus for intervention by breaking the maintenance cycle.
<b>4 Predisposing factors</b> The distal external and internal factors that increased the person's vulnerability to their current problems.	Provides a longitudinal understanding of the problems and a focus for more in depth interventions that aim to maintain change and prevent relapse.
<b>5 Protective factors</b> The person's resilience and strengths that help maintain emotional health.	Provides a path of least resistance by suggesting interventions that build on existing resiliency and strengths. Also provides pathways to long-term recovery.

course of therapy, from description to inference, rather than as a prescriptive protocol for formulation.

### ***Presenting issues: what are the problems?***

When people come to therapy they are usually looking for help with specific problems, even if these may not initially be well articulated in their own minds. For instance, they feel sad, lack energy or feel anxious when around people. The assessment phase seeks to generate a list of presenting issues that is specific, clear and useful to the



client and therapist. For instance, instead of writing the problem as ‘depression’, the person might be asked: ‘In what way does depression show itself in your day, or your life?’ This may indicate very specific and individual problems like not getting out of bed or not answering the telephone. A comprehensive assessment of the presenting problems in terms of cognition, affect and behaviour in the context of relevant psychosocial factors is essential to CBT. Such an assessment would also normally include relevant background and context to the presenting issues (onset of the problems, family, educational, occupational and psychiatric history, personal and social resources, and so on), which in later stages of formulation enable a more in-depth understanding.

This has several important implications for therapy. First, if done skilfully this process begins to develop a strong working alliance and instils hope, because articulating problems can help clients feel understood and that their problems might be solvable. Second, it forms the basis for a goal list that will help specify a therapy contract. While the assessment process is not strictly formulation, it is essential groundwork for CBT formulation. It provides the context and much of the content for the formulation.

### ***Precipitating factors: what triggers the problems?***

The next phase of CBT formulation involves articulating the external and internal factors that tend to trigger the presenting problems. On closer questioning it is usually the case that people experience some variation in their presenting problems according to time and place. At this stage it becomes important to consider the difficulties in relation to a CBT model. The basis of the cognitive model is the important concept that it is not the events themselves, but one’s view of the events, that explains a person’s reaction. When people are asked what has led to them being anxious or sad they often describe events: ‘The reason I am unhappy is because I am divorced/bankrupt/out of a job.’ It goes without saying that these events can be distressing and stressful to us all. However, it is also obvious that we do not all respond to stressful events in the same way. To begin the process of socialisation to the cognitive model we draw upon the ABC model (derived from functional analysis in behavioural approaches), which in this context refers to *A – activating event*, *B – beliefs* and *C – consequences*. This helps separate out the original event from the interpretation or

belief from the consequences. The person may say: 'I am sad because I spilled my coffee.' The ABC model helps illustrate the importance of thoughts (or negative automatic thoughts as they are referred to) in determining distress by explicitly introducing the notion of an appraisal, between the situation and the emotion (see Figure 2.1).

One advantage of the ABC model is that it is easily introduced with specific and personalised examples from the person's recent experience which illustrate the fact that there may be different ways of seeing any situation and that thoughts are not necessarily facts or truths, but points of view or hypotheses. Using the collaborative but questioning style of CBT we can ask whether everyone would feel sad on spilling coffee, would others react differently, would the person themselves have thought and reacted differently before they became depressed. Clients often react to this by remarking that their reactions seem so automatic that they do not pause to question their 'truth'.

### ***Perpetuating factors: what keeps the problems going?***

Whilst the ABC model is a very useful heuristic device, it has limitations when helping us understand emotional disorders. For example, it specifies a linear relationship between the event, the interpretation, and the emotion and behaviour. However, some people report being aware of feelings before thoughts. Furthermore, the ABC model does not really explain what maintains the problem in the long term. Hence, we draw on an expanded model that incorporates a circular relationship between the elements, and helps to show the reinforcing and spiralling nature of the problems. This model often includes more explicit information about the physiological

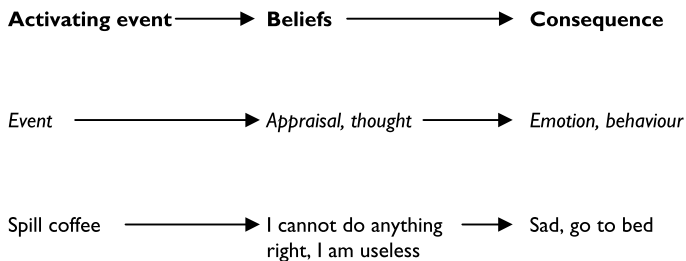


Figure 2.1 An illustration of the ABC model.

responses to a situation that may also be important (Greenberger and Padesky 1995). This cross-sectional or maintenance model emphasises the perpetuating features that add inferential hypotheses about how the problem is maintained by cognitive and behavioural factors (see Figure 2.2.)

The emphasis in this model is on what is maintaining the problems. It also demonstrates the circular relationships which can spiral downwards to escalate problems. When we construct such a model, the direction of the arrows is important and the initial phase of therapy must provide a defensible rationale for the links between components. For instance, we need to consider the way that behaviour in a given model might maintain a belief.

Within the CBT research literature, most notably with regard to the anxiety disorders, there is an increasing emphasis on under-

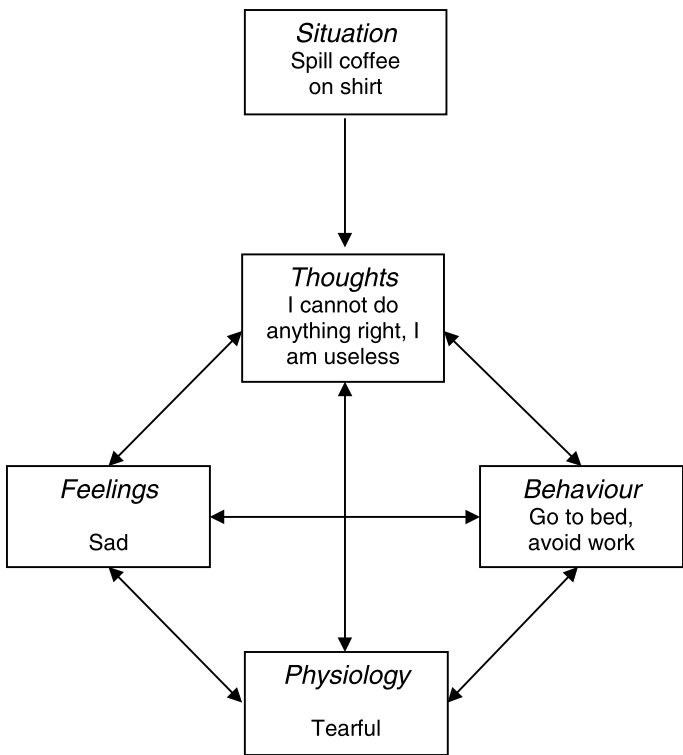


Figure 2.2 Perpetuating factors.

standing the specific and key features unique to each different disorder (see Wells 1996). As noted above, to understand what maintains panic disorder the model would lead us to expect that the person is catastrophically misinterpreting normal bodily sensations. This level of specificity should be incorporated within a maintenance formulation of panic. There are similarly key processes to be considered for problems such as post traumatic stress disorder (PTSD, Ehlers and Clark 2000), obsessive compulsive disorder (OCD, Salkovskis 1999) and depression (Clark and Beck 1999). However, there is also an emerging consensus that there are several core cognitive and behavioural mechanisms that may be key to a range of different types of psychopathology (Harvey *et al.* 2004). These include various forms of emotional and behavioural avoidance such as safety-seeking behaviours and cognitive processes like rumination.

Avoidance is an important perpetuating mechanism in many CBT formulations because by avoiding situations that provoke distress the person prevents themselves from finding out whether a feared consequence will occur. In addition, in the case above (see Figure 2.3), by avoiding going to work the person may confirm a view of himself or herself as useless. Avoiding situations can also lead to a loss of rewarding and pleasurable behaviours and thus maintain problems like depression and agoraphobia. Not everyone avoids all distressing situations, yet problems may continue all the same. It seems that when people do go into situations that they are concerned about, they often engage in subtle behaviours that serve to keep them safe. These are termed safety-seeking behaviours (Salkovskis *et al.* 1996). For instance, someone with social phobia may be worried that people think that he is stupid when he blushes, even though no one has ever said this to him. However, careful assessment of the safety-seeking behaviours may reveal that the person is convinced that if he had not worn his scarf then everyone would have seen him blush. These behaviours, intended to help, prevent disconfirmation of the belief and maintain it. Paradoxically, they can even increase the chance of the experiences that are upsetting; for instance, the scarf may increase heat on the neck and thus make flushing worse.

A range of cognitive processes is also thought to play a role in maintaining emotional problems. These include rumination, extreme all-or-nothing thinking, over-generalisation, dissociation and memory impairments (see Harvey *et al.* 2004).

A cognitive-behavioural model of maintenance is valuable in that it specifies the relationships between elements and provides a rationale for a number of interventions. For instance, within the model, change in any of the maintenance elements will create change in the others. The main cognitive approaches involve teaching clients to be able to identify, evaluate and challenge cognitive distortions (e.g. all-or-nothing thinking). If we can work with the person to appraise situations differently, then they are likely to feel and behave differently. A change in behaviour via behavioural methods may help overcome avoidance and prompt change in feeling and thoughts. The main behavioural approaches involve increasing positively reinforcing behaviours (e.g. behaviours that are pleasurable and generate a sense of mastery in people diagnosed with depression) and extinguishing or replacing negative behaviours (e.g. 'safety behaviours'). Similarly, a pharmacological intervention should lead to elevated mood and a change in thoughts and behaviour.

### ***Predisposing factors: what led to the problems starting?***

Although cross-sectional or maintenance models help us understand what may be perpetuating a problem, we may still be unclear what led to the onset of the problem, and what it is about the interaction between the life events and the person's reactions that has made it such an upsetting experience. To understand this we introduce the notion of a longitudinal or historical formulation that identifies a precipitant or trigger to the difficulties. Typically we find that the person has developed the problems after experiencing a particularly difficult and stressful event or time.

### ***Quantity of stressors***

To help with this process of understanding the onset of difficulties we often draw upon stress-vulnerability models (e.g. Neuchterlain and Dawson 1984). In the simplest form, they postulate that we are all susceptible to stressors in our lives and our vulnerability specifies the point at which we can no longer function or cope. The differences in our abilities to function will be based on our predisposition as well as the resources we have for support and coping in our lives. Vulnerability varies as a function of situations and time. For different reasons (genetic, environmental, social, psychological) we all

have different capacities to cope. Once the person is distressed, we assume that they interpret current events in a biased and unhelpful way and act in a manner that maintains the difficulties.

This broad vulnerability-stress model specifies the likelihood that a breakdown will occur but is less specific on what may lead one person to develop depression and another anxiety. Here, we need to consider the meaning of the events to the person and whether there were specific risks for that person which made those events particularly stressful. To this end cognitive therapists consider the quality rather than the quantity of events. We therefore need to enquire into what is the specific and unique meaning of the events to them, and whether they carried a specific vulnerability or predisposition.

### *Quality of stressors*

To account for potential predisposition or vulnerabilities we draw upon a longitudinal model, in which additional levels are added to help us understand the meaning of specific events. A number of cognitive therapists have specified different models (Persons 1989; Beck 1995), and whilst using slightly different language they broadly agree on the elements. Mostly, the view is that precipitating factors trigger access to a deeply seated view of oneself (core beliefs or schema, or internal predisposing factors) that were learned through formative developmental experiences (external predisposing factors). For instance, a person may see himself or herself as fundamentally unlovable (core belief) owing to early experience of neglect. This basic belief is highly emotionally charged and deeply ingrained. The reason that the distress has not been experienced before a triggering event is that the person has managed or coped with this affect by employing a rule or assumption of some sort that has managed to prevent accessing this affect-laden view of oneself (e.g. 'If I am in a relationship then I am OK'). Rules, assumptions or conditional beliefs are often phrased in this style of 'if . . . then'; or sometimes as imperatives such as 'I must', 'I should'; or as 'I ought', for example, 'I must always be in a relationship'. Hence, whilst in a relationship the person feels OK about him or herself. The rules, assumptions and conditional beliefs in turn are directly linked to a repertoire of coping strategies called compensatory strategies that keep the person living within their belief system (e.g. working hard to maintain relationships and avoid perceived abandonment, perhaps by being unfailingly attentive and loyal to the partner).

Developmental experiences, core beliefs, conditional assumptions and compensatory strategies are related to each other in understandable ways. Thus, in brief, adverse developmental experiences (e.g. early neglect) lead to maladaptive core beliefs (e.g. 'I am unlovable'), with subsidiary beliefs (e.g. 'If I am in a relationship I will feel loved' or 'If I am attentive and loyal at all times, people will love me') that are compensated for by a range of behavioural strategies (e.g. 'In all my interactions I will try to be as attentive as possible').

We consider these developmental experiences, core beliefs, assumptions/rules and compensatory strategies as vulnerabilities or predisposing factors. At the end of the relationship the rule is broken and accesses the very affect-laden core belief. This event acts as the trigger or precipitant for the presentation. Once instated, the presentation is perpetuated through the patterns of relationships outlined in the maintenance models.

### ***Protective factors: what are the person's strengths?***

Precipitating, perpetuating and predisposing factors outline the mechanisms whereby presenting problems have developed and are maintained. However, a good CBT formulation also includes clients' personal and social resources because protective factors (a) have prevented problems from escalating, (b) have enabled clients to build up a repertoire of strengths, resources and successes and (c) suggest an intervention strategy of 'least resistance' that builds on strengths. Protective factors can be described as 'all that is right with a person,' including personal resources (e.g. good sense of humour, vocational skills) and social resources (e.g. a supportive spouse).

Across the levels of the formulation there should be a logical consistence or coherence that helps us to understand the meaning of, and hence the impact of, the triggering event.

### ***Practical aspects of formulation***

It is important to note that although the structure we have outlined is a useful framework, in practice, formulation with clients should not be constrained by it. In particular, formulation in sessions can be messy and the diagrams can be incomplete as it is not a requirement for it to be coherently interlocked in all possible combinations. Formulation within the principles we outlined earlier is a process that is about seeing the world from the client's point of

**Developmental experiences:**

Abandoned by biological mother  
Raised by a series of foster parents,  
and care institutions.

**Core beliefs:**

I am unlovable.

**Rules and assumptions****or conditional beliefs:**

If I am in a relationship, then I am OK.

**Compensatory strategies:**

Work hard to avoid relationship  
ending.

**Triggering events:**

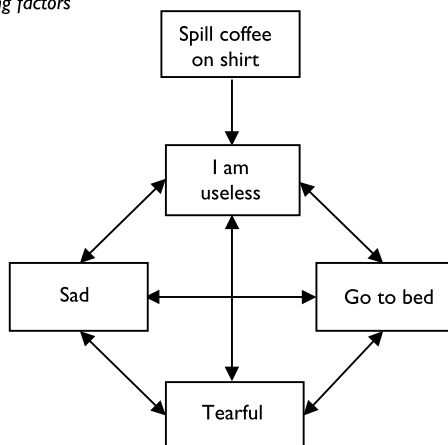
End of the relationship

*Predisposing factors*

*Precipitating factors*

**Maintenance cycles**

*Perpetuating factors*

**Problems**

Difficulty concentrating  
Problems attending work  
Feeling lonely  
Not ringing people to arrange to go out  
Not answering the phone  
Avoiding people in case I cry  
Not being able to sleep  
Feeling sad and low

*Presenting issues*

**Resilience and strengths**

Supportive adoptive mother and sister  
Good friend  
Good job, well paid  
Interest in sports, and plays badminton every week  
Good sense of humour

*Protective factors*

Figure 2.3 An illustration of a longitudinal formulation.



view, about collaboration, about collaborative empiricism and about using theory and research in the service of helping the client. It is not about slotting people's experiences into appropriate boxes. Over time, via a collaborative process with the client, often reflected in the therapist and client working together on a whiteboard or sheet of paper, jointly developing these formulations and through accessing supervision and consulting the literature, the formulation will take shape. The literature may indicate specific features that need to be incorporated into the formulation in order to aid understanding, such as the process of catastrophic misinterpretation if the client experiences a panic disorder. The process we have outlined is a useful framework for ordering and organising information but it is not completed at session one, and it is not the only format that is useful. However, for novice therapists having an explicit framework is likely to be useful. As with all skills, once a therapist is familiar with the principles, structures and goals of formulation there is perhaps more scope for more idiosyncratic variation.

### ***Towards intervention***

Within the cognitive model, there is a span from clearly defined maintenance processes through to speculative and historical messages about oneself. The value of our interventions can also be mapped. We have good evidence for the value of interventions at the cross-sectional level but decreasing evidence for the effectiveness of the interventions at conditional and unconditional belief levels (James 2001; Bieling and Kuyken 2003). The cross-sectional formulation will offer clues to the best intervention techniques (thought records, and rational responding, mastery and pleasure, etc.). The longitudinal formulation will help identify what led to the person experiencing distress. Is there something excessively rigid and inflexible at the assumption level that will lead to that person encountering difficulties again in the future? Hence, relapse prevention may be based on the need to loosen some of the rigidity in the rules. For instance, we may consider whether it is possible to feel OK when not in a relationship. This may well use different techniques to promote change (perhaps considering the advantages and disadvantages of a rule, and then behavioural tests of the rule to consider whether there are alternatives; see Beck (1995) for a description of some of the change techniques).

Identification of protective factors can similarly lead to interventions. For example, a young woman with enduring and severe depression with psychotic features (beliefs of delusional quality) described herself as ‘utterly useless’. However, in spite of the disabling nature of her internal self-talk she was able to achieve academically at school and maintained a strong caucus of healthy friendships despite several psychiatric hospital admissions. Therapy involved building on these personal and social assets, linking them to emerging beliefs (e.g. ‘people like my dry sense of humour’) rather than tackling her negative beliefs directly.

### **Jack: a cognitive-behavioural formulation**

Before we provide a formulation for Jack, it is important to note that neither of the authors of this chapter have met or spoken to the real Jack (or Janet). Normally within CBT a comprehensive assessment would be a prerequisite for an *agreed* problem list and set of goals, which would set the stage for the formulation. Typically this includes detailed eliciting of the client’s perspective and the thoughts, feelings and behaviours associated with the presenting issues. For cognitive therapists, the principle of collaborative empiricism is always in play, which means that the question ‘What is the evidence?’ is in the forefront of the therapist’s mind. This is especially true as hypotheses and approaches to intervention are developed, where the therapist would constantly be checking to ensure that a shared understanding is being developed. For the purposes of this chapter the cases of Jack, and especially Janet, are presented without the client’s perspective, level of detail and collaboration that would be a normal part of CBT practice. However, in the spirit of the book our intention is to illustrate the process of formulation for the case of Jack based on the cognitive model using the available material.

### **Presenting problems**

Jack is described as experiencing a number of presenting problems including periods of mania and low mood, as well as persistent delusional beliefs with both persecutory and grandiose themes. He has experienced problems with substance misuse and had a period of inpatient admission. He has a diagnosis of a psychotic illness<sup>1</sup> and is prescribed anti-psychotic medication. As with any client, the

goal of the initial work is to engage him effectively in therapy. Formulation helps us understand his perspective, see the world through his eyes, and try, as far as possible, to make the senseless sensible. Thus formulation is especially useful when engaging in therapeutic work with someone presenting with delusional beliefs. Usually, if we know what the person is thinking, the associated emotion and behaviours are logically related, and in most cases we may well feel the same and act similarly. However, in Jack's case the beliefs and their associated emotions perhaps involve a larger leap of understanding.

Despite the development of increasingly specific conceptualisations of problems such as hallucinations and delusional beliefs (Morrison 2001; Freeman and Garety 2004), to date there is no well-validated theory of psychotic symptoms to inform the practice of CBT (however, see Trower *et al.* 2004). Given the lack of evidence for a disorder-specific model of delusional beliefs we will draw on generic models as outlined above when considering Jack's difficulties.

CBT treatment manuals for working with people with psychosis (e.g. Kingdon and Turkington 1994; Morrison *et al.* 2004) all emphasise the importance of the process of engagement and rapport building. As outlined before, we would ask Jack for concrete and specific examples of how his problems affect him. Jack may identify his problems as feeling afraid when out or having no money. His goals may be to feel better, to get his royalties and to be able to go out without being beaten up.

### ***Precipitating factors***

We may initially build up a series of ABC models using recent examples from Jack's life, to help introduce the importance of thoughts in understanding his distress (Figure 2.4).

### ***Perpetuating factors***

We would then go on to construct maintenance formulations or cross-sectional formulations that capture the reinforcing and spiralling nature of Jack's current difficulties (Figure 2.5). For instance, we may pay close attention to subtle forms of avoidance and safety-seeking behaviours that have been demonstrated to be present in people with delusional beliefs (Freeman and Garety 2004). For

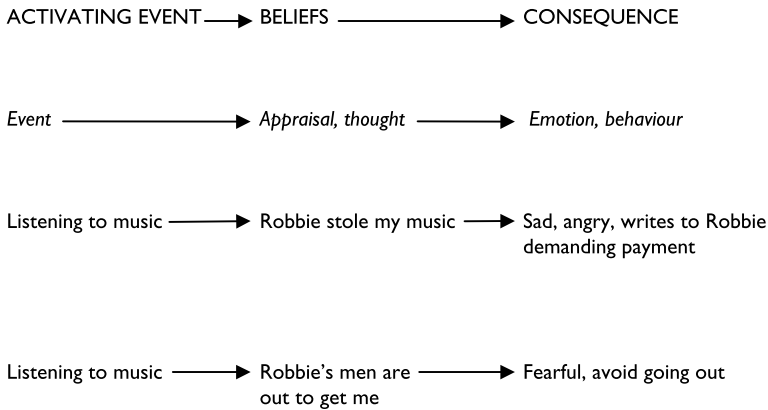


Figure 2.4 Jack's presenting problems.

instance, in Jack's view not going out presumably prevents him from being attacked. Similarly, when he does go out it is possible that he attributes the lack of any attacks on him as due to his constant vigilance.

### **Predisposing factors**

#### *Quantity of events*

When working with people with psychosis a very common process is to generate an understanding of the events leading to the emergence of the first psychotic symptoms using a stress-vulnerability model (Brabban and Turkington 2002). The particular stressors for Jack appeared to consist of having had a series of difficult life events, perhaps precipitated by the sexual abuse experiences (of which we know very little). Trauma experiences are increasingly being recognised as important in the onset and maintenance of psychosis (Morrison *et al.* 2003). For Jack, the trauma seemed to have led to maladaptive coping by drinking and drug taking, and resulted in him failing his GCSEs. These experiences, combined with moving house to a less affluent area where the family was burgled, his father leaving following the parental separation, and loss of contact with his friends, left Jack increasingly isolated. This is very much a quantity model, in that we can see Jack was under

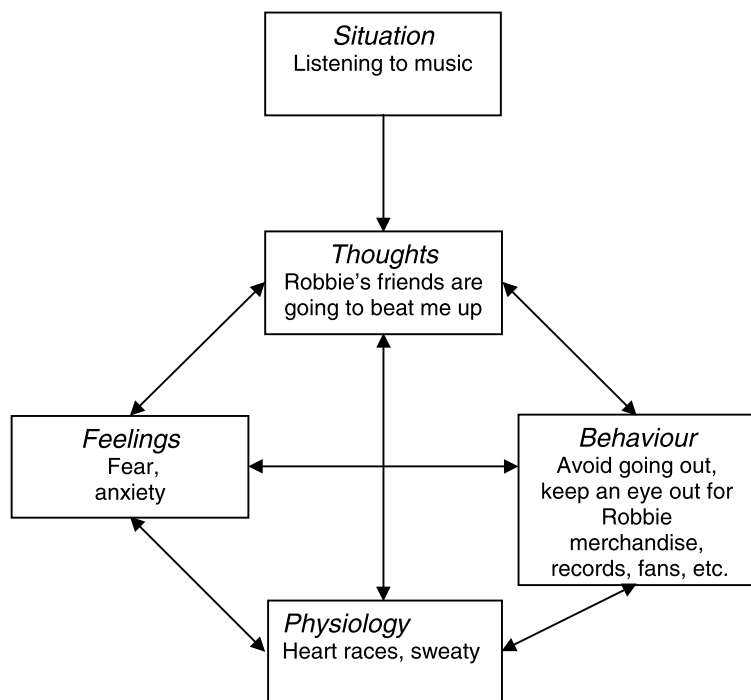


Figure 2.5 A cross-sectional model.

considerable stress in the time preceding the development of his depression and eventual psychotic breakdown.

It is clear that we do not have a longitudinal account of Jack's problems and whilst these previous levels of formulation may help us with symptomatic relief and relapse prevention, we may wish to collaboratively construct a longitudinal formulation with Jack that will help us understand the particular vulnerabilities to his presenting problems and what it was about the triggering events that was so very upsetting for him.

### Quality of events

Jack's early experience indicates that he was subject to physical and presumably verbal abuse when his father was drunk. The effect on Jack is not clear but hypothetically he may have seen himself as to blame for his father's anger, and may have believed that he was a

disappointment in his father's eyes: 'not good enough'. Jack may also have internalised the notion that men cope with their distress by drinking alcohol. Hence, we have a hypothetical and provisional core belief, as well as some possible rules. Jack's early experiences may also have led to him internalising a view of himself as having to protect and provide for his sisters and mother. This is the role his father undertook, and possibly one shared by the community from which he comes. This would probably give Jack a view of success as consisting of working hard, being financially successful and fulfilling the roles expected of a man. As a result Jack may once again see himself as weak or as not good enough. His compensatory strategies are to cope with difficult emotions with drugs, and to work hard to achieve success and financial security. However, abuse of alcohol eventually led to him losing his job. This increased the pressure on him to succeed, and hence increased the pressure to cope by drinking.

Owing to the speculative nature of this formulation there is no way in which we can determine whether it is accurate. However, we can outline some of the methods we would use to help derive the information included in the formulation. Initially we would pay very close attention to common themes across situations identified in the perpetuating cycles, such as not being a man, or being weak. Another route to access this information is to ask about the meaning of events both in the present and in the past. This technique is known as downward arrow or downward chaining. It is a powerful technique because it often very quickly accesses strong feelings connected to the meanings and therefore is usually only appropriate in the context of an established therapeutic relationship, and one where symptomatic relief has been achieved. We would also look out for changes in emotions because where someone noticeably experiences a change in affect, perhaps looking anxious or sad, gentle questioning can often reveal a very salient thought. There are many other sources of information on which to build a formulation including questionnaires, thought diaries, and journals (Beck 1995).

A number of key events appear to have happened to Jack and his family in his teenage years. Trauma such as sexual abuse can manifest itself as a post traumatic stress disorder (PTSD), or as a damaged view of self (Morrison *et al.* 2003). In the absence of overt PTSD symptomatology we would consider the possible meaning of these events for Jack: perhaps he concluded that he is in some way a

bad person; or that he should have stood up for himself like a ‘real man’; or he may have internalised blame in the form of shame; or he may have questioned his own sexuality. Given the role of masculinity in Jack’s community, an experience like this would probably be difficult to discuss, thus denying Jack the opportunity to consider alternative perspectives on abuse. All of these hypotheses would be examined by questioning Jack gently about what he understood to have happened to him, and what this says about him as a person.

Around this time Jack’s parents’ relationship deteriorated to the point where his father left and no longer maintained contact. At 15, faced with this pressure, Jack began to drink as presumably this was his model of how men coped with stress. He failed his GCSEs, the family moved, and his mother had to go to work, further reminding Jack that he was not providing for the family. It is likely that he was depressed from around this time. His mother’s ill health presumably increased the pressure on Jack even more, and he began to develop psychotic and persecutory beliefs.

Jack declined to the point of sleeping rough, coping by using drink and drugs. This life style will have dysregulated his basic self-care (e.g. sleep, diet), increasing the chance of abnormal ideation (Kingdon and Turkington 1994).

### **Protective factors**

Among Jack’s strengths are his ability to form and make good use of a number of family relationships in the past, notably with his sisters; and his positive engagement with mental health services, which bodes well for considering integrated interventions. Our provisional CBT formulation is diagrammatically represented in Figure 2.6.

### **Towards intervention**

We have drawn upon a generic model of CBT formulation as there is currently no empirically tested model of delusional beliefs. However, there are still delusion-specific processes that are important to be aware of and that may need to be incorporated into the formulation. As with the different anxiety disorders, it is important to consider the specificity of cognitive processes within delusional beliefs. There is some evidence that those people with delusional beliefs who are able to consider that they are mistaken, or can consider

**Early experiences**

- Father physically and verbally abusive when drunk.
- Only son in a family in which the expectations are that men will provide for the family.
- Successful father works hard and provides a high standard of living.

**Core beliefs**

- I am not good enough.

**Rules and assumptions or conditional beliefs**

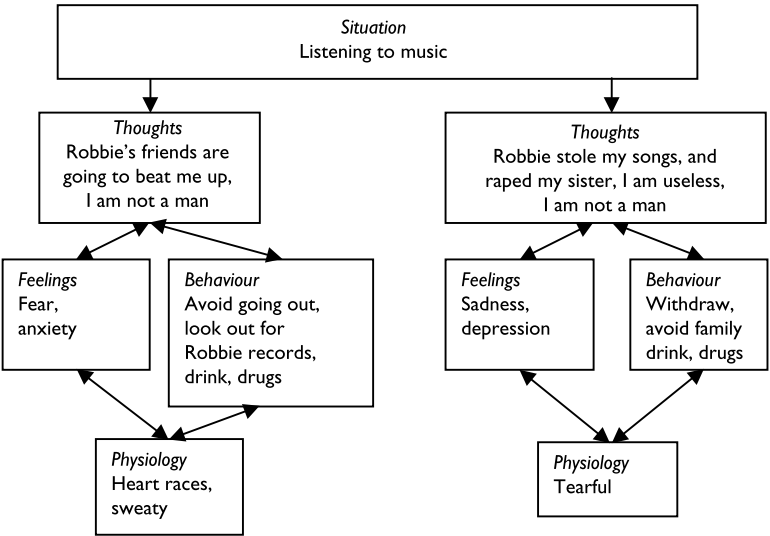
- A man must provide for his family.
- You have to work hard to succeed.
- When bad things happen you do not talk about them.
- Men do not show their emotions, they cope by drinking, etc.
- I must be successful like father to be a man.
- If I am not successful then I am a failure and weak.

**Compensatory strategies**

- Work hard to achieve and provide for others through work.

**Triggering events**

- Sexual abuse, end of the parental relationship, social changes, change in house and lifestyle.



**Protective factors**

- Music, school, previous community, mother and sisters.

Figure 2.6 Jack’s longitudinal formulation.



another possible explanation, may have a better response to therapy (Turkington and Dudley 2004). This would help us decide whether to consider a trial of therapy with Jack.

People with delusions have been shown to have a characteristic reasoning style; they jump to conclusions. This means that they tend to make decisions on the basis of less evidence than people without delusional beliefs (Freeman and Garety 2004). This characteristic reasoning style may contribute to the development and maintenance of delusional beliefs and needs to be addressed when trying to help people come up with less distressing alternative explanations. Another well-replicated reasoning style of people with persecutory delusions is the tendency to blame others for negative events. This would also need to be addressed when generating alternative explanations (Bentall 2003).

Interestingly, it seems that people with delusions generally do not have ready access to an alternative explanation for their experiences (Freeman *et al.* 2004). Those who did have an explanation often based it on an illness model ('I am ill, I have schizophrenia', etc.) which may be upsetting in itself. Thus, if people with delusions exhibit a very extreme response style in that they jump to conclusions, do not consider that they could be mistaken, or lack a possible alternative, then these features would need to be acknowledged within the formulation and addressed in therapy. From the description of Jack it seems he did not consider it likely that he could be mistaken. We do not know about these other features.

Clearly, the acid test of a formulation is whether it leads to helpful interventions. Chadwick and colleagues (2003) have demonstrated that people with psychosis who are receiving therapy do not necessarily think formulations increase therapeutic alliance or that formulations alleviate distress in themselves. This is not surprising as CBT is not an insight-oriented therapy. We consider increased understanding as valuable if it leads to a change in cognitions and a change in behaviour. The formulation can be helpful in providing an alternative explanation that can be tested to see if it accounts for the experiences. In addition, the formulation should direct us to appropriate interventions. Discussion of all of the appropriate interventions is well beyond the scope of this chapter, but readers are directed to the work of Kingdon and Turkington (1994), Chadwick *et al.* (1996) and Morrison *et al.* (2004).

In the perpetuating cycle we have concentrated on developing an understanding of the specific thoughts, and specific examples of

avoidance, and safety-seeking behaviours that serve to prevent disconfirmation of Jack's upsetting thoughts. We would use this to help introduce thought challenge techniques such as using thought records, Socratic questioning, and pie chart techniques (see Beck 1995 for a more detailed description). We would also use behavioural experiments to help overcome the avoidance and safety-seeking behaviours. These experiments may highlight the helpfulness or not of the vigilance to material by Robbie Williams. They may also involve Jack going out to find out whether he is at risk of attack, and asking his sister whether she was raped. Clearly, these would be difficult tasks if not conducted in the context of a trusting therapeutic relationship, and with the use of an agreed formulation that was being tested as a possible alternative explanation for Jack's distress.

Understanding of the precipitants would allow the provision of information about the role of sleep deprivation, trauma, drug use and so on in the onset of persecutory beliefs. This information could also be used to help Jack identify triggers and risk factors that he should take efforts to reduce or avoid.

Understanding of the predisposing factors will allow us to address any rigid beliefs and assumptions, and if appropriate core belief level work if guided by formulation (Moorhead and Turkington 2001) may address Jack's sense of worth.

Protective factors are also potential guides for interventions. For instance, Hall and Tarrier (2003) recently reported on the results of an intervention for self-esteem in people with psychosis. They asked people to list their good qualities and then actively seek evidence for them, or act in ways that would increase this positive view of themselves. Even though psychotic symptoms such as hallucinations and delusional beliefs were not directly addressed, there was a reduction in distress reported in relation to these experiences. In Jack's case we might try and encourage him to revisit some of his previous strengths such as playing music (with obvious consideration of the link to his delusional belief), rebuilding his relationship with his sisters, and other activities that indicate he is a good person.

### **Janet: towards a cognitive-behavioural formulation**

When working with children and adolescents it is important to consider potential differences in comparison to working with adults (Stallard 2002). These include:

- the cognitive and emotional developmental stage of the child
- the importance of the route of referral
- the related consideration of the social context from which the child comes. These factors will influence the nature of the formulation, as well as guiding the appropriate level of intervention.

Formulation of Janet's problems from a cognitive perspective is difficult as we lack a clear sense of Janet's cognitive and emotional ability as well as a sense of her perspective. CBT formulation is derived from the principles outlined above, and is based on an assessment of thoughts in relation to triggering events, or situations, with the aim of trying to see the world from the other person's point of view. Unfortunately, there is little in the material that indicates Janet's perspective. Hence, we would need to clearly define a problem list with Janet and ask questions to elicit a clearer understanding of her point of view. This may be achieved with questions such as 'What does Janet think when her mum puts food on the table?' 'What does Janet think to herself when she is upset at bedtime?' Questions such as these, and the use of techniques like family trees or genograms, may help to determine her view of the problems and of her family relationships and thus give the window into her world that is necessary for the formulation process. It will also help us to understand how able Janet is to describe and label thoughts and emotions, which is clearly an important factor when considering her suitability for a CBT approach (Braswell and Kendall, 2001).

The refusal to visit her father overnight and the night terrors could be regarded as signs of serious assaults and/or abuse of Janet. However, without more detail, and in the absence of confirming sources of information it would be out of keeping with the process of formulation as undertaken within CBT to speculate on such events and their possible impact on Janet. There are many people involved in this case and we would draw on all these sources (school reports, CAMHS reports, social services, paediatricians, health visitors, etc.) in deriving a formulation as well as incorporating Janet's view.

After collating information from these various sources, one possible use of formulation would be to help us to work with Janet indirectly, as has been tried with the carers of people with dementia (James 2002). Difficult-to-understand behaviours (such as avoiding public transport, or food refusal) can be conceptualised within a CBT framework and used with the carers to help convey a

different, alternative explanation to the potentially unhelpful ones that the carer has developed. For instance, Mary may attribute Janet's food refusal to the fact that Janet hates her, and is trying to punish her for not bonding with her when Janet was a child. This attribution is likely to make Mary feel very sad. However, there could be alternative explanations through a formulation that does not attribute blame to Mary, thus reducing her sadness and guilt, and increasing her ability to help Janet. The same principle can be used when working with families of people with psychotic illness and may apply to working with Jack's family (Barrowclough and Tarrier 1992).

Clearly, addressing the needs of a child as young as Janet raises the question of who is the client and what is the most effective route to creating change. Mary seems to have requested help for Janet, yet it is clear that Mary herself has experienced and continues to experience very difficult circumstances and has reported feeling depressed. A cognitive approach may be useful in helping understand Mary's reported depression. A perpetuating model of Mary's post-natal difficulties might start with Mary looking at Janet and thinking 'I do not feel close to my baby'. This may lead Mary to think that she is a bad mother, as she did not feel this way towards her other children, and in turn she feels guilty and depressed. When depressed, she withdraws from Janet, hence reinforcing the sense of being distant and uncaring. The loss of energy and tiredness associated with depression make it even harder to motivate herself to care for Janet. Her withdrawal means that it is likely that other people such as her husband will assume responsibility for Janet, hence increasing Mary's guilt. Mary now involves herself heavily in the care of her grandchildren, perhaps as an attempt to compensate for her difficulties with Janet, but this may serve to remind her that she did not do the same with Janet, thus perpetuating her guilt all these years later. A provisional formulation such as this, albeit very tentative, could form the basis of an intervention designed to improve Mary's functioning, and hence, indirectly lead to improvements in Janet's perceived problems as Mary becomes better able to manage these difficulties.

While we are not able to provide a formulation for Janet within a CBT framework, we have indicated the potential routes to information that might make this possible. We have also considered how a CBT conceptualisation of Janet could be used with Mary and other carers to help address unhelpful views of Janet. Moreover, we have

highlighted how a CBT framework may be useful in understanding and helping Mary. By this method, it would be assumed that Mary would be better able to help Janet. In summary, CBT formulations may be appropriate with the individual child, in an indirect way to help the carers view Janet in a less negative manner, or with the carer to address their individual difficulties.

## Reflections

We have presented a particular CBT formulation based on the available information about Jack. It is important to re-emphasise that what would make this a CBT formulation are the principles set out earlier, which can be used with a range of presenting problems and clients of different ages and socio-cultural backgrounds. We have elected to draw on a generic CBT model to describe and explain Jack's presentation. Other focuses, for example on PTSD, trauma and psychosis (Morrison *et al.* 2003) or mania (Basco and Rush 1996) could have been quite credible alternative frameworks. The only way of establishing the value of a formulation is to develop it in the spirit of collaborative empiricism, changing it as new understandings emerge from the assessment and therapy. Done well, this leads to strengthening of the therapeutic relationship and better targeted interventions.

We have to ask ourselves what evidence there is that this is a good formulation. Gillian Butler (1998) outlines ten tests for a formulation to meet. These include whether the formulation demonstrates a logical coherence across the levels, and whether it accounts for the onset and maintenance, and anticipates difficulties. We could also consider this formulation against the criteria set out in Chapter 1 and consider whether this formulation accounts for the distress experienced, as well as guiding us towards a shared understanding and appropriate intervention selection.

CBT, like other psychotherapeutic approaches, places a strong emphasis on formulation. CBT formulation is like a crucible where the individual particularities of a given case, relevant theory and research are synthesised into an understanding of the person's presenting issues in CBT terms that informs the intervention. As such, formulation is considered to be central to the process of undertaking effective CBT, mirroring its relationship with evidence-based practice. We have argued that what makes CBT formulation distinct is its use of CBT theory, its emphasis on collaborative empiricism,

its emphasis on the current problems and goals and its evolving status as new understandings come to light throughout therapy. We have suggested a framework for CBT formulation that moves from descriptive frameworks in CBT terms, to simple inferential models (Antecedents–Beliefs–Consequences), to more complex explanatory models of what maintains the presentation and what may have made the person vulnerable.

## Acknowledgements

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## Note

- 1 At the outset we stated that prior to embarking on CBT with a person it is important to consider whether there is an evidence base demonstrating the effectiveness of work with that problem. The value of CBT for psychosis including treatment-resistant schizophrenia has been demonstrated in a number of research trials (NICE *Guidelines* 2002). Hence, we do have an evidence base endorsing work with Jack's presentation.

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## Further reading

- Beck, J. (1995) *Cognitive Therapy: Basics and Beyond*, New York: Guilford Press.  
This book is an excellent practitioner manual. It describes the core components of CBT and concentrates on detailed descriptions of the use of CBT techniques such as thought records, Socratic questioning, and Continuous methods.
- Morrison, A.P., Renton, J.C. and Dunn, H. (2004) *Cognitive Therapy For Psychosis: A Formulation-Based Approach*, Hove, UK: Brunner-Routledge.  
This book provides an overview of CBT treatment approaches to working with people with psychosis. It draws heavily on specific models of voice hearing and delusions, and uses these as a basis for deriving person-specific formulations to help understand the maintenance of the problems. Therapy techniques are derived from the formulation and are well described in this text.
- Needleman, L.D. (1999) *Cognitive Case Conceptualisation: A Guidebook for Practitioners*, Mahwah, NJ: Lawrence Erlbaum Associates, Inc.  
This practitioner guide is a rich and detailed account of formulation in practice, written by a CBT practitioner with extensive experience of a range of formulation approaches and techniques.
- Tarrier, N. (ed.) (2005) *Case Formulation in Cognitive Behaviour Therapy: The Treatment of Challenging and Complex Cases*, Hove, UK: Brunner-Routledge.  
This book describes the history and background to CBT formulation, the research and evidence base for case formulation and the application of case formulation in a range of important and contemporary clinical areas, including mood disorders, anxiety disorders, trauma, health anxiety, personality disorders, insomnia and psychosis. There are interesting chapters on formulation and supervision and training.

# Psychodynamic formulation

## A prince betrayed and disinherited

*Rob Leiper*

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### **What is a psychodynamic approach?**

There is no single psychodynamic theory and hence no single way of constructing a psychodynamic formulation. Psychoanalysis has reproduced within itself many of the controversies of the entire field. It contains a multiplicity of ideas and approaches: there are competing visions, differing assumptions and a wide variety of possible conceptualisations which have led to an endless debate. The term psychodynamic is now used generically to encompass the many theoretical approaches that remain connected to these psychoanalytic roots. A key feature of the psychodynamic use of formulation can be related to this confusing multiplicity: that sustaining a sense of uncertainty is in itself a value that has come to be held very close to the heart of the modern psychodynamic stance. In the realm of unconscious processes one should not presume to know too much. No form or formula can be clung to as a secure guide – except perhaps that of ‘not knowing’.

Within the array of ideas and approaches that constitutes the psychodynamic tradition, there is, nonetheless, a commonality of outlook which holds the different strands together (Wallerstein 2002; Leiper and Maltby 2004). This is not the enforced unity of ideas that Freud once thought was essential to protect the analytic ideal from watered-down versions or wild practitioners. However, certain key perspectives and shared values constitute the essentials of a coherent approach. At its most basic, what is held in common exists at the level of the perception of the human condition rather than its conceptualisation: it is, in a sense, pre-theoretical. This shared vision forms the basis of a recognisable clinical orientation – a sensibility about the nature of therapeutic practice rather than an

articulated psychological paradigm. Such a general way of looking at clinical material leaves a lot of scope for diversity in what an ‘accurate’, or even a simply useful, formulation might look like.

### **Core features of a psychodynamic approach**

What ideas constitute the core of the psychodynamic approach? Perhaps the most fundamental one is the focus on psychological or emotional pain. Life is thought of as a difficult and demanding process and the psyche is constructed in the struggle to deal with it. What is ‘dynamic’ is the turbulence created in the currents of mental life by these struggles. Means of avoiding pain are developed: ways of seeing, thinking, feeling and behaving can all serve this purpose. Much of this activity takes place out of awareness. There is an ‘internal world’ constituted differently from external reality, the unconscious elements of which have a fundamental influence on the way we live our lives. These unconscious attempts to avoid pain often fail, but since our awareness is limited, they are nonetheless repeated again and again. Failing defences are what give form to and maintain patterns of psychological disorder. Therapy is about getting in touch with thoughts and feelings which were previously ‘warded off’, kept hidden from the conscious mind because they seemed to be too much to deal with. Psychodynamic therapy is about helping the client to ‘reformulate’ what they are experiencing in a more inclusive way, and to tolerate the discomfort that this involves. The understanding that the therapist and client develop about these difficulties expands the client’s awareness and opens up new options for managing conflict. The client’s capacity to bear emotional pain and cope constructively with dissatisfaction is enhanced, and the ability to reflect on and be curious about their experience is developed.

This view of human life, personal development and psychological functioning underpins the ‘clinical theory’ of psychodynamics, and informs and guides the therapist’s thinking and actions (Wallerstein 1988). At this level of theory, it is possible to pull together (to some extent at least) the competing psychodynamic conceptualisations of psychological development and structure and establish the elements of an approach to case formulation. These complementary ‘points of view’ (Rappaport 1959) can help to systematise our understanding both of the general theory and of a particular individual clinical situation. I will emphasise four main perspectives: the *dynamic*, the

*developmental*, the *structural* and the *adaptive*. These can be used to organise the diverse array of information that needs to be integrated into a coherent narrative to arrive at a useful formulation. (Compare McWilliams 1999 for an alternative approach.)

### **The dynamic perspective**

One radical implication of Freud's vision of the unconscious is that all behaviour is purposeful and motivated; all human activity is meaningful, and has potential significance. Obscure or seemingly meaningless actions, experiences or behaviour can be understood in terms of the logic of the unconscious, through which we can interpret the hidden meaning. Such 'latent' meaning can only be unravelled through a careful process of detective work that involves interpreting the surface material to arrive at the unconscious intentions that lie at their source. Dynamic formulation is a process of discovering (or constructing) meaning in previously inchoate areas of experience. It retells the client's story as intentional and meaningful.

The dynamic perspective views mental life as a shifting flow constantly influenced by interacting forces. Fundamentally, these forces concern psychic pain and the wish to avoid it through distorting or concealing our knowledge of its sources. Pain was initially thought of as the product of trauma, a consequence of externally imposed hurts, the memory of distressing events. A crucial theoretical move was made in seeing the source of pain as more fundamental, as having inevitable internal roots: pain is identified as being due to inner conflict between parts of the self.

These conflicting internal forces can be conceptualised in various ways, including Freud's view about acceptable and unacceptable impulses. Probably the simplest and most flexible way of representing these ideas is via the diagram in Figure 3.1, commonly known as the 'triangle of conflict' (Malan 1995). This portrays conflict as arising from a 'hidden feeling', which could be a wish or an impulse. Awareness of this feeling arouses anxiety, because its expression in conflict with another perceived need, and thus is feared to have catastrophic consequences. For example, a feeling of anger or rage and an associated impulse to hurt is disturbing, perhaps unacceptable, in the context of a relationship in which you are dependent on the other person and need their love or good opinion for continued well-being. Expressed verbally, the conflict becomes: 'I hate you'

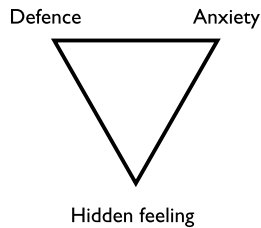


Figure 3.1 The triangle of conflict.

*but* 'I am afraid that I will destroy our relationship, which I need and depend on'. In the case of Jack, our main clinical example, there seems to be conflict between his intense desire for success and admiration, and an associated fear which appears to involve feelings of threat and shame.

However, conflicts are always unique and generally more complex than any simplified formulation can capture. Hinshelwood (1991), building on object relations theory (see below), proposes that the underlying conflict can be viewed as an ambivalent and anxiety-ridden personal relationship – but one operating internally between parts of the self (what has come to be called an 'object relationship' in psychodynamic theory). It can often be thought of (again in a simplified way) in terms of a parent and child trying to manage a conflicted situation. This kind of formulation allows us to visualise the internal situation in a familiar and humanly rich way. However, it has to be borne in mind that a crucial element of this perspective is that these relationships are subject to the rather different 'rules' of unconscious mental life (which will be outlined below).

The anxiety signals that there is an internal danger situation. Some action must be taken to avert the threat posed by the conflicting aspects of the self, the ambivalent state of mind. The 'solution' is to avoid conscious acknowledgement of the conflict. This is the third element in the triangle – the process of defence. Where the person does not have the capacity to tolerate or cope consciously with the threat posed by an internal conflict, some aspects must be warded off, to avoid the threat to personal coherence: there is a feeling that the personality is in danger of disintegrating. This defensive alteration of experience is a kind of self-deception: some aspect of the self is disguised.

There are myriad ways in which this disguise can be achieved. Almost any element of experience can be used defensively in some context or other. Jack, for example, initially turned to delinquent 'acting out' which substitutes dramatic and provocative behaviour for the uncomfortable experience of difficult feelings. His subsequent substance misuse equally distracts from and dulls emotional pain and prevents thought. Hinshelwood (1991) suggests that these strategies can be thought of as the establishment of a different internal object relationship which 'evades' the anxiety-provoking situation. There will typically be more than one such diversionary route available, and different possible 'substitute' ways of relating.

A number of writers have offered simplified 'formulae' for representing such key dynamic processes. Luborsky (1984) termed them the Core Conflict Relationship Theme and Levenson (1995) the Cyclical Maladaptive Pattern. Both, like Malan, are endeavouring to narrow the range of the numerous interlinked dynamic processes that may be active in any individual, and to seek a core issue that runs through different areas of the client's life and which can be a focus for shorter term psychotherapeutic work. However (like Hinshelwood), both bring a more interpersonal element explicitly into their way of viewing the conflict: it is understood in terms of the responses (both actual and expected) of others to the wishes and acts of the self, while 'defence' is viewed in terms of the self's responses in its attempts to deal with those relational conflicts.

A number of consequences follow from our tendency to distort awareness in order to sustain a sense of internal coherence. Crucial elements of our actions are taken out of conscious control and as a result we are poorly equipped to manage our true internal state and less able to adapt our behaviour to the external world. We are limited in our ability to anticipate damaging consequences of our actions and to learn from our experience. We may blindly repeat patterns of behaviour again and again.

When routine defences do not work well enough to manage the conflict, further measures may have to be resorted to as a 'second line of defence', which may take the form of a 'symptom'. This is understood as a solution to a conflict through the formation of a compromise in which both sides of the conflict find a means of expression. Both the need to keep a wish out of awareness and the force of the wish itself can be felt in these situations. For example, obsessional checking is often thought to be a way of managing unacceptable hostility. The damage which, it is feared, would result

from the hostility requires the constant reassurance of the checking. Meanwhile the hostile impulses push for expression via the compulsive quality of the behaviour, and achieve some results by torturing the person, and those round them, with its frustrating repetitiveness. Such manifestation of the underlying impulse in a distorted form has been called 'the return of the repressed'. Thus in Jack's case, the delusional belief system which he retreats into has the same quality of a desperate further attempt to manage his unbearable experience after his initial defensive strategies failed him. Equally, this delusional system seems to reveal at every turn something of the underlying nature of his core wishes and anxieties.

From the dynamic point of view, then, personal difficulties are considered in terms of the meanings and motivations that individuals bring to them. These meanings are formulated as conflicted desires and relationships and the unmanageable anxiety which they generate. Such meanings always have to be sought behind the defensive surface presentation which serves to protect us from overwhelming anxiety. Psychological problems arise from the rigidities and restrictions in behaviour and experience created by these compulsive defences. The aim of therapy is to reduce their hold over us, to facilitate greater flexibility and increase the scope for choice by bringing about some resolution of conflict. By integrating the parts of the personality that have been defended against we can have a more full ownership of all aspects of the self. Thus in considering a psychodynamic formulation, the dynamic perspective suggests that we consider the following:

- What are the main underlying conflicts? What self–other relationship or motivational 'elements' comprise these?
- What is the quality of the anxieties that arise from the core conflicts? How manageable do they seem to the individual?
- What defensive strategies and relationship patterns are deployed to manage these anxieties? How effective are they and what are their maladaptive impacts?
- How are the presenting problems or symptoms related to these defensive strategies and to the underlying conflicts?

### ***The developmental perspective***

In the developmental perspective we look to the past to understand the present. While this has in some ways become a commonplace of

psychology – childhood as being both different from and crucially influential on adulthood – this perspective originated in and remains strongly associated with psychodynamic theory. Early experiences are considered to be of fundamental significance in forming both dynamic and structural aspects of our mental life.

Perhaps the main element of this psychodynamic construction of childhood is the idea of a sequence of developmental phases. Originally conceived in terms of libidinal energies and erogenous zones – the oral, anal and phallic – it became clear that these phases also characterised particular modes of relationship with caretakers that seem to have a much wider significance than just deriving pleasure. For example, the idea of an oral phase highlights issues of taking in sustenance, of dependence on others for life and the issues of what is inside and what is outside, of who is who. Erikson (1950) portrayed these phases in terms of a sequence of psychosocial issues that highlighted this relational dimension of the developmental sequence. Subsequent theories have emphasised interpersonal attachments but also (like Freud and Erikson) organise the course of development in terms of a progressively more comprehensive and integrated relationship with the world. A narrative of progressive separation and differentiation from an early unity towards individuation and integration in a coherent sense of self (Mahler *et al.* 1975) underlies and unites the various versions of the ‘object relations’ perspective.

Object relations theories have highlighted the crucial role of the parental relationship, particularly with the mother. However, it is the personal meaning of such experiences that is important in the psychodynamic view. What needs to be understood in any given case is what sense the child made of any particular traumatic separation or personal abuse or conflicted family constellation. What were the unconscious meanings and fantasy elaborations of the situation and of the pain it caused? What were the defensive strategies that the child had available and resorted to in order to manage the distress? The interplay of internal reactions and external events is regarded as forming the matrix out of which personality is created. The child manages early deficits and traumas as well as he or she can, and these adaptations become the foundation for later distortions in relating which may ameliorate, maintain or exacerbate the early failures. Jack’s difficulties seem to emerge in mid-adolescence when the developmental pressures of sexuality, gender identity and achievement in the wider world start to make



themselves felt. However, psychodynamically we would want to think also of the impact of earlier events and relationships – perhaps his father’s successes and difficulties and the reactions of his mother both to those and to her growing son, and how Jack might wish and be wished to be the same as and also different from his father.

A key idea in the developmental point of view is that subsequent dysfunction is closely associated with problems occurring at particular developmental stages. Childhood problems – whether thought of as stemming principally from the quality of environment and caregiving, the occurrence of life events or from sources more internal to the child’s changing instinctual and mental life – are experienced in relation to, and have their subsequent impact through, the particular developmental issues that are ‘active’ in that phase of life. The effect may be to disrupt the developmental process, hindering or distorting further progress.

A central feature of the psychodynamic perspective, unlike that of developmental psychology in general, is that the present is interpreted in terms of the developmental past: the past is ‘alive’ in the here and now. Dysfunction may be thought of as repetition. Patterns of feeling, thinking and acting which were established in previous developmental contexts are replayed in current, often very different, situations. These patterns are rigid and not readily open to correction through new experience. Indeed present experience comes to be actively organised in terms of patterns that were current at some earlier time. Thus infantile modes of experience and behaviour persist but in a way that is sealed off from the influence of the present day. Early patterns of relating to the world, normal at their appropriate developmental phase, become a template for understanding the nature of current psychological dysfunction.

Malan (1995) has schematised this in another diagram which he terms the triangle of person (see Figure 3.2), which shows how the past (particularly family) relationships are echoed in the present. But – and this is a distinctive feature of the psychodynamic therapeutic approach – they are replayed not just in the client’s current relationships but also in the therapy room; they form the basis of the ‘transference’. How the client approaches and experiences the therapist is a clue to how they experience (and perhaps distort) other relationships. This also casts light on the past and the way the situations experienced in childhood and adolescence were understood and responded to. Jack’s defensive distancing of the (female) therapist through his retreat into delusional ruminations might

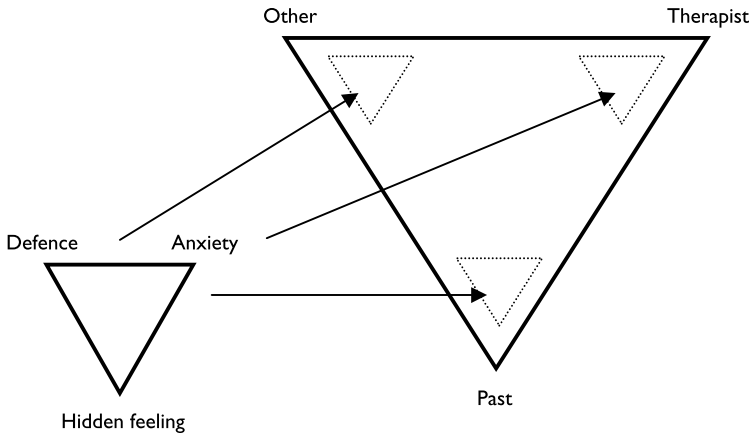


Figure 3.2 The triangle of person combined with the triangle of conflict (adapted from Molnos 1984).

offer a clue to his experience of some unmanageable pressure (to perform? to merge?) that he feels from others, particularly when they get close to him. The therapist's own response – at both an emotional and behavioural level – to how the client presents in the therapy room is often a vital key to assessing the hidden emotional quality of these repetitions. These 'countertransferences' are viewed as an unconscious resonance to the unconscious dimensions of the interpersonal situation which is being replicated in each relationship context. Furthermore, it is the dynamic elements of the relationships that are crucial to the repetitions; in each relational context we can see the same underlying patterns of conflict and defence in action.

In summary, the developmental point of view looks to the past in order to cast light on what might be thought of as the personal context in which certain existential 'decisions' were originally made. Patterns that are thus established often create self-perpetuating cycles. Individuals are seen as both the product and the author of their life history. Framing understanding in the light of development in this way can often enable people to acknowledge less acceptable aspects of their personality. In considering a formulation, the developmental point of view directs our attention to such issues as the following:

- What were the nature and quality of family (and other social) relationships at various times during the person's life (in childhood, adolescence and subsequently)?
- What events and experiences appear to have been significant in the person's life?
- At what ages/developmental phases were these relationships or events experienced and what may have been the impact of these on psychological development?
- What has been the person's conscious experience/account of these experiences? Does this accord with what might be expected or is there the possibility of defensive distortion? What meaning may these have had?
- What relationship and coping patterns or themes appear to be repeated at different phases of development and across different relationship contexts?
- What developmental phase appears to be most associated with these thematic issues?
- How are these themes represented within the therapeutic relationship? What is the pattern of transference and countertransference interaction and experience?

### ***The structural perspective***

The structural perspective focuses on the framework within which psychological functioning is understood and the ways in which individuals might differ in their psychological structures. In psychodynamic theory the principal feature of this psychological map is the presence of different levels of organisation operating in the mind. In particular, we need to be aware of the very different ways that the unconscious, as opposed to the conscious, realm functions; mental life 'as we know it' structured by verbal syntax and logic, abstract conceptualisation and clear delineation of difference is not all there is to us. In the world of the unconscious there are no opposites and no negation so that contradictory propositions co-exist without challenge. There are no ordered sequences and so no sense of time. There is no clear division between different things or between subject and object, and so one thing can stand for another (displacement) or for many things at once (condensation). Meanings are absolute rather than conditional and there is no doubt or degrees of certainty. In this realm of internal rather than external reality, everything is at once single minded and fluid; mental

phenomena have a similar character to dreams. This model is used as a framework for interpreting the presence of hidden meaning, transformed and disguised by the need to maintain repression.

In psychodynamic theory, it is the internal world that is felt to be the dominant force, structuring our perception of the world. By selection and manipulation, all the situations, people and relationships that we encounter can be made to conform to its assumptions and expectations. The structural perspective considers the characteristic forms of the relationship between these internal and external realities. Freud made the famous division of the mind into three mental 'agencies' (the ego, id and superego). While the tripartite model plays a much less significant part in modern psychodynamic thinking, it does point to some vital elements in an overall formulation, particularly the degree to which our perceptions of and responses to the world are dominated and distorted by unconscious needs or are, alternatively, reasonably flexible and reality based.

It is usual to think in terms of more or less 'healthy' kinds of defence, that is, degrees to which we need to alter our experience of reality. *Repression*, which involves keeping some impulse or emotion out of conscious awareness, is a relatively straightforward form of avoidance. It involves only the distortion of one element of our internal reality, although it often lays the foundation for further defensive transformations of it. *Dissociation* involves cutting off a whole area of self-experience with an associated complex of feelings, memories and aspects of the self: there is thus a more radical alteration to internal reality. *Denial* can be thought of as more serious still, involving the disavowal and distortion of significant aspects of both internal and external reality. Jack's use of acting out and substance abuse would be regarded as a relatively serious deficit in his capacity to manage reality, involving significant levels of denial and associated 'primitive' defences such as projection (of feelings into others) and weak behavioural controls. These are the context for his further regression to psychotic levels of disordered functioning. This suggests that he has what is termed poor 'ego strength'. We all have our ways of defending ourselves and to the extent that these are routinely employed they are built into our very character structure. The pervasiveness, rigidity and severity of these distortions distinguish personality style from 'personality disorder'.

Derived from the developmental perspective is the structural idea that the seriousness of dysfunction depends on how early the developmental disruption occurred and how severe it was. Thus

problems in the first year of life (Freud's 'oral stage'), such as a deficit in caretaking due to a mother being incapacitated by depression or absent through illness, could cause quite fundamental developmental damage, resulting in distortions to the basic sense of reality and whether the world and people in it can be experienced as dependable. Both Winnicott (1965) and Kohut (1977) suggest, for example, that an experience of 'good-enough' dependence provided by the mother's empathic attunement to the infant's needs and communications, lays the foundation for future development. 'Deficits' in this may cause fundamental damage to the development of the capacity to relate to others and to regulate the self. These developmental gaps may have to be filled defensively with a 'false self' – an artificial persona and way of relating to others which conceal the internal lack arising from the unmet dependency needs.

Formulation from this perspective, then, is an understanding of the forms in which mental life is structured so that some balance is maintained in the psyche in the face of its internal stresses. Therapeutic change would consist of an increased capacity to take responsibility for our behaviour and to widen our flexibility and sense of agency through an expansion of awareness and capability. The 'structural theory' is clear too about the limits to change; we are always engaged in a balancing act between conflicting demands. However, if the ego is strengthened and the power of the primitive superego reduced, a more effective, satisfying and less self-defeating balance is achievable. In considering a formulation from a structural point of view we might ask:

- What are the person's characteristic defences? What level of 'maturity' do these suggest, how effective are they and at what cost of personal restriction?
- What is the person's capacity for self-reflection? Can they think about their internal states and motivations in a 'psychological' way?
- What degree of 'ego strength' does the person display? Are they resilient or fragile, flexible or rigid? Can they utilise their adaptive strengths and abilities?
- How able is the person to regulate their emotions: is there an ability to manage distress and anxiety and reasonable differentiation of response to different situations? Is there a capacity to sustain disappointment and loss?
- Is the person able to regulate and sustain their sense of

self-functioning? Is there a sense of personal coherence, stability and self-esteem? Susceptibility to shame or self-inflation? Identifications which are stable or fraught with ambivalence? Clear and stable ideals, goals and values?

- Does the person's mode of relating to others achieve a balance between the tensions of intimacy and autonomy, dominance and submission, neediness and nurturing?

### ***The adaptive perspective***

One of the many developments in psychodynamic theory has been an increased interest, influenced partly by systemic and behavioural thinking from the 1970s onwards, in the relationship of the internal to the external 'real' world: that is, how experience affects and interacts with our life situation and interpersonal relations. Strupp and Binder (1984), followed by Levenson (1995), for example, explicitly introduce this element into their system of formulation. Defensive responses to relational conflicts often end up as self-perpetuating because they tend to confirm the individual's worst fears. This happens through a variety of linked processes: the distortion and misinterpretation of other people's motives and actions; the selection of specific individuals and relationship contexts which are familiar and meet our expectations; and the subtle pressure which at unconscious levels invites others to respond in particular ways. For example, someone who tends to expect and fear rejection in close relationships may have a tendency to approach intimacy in a guarded and suspicious way (in spite of, indeed because of, the strong underlying sense of need), and so react strongly to any minor rift and interpret it as betrayal. This produces the feared result of a breakdown in the relationship: people are untrustworthy and always disappoint you in the end; the cyclical pattern is strengthened; the person becomes further 'locked in' to their maladaptive mode of acting in the world.

Jack appears to be caught in a version of just this kind of trap. However, from a psychodynamic perspective this is a golden opportunity for both therapist and client to understand these patterns and to intervene with them directly as they are played out in the therapeutic relationship; to ensure that something is learned and to discover the possibility of a new outcome.

Malan (1995) believes that such an adaptive perspective is necessary to integrate the various psychodynamic issues during the

process of assessment and formulation. The key to this is what he calls the 'life problem', the way in which the underlying dynamic and developmental issues intersect with the current situation in the person's life. Careful note must be taken of an individual's lifestyle, work circumstances and intimate relationships, but this is read not primarily in relation to their surface meanings – say the rewards and stressors which they provide – but in terms of the way they reflect the key developmental and dynamic themes and issues which are crucial for that client. Events and relationships have an idiosyncratic meaning for that individual which gives them their particular force. It is especially important (as in so much psychological understanding) to take note of – perhaps to seek out – what may have changed in the life situation in order to understand what has created the perceived need for outside help. A dynamic compromise may have been working, however unsatisfactorily, until something occurred. What that was may lead to an exploration of what it meant and so to what the prior conflicts and compromise solutions might have been.

However, this perspective should also encourage more of an interest in what is going well for an individual. Just as the psychodynamic tendency to see all living as a kind of 'compromise' between conflicting needs can lend a rather pessimistic, even cynical tone to its understanding of people, there is also a corrective and compassionate sense that we are all in the same boat. If there is – as some not unreasonably claim – a pathologising tendency in the language that psychodynamic theory uses in its formulations, it is a democracy of pathology; clients are no different from therapists in the issues that we all struggle with. We should also look therefore at what is working in the person's life. What compromises are successful? How have developmental traumas been managed and what achievements have been won in the struggle?

The adaptive view thus sees psychopathology as a process of mismatch with the environment in which compromise solutions to conflict are limiting to the person's creative responses to life's challenges and self-confirming in their cyclical repetitive quality: they prevent learning from experience. Change is the process of opening up a wider range of creative options and breaking out of maladaptive cycles. In the adaptive point of view on formulation we should ask:

- What pattern is being repeated in these life problems or

symptoms and with what unconscious aim? How are the presenting issues situated in the person's life as a whole?

- Why has this arisen *now* or become intolerable and presented for help at this time? What has destabilised the pre-existing compromise?
- What maladaptive cycles are operating which maintain the management of the core conflicts? In what ways are these self-confirming responses engaging life experience to bring about these repetitions?
- How are these stereotyped patterns of response self-limiting for the person's continued development and achievement in life?
- What ways of handling conflict have worked relatively well and how have these been a positive response to developmental problems?

An intrinsic part of the psychodynamic approach (and perhaps of the creation of any psychological narrative) is the search for themes and patterns appearing across these differing perspectives and contexts, which help to build a coherent formulation of an individual's experience of personal difficulty. The presence of thematic resonances in different arenas and from diverse points of view will tend to confirm the validity of a hypothesised formulation. This circularity – though potentially problematic 'scientifically' – is a key to how formulations are created in practice. The therapist must test out hypotheses with the client in the therapeutic context through interpretation and attention to the response it receives. The difference from other more cognitively based approaches to this task is that it is not the client's conscious assent to a 'formulation' (offered in the form of an interpretive intervention) that counts, but their unconscious reaction to and elaboration of it. This is a subtle process and certainly one with considerable room for error. This difficulty is greatly exaggerated when we only have rather abstract case material to work from, with no data about the therapist's experience or the client's response to her interpretations.

## **Jack: a psychodynamic formulation**

### ***A prince betrayed and disinherited***

The main themes of Jack's developmental history as offered to us hinge around the success and then failure of his father and its effect



on the family. From nothing he builds a business 'empire', but then destroys it. His is initially a success story but there is a dark side of violence and drunken unreliability to it. He abuses then abandons his family and becomes (to the women) a denigrated figure. The heart of Jack's story might be read in his relationship to this: he is offered and responds to a vision of himself as the inheritor of the 'kingdom'. He has a sense of himself as growing into a man entitled to power, seemingly secure and enabled to develop and use his talents and social position. However, the shadow elements of this emerge as his father's 'realm' disintegrates and a substitute father is found who replicates an abuse he already feels in a seduction and betrayal of his sexuality just as he is becoming heir to it as an adult. Jack's life starts to disintegrate in a mirror image of his father's before it has even started.

This somewhat dramatised narrative certainly makes various speculative assumptions, but it endeavours to capture something of the possible experiential quality of the young man's life. The impact of Jack's story (on me) is of an overwhelming feeling of devastation and loss together with the omnipresent sense of threat and betrayal. It also points towards key themes to be explored in dynamic terms in other parts of the case material. These themes are the nature of masculinity; its roots in the identification with both parents and their images of manhood as a foundation for self-esteem and entitlement to success in life and for sustaining work, creativity and personal relationships in the real world; and the relation of sexuality and aggression to these. How does one 'come into one's own'? This is the core conflictual area – 'narcissistic' strivings probably closely linked to masculine identity but involving ambition and pride and the desire for recognition against the fear of failure, shame and humiliation. Jack's identification with his father is highly ambivalent – as perhaps it would inevitably be in a family situation where this father, and hence perhaps men in general, are both idealised and denigrated. To be strong and in charge is also to be violent and untrustworthy. Success leads to failure and failure is not sustainable and leads to collapse, abandonment of others and shame for oneself. This ambivalence is intense enough to lead to confusion over what is reliable and, indeed, what is real. It is experienced as a profound betrayal: Jack needs his father desperately but feels as though his birthright has been taken from him by some trick – but one in which by his need and his ambivalence he is complicit. The sexual abuse (presumably) has this quality in his mind. This leads to

further guilt as well as shame – because sexuality appears to figure as dangerous and destructive, a kind of rape. Someone in this story is sexually dangerous and it is (presumably in part experienced as) Jack: he is himself a (fantasised) betrayer. He and the world are unsafe and fragile – collapse is always imminent.

These anxieties about the masculine are likely, of course, to be intimately linked with ideas of femininity: the world that Jack grows up in (though information is lacking) appears to be a very female environment and may be experienced as overwhelming and engulfing. The fear of women may be thought of as an aspect of his need for his father and of his lack of safety with his masculinity. It may also be related (though this is less clear) to the issue of a safe and secure sense of home, of a right to belong. This is obviously connected to the family's immigrant status; are they as a whole lodged and held securely in a homeland? It is the men who principally suffer this uncertainty, and the fragility of their world, their identity and entitlement to a place are emphasised at this wider social level too. This insecurity and the aggression it gives rise to are projected and experienced in a paranoid and persecutory form.

Many of the clinical features of Jack's history may be thought of as defensive responses to these core anxieties and conflicts. Initially there is acting out in delinquency, violence and substance misuse. These are, of course, not only identifications with the father but also escapes from overwhelming affect and anxiety and, one would guess, chiefly experienced in terms of shame and humiliation. This becomes more explicit in the hypomanic symptoms and the omnipotent and compensatory aspects of his fantasy system which are fragile efforts to triumph over these shame-filled experiences. It is likely that these break through again in the depressed phases of his symptoms where escape is into self-blame. These defences are not in themselves sufficient, and they deepen into the severely regressive space of psychotic delusion, blurred reality boundaries and transient hallucinations: primitive unconscious material emerges and massive projection and denial take over at points of stress, including when the therapist (a woman which may or may not be an added threat) attempts to make some meaningful emotional contact. The delusional system is a defensive retreat but is crudely revealing of the fantasies which structure his anxieties: theft and betrayal, revenge and persecution, entitlement to stardom and 'royalty', sexual violence.

In summary then, Jack is a young man whose development

has broken down in adolescence in the face of the demands of his developing sexuality and particularly of the need to forge a successful identity and capacity to achieve in the world. This has activated a core dynamic conflict around self-assertion and creativity that is associated with his sense of masculinity. By virtue of his ambivalent identification with his father these needs are associated with shame and fear of failure and probably also secondarily with anxieties about damage and sexual aggression. He has progressively retreated into increasingly regressive defensive strategies and finally resorted to manic and paranoid psychotic delusional positions to which he is liable to return under stress. Adaptively, this has created a trap for him in heightening the sense of risk associated with efforts to build a life in the real world and of engaging in intimate personal relationships, especially sexual ones. The evidence suggests the presence of considerable structural ego weakness, in his difficulty sustaining his sense of self-coherence and reality and the dangers of severely regressive, particularly psychotic, strategies to deal with interpersonal or other life pressures.

### ***Reflection on the formulation***

It is difficult in such written case material to locate that vital element of psychodynamic thinking, the countertransference (that is, the feelings that the client arouses in the therapist). However, a story may serve to fill some of this gap. I wished to reassure myself that I was not going to ‘over-interpret’ elements of the case material that were in fact put there as disguise, and asked to be alerted to any examples of this. I was not well informed about the details of Robbie Williams’s career and image, so I looked him up on the internet, became duly excited by the correspondences to what I saw as the themes (omnipotence, sexualisation and sexual ambiguity, making good, betrayal and so on) – and only then did I realise that I’d already been told this might be a disguise element. I duly felt ashamed (at my omnipotence and naivety), seduced and betrayed, and perhaps especially, confused, with my sense of what was real undermined: I had turned a blind eye to what I already ‘knew’ and blanked it out in favour of a fantasy. Unconscious material gets into us in the most surprising ways during the process of formulation itself. We have to stay alert and open in order to use it to deepen our capacity for empathic understanding of the subject and their relationships – including those with ourselves and with other professionals.

***Towards intervention***

The recent excitement in psychology generally about our capacity to make sense of psychotic states together with the wish to offer the respect to clients which so often seems withheld by the mental health system might seduce us into being too tactful to mention that Jack is 'mad'! Of course, one has to take note of his abilities and popularity and to feel sympathy that his situation is 'understandable' in terms of the events of his life (as the nurses do in making the referral). However, we should not turn a blind eye to the utter lack of achievement from age 15, the very fragile ego capacities, the failure to find any place to 'lodge' in life and the resort to a delusional identity. These features, all indicating extremely serious structural deficits, should shape a therapeutic response as much as any phenomenological understanding from the dynamic and developmental features of the case material.

For these reasons, intensive exploratory therapy is not indicated as the choice of intervention. There is a considerable risk that Jack will feel too much emotional pressure in such a situation, and since he is unlikely to be able to utilise it to understand himself he will probably cut off emotionally, may act out in some way, and might have to resort to psychotic forms of coping. However, this does not mean that the psychodynamic formulation has nothing to offer. It can and perhaps should inform the more social and life-building interventions and relationships which Jack needs in order to begin to establish a more coherent and well-founded identity and a positive life structure for himself. These might very usefully include as a component a supportive therapeutic relationship which responds to his delusions in an understanding, containing but non-pressurising way that is informed by psychodynamic appreciations of their significance (without 'pushing' interpretations of them). Such a form of therapeutic work would focus on clarifying Jack's relationships in the real world (not on their fantasy meanings), offering positive coping strategies and perhaps provide a positive and safe personal role model to relate to (the preferred therapist for this task would probably be a man). Many of these developmental functions are likely also to be made available in a good social care setting. However, experience suggests that these positive relationships and social opportunities are all too commonly disrupted and subverted by difficulties in the way such care is provided. Psychodynamic theory understands these problems as closely linked to the

countertransference dynamics activated amongst the staff and within the service systems. While some of these are general responses to dealing with psychotic and personality disordered people, in Jack's case one might predict a wish to see him as rather special and make extra efforts to rescue him. He is likely to feel alarmed and pressurised by such opportunities and to retreat from them, which in turn may result in disappointment for the therapists, and rejection or abandonment which Jack will experience as a further betrayal. A dynamically informed care plan would offer consultation and containment to the care team to avoid this kind of replication of an old destructive pattern and enable them to hold Jack as he gradually (and probably falteringly) deals with his shame, self-doubt and fragile sense of safety. Through this process he might be helped to find a place in life in which he can start to establish his sense of himself as a man.

## **Janet: a psychodynamic formulation**

### ***A girl unheld***

Perhaps what is most striking from a psychodynamic perspective about Janet and her situation is how it can seem as though we don't really know her in spite of a proliferation of detail: understanding feels elusive, information fragmentary, and she herself seems to slip through our hands. This is a consequence in part of the nature of the case material that is provided. It might be described as referral-level information and there are numerous gaps at the level of psychological data. However, the fact that this is what has been offered as representing Janet's life story might be taken as in itself significant: we can 'read' the material countertransferentially both in our own reactions as readers and (interpretively) in those of the professionals who provide it in this form. Janet, if not exactly missing, seems to be difficult to take in, to hold coherently in mind, and this can be felt as both enticing and frustrating. It may parallel the ambivalence (between merging and rejecting) that is there in others' reactions to her.

This kind of first impression can be useful as a clue to where to direct attention in assessment and how to integrate the overall story. In Janet's case it fits with and emphasises the evidence that suggests early attachment difficulties – Mary's depression in the post-natal period, problems 'bonding' and feelings of rejection

towards Janet, the possible lack of care demonstrated by the attendances at the accident and emergency department. Features of the current problems certainly lend themselves to being thought about in these terms – anxieties about sleeping in her own bed and transport difficulties. At the same time Mary's possible over-identification and confusion of her own anxieties with those of her daughter (around the issue of mobility problems, for example) are also likely to contribute to difficulty in a developmentally appropriate resolution of the tension between secure attachment and necessary separation. Mary's health problems seem likely to mean that there is a limited amount of attention and emotional 'feeding' available.

These attachment issues within the mother–daughter relationship are set in a wider context. The relationship (of both Janet and Mary) to the father is crucial and the violence, drunkenness, deterioration and final breakdown of the marriage suggest themselves as major contributors to Mary's difficulties and to Janet's insecurities. There are darker hints about possible abuse of Janet but while this needs to be kept in mind during assessment it may be a red herring. The place of the grandchildren in Mary's affections and Janet's reactions (perhaps of displacement and jealousy) to them may be a very important factor, and may indeed be what has precipitated the current worsening of difficulties and the referral. Equally, such issues of insecure attachment are paralleled by some social and cultural aspects of the family's circumstances (the traveller background and the disruption to this culture, the social disintegration of the area and the anticipated but uncertain rehousing). Mary is unlikely to feel 'held' herself in these circumstances and so is less able to offer this to her daughter. On the other hand, Janet's close relationship with another adult (Cindy) may be an important protective factor and a potentially therapeutically helpful resource. In spite of her various problems, she is a girl with areas of achievement and good functioning.

While these features of the case can be pulled together to some degree under a general focus on attachment problems and the way that Janet is insecurely 'lodged' and held in the relationship with her mother and her wider networks, this does not really constitute an adequate basis for a formulation, certainly not a fully articulated psychodynamic account. The details of the attachment anxieties, the fantasy elaborations and meanings that they have for Janet (or indeed the underlying quality of Mary's anxieties and coping

responses or the meaning of her relationship with this 'late' child who has been associated with so much difficulty in her life) remain obscure. Some features of the case – including what may be the main presenting problem of refusal to eat – might be part of this mother–daughter attachment issue, but equally they might not. The material provides all too many enticing opportunities to speculate in various directions. The meanings, both relational and dynamic, of Janet's various 'symptoms' require detailed exploration. The attachment issues and other areas are best regarded as lines of enquiry to follow up in a more detailed assessment process. It would be irresponsible and misleading to pretend to offer a full psychodynamic formulation on the basis of the available information.

However, a psychodynamic approach to this assessment process would also have some features of an intervention, in that there would be an effort to understand some of the experience of both mother and daughter by offering tentative interpretive understandings as part of the enquiry. Further therapy could be with either Mary or Janet (or both) individually, or with both of them jointly, though individual assessment opportunities would be advisable. The aim would be to touch on and perhaps articulate for each their underlying needs and fears within the network of relationships and problem areas, and to differentiate their concerns at a developmentally appropriate level. Assessment and formulation would need to make an appraisal of the accessibility of each to being helped by such an exploratory relationship. But again (as for Jack) intensive individual therapy is not necessarily the only or even the preferred answer from a psychodynamic point of view. The strengths that Janet shows in the ways in which she continues to cope (and indeed the strength that she shows in demanding that her needs are better addressed by being a 'problem'), plus the resources of her family and local community, might provide the means by which she can find the personal attention and security which she craves and needs. At the same time, a major component of the intervention must be to ensure that Mary receives sufficient support for herself and that Janet is not over-identified with her own needs.

## **Reflections**

Each of the viewpoints on formulation proposed in this chapter has been developed and elaborated theoretically in the context of therapeutic work. They are intended to serve the process of change and

support the therapist in what is a personally demanding role: formulation is more than just theorising. A dynamic formulation might help to select the therapeutic strategy and identify risks and aims – exploratory therapy is not necessarily the approach of choice to emerge from this analysis. In cases where this might be the intervention of choice, there are other issues to be considered: the intensity of the therapeutic approach, the length of work, the specificity of the focus, the balance of supportiveness and challenge in the relationship and so on. Above all, each point of view can be thought of as a ‘listening perspective’: a way of hearing and understanding clinical material in a therapeutic session and hence using it to develop for empathy (Hedges 1983). The therapist might monitor the interventions and interpretations made against the overall case formulation to keep herself ‘on track’. But there are risks in this too. Formulations might become a barrier to empathy through objectifying the client. This is one reason why it is not the usual practice in dynamic therapy to explicitly share an overall formulation directly with the client. Such a move is thought likely to be experienced as an impingement or imposition which stands in the way of the client’s autonomous self-exploration and discovery, a process which is in itself as important therapeutically as any explicit new understandings arrived at as its outcome. Understanding is found and offered only in the context of the therapeutic (transferential) relationship as it unfolds.

In this sense, from a psychodynamic perspective we would wish to ask what ‘work’ a formulation is doing (emotionally) for the therapist who is creating it. Often we formulate when we feel a ‘need’ to do so – but that need is formed by the therapeutic relationship itself: we never stand outside that transference/countertransference matrix in such a way as to be objective. For instance, it is a common experience to feel that we have a good and clear understanding of a client at the beginning of therapy and then to lose that as the work proceeds. That sense of understanding is (hopefully) regained – we often have a feeling that this was something we knew all along – but is the meaning the same? In a modern psychodynamic practice, understanding is a mutually constituted process arising through the transformation of the relationship patterns. It is not an external, abstract or objective construction. Formulation in this sense is the therapist’s continuing struggle to make meaningful – to symbolise or ‘mentalise’ – what is inchoate and unformulated in experience. This depends, crucially, on the capacity not to know what is going



on, to allow and tolerate the (often painful) experience of being lost, of disorganisation and confusion. Seeking an abstract formulation may be part of a wish to avoid this experience, to be defined, limited and in control: it can be defensive. This defensive need to understand makes us prone to oversimplify, to coerce meaning – and in doing so to coerce or seduce the client into a self-limiting version of themselves.

One implication of all this is that therapy is a difficult, demanding process for the therapist as well as the client and we need all the help we can get with it! Formulation must find its place in this, not as a refuge from the agonies of uncertainty but as an aid to tolerating the experience of not understanding, managing the sense of risk in relating therapeutically, promoting rather than stifling curiosity and encouraging the possibility of playfulness and aliveness. In that sense, a formulation might function as kind of ‘transitional object’ for the therapist in Winnicott’s (1971) sense: something that is both real and important but not entirely serious, something that we hold on to for security and that helps us think – but which can be discarded as wider fields of mutual understanding open up.

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## Chapter 4

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# **Systemic formulation**

## Mapping the family dance

*Rudi Dallos and Jacqui Stedmon*

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### **The systemic approach**

In this chapter, a brief overview of systemic theory is offered within a historical perspective that describes how it has evolved from a relatively modernist and behavioural framework, emphasising patterns and sequences, to one which emphasises meaning. The most recent developments focus on the centrality of language and the joint construction of understanding between family members. This has much in common with the social constructionist approaches to therapy as described in Chapter 5.

### **Symptoms and family processes**

Systemic family therapy is an approach which involves working with families or parts of families. Originally there was a strong insistence on meeting with all of the relevant family members, though therapists nowadays may see parts of a family system and will sometimes even work with an individual member, while keeping the dynamics of the wider family system in mind. The most formal version of family therapy is conducted by a team of therapists, most commonly with one person in the room and the family. The rest of the team observe live through an observation screen or video, or sometimes stay in the room with the family. However, practitioners use the ideas flexibly and they may work alone, in pairs, do home visits, and so on.

A characteristic feature of modern practice is that the therapist and the team will discuss their ideas with the family in the form of reflective conversations. For example, the observation team may come and join the family and the therapist and share their ideas or

formulations with the family. Alternatively, when just working as a pair, the two therapists may periodically turn to each other to have such a conversation in front of the family. Even working alone, a family therapist may still engage in a conversation where they reflect their thoughts about the family back to them. These reflections are followed by a discussion with the family members.

Systemic theory and practice has evolved since its inception in the 1950s from a theory centred on a biological metaphor of families as homeostatic systems, to that of families as 'problem-saturated' linguistic systems. Nevertheless, an enduring concept is that problems apparently suffered by an individual can instead be seen as a product of the relationships in the family. In this way 'symptoms' are seen as problems in interaction and communication between people, rather than as lying within individuals. Importantly, systemic approaches have increasingly come to regard all aspects of therapy as an interactional and collaborative process. Formulation therefore is not seen as something that the therapist *does to* the family but as something that they *do with* the family. The process of formulation itself is seen not as an objective process, but as a perturbation which starts to change the family system. The process of developing a formulation, the questions that are asked, the ways in which they are asked, are all seen as having the potential to bring about significant change. The way in which this process of formulation is undertaken starts to shape the relationship with the family. Thus, there is less of a distinction between the stages of assessment–formulation–intervention than in many therapies.

A cornerstone of early systemic thinking (stage one) was that symptoms in families served the *function* of stabilising a family system. In many ways this appeared a counter-intuitive idea since the established view was that the symptoms were the very thing causing the distress and unhappiness. One of the most enduring and helpful ideas from the first phase is the model of formulation proposed by the Mental Research Institute (MRI) team (Watzlawick *et al.* 1974). This consists of the elegantly simple idea that many problems arise from the failing solutions that are applied to difficulties (see Figure 4.1).

In this approach to formulation the focus is on an identification of what is seen as the problem and the ways in which it is linked to difficulties which the family has attempted to overcome. The formulation consists of the following steps.

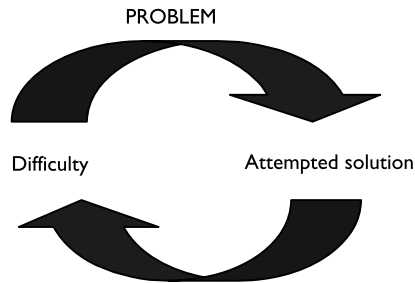


Figure 4.1 Many problems arise from the failing solutions applied to difficulties.

### ***Exploration of the problem***

- Deconstruction of the problem: when did it start, who first noticed, what was first noticed?
- Linking the problem to ordinary difficulties.
- Exploration of what was attempted to solve the difficulties.
- Beliefs about the difficulties and what to do about them.
- Discussion/evaluation of what worked and what did not work.
- What decisions were made about whether to persist with the attempted solutions and which solutions to pursue.

With the growing influence of constructivist ideas (a view that each of us has our unique views of the world, others and our problems and that these shape the choices we make in our lives) about unique personal meanings as being central to human activity and experience (stage two), systemic family therapy came to view descriptions and formulations as having an ‘as if’ quality, in that they were held to be propositions rather than truths. As such, these propositions could be more or less useful in terms of the extent to which they facilitated positive change. Instead of assessment and formulation being seen as a one-off scientific activity it came to be viewed as a continual process of developing, testing and revising formulations (see also Kelly 1955; Hoffman 1993; Proctor 1981; Dallos 1997; and Chapter 8).

### **Progressive hypothesising**

The Milan team of family therapists (Palazzoli *et al.* 1978) added the useful idea that therapy and formulation are intertwined, and inevitably progress through a recursive process of hypothesising:

By hypothesising we refer to the formulation by the therapist of a hypothesis based upon the information he possesses regarding the family that he is interviewing. The hypothesis establishes a starting point for his investigation as well as verification of the validity of that hypothesis based upon scientific methods and skill. If the hypothesis proves false, the therapist must form a second hypothesis based upon the information gathered during the testing of the first.

(Palazzoli *et al.* 1980: 4)

There could be no objective truth about a family. The best we could achieve, therefore, was to formulate hypotheses (hunches) about what was going on which could be more or less helpful in our ways of working. Hence a hypothesis was to be judged in terms of how effective it was in facilitating positive change.

The Milan team argued that the process of developing hypotheses was not only fundamental to the process of formulation but also to the practice of clinical work. The beginning of therapy with a family can be an extremely confusing affair and it would be easy for a therapist to feel overwhelmed by the amount of information which a family presented. A hypothesis helps to cut through this potential chaos and organise the information into a meaningful and manageable structure. It also provides a platform for the therapist to engage the family by asking questions to explore and test the hypothesis, thus eliciting new information. This gives a direction to the work and helps to avoid the risk of unwittingly getting caught up in, or even aggravating, the family's problems. In addition, a formulation can help to reduce the anxiety of the initial contact (which can be considerable for all concerned, not least the therapist). The team went on to note a number of other important aspects of this process:

- Explicitly forming and stating our hypotheses can help to reflect on our implicit assumptions which might otherwise impede therapeutic progress.
- Articulation of hypotheses can help to reveal differences and

agreements within the therapy team which again might hinder therapy if left unstated.

- This view of hypotheses puts less pressure on the therapist to ‘get it right’ and thus reduces anxiety, especially in the early stages of therapy.
- As the engagement with the family is from less of an ‘expert’ position, it may be easier for the therapist and the team to remain curious and interested as opposed to trying to develop a ‘correct’ formulation.

In practice there seemed to be times when the Milan team wandered from a constructivist position to making statements about their hypothesis being ‘correct’ or ‘hitting the nail on the head’. There was also a sense that the hypotheses were not invariably formed in a collaborative way with families. The ‘correctness’ of a hypothesis was seen in terms of whether it was accurate about the family’s beliefs. For example, the team describe a case of an adolescent boy who was displaying delinquent problems. The boy was living alone with his ‘attractive’ divorced mother. Their first hypothesis was that his behaviour was intended to draw his father back into the family. However, this was rapidly disproved and it became clear that a more *accurate* hypothesis was that:

The mother was an attractive and charming woman, and, perhaps after these years of maternal dedication, she had met ‘another man’, and perhaps her son was jealous and angry, and was showing this through his behaviour ... Our second hypothesis hit the target. For the past two months the mother had been dating a friend.

(Palazzoli *et al.* 1980: 2)

### **Family therapy and social constructionism**

Contemporary systemic family practice (the third phase of family therapy; Dallos and Draper 2005) has moved significantly towards social constructionism (stage three; see Chapter 5). This extends constructivist ideas by emphasising the importance of language and culture. Language is seen not just as describing the world but as helping us to actively make sense of and ‘construct’ it. These constructions are shaped by the dominant ideas or discourses that a given culture holds as central. In turn these ideas have their influence

and may be reaffirmed and reproduced in day-to-day conversations. Dominant ideas such as that of ‘mental health’, ‘satisfactory family life’, ‘good mother’ ‘appropriate behaviour’, and so on will shape the expectations and actions of family members. Systemic therapy tries to bring these discourses into consciousness so that families can be less trapped by them. This has also heralded a more collaborative approach to therapy in which the therapist and the team work alongside the family and attempt to work in a transparent and open way.

Recent approaches thus put forward a view of formulation as a shared activity rather than as something predominantly conducted by the therapist (White and Epston 1990). Cecchin (1987) had questioned the notion of ‘hypothesising’ and argued that it implied an inappropriate idea of a ‘scientific’ testing for truth. In contrast, he went on to compare the process of formulation to a form of creative curiosity. The therapist is encouraged to maintain this position of curiosity in relation to the family.

### **A proposed model of systemic formulation**

As we have seen, family therapy has moved through a number of phases. There has been a shift from an emphasis on patterns and processes (stage one) to cognitions (stage two) and finally to language and cultural contexts (stage three; see Dallos and Draper 2005). These phases of systemic family therapy have different implications for formulation, but we suggest that a number of common threads can be drawn out:

- 1 Deconstructing the problem.
- 2 Problem-maintaining patterns and feedback loops.
- 3 Beliefs and explanations.
- 4 Transitions, emotions and attachments.
- 5 Contextual factors.

These phases are also reflected in the overview of formulation proposed by Alan Carr (2000):

- Repetitive problem-maintaining behaviours.
- Constraining belief systems and narratives.
- Historical, contextual or constitutional factors: e.g., family scripts, economic and social support, and cultural values and norms.



Our proposed scheme shares many features of this model but with some additional points of focus. We also suggest that it is important to think about assessment and formulation in terms of two interconnected processes – analysis and synthesis:

- *Analysis* entails exploration with the family about the family, about each other and their problems. This happens not just in the early sessions but throughout therapy.
- *Synthesis* may follow or run alongside the assessment and analysis. Here we start to integrate the strands of information into preliminary hypotheses or formulations of the problem.

This distinction between analysis and synthesis is consistent with a constructivist view which regards observation and gathering of information as an active, selective and interpretative process. In starting to analyse the problem we are inevitably making assumptions and interpretations; for example, about what evidence is relevant and what further material we need. We are selectively attending more to some factors and less to others. By adopting a reflexive stance we may be less vulnerable to being limited by our implicit assumptions. In addition, we emphasise formulation as a dynamic and collaborative process (see also Chapter 7). As in the notion of progressive hypothesising, it is a dynamic ongoing process which is shaped by the relationship that is developing between us and the family. By sharing our ideas with them we move towards a co-constructed formulation.

## **Jack: a systemic formulation**

### ***Mapping the family dance***

Systemic formulations often start with a visual depiction, or genogram, of the immediate family and its connections with external systems (see Figure 4.2).

### ***Deconstructing the problem***

The initial starting point from any therapeutic perspective is to explore the nature of the ‘problem/s’. This involves an analytical process in which we search for clues about what may be causing

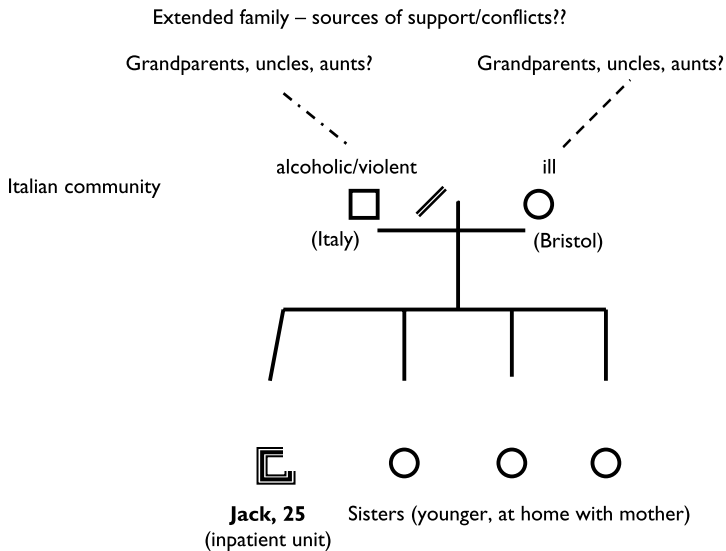


Figure 4.2 Genogram of Jack's family system.

and maintaining them. From a systemic perspective this typically involves a number of related questions:

- How is the problem defined? Is it framed predominantly as individual or interpersonal?
- Contexts – where does the problem occur, in what settings (home, school, work) and where is it at its worst?
- How does the problem affect important relationships in the family and elsewhere? How do relationships affect the problem?
- For whom do the problems cause most difficulties, distress and so on – the parents, siblings, people outside the family?
- What is the life history of the problem, when and how did it start, how has it altered over time, what factors influenced its development?

### Exceptions

Alongside this exploration it is important to consider exceptions since these can offer a clue to what the causal and maintaining

processes might be, and begin to construct a more positive and hopeful framework with the family. Exceptions are times when the family has been successful in resolving the problems or can draw from other aspects of the wider family network to develop stories of competence, achievement and so on such as:

- recent cases of success in overcoming the problem or times when it has been absent
- more distant exceptions, as above
- exceptions in the wider family network
- hypothetical exceptions.

### *Genograms*

The genogram gives a map of the family system and its relationships and sources of support, and helps to direct the gathering of further information. In Jack's case it leads us to ask:

- How isolated is this family? What contact is there with other relatives? How much support has the family had since father left?
- Why is there no contact between Jack and his father?
- What is Jack's relationship with his sisters like? Have they visited him in hospital?
- Who knows about the sexual abuse? Did his parents support him in dealing with this?
- Is Jack the child who carries some allegiance to his father whereas his sisters may have given up on him? Has this led to conflicts between Jack and his mother and sisters? Is Jack's drinking a form of loyalty to his father – following in his footsteps in his use of alcohol?

### ***Problem-maintaining patterns and feedback loops***

It is possible that Jack is in the difficult position of being caught between his father and the women in the family. A cycle may be occurring whereby he has tried to be helpful, to be the 'man of the family', but feels he has failed and is humiliated and displaced from his role as the caring big brother. Perhaps he is now seen by the family as a burden and a cause of problems, which may make them angry with him. This response may carry some of their anger at his

father for ‘abandoning’ them all to poverty and distress. Likewise, Jack may be worried about his mother’s health, but also angry with her for kicking him out and perhaps for taking her feelings about father out on him. Again, Jack may feel caring and protective towards his sisters but also resentful of their ‘good’ role. He may respond to this with a mixture of defeat, confusion and retaliation (see Figure 4.3). It may well be that this pattern has some similarities to one that existed between Jack’s father and mother. It would be interesting to explore whether there have been similar marital dynamics on either or both sides of the parents’ families.

### **Beliefs and explanations**

It is possible that Jack sees himself, and is seen in the family, as being like his father. He is said to miss his father and describes seeing his father’s face in the mirror, which suggests preoccupation with thoughts about him. Given the history of violence in the family, his mother and sisters may be frightened of Jack and worried that he will turn out the same. This perception, along with the fact that Jack does miss his father and may be angry at his mother for ‘driving him away’, could make it more likely that Jack will at times act like his father and subsequently hate himself for doing so.

It can be helpful to consider what some of the shared beliefs between the women in the family might be. Proctor (1981) describes families as holding contrasting beliefs which encapsulate and maintain the patterns of relationships in the family. For example, seeing Jack as dangerous is likely to align the women in the family together in fear of him. In contrast, seeing him as ‘ill’ and

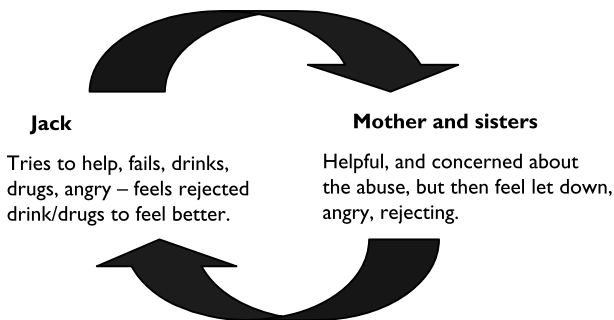


Figure 4.3 Circularity: mixed feelings.

needing care may mean that he is less excluded. Mother's and sisters' beliefs may include the following:

- Jack is abusive like his father, looks like him and acts like him – drinks, drugs and violence.
- Jack is a victim – he has been abused and cannot cope.
- Jack should be helping us, things are bad enough without him causing more problems.
- Men are useless and dangerous.
- (Mother) – I am ill and cannot cope with all of this.
- (Mother) – The girls, in contrast to Jack, are helpful and good.

Jack's beliefs may include:

- I am not like my dad, I hate him for abandoning us.
- I am like my dad and I miss my dad and I don't know why he left – he doesn't care about me/us.
- Mum has made no attempt to get in contact with dad – she doesn't care about how I feel – I am angry with her about that.
- My mother is ill and has been badly treated and I feel sorry for her.
- Men, me included, are useless and dangerous.

### *The role of illness*

Both Jack and his mother are coming to share an illness identity, which can perform the function of helping to resolve some of the mixed feelings, thus:

- If Jack is *ill* then he is not responsible for his actions and we can forgive him and be sympathetic.
- Since mother is *ill* she cannot be expected to resolve Jack's feelings about his dad – she has enough on her plate.

The consequences, though, are that Jack has to remain ill and/or become even more incapacitated. This increases the burden on the family, and the longer he is ill the less possible it becomes to confront the underlying conflicts, which are concealed behind the 'illness' role.

*Transitions, emotions, attachments*

One of the most influential early ideas in systemic family therapy was that families, like other social systems, can experience stress, anxiety and distress at points where significant and fundamental changes need to be made (Haley 1973; Carter and McGoldrick 1988). The onset of problems in families can be seen as connected to the emotionally destabilising aspects of family transitions, especially at key family life cycle points, such as the birth of children and leaving home. This leads to the following thoughts and hypotheses:

- Jack started drinking around the time that his father and mother divorced. Possibly this was to deal with the pain, or in the hope that they would recognise his distress and stay together.
- The divorce was also close to the time that Jack was sexually abused and in need of emotional support, but his parents may have been distracted by their own distress and anger about the separation.
- The divorce also coincided with Jack taking on a job, presumably to help out because of the deteriorating family fortunes.
- Jack's leaving home has occurred in a very negative and destructive way – being thrown out, which was shortly followed by his first referral to the psychiatric services.
- The next escalation in Jack's problems is associated with his mother developing serious health problems – is she now even less able to offer Jack support?

We may observe a pattern in the family whereby distress, illness and misfortune are accompanied by further problems. It seems extremely difficult for this family to meet each other's needs, and people appear to respond in a symmetrical way to each other's neediness by becoming more needy themselves. As a result, there may be so much distress at times of crises that there is no spare emotional capacity to resolve the issues associated with the transitions, for example, negotiating contact between the children and their father (see Figure 4.4).

We could also see the situation here in terms of the entrance of professional agencies – the 'comfort of strangers' becoming a part of the dynamics of the family so that, for example, the hospital takes on the role of the missing parent/s (see Figure 4.5).

The family may benefit by gaining some relief while Jack gets

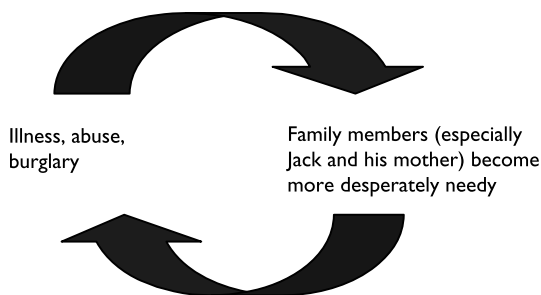


Figure 4.4 The transition to a family–hospital system.

looked after, but at the expense of Jack acquiring a chronic ‘illness’ identity as he is admitted to psychiatric hospital. The support of the hospital system may depend on Jack being seen, and seeing himself, as ‘ill’.

**Contextual factors**

Systemic approaches emphasise that systems are profoundly influenced by contexts. In this they typically include the influence of cultural factors, the extended family, the community and different

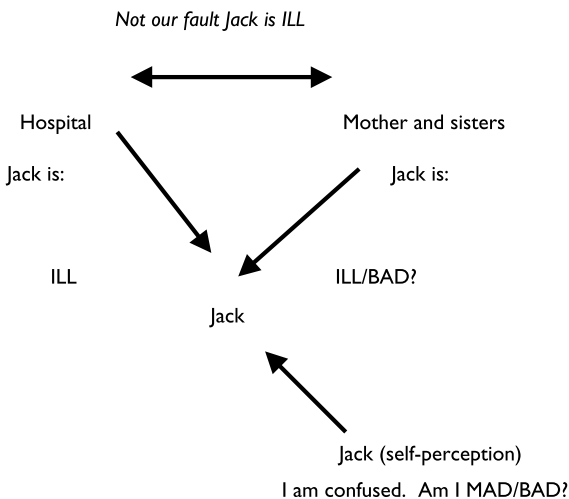


Figure 4.5 Process maintaining the definition of Jack as ‘ill’.

environmental situations. For Jack's family we would consider the following factors:

- The family has roots and connections to a different (Italian) culture which has a strong emphasis on religion, family loyalty and closeness.
- We do not know much about mother's background except that she seems to have come to accept and value her role in an Italian community.
- There appears to be a tradition of drinking on the male side of the family and it would be interesting to know whether there were other problems on either side of the family.
- There is a sense that this family is very socially isolated and that their only support comes from the psychiatric services.
- We do not know whether Jack's sisters have their own friends and supports.

## Summary

The initial stages of formulation consist of the generation of a range of questions. In systemic therapy this is seen as a recursive and fluid process as captured in the notion of 'progressive hypothesising'. The search is not for a definitive formulation but one that helps to orient us in our search for further information and at the same time offers a guide towards possible areas of intervention. In turn, the initial attempts at interventions are seen as offering further information which serves to reshape the formulation and direction of interventions. What determines the usefulness of the formulation is the extent to which the family starts to derive benefits from the work that results from it. One of the main ways that systemic therapists share their formulations with families is through the use of reflecting teams, as already described (see Figure 4.6).

## ***Synthesis and preliminary formulation for Jack***

So what might be a synthesis of our thoughts about Jack and his family? There is a variety of ways we could combine the available information, and the direction we choose will also be shaped by our own clinical and personal experiences. One version that fits for us is the following, though we emphasise that this would only be held as a tentative formulation.



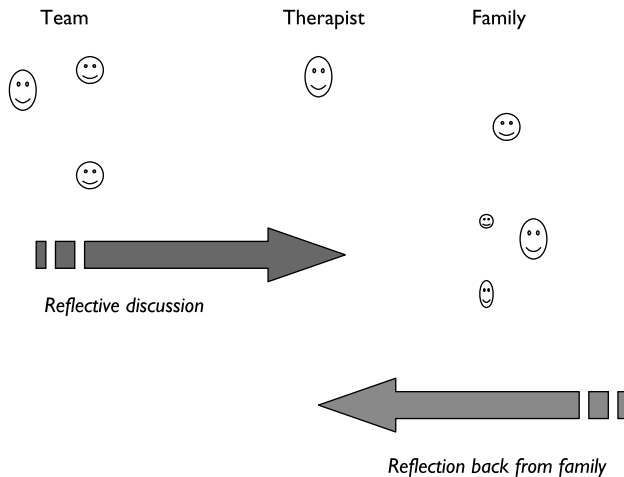


Figure 4.6 Family therapy and reflecting teams – sharing formulations.

Our formulation is centred around a theme of multiple distress. Though Jack is the identified patient in this family there is a sense of the whole family being ‘under siege’. Certainly Jack and his mother are both weighed down by troubles and it seems likely that the sisters are also feeling exhausted. There is a strong sense that when painful, disastrous events happen, this family has not been able to support each other in dealing with the resulting distress. It is as if their lives are taken up with just trying to survive. To feel happy and secure may seem like a luxury they have never been, and never will be, able to enjoy.

Tracing this back in time, Jack seems to have been very distressed by the loss of his father, especially since the breakdown of the marriage may have occurred in a violent and frightening way. This may have left the whole family feeling upset and vulnerable. Subsequently they have experienced multiple traumas, not least the abuse that Jack was subject to by his boss. Since Jack’s mother was herself drained and distressed, it is unlikely that Jack felt he could or should turn to her for support – she had ‘enough on her plate’. So Jack may have attempted to bury the anger and distress that he was feeling in an attempt to play the role of the ‘strong man’ in the family. However, this pressure may have been too much for him, and he subsequently turned to drugs for comfort and showed his distress through outbursts of anger.

Unfortunately, all of this may have led others to see him not as different from, kinder and more caring than his father, but more like his embodiment. Sons are often seen as similar to their fathers, especially if there is a physical resemblance, which can be taken to imply similarities in temperament and personality. Thus, it is possible that Jack has increasingly come to be seen as a threat – like his father. This sense of not being understood, being seen as dangerous despite his good intentions, may be extremely distressing for Jack, and his oscillation between anger, distress and self-medication with drugs may have added to the negative views about him. Because of their own experiences of poverty, burglary and residual distress from the divorce, the women in the family may have had very little ‘spare emotional capacity’ to be understanding towards Jack. However, as Jack’s distress mounted, his frightening actions may increasingly have come to validate the belief that he ‘really’ is just like his father.

The women’s fear and anger may have reached a point where they felt they had no option but to seek outside help and have Jack admitted to a psychiatric unit. This in turn may have compounded Jack’s sense of rejection, distress and anger. There can be a self-perpetuating cycle whereby the hospital becomes perceived as a source of support or a sort of benevolent ‘father figure’. Unfortunately one of the costs of this is that Jack becomes seen, and increasingly sees himself, as mad.

### **Janet: a systemic formulation**

A large proportion of systemic work takes place in the context of work with children, not adults, as the identified clients. This is the genogram for Janet, a 9-year-old girl suffering with anxiety and developmental problems (see Figure 4.7).

#### ***Deconstructing the problem***

Mary has a number of concerns about Janet. She appears to be worried that Janet is not eating properly and that she is becoming socially withdrawn and isolated as a result of her fear of transport and hence loss of contact with friends and family. It is also likely that Mary regards Janet’s temper, especially when directed towards her, as a problem. In addition Mary has concerns about her own feelings about Janet, having found it difficult to bond with her. She

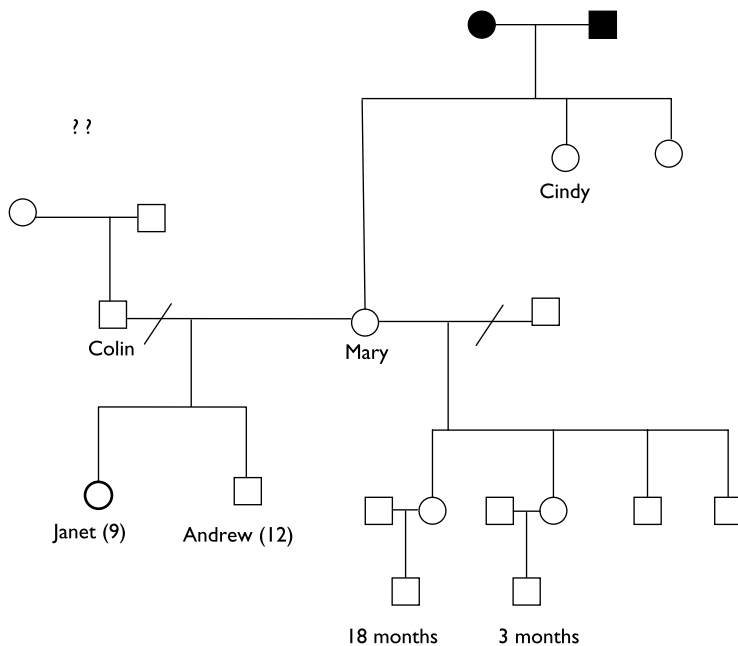


Figure 4.7 Janet's family tree.

links these feelings to the breakdown of her marriage and her fatigue. Given the concerns from social services and school, Mary may feel a failure as a mother and possibly that she is 'under the microscope' in relation to suspicions of abuse or neglect of the children.

Janet appears to be angry with her mother, and may see the problems as mainly to do with home since she is able to go to school and has friends there. Perhaps she is frustrated by her mother's loss of mobility and ill health and is in a sense copying her.

Social services appear to have had serious concerns that Janet might be suffering some abuse or physical neglect resulting in the hospital admissions. This concern has also been voiced by the school nurse, who was worried by Janet's weight loss. Mary's clairvoyant appears to have a supernatural belief that a vision of a 'white van' is connected to Janet's fear of transport. Mary's father's views are not known, but he may feel rejected by Janet and under scrutiny from Mary and social services.

### *Exceptions and competencies*

Janet has friends and is achieving adequately at school. Mary appears to have a close relationship with her sister who is said to be fond of Janet. Mary has also had success as a mother with the son who has become a schoolteacher, and Mary is apparently proud of this achievement.

### ***Problem-maintaining patterns and feedback loops***

There appears to be a pattern of both rejection and dependence between Mary and Janet. Certainly Janet displays both a need for her mother, such as sleeping in her bed, as well as venting her anger on her mother, setting the dog on her and refusing to eat her food. By not eating and being afraid of using transport, Janet stays in an ill, dependent role. Mary also appears to have a mixture of positive and negative feelings towards Janet. This may reflect a dynamic in which Mary attempts to be patient, caring and considerate, but becomes exhausted and then acts in an angry and rejecting way. Janet is the last of Mary's six children. She may have felt desperate exhaustion, but also protectiveness, after the arrival of this 'last straw' (see Figure 4.8).

Janet may have witnessed her father's violence towards her mother and be imitating it. Mary may find it hard to be consistent since she feels both angry about and responsible for the painful

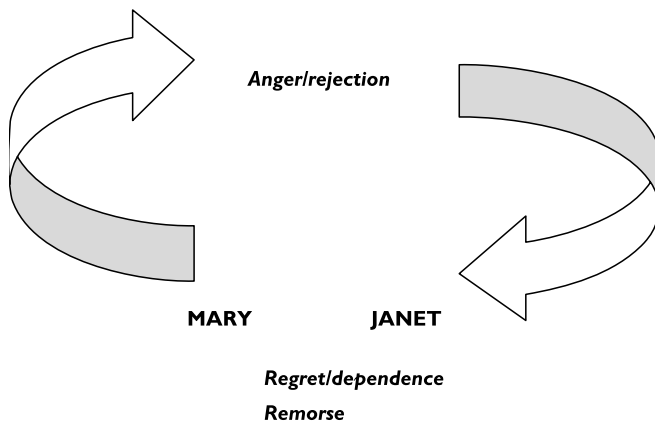


Figure 4.8 Problem-maintaining cycle between Janet and Mary.

events that Janet has experienced, and guilt about her early feelings of wanting to reject her.

### ***Beliefs and explanations***

These are exploration of the meanings that different family members may hold regarding the problems and what should be done about them. Mary appears to believe that Janet's problems are caused by the early difficulties in bonding. In effect, this is a belief that she may be a 'bad mother'. She counters this with the view that lack of bonding was caused by exhaustion and relationship breakdown. She is also likely to see Janet's father as partly to blame because of his violence, though she has tried to maintain contact between him and Janet. Since her children have such different levels of achievement, one a schoolteacher and the other with 'autistic' problems, Mary may have a belief that there is something medically wrong with Janet. She may also believe that Janet has inherited certain characteristics, such as a bad temper, from her father. It is also possible that Mary sees her problems in terms of being tired, living in a poor area, trying to keep contact with a violent ex-partner and coping with ill health.

Janet may believe that her mother does not care about her. She may be frustrated by her mother's ill health. She may be angry or anxious – perhaps feeling unsafe with her father and thus reluctant to stay with him overnight.

### ***Extra-family beliefs***

Social services appear to hold a belief that abuse in the family may be the basis of Janet's anxieties. This belief might be supported further by the fact that Janet seems to be doing reasonably well at school.

### ***Socio-cultural beliefs and discourses***

The dominant discourses shaping the beliefs of the family members and professionals are likely to be either about neglect and abuse, or about some form of organically based problem suffered by Janet. Less dominant discourses might be about their social conditions, living in a socially deprived area and perhaps being marginalised due to their Romany origins.

Another dominant discourse in play may be that of the ‘naturalness of motherhood’; the idea that despite her circumstances Mary, as a good mother, ought to feel warm and loving towards her children rather than have ‘bad’ or ‘unnatural’ thoughts such as wanting to put Janet into care.

### *Ethnic/subcultural beliefs*

Because of their Romany origins the family appears to hold beliefs about the supernatural causes of problems. Although meaningful to them, such views place them outside dominant cultural norms.

### ***Transitions, emotions and attachments***

This refers to the nature of the emotional dynamics, especially the attachments and emotional dependencies between family members and across the generations. It seems clear that there were early problems in the attachment between Mary and Janet. She felt sad and depressed and this may have induced an insecure attachment in Janet, which could partly explain why Janet now behaves in ways which keep her close to her mother. The anxiety about transport may represent a fear of being taken away from her mother. We do not know about Mary’s attachment history though she appears to have a close relationship with her sister. She has certainly had losses – her parents and her relationships with the fathers of her children. It is not clear when her parents died, but this may be linked to the attachment problems with Janet.

We do not know whether Mary’s relationship with the father of her older children was abusive, but women who are abused in relationships have often had a history of insecure childhood relationships, witnessing and/or being a victim of violence. This often leads to a sense of inadequacy and low self-esteem which makes them vulnerable to entering into abusive relationships as adults on the basis of a belief that ‘I don’t deserve any better’.

### ***Contextual factors***

These include the development of the problem, the resources, environmental factors, the extended family, the role of professional agencies, and cultural discourses. Mary and her family face many disadvantages. They live in a socially deprived area, Mary has poor

health, she has no parents to support her and Janet's father has been violent, alcoholic and is possibly still abusive towards her. It is also quite likely that they have limited financial resources. In addition, their Romany identity may contribute to their marginalisation. The professional agencies may have a high degree of suspicion about the family and about Mary's abilities as a parent. This may feed into her anxiety, distress and sense of failure and self-blame. Since the involvement with social services has extended over a considerable period of time, Mary may have become dependent on professionals to give her advice and direction. Equally, she may feel that her authority as a mother is being undermined, leaving her feeling depressed and incompetent (see Figure 4.9).

***Synthesis and preliminary formulations for Janet and Mary***

The above framework may help to direct our attention to the complex web of factors that have shaped and maintain the problem/s. However, it is easy to see that even the brief examples that we

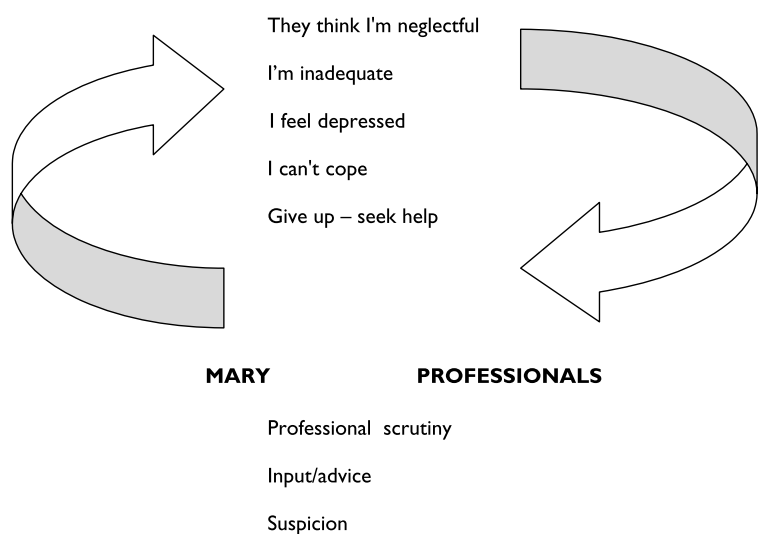


Figure 4.9 Professional–family dependence cycle.

have offered regarding Mary and Janet can quickly turn into an overwhelming kaleidoscope of factors. Somehow this mass of information needs to be combined into a manageable formulation. This requires us to select the factors that we see as key to our understanding of the problem. We need to construct a narrative which links events, actions and contexts into a story or 'pattern that connects'.

As we have seen, systemic therapists commonly offer several different formulations to the family. We have drawn up two possible formulations for Janet and Mary. Neither claims to be exhaustive, but both attempt to offer a view which fits with the available information. In practice, they would, of course, be discussed in detail with the family to see which seems to be more useful. This might be a discussion between the therapist and the family or the formulations could be discussed more informally through a reflecting team conversation.

### *First formulation*

Janet's and the family's difficulties may have arisen from Mary's early parenting experiences with Janet. Mary was experiencing abuse and the family were in difficult circumstances. Since Janet is the last of Mary's six children, Mary may have been physically and emotionally exhausted, and felt she had no energy left for Janet. This was the second child by Janet's father, but because of the marital difficulties Mary may have lost the hope that she perhaps held earlier for the relationship when their first child, Andrew, was born. Not infrequently parents hope that a child will repair a failing relationship or bring about a change in the other partner. If Janet's father did not respond positively to the birth of his daughter, Mary's feelings of being overwhelmed, abused and exhausted may have made it hard to bond with Janet. This may have set in motion a pattern of guilt which left Mary even less able to cope with Janet. For example, it may be hard for Mary to set clear rules about Janet sleeping with her because of her guilt about earlier feelings of rejection. In turn, Janet may respond to and aggravate this pattern by making greater demands for reassurance from her mother and finding ways of becoming dependent on but also hostile towards her. Hence there may be a self-maintaining and escalating pattern of comfort/rejection between them. This pattern may also be fuelled by Mary's self-doubt about her abilities as a parent, and her general



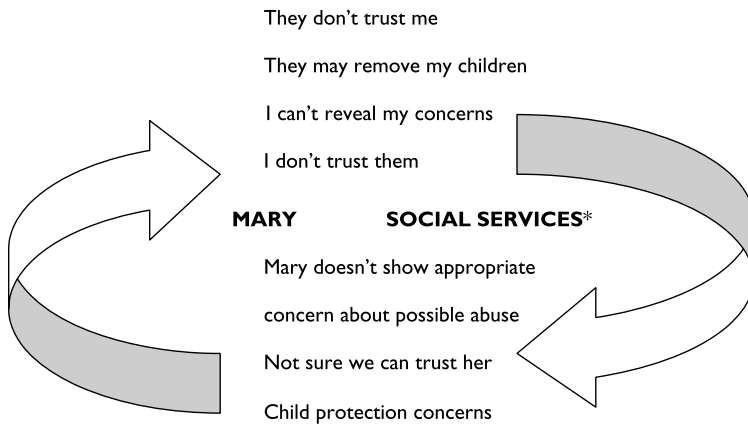
low self-esteem resulting from domestic abuse and her deprived living conditions.

### *Second formulation*

The second formulation is concerned more with the relationships between Janet and her father, and between the professional systems and Mary. Janet has recently refused to stay overnight with her father, suggesting some anxieties about this situation. At home she is afraid of sleeping on her own, which might be connected to possible abusive events with her father. Refusal to eat can also be associated with sexual abuse; for example, being forced to perform oral sexual acts. Mary may be reluctant to think about these possibilities since contact with the father has given her some occasional respite from Janet. Also, as a responsible mother she appreciates that Janet needs to have a relationship with her father. Furthermore, Mary may be aware of the suspicions of social services, and be afraid that being more open about her worries may lead her to being blamed for not having drawn attention to possible abuse earlier. She may even fear that her children might be taken away from her. This lack of action might in turn engender anger in Janet towards her mother for 'not protecting her'. The escalating pattern of mutual suspicion and concern is illustrated in Figure 4.10.

### **Comments**

These two formulations are not exclusive and can be seen as additive. The second one may seem blaming in its suspicions about Janet's father. An alternative view is to see Janet's father as caught up in a process where he is stereotyped as an 'abuser', alcoholic, violent and irresponsible. Families who live in such deprived social contexts may tend to be seen in this way, but it is important to remember that this is not the only context in which abuse occurs. It can be discriminatory to assume that because a family is poor and lives in a deprived area, abuse is occurring. However, in the context of a history of injuries such a hypothesis would at least need to be considered. Importantly, though, a systemic hypothesis attempts to consider how the family-professional system can escalate and make matters worse as well as better. Escalating cycles of suspicion can fuel a sense of failure and eventual hopeless passivity in mothers like Mary.



\* Also other professionals

Figure 4.10 Escalating pattern of distrust between Mary and social services.

## The politics of formulation

It is tempting to try and produce assessment and formulation schemes that set out clear and detailed guidelines for clinicians to follow. While this may be helpful, not least in revealing the complexity of the task involved, we prefer to suggest that formulation contains within it the core conceptual, psychological and philosophical issues relating to all types of therapy. Most fundamentally, we are compelled to reflect about our choice of the 'problem' or 'symptom'. Family therapy offers a social model of the causes and maintenance of problems. It has also become increasingly critical of medical and pathologising processes (White and Epston 1990; Hoffman 1993; Dallos and Draper 2005). Within this framework family therapy offers a critical position that endeavours to question the potentially oppressive assumptions which may be made about family members and which family members may even have been conscripted into holding about themselves:

I sometimes think that 99 per cent of the suffering that comes in through my door has to do with how devalued people feel by

the labels that have been applied to them or the derogatory opinions they hold about themselves.

(Hoffman 1993: 79)

In essence this is the cornerstone of the social constructionist (post-modern) position that characterises contemporary family therapy practice. This places the clinician working with families in a variety of complex positions in relation to formulation:

- As (usually) an employee of the state we may feel pressure to offer formulations which contain elements of social control: for example, to enable a child in a family to become 'less disruptive' and return to school.
- We may be sensitive to and critical of patterns of inequalities and oppression which have shaped the problems in the first place.
- We may be aware of competing opinions about whether there is a 'problem' and what the 'problem' is – the individual's view, the family view, differences of opinions within the family, the view of various agencies such as the police and social services, the school, the legal system, cultural systems and the therapist's professional system.

In effect, a primary aspect of formulation is the juggling of these competing definitions or constructions about problems in families. A clinician engaged in family therapy needs to take account also of the legacy of their profession and the expectations that colleagues hold. For example, there may be an expectation that clinical psychologists are 'experts' at assessment and formulation, and more specifically that they will be able to assess whether an individual in a family 'really' has an individual or a family problem.

Referring back to the quote from Lynn Hoffman, we can see that systemic formulation has attempted an understanding of how self-punishing, negative and destructive views have arisen and are being maintained. Although this approach takes the family as one of the primary points of focus for formulation, this is only the starting point. Systemic therapy recognises that families are connected to multiple systems and that we need to extend formulation to all of these. This is a profound shift from the early days of family therapy when there was a danger of the family becoming just the new site of the pathologising process – subject to formulations which in effect

blamed families for making their members mad or bad. An approach that sees families and their members as influenced by powerful cultural forces, both structural and ideological, shares with others (Boyle 1990; Johnstone 2000) a strong emancipatory aim.

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## Chapter 5

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# Social constructionist formulation

## Telling a different story

*David Harper and David Spellman*

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### Social constructionism

#### ***Where did social constructionism come from?***

Social constructionism developed as a response to, and a critique of, the mainstream approaches in western psychology which were seen as individualistic and ignoring the importance of historical and cultural context. In a sense, social constructionism can be seen as the incorporation into psychology of many of the ideas associated with post-structuralism and postmodernism (these two terms are often used interchangeably: Burr 2003).

A structuralist approach to therapeutic psychology assumes that the foundations of feelings and behaviour are to be found in structures underlying surface phenomena. Thus actions here are seen as behaviours flowing from ‘deeper’ mechanisms like internal states, emotions, drives, thoughts, and so on. We can see this influence today in versions of cognitive therapy (with its cognitions and schemas), psychoanalysis (with its drives and defences), and structuralist family therapy (with its hierarchies and boundaries).

Post-structuralists are those theorists who, like Michel Foucault, reject ‘structuralism’s search for explanatory structures underlying social phenomena’ (Burr 2003: 204). The rejection of structuralist accounts could be seen as a sign of moving beyond the Enlightenment and modernist project of searching for truth and the true nature of reality (Burr 2003). Later, we will describe the impact of post-structuralism and social constructionism on therapy but first we will attempt to define what social constructionism is.

### ***What is social constructionism?***

There is no singular definition of social constructionism, since it is more of a conceptual framework than a clearly delineated theoretical model. Moreover, there is a very broad church of theorists within this tradition. Gergen (1985) has argued, however, that there are four assumptions implicit in most social constructionist work:

- a radical doubt in the taken-for-granted world
- the viewing of knowledge as historically, socially and culturally specific
- the belief that knowledge is not fundamentally dependent on empirical validity but is rather sustained by social processes
- the idea that descriptions and explanations of phenomena can never be neutral but constitute forms of social action which serve to sustain certain viewpoints to the exclusion of others.

Burr (2003) has described a number of key differences between social constructionist and traditional psychological approaches. First, social constructionists are epistemologically<sup>1</sup> anti-essentialist in that they do not search for innate discoverable psychological essences like ‘personality’ or ‘cognitions’ or even ‘emotions’ (which is not the same as claiming that they do not exist at all). Second, they adopt a questioning approach to realism. It is assumed that we cannot directly perceive a naively objective reality ‘out there’. This should not be interpreted to mean that social constructionists deny that reality exists – rather, that what we know as ‘reality’ is socially constructed. Thus, in considering the notion of depression, a social constructionist would not deny that people talk about feeling deeply unhappy and distressed but they would be curious about the terms we use in noticing, talking about and seeking help for that distress in ways which are culturally and historically located.

A third difference is that social constructionists assume that knowledge is bound by time and culture, and thus grand theories which attempt to explain phenomena in an ahistorical and culture-free manner are ultimately flawed. Fourth, language is not a peripheral matter, but is central to the way we view the world. Fifth, language is seen as a form of social action and is constitutive rather than merely descriptive. In other words, by talking and writing about the world in particular ways, we bring into being – or construct – certain ways of seeing the world.

Dallos and Draper (2005) note that social constructionism is not a theory as such but rather a meta-theoretical framework (i.e. a theory about theories). It thus represents a particular stance or orientation towards one's therapeutic tradition rather than being an approach in itself. Indeed, some have argued that so-called 'postmodernist therapies' are a contradiction in terms (Frosh 1995).

One important confusion to clear up is the difference between constructivism and social constructionism. Constructivist approaches to therapy have a long history, for example, in personal construct theory (e.g. Kelly 1955). Constructivists acknowledge that individuals construct their own views of the world. However, social constructionists go one step further, arguing that those individual constructions are developed in a social world where, moreover, different constructions have different social power.

### ***The influence of social constructionism on therapy***

These critiques had an impact on some psychoanalytic theorists (e.g. Frosh 1997) and behaviour therapists (Woolfolk 1992), whilst within cognitive therapy constructivism has had more of an effect than social constructionism (Neimeyer 1999). Some of these ideas also found favour with critical and community psychologists (e.g. Prilleltensky and Nelson 2002; and see Chapter 6).

However, social constructionism found the most receptive audience within the family therapy field, given the interest in systems of social relationships and the awareness of the existence of multiple perspectives on phenomena. *Therapy as Social Construction* (McNamee and Gergen 1992) typifies this range of interest<sup>2</sup> and there are many commonalities in the approaches in their edited collection. Thus, both narrative and solution-oriented therapists see language as the medium of therapeutic change with the therapist as an active questioner and re-author of conversations. However, there are important theoretical and practical differences. Thus in both the 'not-knowing' collaborative language systems approach (Anderson and Goolishian 1988) and Tom Andersen's use of reflecting teams (Andersen 1992) there is a passionate emphasis on the importance of listening to the words people say (as opposed to what we think they mean) rather than the active questioning style of other approaches.

Limitations of space prohibit us from attempting to formulate within each of these approaches. Instead, we will focus on narrative therapy since it is becoming increasingly well known.

### **Narrative therapy**

Narrative therapy (NT) was developed by two family therapists: Michael White (based in Australia) and David Epston (based in New Zealand). Their approach explicitly used narrative and textual metaphors (White and Epston 1990). Interested readers can now find accessible introductions (e.g. Freedman and Combs 1996; Morgan 2000; Payne 2000).

Essentially, NT sees problems in living as occurring when the stories people have available about themselves do not accord with their lived experience. It aims to be non- or anti-pathologising and places an emphasis on a therapeutic stance of respectfulness and non-blame. It assumes that the options available to people for living their lives are not always visible to them. Indeed, they may be made invisible by the influence of *dominant narratives* that can lead to the editing out and forgetting of episodes which do not fit. There is a relationship between these dominant narratives and power in society (see Chapter 6). For example, they obscure and mystify the effects of power relations by inviting people to compare themselves unfavourably to unattainable and idealised images of what is normal. As a result people begin to elaborate problem-saturated descriptions of themselves: for example, as a 'chronic schizophrenic' or as a 'child with ADHD'. Narrative therapy represents a move away from a linear cause and effect paradigm where the role of the expert is to find out and fix. NT has no position on the aetiology or cause of problems (White in Stewart 1995). As a result, causal formulations of problems are not a part of this approach.

### **Social constructionism and formulation**

A formulation is usually interpreted as an explanation of the causes (e.g. precipitants and maintaining factors) of problems that indicates priorities for therapeutic intervention with clients (Butler 1998). Such a definition poses a particular challenge for those influenced by social constructionism because of its structuralist and causal assumptions about the nature of human problems, lending support to the idea of the therapist as a technical expert (Harper and Moss 2003). For example, do formulations only have to be about problems? How might this fit with theoretical traditions which are not based on theories of aetiology and pathology? Moreover, who gets to define what the 'problem' is (Boyle 2001; see also



Chapter 9)? Do formulations have to be causal and historical? How might this fit with traditions that are not based on causal theories of problems like narrative therapy or solution-focused therapy?

One solution to these dilemmas has been proposed by Alan Carr (2000) who has attempted to construct formulations not only of problems but also of exceptions to those problems, drawing on concepts from solution-focused therapy. This is a useful alternative to problem-focused formulations. Another proposal has been made by one of us (DH) in collaboration with Duncan Moss which may be more consistent with other therapies influenced by social constructionist thought. We have suggested that therapists could see their work as a process of ongoing collaborative sense-making rather than one of developing objective or semi-objective descriptions of the causes of a problem. This is similar to the notion of progressive hypothesising found in other family therapy traditions. Formulations, then, are situated in particular contexts and oriented to particular purposes. In other words, they are perspectives: a view from somewhere, rather than the objective scientific notion of a view from nowhere. To express this in more narrative terms we could say that if clinical work is seen as a series of dialogues or conversations, then a therapist's formulation is one person's story (their story) and account of that conversation (Harper and Moss 2003). From this viewpoint, a formulation is a structured story for therapists and clients which gives one account of why things are the way they are and what might need to happen for things to change. It provides an organising story which orients therapist and client towards ways forward (Parry and Doan 1994; Bob 1999). Formulations, then, are stories that are constructed rather than discovered and so it is their usefulness and fit for the client which is most important.

This definition may seem vague, but a social constructionist approach to formulation needs to cover a range of approaches from the more conventional conceptualisation of biographical and historical causes of problems to non-causal and non-pathological understandings.

### **Case examples**

As we begin to discuss how we might approach a formulation of the difficulties which Jack talked about, we are reminded of an episode from a two-day workshop with Tom Andersen in Liverpool in the

mid-1990s. At the end of the workshop one of the attenders described a client with whom she worked who had had a series of traumatic life experiences. She then asked the kind of question which fills trainers with fear: 'What would you do if you were the therapist in this situation?' There was a very long pause whilst Andersen thought deeply about this question. Then he said, 'Well, I would listen very carefully to what she said and then proceed from there.' Many of the people in the room burst out laughing. On the one hand this response could be seen as a bit of a put-down (a 'How the hell should I know?' response). But, on the other, Andersen was being totally consistent with his theoretical position on the impossibility of predicting the direction and outcome of therapeutic conversations.

This expresses the essence of the dilemma of offering formulations of clients whom we have not met (noted also in Chapter 6). Since one of the foundations of therapeutic approaches influenced by social constructionism, like narrative therapy, is the emphasis they place on listening to clients' actual words and asking the kinds of questions which may not be asked in other approaches (and thus having conversations which go off in different directions), it is really quite a challenge to develop our own formulation.

However, rather than stop here, we are persuaded of the pedagogical value of trying to attempt a formulation with the proviso that readers bear in mind that we have not met with these clients or their families and that these case examples, like all vignettes in the literature, are particular narrative constructions based on interviews conducted by therapists from a different theoretical orientation.

Systemic and community psychology traditions see formulations as dynamic and ongoing, and a narrative therapy perspective takes this further in that therapy and formulation are mutually interwoven activities. In the examples that follow, we will develop a more descriptive kind of formulation, focusing both on how we might have proceeded in the sessions (e.g. what questions we might have asked and why) and what narratives might have emerged from these sessions. Since the directions in which the therapeutic conversations went from there would very much depend on how those present in the room responded, the latter will be necessarily more speculative. Since those unfamiliar with narrative therapy are often curious about what narrative therapists do, we have placed some emphasis on what the therapist might actually say or ask.

## **Jack: a social constructionist formulation**

### ***Telling a different story***

The narrative therapist would come to the session with Jack with some knowledge of alternative ways of conceptualising and working with people reporting experiences which others would see as symptoms of psychosis or of 'schizophrenia' (White 1987; O'Neill and Stockell 1991; Dulwich Centre 1995; Parker *et al.* 1995; Stewart 1995; Brigitte *et al.* 1996; Seikkula *et al.* 2001). There has been a great deal of recent interest in more hopeful narratives about experiences seen as psychotic (May 2000).

In the section that follows, we have followed Morgan's (2000) introductory guide to narrative therapy to provide a structure for thinking about how conversations with Jack might proceed. Obviously, therapy is a dynamic and recursive process and so these elements would not necessarily follow each other in a linear fashion and the order in which areas would be explored would depend on both Jack and the therapist. One approach here might be for the therapist to reflect on the referral information, considering both the implicit dominant discourses at work (as expressed by Jack, by his family, by professionals, and in the wider culture) as well as possible subjugated discourses (e.g. Jack's competence and the impact of traumas on him). This might be seen as akin to formulation which also includes elements like externalising and so on which are closer to intervention. In Jack's case, the therapist had little referral information before he was first seen and what we have is a description based on an interview. If the therapist had this information before they saw Jack, they might have had an opportunity to give these issues some thought.

### ***Externalising conversations: naming the problem***

From a social constructionist viewpoint, the therapist's role is as a 'conversational artist' (Anderson and Goolishian 1988: 372), who aims to collaborate with Jack to help him develop new stories about himself. Narrative therapists use a variety of practices in order to try to make previously invisible options visible by helping clients elaborate more hopeful and yet marginalised or *alternative narratives*.

One way in which this is done is to create a separation between the problem and the person by engaging in *externalising conversations*,

a way of interviewing people about a problem which is seen as separate. The therapist, client and others are thus united in a struggle against a problem which is seen as external ('the problem, not the person, is the problem'). Practices like this can help to undermine the sense of failure that is often a consequence of the dominant narrative. This can pave the way for co-operation in struggling against the problem.

Morgan (2000) suggests that a number of things can be externalised: feelings; problems between people; cultural and social practices; and the metaphors people use in talking about their problems. From the account of Jack's difficulties there seem to be a number of candidates for externalisation. It is important to bear in mind the question of whether there is a problem and, if so, who gets to define it. As a result the therapist would very much focus on how Jack saw the problem, if he saw one at all.

The therapist would listen out for opportunities to externalise using Jack's own words and phrases, rather than professional jargon. Indeed, many clients spontaneously talk about an issue in an externalising way, which the therapist can then extend.

From our reading of the material presented on Jack we surmise that he might talk about the problem of fear. Fear impacts on Jack's life in a number of ways. He is afraid of Robbie Williams and his minders. He is fearful about leaving his accommodation in case he is attacked. He was also afraid of seeing his father's face reflected back at him in the mirror, possibly suggesting 'Fear' might persuade him that he was like his father (especially given that he has developed similar difficulties in relation to alcohol). He was afraid that he might be arrested for sexual offences although there is no evidence that he has committed any. He is also afraid for his mother and sisters, especially the sister who, he believed, had been raped by Robbie Williams (although, again, there was no evidence of this).

Another thing that might be externalised is guilt. One might be interested in how 'Guilt' affected Jack. He might talk here about guilt about sex, particularly given that he had been sexually victimised by the male manager at his Saturday delivery job. He might also talk about guilt at feeling he had brought trouble on the family and about the events which led up to his mother asking him to leave the house. Given dominant cultural discourses about men being the breadwinners he may feel guilty that he has been a 'failure' according to these dominant stories. Guilt might also have persuaded him that he might be to blame for his parents separating.

Although anger might present itself as ideal for externalising, this would need careful thought – Carey and Russell (2002) discuss some of the issues involved when considering whether, when and what to externalise. For example, externalising ‘Anger’ here might invite Jack to move away from a sense of responsibility for the effects of his actions. Alan Jenkins has outlined some other alternatives, were Jack to want to focus on his anger (Jenkins 1990). However, one might be able to explore what impact the anger has had on Jack and those close to him: for example, anger about Robbie Williams; his father’s behaviour; and his own abuse. Similarly, Jack might wish to talk about the effect that drink, drugs, theft and homelessness have had on his life and on the lives of others.

Our main point is that there are many things that could be externalised but which are taken up depends on Jack and the therapist working together. Interestingly, from his own account Jack did not identify his *beliefs* about Robbie Williams, the royalty cheque, the alleged rape of his sister or that he himself might be arrested for sexual offences per se as problems, so we have not included them here as targets for intervention. Were they to prove a focus for Jack, the therapist might approach it in a slightly different way from other therapies. For example, social constructionist work on beliefs not shared by others notes how they become constructed as socially devalued by more powerful others like professionals (Heise 1988; Boyle 2002; Georgaca 2000). However, they often provide dramatic narratives for those who believe them (de Rivera and Sarbin 1998). This suggests that it may be less important to focus on the veracity of the beliefs than on the person’s relationship with them; for example, the extent to which the beliefs disrupt the life they wish to lead (Harper 2004). Narrative therapy and social constructionist thinking about ‘paranoia’, for example, readily link it to experiences of victimisation, surveillance and discrimination in western culture (Hardy 2001; Harper 1996; Harper and Cromby 2004; White in Allen 1994). As Miller and McClelland (Chapter 6) have demonstrated, there is evidence of a significant link between mental health problems and racism (Patel and Fatimilehin 1999) and other forms of social inequality (Williams 1999).

Morgan (2000) suggests that narrative therapists ask the client to give the problem a name. Then begins a thorough exploration and personification of the problem in order to continue the process of helping the person to separate their identity from that of the problem/s. Questions here might focus on the tricks and tactics

which the problem uses to gain the upper hand in Jack's life. What are its purposes for Jack? Who are the problem's allies? For example, Jack might say that throughout his life he had had jokes aimed at him as a British Italian man or had experienced discrimination because of mental health problems, and thus, racism and injustice might be seen as an ally of the problem (see Patel and Fatimilehin 1999).

Following this kind of conversation, the therapist would ask Jack about how he described his relationship with the problem. Was he happy with how it was or would he like it to change? Jack might say he was unhappy with how the problems dominated him and that he wanted things to change, to be more hopeful for the future.

### ***Tracing the history of the problem***

Next, the therapist would examine the history of the problems in Jack's life. For ease of reading we will refer here to one problem, though in cases where clients discuss a number of problems, Morgan (2000) suggests asking them to prioritise the difficulties.

One might ask Jack when he first noticed the influence of the problem. How has it changed over time? Conversations like this can help people to feel that the problem is not necessarily static and unchanging and a space begins to be opened whereby alternative histories are possible. Allen (1994) quotes an example from Michael White about how he might approach a client diagnosed as 'paranoid':

If a person is totalized as 'paranoid', I might ask them a series of questions like: How did you get recruited into the sense that you are under surveillance? In response to this question, persons speak of their experience more politically.

(White in Allen 1994: 31)

So one might ask Jack when he first starting feeling fearful about being attacked. He might say that this began around the time his mother became physically ill and when finances were stretched.

### ***Exploring the effects of the problem***

It has been a criticism of some solution-focused approaches that clients can feel they have not been heard by the therapist, because they have not been given the opportunity to convey how difficult

things are. In narrative therapy there is a wish to allow clients to do this, but in a way which still allows them to separate their identity from that of the problem. One way of doing this is to map the effects of the problem on the person's life, as described below.

Thus, one might ask Jack how the problem has affected his view of himself and his future. How does it interfere with his life? For example, what does 'Fear' stop him doing? Jack might say that it has stopped him going out and he has begun to lose significant relationships with others like family members. He might talk about how he has begun to lose his interest in music. One could also ask him about how 'Guilt' has changed the way he views himself. How has 'Anger' changed his relationships with those close to him?

The therapist also asks the client to evaluate these effects. One might ask Jack what these effects are like for him and his family. If Jack saw these in negative terms, one could ask him why, and this usually provides clients with an opportunity to talk about their interests, hopes, values and preferences. Thus, for example, Jack might talk about how these problems get in the way of him showing his love for others; developing friendships outside his family; allowing him to be as close to his family as he would like; and/or of doing good to others as he would like.

### ***Situating the problem in context: deconstruction***

Morgan (2000: 45) argues that from a narrative therapy perspective 'problems only survive and thrive when they are supported and backed up by particular ideas, beliefs and principles'. Thus narrative therapists are interested in making these assumptions available for questioning. Morgan refers to this as a deconstruction. Dallos and Stedmon (Chapter 4) have discussed how systemic therapists also use this practice.

One might be interested, for example, in taken-for-granted cultural ideas which may be related to the problems. As a British-Italian man there might, for example, be particular Roman Catholic ideas about guilt, the role of men and the place of the family which might play a role in his story. As a man, there might be culturally available stories about alcohol, violence and the expression of some emotions (e.g. anger) but not others (e.g. fear, sadness, loneliness, etc.). There might also be beliefs about who should be the breadwinner in a family and the role of fathers and sons (such as carrying

on the family business) in relation to mothers and sisters. In a group or community context, these kinds of conversations can be extremely powerful (O'Neill and Stockell 1991; Brigitte *et al.* 1996). One option can be to encourage group members to look through magazines and newspapers or videotapes of TV programmes and films to see what dominant stories are culturally available, for example, about mental health, or about young men. Such conversations can help people to begin to stand back from these dominant stories, situating them culturally and historically.

### **Unique outcomes**

The therapist shows particular interest in *unique outcomes* or times when the person has, even in a small way, managed to challenge, resist or in some other way develop a more hopeful relationship with the problem. These have an analogue in solution-oriented/focused work where such times are known as *exceptions*. During therapeutic conversations, the narrative therapist will listen for any times when the problem appears to have had less of an influence on the client or even no influence at all. The therapist does not then simply 'point out the positive', but uses these as an opportunity to start to plot an alternative story to the dominant problem-saturated one. Unique outcomes could include a plan, an action, a feeling, a dream, a commitment, a thought, etc. (Morgan 2000). If the client is unable to think of episodes like this, the therapist might ask something like 'How have you managed to stop the problem from getting even worse?'

Thus, one might ask Jack in what ways he has resisted the power of 'Fear'. He might describe how he had overcome 'Fear' to come along to the session or to accompany his mother to the corner shop. The therapist would be curious about how Jack had managed to deal with the 'Fear' that, at other times, appears to paralyse him. One could also ask whether the influence of 'Guilt' on his life has ever changed or whether there have been any times when he has been able to resist the urges of 'Anger'.

From what we know of Jack there are a number of avenues which might lead us to unique outcomes. One might ask about how he had managed to survive on the streets when he was homeless, or develop new relationships in the homeless project. How did he manage to stick at jobs even for a short time? The therapist might also ask how Jack had coped with his own sexual abuse and his father's violence.



Wade (1997: 23) has argued that whenever people are badly treated, they find some way to resist. Thus 'alongside each history of violence and oppression, there runs a parallel history of prudent, creative and determined resistance'. Similarly, Warner (2000) has pointed out how activities like drinking alcohol or using legal and illegal drugs to excess, which may be viewed as problems by professionals, can also be seen as creative ways of coping with the legacy of abuse.

These unique outcomes and the responses of the person and those around them become the building blocks of the subjugated narratives of the person's life. As a result of rich descriptions of these unique outcomes or 'sparkling events', Jack might develop new stories of his life. For example, he might begin to see himself less as a passive observer of his life and more as an active agent. These new stories are often very fragile and considerable effort and skill goes into helping the person elaborate rich and thick accounts, by rooting them in their history.

Having identified unique outcomes, the therapist attempts to trace their history in order to 'firmly ground them, make them more visible, and link them in some way with an emerging new story' (Morgan 2000: 59). This takes a lot of effort: the therapist is interested in the particularities of each unique outcome. Who? What? Where? When? Two particular categories of questions which are used are 'landscape of action' questions, and 'landscape of identity' questions.

Landscape of action questions might be: 'How did you manage to look after yourself whilst you were homeless? When did it happen? Who else was there? How long did it last? What happened just before or after? How did you prepare yourself?'

Jack would then be invited to consider the meaning of a new development or unique outcome using these questions which focus on the person's desires, intentions, preferences, beliefs, hopes, personal qualities, values, commitments, plans, and so on. For example, one might ask Jack whether his survival on the street led him to revise his opinion of himself as a 'failure', and he might be able to see that he drew on his ability to be streetwise to keep himself safe at times. Thus, Jack might begin to reconnect with his own knowledges, qualities and agency.

After tracing and elaborating an alternative story like this, the client might then be invited to name it. Jack might name this as a story of strength and survival in the face of 'Failure' and 'Fear'.

However, it is important to go further and to thicken these alternative stories, rooting these new discoveries.

### ***Re-membering conversations***

As Morgan (2000) notes, people can often feel isolated and disconnected from relationships when faced with problems. 'Re-membering' conversations are attempts to help clients reconnect with these significant relationships or 'memberships'. Such memberships can include people alive or dead, real or imaginary, and may also include animals, toys, pets, places, symbols or objects. So one might ask Jack: 'Who else would know that you stand up to Fear?' or 'Can you think of someone who could tell a story about your commitment to fight injustice?' As well as being helpful in themselves, such conversations might lead the therapist to try to contact these people (Jack's mother, sisters and perhaps others) and interview them about their knowledge of Jack. Some of them might be invited, with Jack's consent, to the sessions.

### ***Therapeutic documents***

Morgan notes that therapeutic documents are often written 'when people make important commitments or when people are ready to celebrate important achievements' (2000: 85), and Fox (2003) has reviewed a number of types. They are written collaboratively with the client and can act as 'counter-documents' to the more usual pathologising and problem-saturated descriptions that clients find in their case notes or discharge letters. Something that might help Jack is a 'document of identity' which records new stories about the person. This has been found to be useful in helping people cope with victimising voice hearing (Stewart 1995; Brigitte *et al.* 1996).

Letters have become increasingly popular in psychotherapies like cognitive analytic therapy (Ryle 1991; and see Chapter 8). Various types of letter can be used in narrative therapy (Fox 2003; Morgan 2000; White and Epston 1990). Two types that might be of help to Jack are letters written after each session to summarise the new stories which had been heard in them (and perhaps pose questions to consider before the next session); and a letter of reference addressed 'To whom it may concern' which records accounts of a person's developing identity and aims to counter negative reputations. There are also *rituals and celebrations* that can be constructed

to celebrate particular steps away from the dominant problem story. This might draw on particular family or cultural traditions.

### ***Expanding the conversation: leagues and teams***

Those who have experienced problems and escaped from their influence have considerable knowledge, skills and expertise. Narrative therapists try to draw on this knowledge by helping clients to enlist the support of, for example, other young men who had struggled with feelings of fear, or coped with the legacy of physical or sexual abuse, or managed to revise their relationship with drugs or alcohol. Of course, therapeutic work could be done in a group setting which provides a ready context for meeting others facing similar predicaments who can share their expertise. O'Neill and Stockell (1991) have described work with a group of marginalised young men with a diagnosis of 'schizophrenia' who had attracted negative reputations amongst professionals. Such an approach might be very useful in helping Jack to feel less isolated. Michael White facilitates a group for people who hear voices (Brigitte *et al.* 1996). James (2003) and Knight (2004) describe an innovative group approach to paranoia, though this is not explicitly narrative in focus. Narrative work can also be conducted in large community gatherings (ACT Mental Health Users Network and Dulwich Centre 2003; Dulwich Centre 1995; White 2003). Finally, some of this work could potentially be done through others (e.g. nursing staff, the community psychiatric nurse, and so on).

### ***Outsider-witness groups and definitional ceremonies***

This is a final way of elaborating the alternative stories told by clients. Narrative therapists occasionally recruit people to be an audience to the conversations between therapist and client, and these are called outsider-witness groups. These kinds of processes come under the category of definitional ceremonies. In Jack's case the 'audience' might include family members, professionals involved in his care, or other people (e.g. young men, O'Neill and Stockell 1991) who have struggled with similar issues. Such meetings follow a particular structure of a conversation between the therapist and Jack (a 'telling') followed by the therapist interviewing those in the 'audience' position about what they have heard and exploring whether this leads them to new ways of seeing Jack (a

're-telling'). The therapist would then interview Jack about what he heard and whether this led him to develop new stories about himself (a 're-telling of the re-telling'). Conversations can move between tellings and re-tellings and often prove to be enormously enriching and profoundly moving.

Of course, it is important that these new stories are also rooted in action. As Jack begins to develop an account of his hopes for the future, he can be enabled to make choices about what he wants to do next in his life. This might lead into conversations about where he wants to live: with his family, on his own, with others? How would he like to spend his time? Would he like to use his creative and musical talents in some way, undertake further education, or make other choices?

### ***To formulate or not to formulate?***

Given that narrative therapists do not aim to produce causal stories about problems, we do not feel it would be appropriate to shoehorn the approach into the traditional formulation structure with a flow diagram including arrows illustrating causal pathways. A more theoretically consistent narrative therapy analogue of a formulation would be a therapeutic document. One such document is a summary letter that describes what has been discussed in a therapy session, detailing the effects of the problem and outlining the emerging traces of an alternative story. Normally, as we have already noted, this would be done in collaboration with Jack, using his own language and preferences and with actual examples of unique outcomes. As a result, what follows is quite speculative. The content of the letter might be influenced by whether the letter was for Jack alone or intended to be read by others, such as his family, as well.

Dear Jack

You'll remember that when we met recently we said that we would write to you to put on record some of the important things which we have been talking about recently.

You told us about the ways in which Fear had entered your life soon after your mum became physically ill and money at home was short. It seemed it had crept up on you and was stopping you doing the things you wanted to do and living the life you wanted to lead. The Fear tried to convince you of many frightening things. However, as we talked, it seemed to us that

you were now onto what this Fear wanted to do to your life. We were very moved by the many small ways you stood up to it, for example, in actually managing to get out of the house at some points and in attending our meetings. You said that you thought your medication had a part to play in this. However, we felt strongly that it could not have had these effects without your help through qualities like your inner strength. You recognised that what the Fear wanted with your life and what you wanted were two very different things, and you started to tell us about some of the hopes you had for the future which we found very inspiring.

Another problem which you identified was the way that Guilt was trying to wreck your life by making you feel that you were to blame for many of the difficulties you faced. It seemed that Guilt was in league with some of the people who had abused their positions of trust in your life in the past. However, it could not cope with hearing of how your family loved you, or you talking about the times when you accepted yourself or you expressing your hopes for the future.

We got wise to some of Guilt's tactics: it tended to pick on you when you were feeling low and also sensationalised any little setbacks which cropped up in your life, as they do in all of our lives at some point. Throughout all this, you began to rely on your qualities of wanting to do good in the world and wanting the best for your family. These qualities seemed to give you strength in your attempts to win your life back from Guilt.

You have really been through the mill recently with these problems and the challenges you have faced in dealing with your anger, the drink and drugs and homelessness. Many people do not realise how hard it can be to survive on the streets and how much it takes, when facing problems like these, to manage to go to work. However, in our meetings with you we heard how creative you had been in surviving from day to day on the street and were amazed at how long you had stuck at the jobs you'd had, and how, after a setback, you had picked yourself up and gone for another job. These did not sound to us like a story of 'failure', more a story of hope and inner strength.

We very much look forward to meeting you again in the near future. We wondered, in the meantime, whether there might be other small ways in which you were managing to get your life back from the control of these problems. Perhaps you could

keep an eye out for these so that we can hear more about them when we meet?

Best wishes,

Dave Harper and Dave Spellman

### **Janet: a social constructionist formulation**

As before, the practitioner working from a narrative perspective would be familiar with some of the literature pertinent to adopting this approach with children and their families (e.g. Freeman *et al.* 1997; Morgan 1999; Smith and Nyland 1997). Having outlined this perspective in some detail in relation to Jack we will illustrate some possible approaches to Janet and her family more briefly.

#### ***The context of the referral***

Finding a starting point that is likely to be helpful can be difficult. A useful question to ask oneself at this point is 'What is being asked of me and by whom?' Long lists of 'concerns' are often provided by referrers with little indication as to why they are a concern and to whom. It is important to explore such assumptions and not be automatically organised by them. As in the case of Jack then, one might already be deconstructing the dominant and subjugated stories in the referral letter and initial conversations (e.g. with referrers and with the clients).

Although adults often have little part to play in their referral to mental health services, this is even more true of children, who may be unaware of the referral, let alone consulted about it. Their views are rarely included in referrals, and the social convention is that adults speak first and convey what they see as the truth of the problem.

It is very important to begin the first session with a friendly introduction and a simple but open description of the aims of the session. It is also important to get to know a family aside from the problem, if that is possible, by finding out a little about them and hearing from everyone rather than launching straight into what solution-focused therapists refer to as 'problem talk'.

#### ***Collaboration***

After some general conversation oriented to getting to know the family, it is helpful to hear from members about what has brought

them to the service. Questions might be asked about what they would like to change and whether they agree with the referrer's ideas about the nature and priority of particular worries. Narrative therapists tend to place an emphasis on describing in detail how everyone would prefer things to be. After this the therapist sets about interviewing with an eye to helping the family colour the picture in. In this way the scene is set for a more collaborative way of working with, and relating to, family members.

If we treat the case description as a referral, then we can attempt to delineate some key themes. From our reading, these seem to include concern about Janet eating enough; Janet losing her temper; the effects of potential social exclusion; and some difficult aspects of the family history. With such a range of issues it can be difficult to know whether to try and find a central theme or deal with each separately. Checking out such dilemmas with the family directly would be common practice for us.

Our preference is to consider themes that connect with relationships rather than those which seem more individualised. Referrals tend to be focused on individual 'pathology' and request 'anger management' or 'parent training'. We would draw on systemic ideas (see Chapter 4) and invite family members to think about the effects of events upon relationships (e.g. 'How does the temper affect the way you both get along?' 'To what extent does arguing about how much Janet eats stop the two of you having fun together?') In mapping the effects of the problem in this way, attempting to uncover how it exerts its power and exposing its strategies, the practitioner's stance is more akin to that of an investigative journalist than that of a therapist. These ideas can be blended with narrative approaches which would plot the influence of a problem in a way that aims to disentangle it from people.

Throughout such interviews, clients are asked to make evaluations, even when it may seem pretty obvious how they might respond. For example, one might ask, 'When you managed to count to ten and not lose your temper that time, how did that turn out for you and your Mum?' If the reply was, 'Oh it was much better when I did that', this would be followed by an invitation to justify the evaluation, by asking, for example: 'How was that a good thing for you?' 'What good effects did you notice?' 'Good in what kind of way?' A sensitive and careful monitoring of the clients' responses is required here. What kind of questions do they prefer? How do they like to talk? What images or metaphors do they respond to?

Narrative practitioners aim to be particularly alert to the actual words and phrases clients use.

Conversations with Janet and family members might focus on who expresses a preference for change and what kind of change they prefer. This is important, as family members and professional systems are likely to have very different stories about these issues. Professionals commonly hold quite clear views about what 'needs' to change and make referrals with this in mind, sometimes without much regard for the wishes or preferences of parents and children. Narrative practitioners would aim at developing stories that do not blame anyone in the family or professional system. However, finding out how children and parents would like things to be, without assuming that their preferences will match ours, is essential to successful work.

The next steps in these therapeutic conversations might include a chance to explore unique outcomes, for example, how close the family have come to seeing their preferences enacted. These might include times when the arguing did not have such a negative effect on their relationships; or when Janet was able to give herself more nourishment; or when, despite their alleged history of 'lack of bonding', they had a good time together. We would explore these unique outcomes and consider in detail how they happened.

In work like this with parents it is often important to identify common unhelpful dominant stories which occupy prominent positions in our culture such as 'child blaming', 'parent blaming' or 'mother blaming', some of which may originate from the 'psy' disciplines (see also Chapters 4 and 6). It can be helpful to develop stories that counter these viewpoints.

### **Externalisation**

Possibilities for externalising something that both Mary and Janet could identify and join forces against include the Fears, the Temper, the Arguing, the Not Eating, the Conflicts between Mary and Janet, and so on. Finding imaginative names for problems to be externalised can also be fun for all family members.

In a narrative approach it is not just one person's job to tackle a problem; a team of co-workers needs to be recruited. Team metaphors raise questions of how the team will be led, work together, practise, communicate, stay focused and develop common tactics. These kinds of concerns can be an antidote to the fragmentation



seen when the problem can appear to get in between people and disrupt their working together. Moreover, such an approach can enable the separation of person from problem. So, one option is to invite the family to consider themselves as a team fighting an external problem together. The therapist can discuss with the family what might be achieved if it was possible for everyone to agree on some goals and work together, harnessing the strengths of all. This can help them develop ideas about alternative possibilities for themselves that may have been less visible to them when they felt so entangled in the problem.

Since an aim of narrative therapy is to change the direction of the traffic away from where the problem has all the power and calls the shots, individuals can be helped to find the resources to have more influence of their own in the direction of their choosing. One potential resource here might be Mary's strong interest in spiritualism and clairvoyance. We could invite the family to say something about how these notions influence their lives in positive ways. It may well be that these notions are rooted in the rich history of Romany tradition and that there are significant people, alive or dead, who could be talked about in re-membering conversations.

There are obviously countless ways in which therapeutic conversations may develop, but for the purposes of this chapter we have put together a letter that might be written to Janet and her mother as part of a narrative approach. It would usually include many of the actual phrases used by the family. Since letters are not always helpful, it is essential to discuss with families how they might feel about being sent one, and afterwards what it was like to receive it.

Dear Mary and Janet

When we met today we agreed to write to you to record some of the things we talked about and wanted to remember. It would be great if you could tell us what it was like getting this letter.

We both admire the commitment the two of you are showing, trying to work out some of the difficulties. You have demonstrated that you are not willing to let your relationship slip away from you and that you are determined to win it back.

We wondered what it was that made you both feel the relationship meant so much to you. You told us what a difficult start in life you had together. It would be hard to list all the

setbacks you had, but there were many. You, Mary, felt very guilty at how the sadness and depression got in the way of you being with Janet in the way that you wanted to be when she was very young. Guilt made you feel that the violence which you experienced at the hands of Colin was your fault, rather than *his* responsibility. Despite this, you have not lost sight of how you would like things to be. Some people would have given up and lost hope by now, but something seems to have kept the hope alive for you. We were really curious about that and wondered what that could be.

It was also quite striking to see how you, Janet, had made a decision to stay in touch with your dad but not to stay over-night anymore. We wondered how you found the courage to make such a big decision to take care of yourself. This also questions the idea (which you had heard from others) that you weren't able to look after yourself, wouldn't you say? We have talked quite a lot about how the arguments seem to overshadow everything in the house sometimes. You said it was like a big fat rain cloud, didn't you, Janet?

You both said very clearly that that's *not* how you want it to be. You, Mary, said you'd like to see the sunshine again and you agreed with that, Janet. We were delighted to see some sunshine in our meeting when you were able to hold hands at the point when you were both feeling upset. Did you notice that? Is that a sign of the sunshine you'd like to see more of?

When we started to look closely at your lives we thought there were quite a few shafts of sunlight that crept in, like the way you laugh together when you watch your favourite TV programmes and how you enjoyed your day trip to the seaside a few weeks ago. You both seemed to start noticing the sunshine in your lives more than the rain cloud by the end of our meeting. Was that a good thing, do you think? We can't ignore the rain cloud but we wonder what the effects would be if you were able to team up together and notice the sunshine more?

If you thought it was a good idea, you could both try to do that and we could talk about how you got along at our next meeting. We'd be interested to hear what your lives would be like if you were able to bring in more sunshine.

Best wishes

Dave Spellman and Dave Harper

## Reflections

We have discussed some of the ways in which therapies influenced by social constructionist and post-structuralist thought, like narrative therapy, might approach formulation. However, there are some wider issues that need to be addressed in using these approaches.

### *The need for critique and debate*

There are a number of cogent critiques of approaches like these. From a theoretical viewpoint, Danziger (1997) has argued that these therapies run the risk of the ‘new wine, old bottles’ syndrome in that new therapies assimilate critical ideas but do not fundamentally alter practices developed in a more modernist time. Indeed, Smail (2004) notes how they appear to sit very comfortably in many mainstream journals and training programmes. He has warned of the dangers of a naive social constructionism and ‘magical voluntarism’ which assumes that people can simply re-story their lives at will.

A recent survey of narrative practitioners in the UK noted that many of them were attracted to this work because of its stance on social justice, but that some of the more counter-cultural practices like using outsider-witnesses were not rated as important (Wallis 2003). It is perhaps no surprise that most of these practitioners worked in statutory settings as opposed to private practice. Both David Epston and Michael White have independent practices in the mixed state/independent health systems of New Zealand and Australia which might conceivably offer more freedom for these kinds of approaches. There is always a danger of new ideas becoming assimilated into traditional forms, thus becoming ameliorative rather than transformative (Prilleltensky and Nelson 2002). We would like to see more debate and critique within the narrative and social constructionist therapy community (Harper and Spellman 2002) and even some irreverence and humour (Harper and Smith 1995).

We are not purists in our use of narrative approaches, preferring to attempt to integrate them with other traditions, but this is far from straightforward (see Chapter 7). John Burnham has made some interesting suggestions about achieving a theoretically and personally congruent approach (Burnham 1992; Burnham *et al.* 1994). Whilst models can help, we feel it is also important for

practitioners to develop a personal style that fits both them and their clients. This requires us to have continuing conversations with ourselves and others about what kinds of practitioner we would like to be.

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## Notes

- 1 Epistemology refers to the study of the nature of knowledge and the methods for obtaining it whereas the related term, ontology, refers to the attempt to discover the fundamental categories of what exists (Burr 2003).
- 2 Since the publication of McNamee and Gergen (1992) a number of other approaches which chime well with a social constructionist perspective have appeared: for example, Ekdawi *et al.*'s (2000) training manual, Sam Warner's visible therapy approach to working with sexual abuse (Warner 2000, 2001) and the contributors to Parker (1999).

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## Chapter 6

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# Social inequalities formulation

Mad, bad and dangerous to know

*Joe Miller and Lynn McClelland*

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### What is a social inequalities approach?

The relationship between social inequalities, health and mental health has been extensively documented in national and international health and social care policy reports (Bates 2002; Department of Health 2003a, 2003b) and in service user consultations (Morgan *et al.* 2001; Sashidharan 2003).

Despite a number of attempts to call attention to these links within clinical psychology (Williams and Watson 1988; Kitzinger and Perkins 1993; Orford 1994; Fryer 1998; Hagan and Donnison 1999; Williams 1999; Patel *et al.* 2000; Bostock 2003, 2004; Smail 2004), this perspective remains peripheral to clinical psychology theory and practice (Boyle 1997). This is also the case for mental health services generally, and mental health workers within them (Williams 1999). Clinical psychologists are still likely, therefore, to be working alongside other mental health professionals in settings that are 'unsafe, ineffective, oppressive and wasteful of human and financial resources' (Williams 1999: 29), where the reproduction of inequalities within the services themselves is commonplace.

There are many different possible definitions of inequality and a number of psychological perspectives that attempt to address the intersection between the person and oppression, for example, critical, community, narrative/social constructionist, and feminist approaches. Indeed, as Orford (1994) has pointed out, this cross-disciplinary aspect of a social inequalities approach is both a strength and weakness in terms of coherence and depth of formulation. We have found the following definition helpful:

Social inequality exists when an ascribed characteristic such as

sex, race, ethnicity, class, and disability determines access to socially valued resources. These resources include access to money, status and power, especially the power to define societal rules, rights and privileges.

(Williams and Watson 1988: 292)

It is possible to develop a working model of the impact of social inequalities on mental health from this definition, which may help us articulate the processes through which people experience and resist the operation of inequality in their lives. An example of the model that has informed our formulation approach is given in Figure 6.1.

The assumptions behind the model in Figure 6.1 are that social inequalities are structured differences or hierarchies of power that limit and constrain some and privilege and empower others, thereby creating and revealing conflicts of interest. This perspective has more in common with Marxist, Weberian or social constructionist models of society than the more traditional individualised accounts of drives, motives, intentions or internal conflicts dominant within psychology and psychotherapy. The unequal distribution of economic and social resources in society is central to explaining why certain groups are more likely than others to seek help from psychological services (Fryer 1998). Unfortunately, as has been documented many times, it is 'low status' groups who also experience the most negative and disempowering contact with services (Morgan *et al.* 2001; Department of Health 2003b).

A further consequence of this model is that it becomes necessary to create ideologies or dominant discourses that mask and legitimise these inequalities, in order to avoid disrupting relationships and the smooth operation of societies and to sustain established power balances (Thompson 1990; Williams 1999). Mental health professions and disciplines such as medicine and psychology are seen as key sites for the production of such discourses (Foucault 1980; Rose 1989). The institutional context of clinical discourses is the 'clinic' in its broadest sense, which shapes and is shaped by what can and cannot be said. This is part of a historical process of the development of ideas about madness/normality, and a co-dependency between mental health professions and marginalised groups (who treats/who is treated). From this perspective, it can be argued that in formulating we are located within a process of social control which has shifted away from overt forms of extended incarceration and

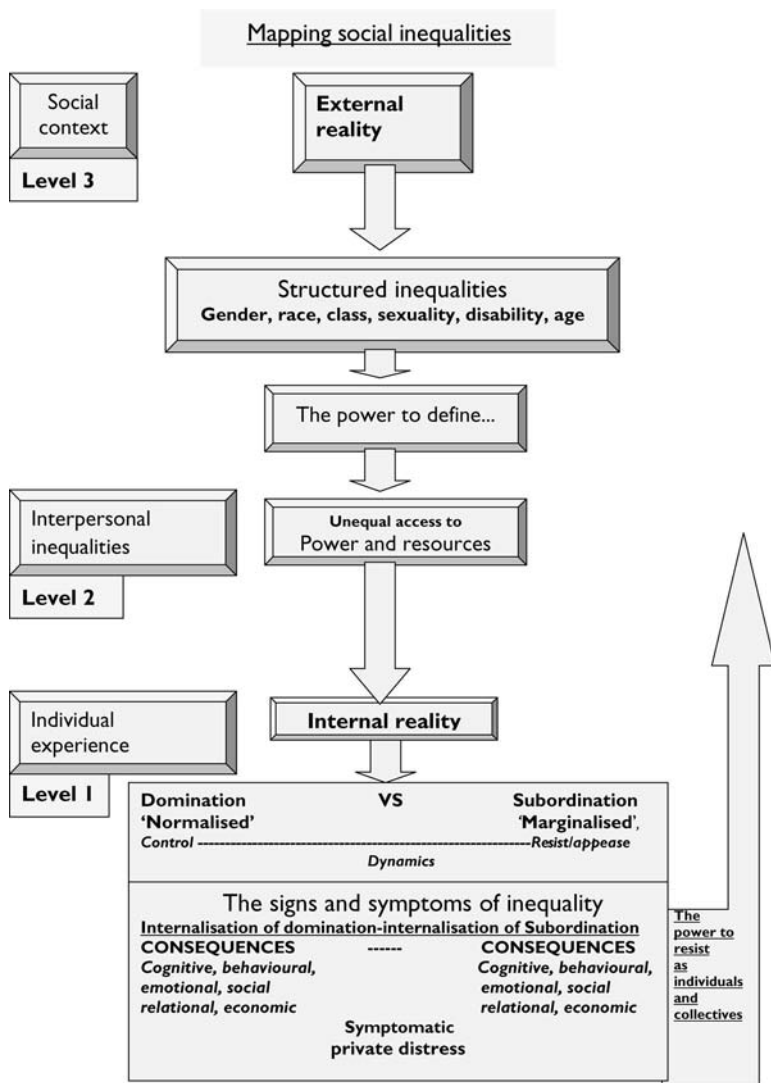


Figure 6.1 Working model: mapping social inequalities.

the more brutal physical treatments towards subtler forms of control such as the processes and technologies of diagnosis, medication and therapy, but continues to serve the same ends.

Consequently, a social inequalities formulation places emphasis on certain assumptions: the socio-political context of mental health, the operation of power, and the interaction between social structure and individual agency. This approach recognises that people are not passive in the face of trauma and oppression, but engage in 'counter-power practices' or resistances (White 2004). These in turn tend to get minimised, silenced and resisted by others, leading to perceptions and beliefs about failure, blame and victimhood, and eventually to mental health problems.

Formulation within this model is carried out at various levels of analysis from the individual to the collective, with the aim of steering a course between the two dangers of presenting people as either passive victims of oppression, or heroic agents of change. As feminist practitioners have suggested, a coherent approach must deal with the individual, subjective and embodied impact of social inequalities (e.g. impact of abuse leading to self-harm). It is possible, as Bostock (2003: 36) asserts, to formulate problems and generate explanations that reveal how subjective individual experience is 'embodied through the powers and resources with which we are socially invested'. These are inextricably linked with our social class, physical build and race and gender (Smail 1996). We are influenced by the mediation of these processes through our relationships with important others (e.g. by the ways in which parents and partners handle power differences, and by the transmission of ideas and feelings from adults to children).

A social inequalities perspective is also part of a wider challenge to the cultural dominance and status of western individualism (Rose 1989; Fernando 2003). For instance, it involves naming the effects of social inequality on men as well as women, on white as well as black, on heterosexual as well as lesbian and gay clients. It also involves identifying the processes whereby distress becomes normalised and accepted. This may lead to creating new languages of experience, or appropriating old ones – hence we talk about the 'signs and symptoms' of inequality (Figure 6.1) as a deliberate attempt to make conceptual links and disrupt the common use of these terms to define distress in terms of a medical model.

A social inequalities perspective may also embrace diversity approaches that attempt to value difference and produce specific

context-sensitive formulations (e.g. for black people's experience of psychosis or for gendered experience of depression or abuse). For instance, the devastating psychological consequences of experiencing individual and institutional racism as a member of an ethnic minority community have been documented repeatedly (Patel *et al.* 2000). The development of powerlessness, helplessness, the formation of negative identities, and the need for resistance must therefore be central to our formulations in such situations:

For the therapist, the task in hand is to explore this context and presenting issues, whilst also identifying the strengths and resources of a client/family, ultimately in an effort to empower them to live in a world which may be experienced as constantly seeking to disempower them.

(Patel *et al.* 2000: 24)

An understanding of gender as one of the key structuring tendencies within social relationships, and therefore within mental health problems as well, is integral to this approach to formulation (Williams and Watson 1988; Ussher and Nicholson 1992; Kitzinger and Perkins 1993; Burman 1994; Miller and Bell 1996):

There is abundant evidence that women and men are positioned differently in our structures, are constructed by very different discourses and have very different experiences of the world . . . [so] it is stretching credulity to assume that these differences have little impact on the problems brought to clinical psychology.

(Boyle 1997: 237)

Finally, the impact of multiple sources of inequality is recognised as a 'risk factor' for mental health, and a common element in service user accounts. Further research and theory development are needed to create formulations that capture this complexity (e.g. the interaction of gender and learning disabilities on mental health; the impact of higher rates of unemployment and poorly paid employment in black and minority ethnic groups; access and sensitivity issues for older, lesbian and gay clients; class-based assumptions and language, etc.) and to make links with severe and enduring mental health problems. For instance, the Women's Mental Health Strategy (Department of Health 2003b, 2003c) has identified

particularly vulnerable groups: women from black and ethnic minority communities, mothers/carers, women who have experience of violence and abuse, women diagnosed with personality disorder, and so on. A men's mental health strategy might do the same.

## **Formulating within a social inequalities model**

### ***Formulating power***

It was through attempts to diagnose, conceptualise and regulate pathologies of conduct that psychological knowledge and expertise first began to establish its claims for scientific credibility, professional status and social importance.

(Rose 1985: 226)

These professional and academic aspirations are often achieved through the invalidation of whole areas of human experience, usually that of socially marginalised groups. Banished from the mainstream discourse, representations of experiences of inequality become problematic, pathologised or silent. Smail (1996, 2004) has helpfully reminded us that therapeutic practice should acknowledge its limitations in order to avoid omnipotence and a kind of 'magical voluntarism' (Smail 2004: 11), or the notion that recovery from mental health difficulty is simply an act of will-power or choice on an individual's part, regardless of whether the causes of it are accessible or not. Empowerment of poorly resourced groups and individuals in a finite or limited resource environment such as the NHS, implies disempowerment of powerful others, and is therefore unlikely to be a comfortable or smooth process.

The oppressive and often hidden nature of power processes is evidenced in the high rates of sexual, physical and emotional abuse present in the histories of people who develop mental health problems (Department of Health 2003b, 2003c). Formulation from a social inequalities perspective allows a central place for abusive experiences as a particularly invasive, personal and widespread form of power process.

### ***Theory–practice links***

A social inequalities perspective takes a particular approach to the current emphasis on evidence-based practice within clinical

psychology, medicine and other disciplines. This involves a recovery or archaeology of bodies of theory and practice which tend to be obscured or marginalised (Boyle 2002; Smail 1994). Much of this evidence lies within social psychology, feminist theory and a 'critical' approach to the widespread adoption of a 'metaphorical medical model' (Boyle 2002: 233) within the mental health professions. A social inequalities perspective disrupts the notion of an objective, socially neutral investigation which is inherent in the scientist-practitioner model.

Various attempts have been made to develop theories of mental health experience that derive their 'knowledge base' from an experientially contextualised perspective (e.g. Holland 1992; Romme and Escher 1993; Walkerdine 1996; Coleman 1999; Melliush and Bulmer 1999; May 2000). Currently, theories grounded in the experience of particular service-user reference groups are gaining in popularity (e.g. Coleman 1999; Faulkner and Layzell 2000; Department of Health 2001; Copeland 2002; Fernando 2003).

### ***Guidelines on formulation***

As Prilleltensky and Nelson (2002: 26) have recommended, a critical approach to formulation should involve reflection on the value base as well as the evidence base. They provide some helpful questions we might use to develop a formulation:

- What ideas of a 'good life' and 'good society' are promoted by our formulations (self-interest or cooperation? based on pursuit of equality or at the expense of others?)?
- Do they lead to interventions that are purely intrapsychic or do they involve social relations and systems?
- Are they pro-active (timely, preventative) or only applicable after damage has occurred?

This involves a challenge to individualistic explanations of the origins of mental health problems and relocates responsibility for oppression and change. These questions also highlight issues of ownership of the problem. In other words, we need to ask: Whose problem is this? This line of questioning should encourage increased client/user feedback and interaction with the practitioner so that formulation becomes a shared responsibility. Bostock (2003: 38) has suggested that in addressing power we ask:

- What forces are and have been at work in this person's life so far?
- How has this person dealt with diverse demands?
- How have they gained power/agency in any domain?
- How can this person's context contribute to change?

Similarly, Prilleltensky and Nelson (2002) focus on:

- Who has power in relationships?
- Are there attempts to share power?

Many of these questions are allied to a narrative approach to formulation. Foucault (1979) drew attention to the all-encompassing nature of power as well as its fragility under certain conditions. We should look at how public discourses and private conversations can strengthen or damage us, for example:

- What discourses are at work in this case?
- Are new discourses being created, for example, of 'disenfranchised men', 'teenage mothers', 'new lad culture'?
- Are old ones reappearing, for example, the impact of working mothers on child development?

More recent theories of power emphasise the mobility and distribution of power. This equally implies the creation of new resistances and strategies for survival that people and groups develop. We hope to show how these are at work in the lives of Jack, Mary and Janet.

## **Jack: a social inequalities formulation**

### ***Mad, bad and dangerous to know***

This section explores Jack's life story and his struggles from a social inequalities perspective. Before we consider what this means and how it may help us understand Jack or inform our role, it is important to recognise how little we can do without Jack's personal involvement and participation. It isn't Jack telling us about himself. It isn't Jack who appears to be directly involved in the process of making sense of his predicament. Within 'expert' models of therapy the emphasis is on the knowledge of the therapist to make sense and bring order. Within 'decentred' therapies such as narrative therapy



it is Jack who is at the heart of his own story, and Jack who is the expert on his own life. This cautions us not to complicate Jack's already tenuous feeling (one supposes) of ownership over his own life with well-meaning but potentially oppressive narratives.

Furthermore, it is likely that as a mental health service user Jack will already have been subjected to medicalised, pathologising accounts about his difficulties, and that his own account of his experiences will have been ignored except as an indicator of various symptoms. One need only look through the often voluminous notes regarding the treatment and care of mental health service users to confirm the detachment of the 'person' from the 'story'. The psychiatrising or psychologising of distress can achieve this separation very easily with people already made vulnerable by distress, confusion, and hopelessness. Clinical formulation runs the risk of simply being another 'expert' dialogue which, in the attempt to obtain clinical coherence, locates the centre for recovery at arm's length from the person, adding to their experience of objectification and alienation, and complicating genuine therapeutic engagement. Clinical formulation must therefore demonstrate its credentials in terms of how the service user experiences it. In particular we would ask: How participatory is the process? How well is it rooted in the person's own experience and beliefs? So, for these reasons we are uneasy about having this conversation about Jack, without Jack.

We thought we would take this problem to a 'reference group' of young men whose life experiences seemed to us (and them) to provide some basis for informed 'witnessing' of some of the themes identified in the account about Jack. These young men had all encountered mental health services, had all experienced alienation, and had all been subjected to abuse in one form or another. They all had many other kinds of experiences too, not to mention a diverse range of talents, interests and hopes for their lives. We can only hope that Jack would have shared in this sense of commonality. This idea is different to the narrative therapy technique of a reflecting team in terms of its membership being non-professional, although in this case a summary is provided by a male clinical psychologist (JM). The conversation that unfolded helped us to identify some key issues and themes. What follows then is a limited piece of speculation/interpretation about the themes that are raised by the conversation, rather than very specific to Jack.

*(Jack, paragraph 1, p. 12)*

#### DISCUSSION

The descriptions of Jack drew interest. Several of the young men shared their experience of having their emotions ‘measured’ against some invisible norm. A medicalised context allows this, and reserves the right to determine ‘appropriateness’ against a template of signs and symptoms. The quantifying and objectifying of expressed feeling can obscure the simpler question of why? Why is Jack feeling what he is feeling?

We begin with the assumption that feeling is meaningful and valid even if it is not obvious, initially, in what ways. However, Jack’s tears seem clear enough.

*(Jack, paragraph 2)*

#### DISCUSSION

Several young men identified with the theme of social and familial expectation. This led into an interesting discussion about the privileges and burden of being ‘favoured’. People spoke about the costs of compliance in terms of giving up your own ambitions, and the costs of resisting, such as rejection or censure or further pressure. One young man said that as the only son he had felt this pressure of expectation as a ‘heavy hand on my shoulder’ and that, looking back, the only means of resistance was to fail. Several in the group also enjoy music and wondered if this put Jack in conflict with the expectation of running the family business.

*(Jack, paragraph 3)*

#### DISCUSSION

This provoked considerable discussion amongst the group. One man commented: ‘A few lines about a world of trouble’. Does this reflect the tendency of mental health services to minimise the impact of either witnessing or experiencing violence, or being subjected to sexual abuse as a child? The group identified similar experiences in their own lives and the often ruinous consequences for them.

*(Jack, paragraph 4)*

#### DISCUSSION

The group quickly noted the chronological proximity between sexual abuse and the emergence of alcohol use. Many of our young men identified with the use of alcohol and drugs as a seductive means of 'self-medicating' distress. Other possible factors were identified:

- Stresses associated with GCSEs.
- The fact that Jack also has to contend with the breaking up of the family, his parents, and the disappearance of his father back to Italy. Perhaps it was his gender as a man that made his father's departure more difficult for Jack than for his sisters.
- The group speculated about the period leading up to the separation. How emotionally available would Jack's parents have been to Jack and his two sisters? Several, perhaps like Jack, had not felt able to disclose their abuse because they felt they wouldn't or couldn't be heard.

*(Jack, paragraph 5, pp. 12–13)*

#### DISCUSSION

One or two of the young men spoke about having lived through similar periods in their own lives. They described these times as like being 'lost to the world', feeling uncared for and not caring for anything or anyone, least of all themselves. One said, 'Someone should have seen that being depressed isn't just about your head, but your life; they didn't for me and they didn't for him.' Many, though not all, described their first contacts with mental health services as like 'confirming all the worst things you thought about yourself'.

*(Jack, paragraph 6, p. 13)*

#### DISCUSSION

The whole family now appeared to be struggling. Our group thought that Jack was sounding in desperate straits at this stage.

The diagnoses Jack was attracting are more serious, with more power to label Jack negatively, and yet, our group felt, were still missing the point of what may have been going on for him. Some observations were: 'He wants out of his life.' 'He sounds like he's really lost it, he just doesn't want his life anymore, he wants Robbie's life.' 'Is he worrying about his family? His sisters? Does he feel bad because he hasn't helped them?' 'He is really haunted by his father.' 'He'd rather be Robbie than his father, maybe? Well, he needs to be someone! But who?'

We have identified the main sources of inequalities in Jack's case in Figure 6.2. We now will consider in more detail the themes that emerged from the discussions above.

### ***Masculinity***

Masculinity, the experience of being born male, of trying to learn how to relate to himself and the world as a male, seems to play a significant role in several key areas of Jack's life. In relation to his father: 'He described the frightening experience of looking in the mirror and seeing his father's face reflected back at him.' Jack is exposed to his father's alcoholism and his violence towards his family and towards Jack himself. Jack was also expected to carry on the family business, literally, to follow in his father's footsteps. These experiences form part of Jack's socialisation and introduction to masculinity.

More specifically, we wonder if Jack has learned the male-typical strategies for managing distress. Miller and Bell (1996) and other writers (e.g. Baker-Miller 1986; Thomas 1993; Collins 1998) argue that the privileged male role imposes expectations about masculinity that may have a serious detrimental effect on the mental health problems of men and the women and children in their families. They argue that one of the most pernicious consequences of masculinity is the injunction about emotional entitlement. Successful male socialisation requires men to be silent and strong, leaving individuals little scope to acknowledge and deal constructively with feelings of vulnerability or powerlessness. Instead, men are offered safety through dominance and control of the external world, and survival through the sanctioned means of violence. Does Jack learn that this is how men manage their distress – through objectifying others and through violence and alcohol abuse? Does Jack feel 'caught' between his family and his father? Does Jack identify with

**Social context (level 3)**

- Cultural factors: dislocated, immigrant family from Southern Italy, lower socio-economic class
- Marriage as an institution: traditional gendered divisions of labour
- Psychiatry: dominant medical discourse for mental health problems
- Homelessness
- Social and economic context of living life as a single-parent family
- Access to housing, employment
- Community resources, e.g. domestic violence, young people's projects

**Interpersonal inequalities (level 2)**

- Father-family: domestic and family violence, alcoholism
- Father-Jack: male socialisation and affiliation, paternal expectation, paternal denigration/rejection
- Estranged father: only remaining male with three younger sisters and mother
- Divorce and separation: leads to family impoverishment, dislocation, and further exposure to exploitation and abuse, e.g. burglary and harassment
- Sexual abuse by a male in position of relative power. Absence of protective relationships or someone to confide in
- Psychiatry and mental health services: emphasis on diagnosis, avoidance of meaning, expert position, diagnosed, labelled, initially as 'depressed', then variously as 'paranoid', 'persistent delusional disorder', medication

**Individual experience (level 1)**

- Distress mediated and shaped by masculinity
  - distress expressed indirectly
  - protest and resistance also expressed indirectly
- Signs and symptoms of inequality: signs of resistance and protest
  - going 'off the rails'
  - fails GCSEs, petty theft, violent confrontations with mother
  - alcohol and drug abuse
  - unable to speak of abuse experience
  - periods of homelessness
  - unable to sustain employment
  - alienation from significant others
  - beliefs about self and others
  - emotional and mental states (seen as deviant 'depression, paranoia, delusions')

Figure 6.2 Mapping sources of social inequalities for Jack.

his disempowered, female, victimised family? Does he also crave acceptance and inclusion from his father? We might speculate as to whether Jack experiences himself as alienated from both, a member of neither. He may experience his father as powerful, but it seems that Jack experiences himself as powerless. Jack is left to somehow reconcile the disparity between the expectation of dominance and the actualities of his life.

This dilemma is dramatically and seriously compounded by Jack's sexual abuse by another male in a position of power in relation to him. That Jack was silent about this is unremarkable. In a review, Watkins and Bentovim (1992) suggest that the under-reporting of sexual abuse is consistent and universal. Within the terms of masculinity the consequences of assault are compounded by a form of psychological emasculation, literally implying a loss of power, gender, and the failure to be a man (McMullen 1990). For Jack this occurs at a highly critical and vulnerable period in his life. The man in question could have made a huge difference to Jack, by taking a fatherly interest in a vulnerable boy. Instead, his vulnerability was exploited. Jack, as we know, did not disclose this to his parents at the time, and is barely able to mention it subsequently.

### ***Delusions, lies and stereotypes***

The deconstruction of Jack's diagnosis ('paranoia' and 'delusions') is an important component of our formulation, as are attempts to increase his agency within the context of a service arranged around 'a focus on pathological individuals rather than pathological social structures' (Boyle 2002: 233). Given this context, it is especially important in considering Jack's situation to pay attention to the iatrogenic effects of contact with mental health services that tend to retraumatise and reproduce inequalities (Lindow 1991).

We have tried to focus on experience, not symptoms, using thick not thin descriptions of people's lives (White 1995). Whether we have succeeded in avoiding reductionism can, perhaps, only be judged by Jack himself. Our formulation has sought to avoid 'vocabularies of deficit' (Gergen 1999). Jack has been diagnosed as, not is, a 'delusional schizophrenic', so we do not imply a consensus or objective reality that is in fact highly debated (Johnstone 2000; Harper 2001; Boyle 2002). This approach recognises that diagnosis and formulation are relational processes involving power imbalances. A response that renders his behaviour insane/psychotic, or 'beyond the pale', would confirm his process of alienation, and contribute to the 'loss of myself' already set off by the experience of multiple trauma (White 2004).

The initial and primary focus is not on the removal of delusions. Rather, the beliefs Jack holds are accepted and meaning is co-constructed. The 'delusions' are re-framed as a positive, active

coping strategy that works to keep him safe at the moment. The confusion over reality in Jack's case relates more to the feeling that there has been a 'cover-up' on many levels in his life, than to an organic disease process. There have been many times when he had to lose himself to survive and contort himself to fit with others' actions. Real threats and persecutions to abused children, and consequent fears of dying, are common tactics of abusers. When compounded by secrecy and the sanctioning of emotional expression due to social stigma and taboo, this creates still further potential confusion. So a belief that 'I mustn't go out – I might get attacked' is embedded within a real experience of lack of protection and exploitation in the world. It is not a figment of Jack's imagination, nor a dysfunctional belief, but rather an attempted solution to real-life conditions.

If we do not assume the discontinuity between normality/abnormality that so much of mental health practice seems to rely on (Thomas 1997), we minimise the development of otherness or 'them-and-us' thinking (May 2000) that is characteristic of so many practitioner–client relationships. In positioning Jack as 'delusional' and 'paranoid', we position ourselves in contrast as sane, balanced and informed. Jack is then forced into a false choice between 'I am wrong' or 'the world is wrong' that mirrors and exacerbates these dynamics.

In contrast, as social constructionists, we are more interested in making sense of Jack's so-called 'delusions' in terms of his local and cultural context, than in categorising his experience to fit with particular diagnoses. We do not have to look far to see the potential for empowerment and recovery in an alliance between Jack and Robbie Williams, a powerful collective cultural icon of contemporary masculinity representing success, a rags-to-riches journey (a working-class hero who has proved the existence of social mobility), potent sexuality, and musical creativity. Jack's choice of 'delusion' is not random or meaningless, and provides a positive contrast to other male role models in his life. Nor is Robbie such an idealised image that Jack is unable to relate to him. Robbie is known for his own struggles with substance abuse, sexuality and pressure. Similarly, Jack's preoccupation with 'stolen money' and 'money owed' has deep resonances with a sense of social justice and the profound impact that socio-economic decline has had on his life. He is owed something, a lot has already been taken away from him. The world needs to give him back something he has lost.

In common with many other victims of abuse and domestic violence, Jack can be seen as having been socialised into a hierarchical victim–perpetrator model of social relations. He anticipates the possibility of causing sexual harm and appears stuck in a traumatic process commonly seen in abuse victims (Baker and Duncan 1985) where the potential for abuse and revenge, and ultimately a repeat of the violence he experienced, can become a paralysing preoccupation. Jack may be influenced by a dominant discourse that is widely held both outside and within mental health services, despite research that shows that victims are at least as likely as not to abuse as become abusers themselves (Hester *et al.* 2000). In dwelling on these fears he inadvertently draws attention to the denial of social inequalities and power processes that are so central to abuse.

Sources of resistance for Jack are clearly to be found within the survivor and service user movement, or clinical approaches that encourage the ‘transformative’ (where emphasis is placed on meaningfulness and creativity, e.g. Mad Pride, the Hearing Voices movement, the Survivor movement, Experts by Experience groups), rather than on the accommodative (where the emphasis is on resignation and disability). Jack’s passion for music appears to us to be a major resource and a possible source of creativity and resistance, part of his self that feels OK, pre-disempowerment, free, able and whole. This may contain potential for a redefinition of a positive male role. Significantly, when we created a local space for young men experiencing psychosis in our clinical work, their chosen means of connection was music rather than talk.

### **Janet: a social inequalities formulation**

Space does not permit us to describe a reference group for Janet and Mary, although Appleton *et al.* (2003) provide us with a relevant example in the form of a consultation with a group of Gypsy and Traveller women. However, we can outline the themes that we would consider important to a social inequalities formulation in this situation.

First, there is a fundamental ‘risk of being’ for women presenting to services with experience of oppression (Ussher 1991; Beckwith 1993; Chesler 1994; Williams 1999) where their thoughts, feelings and behaviour are highly likely to be interpreted as ‘madness’ or ‘badness’ depending on whether they encounter psychiatric or



social care institutions. Second, as Walkerdine (1996) asserts following her analysis of dominant discourses within sociological and psychological literature, women are present in discussions of disadvantaged or 'working-class' women in Britain primarily as a mother:

a mother who must be watched and monitored at all times through the available medical, educational, social work and legal apparatuses because she is seen as the relay point in the production of the democratic citizen. It is she, above all others, who will obey the moral and political order and not rebel.

(Walkerdine 1996: 146)

This, she argues, has led to a mode of regulation through psychology which targets groups of women, particularly mothers, and ascribes them the role of reproducers of social pathology (e.g. through faulty or damaging child-rearing practices, or failure to bond). At the same time, any attempt to engage seriously in the psychological effects of their oppression is avoided. This dynamic is even more likely to be present when mothers have lived experience of other kinds of difference – mothers from minority groups, lesbian mothers, teenage mothers, older mothers, mothers of sexually abused children, etc. These 'soft forms of regulation' are in operation in a wide variety of institutional settings (e.g. social services), and particularly within mental health services (e.g. child and adolescence mental health teams), where subjectivity and development are only understood in terms of normality or pathology, as applied to children or mothers.

Thus, in the case of Mary and Janet we would want to recognise the ideological function of much of research and practice which claims expertise about motherhood, often from a white, male, middle-class vantage point. Instead we would be searching for grounded, contextualised evidence where attempts are made to consult and put mothers themselves in a central position. One complication that arises from this suggestion is that 'the anxieties and projections onto them, which are entailed in their regulation, will be present in their views of themselves and their own insecurities' (Walkerdine 1996: 152) For example, they may have internalised views of themselves as stupid, sexually damaged, or inadequate mothers. This does not need to be conceptualised as a straightforward process of internalisation by a passive subject, but can be

seen as the outcome of a long historical practice of survival within deprived material conditions and in defence of the myths and fantasies of dominant oppressive groups. Formulation would therefore need to take this into account.

One way to do this is through the deconstruction of diagnoses and pathologised accounts of motherhood (Woollett and Phoenix 1997; Van Scoyoc 2000). There are a number of power processes that may be operating in Janet and Mary's case: first, Mary being 'captured' by medical diagnoses, a traditional way of concealing social inequalities by pathologising and medicalising women's distress (Ussher 1991; Woollett and Phoenix 1997). Second, there is the obscuring of the impact of domestic violence on both Mary and Janet, which is perhaps being played out in Janet's night terrors, aggression towards her mother, and eating problems.

We might hypothesise that the formulation of Mary and Janet so far is likely to be influenced by mother-blaming discourses (Woollett and Phoenix 1997), the double-bind of traditional motherhood roles within heterosexual relationships (lack of power and access to resources combined with full responsibility for childcare; exposure to violence; lack of childcare support; the psychological and emotional costs of caring), and the absence of accounts of fathers' influences on relationships and development of children within families. As is typical of many referrals to CAMHS services, the gendered nature of clinical discourses about families remains unquestioned. We might ask why there is ongoing unsupervised contact with an abusive father when there are many personal accounts as well as established research pointing to the risk of further harassment for Mary, and abuse for Janet (Hester *et al.* 2000).

Janet's hidden and internalised distress is characteristic not only of being a girl, but also of being a child witness to domestic violence. Boys' needs, although no less complex, may tend to be more evident in mental health services, schools and society as a whole, due to their tendency to act out distress in highly visible ways such as behavioural problems, youth offending, and so on. Similarly, the interdependence of mothers and daughters as a survival strategy in adverse conditions is unlikely to be valued, but will tend to be pathologised and measured against socially constructed western, gendered norms of separation and autonomy. In extreme cases there may even be a diagnosis of 'Munchausen's by proxy' syndrome. The relational needs of women in services are recognised in

the recent women's mental health strategy (Department of Health 2003b, 2003c). This might suggest the possibility of Cindy as a potential non-abusive co-parent, and the involvement of 'outsider witnesses' (White 1995: 26) within the Romany or local community. Mary could therefore be reframed as a 'surviving mother' and grandmother instead of a 'failing mother' as she appears to be in the referral. Mary's experience as a mother of older children, one of whom has special needs/disabilities (autism), would be an important part of her story, her sense of self and the skills that she could bring to an encounter with services.

### ***The socio-economic context***

There is growing interest in the development of grounded theories of family intervention (Department of Health 2003a) where greater emphasis is placed on broader social contexts. Korbin (2003), for example, highlights the contextual and multidimensional factors in child maltreatment, especially the influence of social networks, neighbourhood ties, and community connectedness: 'While child maltreatment is in its most proximal sense an individual act of omission or commission, it is embedded in a larger context of family, neighbourhood, community, society and culture' (Korbin 2003: 137).

Smail (1993) has provided a model of assessment that could be used to look at the proximal to distal forces at work in this case by mapping sources of abuse and alienation. Neighbourhood rates of child maltreatment tend to be related to socio-economic factors such as demography, economic disadvantage, and residential mobility (Coulton *et al.* 1999). An ecological-developmental framework (Bronfenbrenner 1979) might be consistent with a social inequalities approach where risk and protective factors are recognised as existing at all levels, including local policy and planning issues, community and neighbourhood contexts, as well as interpersonal dynamics. In Gracia and Musitu's (2003) comparison of families in two different cultural contexts, families where abuse had occurred were less involved in local activities and held more negative attitudes towards the wider community. Abusing parents had smaller peer groups, less contact with families of origin, received less help from family relations, and felt more isolated in their communities. The existence and meaning of these kinds of subcultures is not necessarily picked up by mainstream services. Gracia and Musitu

(2003) described a process of 'social impoverishment'; an isolation from formal and informal sources of support so that some families do not use services even when they are available. There is potential for this kind of marginalisation in Mary and Janet's case.

This kind of marginalisation further obscures socio-economic conditions because of the tendency to stigmatise and blame the individuals and families who live in such areas. There may be a lack of child protection services, and a reluctance to recognise the extent of abuse and disadvantage and its impact on health and mental health problems. Sheppard's (1998) study in the UK has shown the influence of disadvantage, low income and lack of social support on the 'progression' of families towards social service caseness, and the link between disadvantage, abuse and depression amongst mothers on social service and health visitor caseloads, independent of pathways into care. Where social support and involvement of services was lowest, there was an increased risk of injury and neglect of children.

There are a number of cultural factors that also appear significant: dislocation from a Romany culture with a potential loss of rituals and meanings, and attempts to create new ones. A formulation would therefore include an attempt to understand the social construction of childhood, motherhood and fatherhood from a Romany perspective. Questions that arise from this are: Which cultures are informing the situation? What ties exist to other families in the area? What relationship does spiritualism have to the meanings created in this family?

The theme of mobility appears to be a dominant one in Mary and Janet's case. Lack of mobility, fear of using transport, and 'agoraphobia' as a metaphor of limited movement and power in gendered and cultural terms, may be relevant. Fatimilehin *et al.* (2000) have made some important points that we should consider in our formulation:

- The combination of factors in this case because of minority group status: multiple disadvantage regarding the power and dominance of mainstream cultural values, racism, harassment, alienation from professional discourses (Ghuman 1999). Generational impact of acculturation through assimilation, and the consequent dilution or disconnection from cultural history and heritage (Tizard and Phoenix 1993).
- Normative theories of child development: independence, separation, child-rearing practices.

- Formation of self-identity and racial/ethnic identity problematic.
- Disrupted life cycle and patterns of family organisation: rites of passage, conflicts, roles.
- Ethnic definitions of distress differing from mainstream: child abuse, bereavement, impact of racism, harassment denied.
- Migration effects and refugee status for families.
- Interaction with education system problematic: language, aspirations, stigma, achievement.
- Disconnection from alternative same culture support: foster families, birth family, placements.
- Culture-specific health problems: prevalence, coping skills, beliefs.
- Lack of specific provision for black and minority ethnic (BME) family support for parents with mental health problems.

We would also want to make a note of the many resiliences Janet shows: for example, her enthusiasm for school, her sociability, and the family's spiritualism as a potential connection to the past.

Practitioners should be able to work with difference (Patel *et al.* 2000), and the cultural competence of services is increasingly becoming important. We would want to explore family belief systems and meanings through, for example, the use of cultural genograms (cultural family trees; Hardy and Laszloffy 1995). We would also want to develop an understanding of the institutional inequalities (myths, explanations, racism) that are present. We would focus on qualitative assessments and seek the involvement of cultural consultants, outsider-witnesses, community groups or representatives to assist with the issues of cultural accountability (Tamasese and Waldegrave 1993). We could also explore the possibility of alternative interventions: spiritual and holistic, and a community base for delivery.

### **Formulation from a social inequalities perspective: some guidelines**

- 1 Attention to the co-construction of meanings and use of narratives. Exploration of diverse narratives within the account. Attention to language used. Placing the stream of individuals' accounts within the collective 'sea' of user-based narratives.
- 2 Mapping significant events and reactions across time; mapping

the social-individual dialectic to explore both personal impact and resistances/reactions to these.

- 3 Recognition of embodiment as a psychosocial process where oppressive practices become internalised and interact with identity formation.
- 4 Centrality of the client. Decentredness of the therapist, who offers non-expert 'solidarity' with the person, the emerging accounts of victimisation and the social plights that underpin these.
- 5 Making visible social realities and relevant social contexts (domains of life, structures, relationships, resources, processes (Hagan and Smail 1997a, 1997b)).
- 6 Attention to class consciousness, presence of ideology, dominant discourses that lead to obscuring of social inequalities.
- 7 Acknowledgement of resources, abilities, resiliences, survival strategies, counter power processes.
- 8 Naming of power processes and abuses. Creating of further opportunities for disclosure of abuse or other inequalities. Embargos on the expression of distress acknowledged and explored in terms of culture, gender, and personal narratives.
- 9 Naming of impact of social inequalities on the person and their attempts to deal with them. Making links with problem she or he names and the hidden and not so hidden realities of disempowerment that these speak of.
- 10 Deconstruction of symptoms/diagnosis: jettisoning of burdens, useless or disempowering concepts (abnormality, medical model) and reclaiming of ownership, power to resist, challenge, contesting and talking back to the ascribed diagnoses. Constructions of alternative models of distress.
- 11 Collaborative or participatory formulation. Does it promote peaceful, respectful and equitable process whereby people have meaningful input into decisions affecting their lives? Is client constructed as active/passive in this formulation? What does the formulation act upon? Does it promote respect for diversity (identities, meanings, actions)? Does it address issues of social justice?

## **Towards intervention**

Clearly, there is a menu of approaches that can inform a social inequalities intervention: narrative, feminist, gay and lesbian,

cultural/diversity, anti-racist, disability, critical and community psychology, to name a few. It could be said that a social inequalities approach attempts to unite a diverse group of methods. This leaves the practitioner with choice, complexity and decisions to make. As Prilleltensky and Nelson (2002) suggest, there are many different roles (therapist, researcher, consultant, planner, advocate, activist, etc.) that overlap at a number of different levels of analysis, from the individual to the environmental, from the clinic to the community. Bostock (1998), for instance, emphasises the importance of local dialogue, research and ownership of intervention, including feedback to local services on what helps. A range of empowerment-based approaches is available within this framework.

A social inequalities approach implies a reclaiming of the reflexive practitioner (Bleakley 2000). This demands personal and collective reflection on both the content and context of formulation. It highlights the vulnerability of formulation to the idiosyncratic as well as the normative, and the importance of creating a context for it that shapes its accountability. Are we, in this, speaking for the other? Are we closely attending to the client's story or indulging our own intellectual interests and predilections?

We also need to adopt the position of the critical practitioner who recognises the wider social processes, the organisational and institutional context and their own value-based practice as much as possible. A supervision process that takes power into account and develops awareness of social inequalities (Aitken and Dennis 2004; Patel 2004) is of enormous help in developing and sustaining this.

## **Reflections**

Finally, on a personal note, we would not wish to close this account without also making real some of the difficulties in trying to work as clinicians in ways that are informed by a social inequalities perspective, and there are many. First, it is never easy to hold a position that is almost inevitably counter-culture and sits often in painful contrast with the dominant discourses and ideologies. These dilemmas can be played out on a daily basis and at every level: 'Do I attend a ward round?' 'Do I challenge diagnosis x or treatment plan y?' 'Do I participate in a flawed service development plan?' These questions can seem endless and difficult to answer. Similarly, the challenge of working in these ways brings complexity rather than simplification. The answer to the question 'What do I do?' is unlikely to consist

of one straightforward answer. Perhaps, most of all, it places a requirement on us to subject our values and practices, and our own life experiences with oppression and victimisation, to critical scrutiny. We believe what helps with many of these challenges is to look to our own social contexts, and to actively seek connection with like-mindedness wherever it is to be found. For us, this has included our involvements with user groups as well as professional networks. These are hugely important sources of support and sanity.

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## Chapter 7

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# Integrative formulation

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### Integrative formulations

In this chapter we start to look at integrative formulations. We illustrate the issues by focusing on one widely used approach by Weerasekera (1996) and applying it to the case of Jack. We then offer reflections on the strengths and weaknesses of this model as a way of considering a range of core issues in integrative formulation. Through this process we attempt to move towards a more complex and dynamic model drawing on reflexivity, the therapeutic relationship and the idea of formulating as a fluid process.

### Approaches to integration

Psychological formulating is bedevilled by divisions and splits, even within a so-called 'single model perspective' such as cognitive-behavioural therapy (CBT), psychodynamic or systemic. These include differences about technique versus non-specific factors, about an open-ended versus time-limited focus, and about emphasising the individual versus the social context. There is a general tendency to ignore these divisions, or adhere to one side, or profess non-aligned eclecticism where multiple models are used in the service of clinical necessity. But while such solutions have pragmatic advantages they lack technical and epistemological coherence. So how might we consider approaching an integrative formulation?

One way of looking at integration is in terms of the complexity and uniqueness of the formulations that are developed. We have summarised below some of the main types of integrative approach:

- off the shelf
- aptitude–treatment mix (A–T)
- idiosyncratic formulation.

### **Off the shelf**

These are approaches that use standardised integrative formulations combining a number of models. A good example of this is cognitive analytic therapy (CAT) where there has been an attempt to develop a coherent new model which integrates a number of other models, such as personal construct theory and object relations theory (see Chapter 8). The same formulation process and format is applied to all clients, although it is acknowledged that the approach may be less suitable for some, for example, those who are actively ‘psychotic’.

### **Aptitude–treatment mix (A–T)**

In these approaches there is a greater emphasis on matching ‘diagnosis’ or ‘symptoms’ to the type of therapy. The integrative formulation can involve considering, for example, the clinical utility of exploratory (brief psychodynamic) versus prescriptive (e.g. CBT) therapies for a given problem such as depression. This approach has also been described as drawing on a ‘drug metaphor’ (Stiles and Shapiro 1994), whereby we reach for the appropriate drug from the cabinet for the particular ailment. There are a number of important issues worth noting with regard to the A–T approach.

### **Evidence base**

The A–T approach often claims to be guided by a research ‘evidence base’ that points towards integration. This assumes that we know and can identify the active ingredients of a helpful therapy for clinical conditions: for example, a combination of CBT and systemic therapy has been said to be an effective treatment for adolescents with eating disorders (Dare *et al.* 1990).

### **Eclectic versus conceptual synthesis**

In an eclectic approach we are not particularly concerned about reconciling and integrating the conceptual features of different

models. Instead, the integration is a pragmatically driven one, combining models or aspects of models. An example might again be drawn from work with eating disorders where systemic family therapy and CBT may be used side by side without any real attempt at a conceptual integration.

### *Developmental features*

These are based on the finding that different therapeutic approaches may be suitable for the same client at different stages/points in therapy. Two of the most well known include the assimilation model (Stiles and Shapiro 1994) and stages of change model (Prochaska and DiClemente 1982).

### ***Idiosyncratic formulation***

Here, the integration consists of a multifaceted, high-level formulation that aims to encompass the complexity of an individual client, their family and their context. This can incorporate a 'functional' approach which considers a client's behaviour in terms of what it solves, what it conceals or avoids, and what the costs and benefits are, both for the individual and their social context. Integration at this level also requires the therapist to draw on personal qualities such as intuition, capacity to listen and ability to synthesise disparate information; and to hold a tentative position which tries to integrate different perspectives. This is sometimes described as a 'both/and' position.

### ***Key differences***

In summary, the key differences are:

- 'off the shelf' versus 'idiosyncratic'

and

- pragmatic eclecticism versus conceptual synthesis.

The search for more conceptually coherent integrations has in part been fuelled by a wider interest in the idea that it may be possible to identify common active ingredients across different

psychotherapies – the ‘Holy Grail’ of psychotherapy researchers. The most consistent and useful findings here appear to be related to what has come to be called the ‘therapeutic alliance’, which encompasses the relationship between client and therapist, and the degree of agreement on the aims of the therapy and on how to achieve change (Bordin 1979; Luborsky *et al.* 1983; Toukmanian and Rennie 1992). Second, there is the finding that effective therapy involves a ‘transformation of meanings’ (Sluzki 1992), that is, a fundamental shift in how the problems are seen and in the person’s view of themselves.

However, an examination of the broad literature base on psychotherapies suggests that these findings have not been apparent to all researchers. Instead, there has been an excessive focus on technique (‘head-to-head’ direct comparisons of different therapies) at the expense of viewing psychotherapy fundamentally as a relationship, and exploring the factors involved in building and using this relationship (Toukmanian and Rennie 1992; Bergin and Garfield 1994; McLeod 2001; Dallos and Vetere 2005). Integrative formulation that attempts a conceptual synthesis can be said to share the aim of extracting core features from different models in order to create a fresh and vibrant new perspective. By analogy, the task is to make a dish from the very best and complementary ingredients that will look good, taste good and do you good! This is an important point since in a context of financial uncertainty, restricted budgets and long waiting lists, new developments typically compete for these limited resources with more established practices by claiming to be more cost effective and more effective with difficult cases. As a result, new integrative developments may feel pressure to make strong claims about effectiveness to justify themselves to purchasers.

### ***Implicit integration***

We will return to the broader question of efficacy in the next chapter, but a final point is a wider question about the extent to which all models necessarily involve integration in actual practice. We have witnessed many conversations where therapists from different schools have levelled criticisms of each other’s model: for example, CBT is sometimes accused of emphasising techniques to change dysfunctional cognitions at the expense of ignoring the therapeutic relationship. In defence, CBT practitioners typically reply that they are very sensitive to the need to build a therapeutic relationship and



that clients will not undertake the laborious homework tasks involved in CBT unless they have faith in and trust the therapist. Interestingly, this is borne out by a qualitative study by Borrill and Foreman (1996) of CBT therapy for clients who had a fear of flying. The clients reported that the most important factor for them was establishing a good relationship with the therapist. This was poignantly illustrated by one of the core themes which was expressed as 'being able to borrow belief' from the therapist that they would be able to overcome their fear. In a similar vein, psychoanalytic therapists are often criticised for being too concerned with predisposing intrapsychic processes and not paying adequate attention to the current interpersonal dynamics that may be maintaining problems. In defence they typically argue that in practice there will be considerable discussion about current circumstances and how to work with these dynamics in order for progress to be possible.

Part of this discussion turns around the question of whether what therapists say they do in terms of their theory corresponds with what they do in practice. A classic investigation of this is Truax's (1966) study, which showed that Rogerian (1955) non-directive counselling could be conceptualised not so much in existential terms of acceptance and trust, but in terms of subtle changes in reward contingencies during the process of therapy. Thus, the therapist was seen as differentially encouraging types of behaviours such as self-disclosure, insight and self-acceptance in clients by nods and smiles, by vocalisations such as 'Yes I see' and 'That's interesting', by paralinguistic messages ('ahhms'), and by non-verbal communication by posture and so on. It is also true that as the basic models have developed and become more sophisticated, they have increasingly borrowed ideas from each other, though often without acknowledgment. For example, CBT has incorporated a concept very like the unconscious in its recent focus on 'schemas', which are deeply rooted core beliefs that the client may not be aware of.

Finally, it is highly likely that therapists are influenced by other models in their conceptualisations even if this is not overtly stated in their work. To take an obvious example, it would be hard for any therapist not to be aware of ideas about the therapeutic relationship originating from psychodynamic theory even if they disagreed with many of the tenets of psychodynamic models. Such an awareness is likely to influence the therapeutic relationship even if it is expressed in terms of patterns of reinforcement and rewards.

## **Integration strategies**

Below is a summary list of strategies that may be utilised in the development of all types of integrative formulation:

### ***Making conceptual connections***

- Identifying and using points of conceptual similarity: for example, identifying what is similar about the models.
- Linking conceptual aspects which are complementary: for example, identifying how one model can extend the other; systemic approaches encompass interpersonal issues that a largely intrapsychic model may not focus on in depth.
- Identifying how one model may fill gaps in another: for example, in systemic models there may be an inadequate account of emotions.
- Using different aspects of the models to offer a developmental account of the problems.

### ***Making practical connections***

- Identifying what it is that is similar about the models in terms of what we do: for example, most models see the therapeutic relationship as important.
- Identifying what is involved in the process of therapy: for example, verbal communication as opposed to experiential work such as role play, sculpting, and so on.
- Recognising that most or all models involve addressing or confronting difficult and painful emotional issues.
- Recognising that most or all models offer a framework for hopefulness, validation and building on successes.

## **Weerasekera's integrative formulation**

We will now describe one approach that has been influential in developing the integrative approach to formulation. Weerasekera's (1996) model of formulation offers a structure which helps us to be systematic about what information we seek and also generates some ideas about how it might all be woven together. Within the two dimensions idiosyncratic/off the shelf and synthesis/eclectic described above, this model can broadly be described as

idiosyncratic and eclectic. After putting forward some reflections and critical considerations we will suggest a dynamic-contextual framework for integration that can be used to expand and develop Weerasekera's basic model.

Weerasekera's model is a matrix which has *levels of analysis* as one of the dimensions and *events/factors*, both triggering and maintaining, as the other dimension (see Table 7.1).

Weerasekera's scheme highlights the fact that different therapeutic models operate at different levels of analysis and have different assumptions about causation and maintenance. For example, as described in Chapter 2, cognitive models such as CBT operate largely at the individual level and emphasise the role of cognitive distortions such as negative automatic thoughts in the development (predisposing and precipitating) and maintenance (perpetuating) of problems (see Table 7.2).

This framework represents the dimensions that cut across all therapeutic models. To some extent it draws on ideas from 'functional analysis', the behavioural perspective which emphasised both historical events and contemporary maintaining factors in the development of problems.

Importantly, the model also includes the idea of *coping styles* – characteristic ways that a client uses to deal with problems. These styles can be dispositional or episodic, which draws a distinction between general ways of dealing with events, and more variable and specific ways of coping in particular situations. As an example, a

Table 7.1 Overview of Weerasekera's model

	<i>Individual factors</i> <i>Biological: behavioural:</i> <i>cognitive: psychodynamic</i>	<i>Systemic factors</i> <i>Couple: family:</i> <i>occupation/school: social</i>
Predisposing		
Precipitating		
Perpetuating		
Protective		



COPING STYLES ← → CHOICE OF TREATMENT

Table 7.2 Weerasekera's four Ps scheme

<b>Predisposing</b>	Factors that make the person or the system vulnerable to specific events or conditions: for example, family history of depression, loss of a parent in childhood, childhood trauma.
<b>Precipitating</b>	Events that are close in time to the development of a problem: for example, a recent divorce, loss of a job, an attack or assault.
<b>Perpetuating</b>	Factors involved in maintaining a problem. These might be the secondary gains that result from a problem, or the attempted solutions in a family, such as taking over from someone who is depressed which leads them to feel increasingly inadequate and burdensome.
<b>Protective</b>	Factors that contribute to resilience: for example, a sense of humour, abilities or skills, family support, success at work.
<b>Coping style</b>	Characteristic ways of reacting to stress and distress: <ol style="list-style-type: none"> <li>1 Dispositional – enduring personal styles</li> <li>2 Episodic – varying from situation to situation</li> <li>3 Individual – biological, behavioural, cognitive, psychodynamic</li> <li>4 Systemic – couple, family, occupational or social.</li> </ol>

person who has a general tendency to withdraw and become sad in the face of problems may nevertheless be able to maintain interactions in their work situation.

The coping style is also considered in terms of patterns in interpersonal or family relationships. For example, we frequently find that one member of a family appears more able and willing to address problems by discussing them openly and values this activity more than other family members do. There is a link here with systemic family therapy notions of 'attempted solutions' – ways in which the client and family have tried to deal with difficulties, both in the past and currently.

This model also includes ideas about the timing of interventions. For example, if a client appears to prefer to solve his or her problems in an action-oriented behavioural way, a behavioural approach which fits with this is may be chosen as a first step. However, it is recognised that as treatment progresses a client may be able to shift to a more cognitive (e.g. CBT) approach, and later to a more psychodynamic approach which involves and exploration of feelings and attachments.

Table 7.3 The individual/systemic axis

<b>Individual factors</b>	1 Biological – temperament, physical disabilities 2 Behavioural – learning, modelling 3 Cognitive – negative thoughts, assumptions, schemas 4 Psychodynamic – defensive styles, attachments, developmental preoccupations
<b>Systemic factors</b>	1 Couple – communication, intimacy, support 2 Family – family dynamics, traditions 3 Occupational/school – employment, school 4 Social – race, gender, class, community resources

The second axis of Weerasekera's framework consists of the various models that we may choose from. These are broadly divided into individual and systemic models outlined in Table 7.3.

### Jack: an integrative formulation

The first stage is to carry out an assessment using the four Ps as an initial guide. This involves thinking about each P in relation to both the individual and systemic factors. The information for this is drawn widely from case notes, referral information and assessment interviews with the client and (if appropriate) their family. In order to establish some of the maintaining factors it may also be necessary to collect extra information: for example, diaries of behaviours and thoughts; observations of family interactions; and the therapist's reflections on the interaction with the client and family. As this assessment proceeds, ideas about characteristic coping styles and how the family deals with problems are being developed. Weerasekera's grid is useful not only for collecting information but also for highlighting what further information we might require – the gaps in our knowledge about Jack. We now suggest some ideas in each of the four Ps categories, although more details of these are available in the earlier chapters.

### Predisposing factors

#### *Individual factors*

There is considerable evidence of events in the past which are likely to create individual vulnerability in Jack. These include sexual

abuse, family disintegration, family violence, an alcoholic father, failure of the family business, financial problems, loss of contact with his father and loss of contact with the family's cultural network. Overall, Jack has changed from a bright, capable student to someone with multiple experiences of loss, failure and disintegration, which could have shifted his sense of security from a relatively secure one very early in his life to a much more insecure and anxious attachment style now (Crittenden 1998).

### *Systemic factors*

A similar pattern of stress and distress applies here, which appears to have resulted in the family feeling overwhelmed, threatened and inadequate. They have also lost their important and supportive connections with the Italian community.

### **Precipitating factors**

#### *Individual factors*

Jack's 'paranoid' symptoms appear to coincide with his mother developing 'serious' health problems and the family finances becoming 'even more stretched'.

#### *Family factors*

There had previously been violent rows at home. It is possible that these had continued and that one or more of them had also served to precipitate Jack's problems. This would be consistent with expressed emotion theories which suggest that high levels of negative feelings and hostility can trigger psychotic episodes (Leff and Vaughn 1985).

### **Perpetuating factors**

#### *Individual factors*

Jack's problems are likely to be maintained by his low self-esteem, his negative beliefs about himself and his insecure attachment style. He may continue to identify with his father but be very ambivalent about this. His view of himself as inadequate, failed and 'ill' is now

likely to be maintained by his position as a 'psychiatric patient'. The medication he is taking may further reinforce the idea that there is something wrong with him and make it harder to engage in helpful therapeutic activities, perhaps by making him more lethargic. It may also carry the message that his problems are so serious that they can only be solved by medication. This may increase both Jack's and his family's dependence on drugs. The family may see medication as necessary to calm and control Jack so that they feel less threatened by him.

### *Systemic factors*

Jack may feel cast out by the family who are anxious about and afraid of him. This cycle of rejection and fear may serve to keep Jack outside the family. Because the family are worried about his possible return they may continue to require psychiatric support, which will maintain Jack in his 'ill' identity. In effect, the psychiatric system can be seen as co-parenting Jack, which can lead to a self-perpetuating dependency.

### **Protective factors**

#### *Individual factors*

Jack is said to have been an intelligent, sociable and creative child. These assets and abilities could still be utilised. He is also described as compliant in hospital which perhaps indicates potential for forming a therapeutic alliance. Jack displays care and concern about his family.

#### *Family factors*

Despite their many adversities the family appears to remain connected and to have survived financially. We do not know much about Jack's sisters but they may have strengths and successes in their lives from which the family could draw some hope.

## **Coping styles**

### *Individual*

Jack currently seems to be most accepting of a biological perspective in that he is compliant with medication and finds it ‘useful’. He seems to see the value of doing things (protecting his family and so on) which suggests that a focus on more action-orientated techniques might initially appeal more to him than exploring his feelings and thoughts. Jack was not able to tell his family about some very bad past experiences, such as the abuse. Perhaps he has adopted the strategy of keeping things to himself and not worrying his family when they are already stretched to the limit. However, this also appears to be a coping style in which problems are unresolved and escalate until they become much more serious.

### *Systemic*

Like Jack, his family appears to value a biological input at this point. Given their traumatic experiences to date, it seems likely that their coping style is also action-orientated. They may need to feel safe and to have strategies in place for how to manage Jack and get help when they need it. In the past, difficulties with Jack were solved by separation, eventually throwing him out of the family home.

## **Reflections on the model**

We offer a brief summary of some points regarding the model.

### **Advantages**

- *Offers a systematic and thorough analysis:* alerts us to look for factors that we might miss or ignore.
- *Considers timing and ordering of treatment:* can offer some guidance as to how treatment might progress.
- *Includes coping styles:* consideration of matching treatment to client/family styles of coping can promote a collaborative stance and strengthen the therapeutic alliance.



**Disadvantages**

- *Lack of emphasis on the therapeutic relationship*: there is little in the model about the nature of the therapeutic alliance and how to promote this, apart from some discussion increasing client co-operation by matching models of therapy to the client's coping style.
- *Non-reflexive*: related to the above, the model does not allow for the ongoing process of therapist and client reflecting on what is happening in the therapy, what is going on between them, how they each feel about progress or lack of it and so on.
- *Different models may be incompatible*: for example, individual and systemic therapies imply different kinds of causation and responsibility for the problems.
- *Unclear how to combine models*: does not clarify how the different models might be used together – leaves it to our imagination! This suggests that the model is essentially eclectic and not conceptually synthesised.
- *No guidance on changing focus*: it is not clear how, when and why we might shift the level and focus of analysis.
- *Assumes linear change*: however, change may not be linear, as implied in the model, and clients and families may relapse.
- *Certainty and pattern matching*: at times the model appears to take the view that particular treatments can be matched to particular types of problems in an 'off-the-shelf' manner according to the available 'evidence base'.
- *Non-collaborative, expert*: again, apart from the aspects about the matching of coping styles there appears to be an assumption that formulation is done by the therapist rather than the client.
- *Little consideration of wider contexts*: though immediate contexts such as social, occupational and so on are included, there is little discussion of issues of power and the ideological dominance of some of these, for example, the dominance of the individualising and medical models propounded by psychiatry.
- *Impractical*: finally, an obvious practical point is that busy clinicians may not have the time or resources to undertake assessment in such detail.

We will discuss some of these points further as a springboard to extending the integrative model.

## Extending the integrative model

### *The therapeutic relationship in 'live' formulation*

We feel strongly that fluidity and flexibility in the co-construction of distress and difficulty are essential to forming a productive working alliance. In this and earlier chapters the impression has perhaps been conveyed that the therapist formulates from within a preordained and prescriptive framework. From a developmental perspective it is as if these models of therapy advocate a Piagetian (1955) linear stage model, where the progression and goals of the client unfold inexorably as a product of the therapeutic process. The therapist's role would then be as a skilled administrator of technique who troubleshoots stuck points in order to keep the process on track.

However, in our experience, people and therapy rarely fit this kind of linear model. Rather, as therapist one needs to hold a position akin to Vygotsky's (1962) 'zone of proximal development'. This acknowledges the potential for growth that a child has at any given point in his or her development and, importantly, what the child is capable of achieving with the support or 'scaffolding' of a helpful adult. Similarly, in therapy we need to consider not just what the person can do as shown by 'objective' measures and tests, but what their potential for change may be given the support of an open therapeutic relationship. Many leading figures in the world of psychotherapy have advocated this in different ways. The reader is referred to Bion's (1970) need for being without memory or desire, the Milan school's ideas on curiosity and neutrality (Boscolo and Bertrando 1996), and Freud's (1923) evenly hovering attention. These concepts all point towards adopting a position of 'not knowing' or uncertainty, and emphasise the importance of the therapeutic relationship itself in the process of formulation.

As in the previous chapters, we have used the example of Jack to illustrate our formulation. However, as the other authors in this book have acknowledged, this does not answer the question of what 'live' formulation might look like. Arguably, we might need to change our language from formulation as a noun to *formulating* as a verb.

Formulating is an active process in clinical work. It is an interactive, vibrant and live activity during which we start to get to know and engage with our clients. Formulation is not simply an

intellectual activity but a subjective and interpersonal one, as we interact with our clients within a dynamic social context. It is not, as might be implied by the way it has to be described in a book, about collecting facts in a rational 'objective' manner, but rather takes place within the context of an evolving therapeutic relationship. What we learn about our clients unfolds over time and is based on the development of trust and openness, so that any early formulation must by definition be tentative and open to revision. For example, within the systemic perspective (Chapter 4), formulation is viewed as an ongoing activity in the concept of 'progressive hypothesising', or formulation as a recursive process. The language of certainty can creep into pre-formed therapy models, implying the possibility of being firm and definite much sooner than is our experience in actual clinical practice.

### ***Reflexivity***

Reflexivity is central to good clinical formulating. By this we mean that our own assumptions, motives, cultural attitudes and interpretative lenses need to be transparent in order to ensure an open working formulation. Central to this is self-awareness. The various therapeutic models address the issue of reflexivity in different ways. Psychodynamic approaches couch it in terms of the concepts of transference and countertransference, whereby feelings encountered during therapy can be linked to past and present relationships. Systemic models analyse the observing system (supervision team) by looking at the therapist–family relationship and in turn attempting to look at how the supervision team is relating to the therapists and the family. However, while we want to make our assumptions as visible and open as possible, a reflexive approach implies that we acknowledge that this can only be an aim to strive towards. Our formulations inevitably arise from, and are shaped by, our own professional and personal experiences, beliefs and assumptions.

### ***The choice of models***

There needs to be more recognition of the implications that different models convey; for example, an individual therapy such as CBT or psychodynamic may carry the message that the problem lies within Jack, while drug therapy may signal to the family system that Jack is 'ill'. (The issues raised by combining medical and

psychological models are discussed further in Chapter 9.) As already discussed, these messages may reinforce and maintain Jack's sense of failure and helplessness and his development of a flawed, failed identity.

Weerasekera (1996) suggests that we may start with one model and move on to another, for example behavioural/cognitive to psychodynamic to systemic. This opens up the possibility that the formulation will change as more material emerges about the client's life. In other words, we may need to 'pace' the intervention in accordance with the client's wishes and the rate of progress. However, there is also the possibility of choosing to employ different models at the same time, for example, individual CBT for a child, coupled with systemic family sessions with other family members. In Jack's case, there could be some individual sessions that would build on his agreement to take medication, while at the same time sessions with his family could give them reassurance and support. It might not be possible or advisable to attempt joint sessions with Jack at first, though these could be helpful at a later stage to discuss whether he is going to return home, how the family might support him, and so on. There are also the broader questions of whether Jack's father knows of his difficulties and how he might be involved.

### ***Certainty and pattern matching***

Weerasekera's model can be interpreted as assuming that the task of formulating is based upon the 'scientist-practitioner model' where an objective assessment of the client's coping style forms the basis for pattern matching to models of psychotherapy. While client-therapy variables have been a focus of research interest in recent years, such studies are usually based on generalisations drawn from large samples and meant to apply to all cases with that particular diagnosis. In contrast, as described above, our actual clinical practice is characterised by an intersubjective reflexive process. This means that the goal is not to match the person to a model but to uncover what is possible for this person in relation to a specific set of problems, and particularly what common ground can be shared between therapist and client around the meaning of their problems. This, we feel, describes a less linear and more holistic approach to formulating.

Therapists sometimes describe this activity as having several strands to the intervention. For example, one strand may formulate

symptomatic behaviour such as agoraphobia using a CBT model, while a second may involve ongoing exploratory therapy into past experiences and current relationship difficulties. The strands are united by a recognition of the functional significance of the person's fear of leaving the home. Thus, CBT would look at cognitions about the outside world as unsafe and the client as unable to cope with his anxiety, leading to the need to avoid the source of the fears, while a systemic approach might see the anxiety as having the interpersonal function of maintaining contact with the family and gaining attention and comfort.

The therapist may then use these strands as a basis for moving between a focus on behaviour, an exploration of the past, and perhaps marital or family work as well. Wachtel's (1991, 1997) classic integrative ideas combining behavioural and psychoanalytic work come to mind, as well as more contemporary projects such as Broughton *et al.*'s (1992) relationship play therapy, which combines aspects of attachment theory, behaviour therapy and group work within the context of mother-child play interactions.

### **Collaboration**

Weerasekera sees her model as collaborative in the sense that the client does have a say in choosing what treatment is offered. However, the model suggests that the therapist plays a central role in deciding what the client's coping style is and suggesting what might fit. This would encourage us to engage in discussions with Jack and his family about the ways in which they might wish to work. This framework could help establish both where we might start and what type of work we might go on to at a later date.

This still leaves the question of how much and when our formulations can or should be shared with our clients. Our understandings as therapists may be a long way off from the client's view of their problem, despite appearing to be theoretically or technically correct. This raises issues about whether we assess people as expert outsiders, or join with them in developing our ideas about the problems. In our experience, and drawing on Vygotsky's idea that people may be able to perform at a higher level with some minimal input from a more experienced helper, shared formulations are often most effective and helpful when they are able to offer an advance on what the client has realised for themselves, but are not so far beyond their ken that they make no sense to the client.

All of the models Weerasekeera describes are capable of being translated into client-friendly language sensitive to the emotional needs and understandings of the client. It is possible, for example, to imagine sharing understanding of the four Ps with clients. In practice the model does not seem to be employed in this way and the formulation tends to be held by the therapist. Arguably, there are times when clients might be overwhelmed and confused by a mass of information such that given by Weerasakera's grid, but it is also possible that this could be simplified and shared with the client as an ongoing part of the therapy.

Sharing formulations also involves reflexivity at a number of different levels. For example, our view about Jack's readiness to hear our formulations may be influenced by the ways in which his situation connects with our own family experiences. Family members may also be unhappy, or even angry about a formulation which differs radically from theirs. For example, our hypothesis that Jack's father is an important part of the problem and that Jack may be helped by making contact with him may generate anxiety and anger in the women in the family who feel threatened by him and do not wish to 'open up old wounds'. Thus the formulation process can be seen as a joint constructive process which moves between layers of reflections about the therapist's feelings, the family's feelings, their possible views of the therapist's ideas, and so on.

### ***The context in which we practise***

No therapist is an island, to paraphrase Donne (1684), and yet a naive reading of multi-perspective formulation could result in frustration and disappointment for this very reason. A common source of these feelings is, in our experience, a failure to recognise that we formulate within social and political healthcare systems which do not prize all models of therapy equally. Arguably, the drive for evidence-based treatment in therapy (see *What Works for Whom?*, Roth and Fonagy 1996) has created an environment where what counts as legitimate therapeutic activity is more restricted than a comprehensive grid might allow. Unless we can ignore or minimise these constraints, and in a sense deceive ourselves into believing that the majority of cases seem to fit with what we can offer, we are likely to become frustrated when a comprehensive approach to formulating merely serves to highlight what we cannot do or provide. There is nothing to be gained from producing massive wish

lists of what a client needs that are totally divorced from the practical realities of what is available within the geographical or financial environment.

## **Summary**

To summarise, we believe that formulation requires a broad framework to help therapists to resist the temptation of tunnel vision and over-valued facts. Such an approach does not discard evidence from research or the idea that it is important to find the most appropriate model of therapy for particular types of problems. However, we have suggested that this needs to be a critical and reflective activity in which the evidence is considered carefully in terms of its relevance and assumptions. Furthermore, we make the important point that integrative formulation needs to be collaborative. This means that at times we may have to accept that clients too have strong views about evidence, and will themselves bring in notions of ‘expertness’ and ‘evidence-base’ when they ask for or even demand particular treatments. For example, a client may hold the formulation that a medical treatment (Ritalin) is what is needed for their child, or that their partner ‘needs’ CBT for their unreasonable reactions. These formulations from our clients need to be treated respectfully, even if our own views are different, so that we can achieve our aim of working together – collaboratively.

## **A contextual-dynamic view of integrative formulation**

### **Contexts**

We can now draw together some of our reflections on Weerasekera’s model. Although the model already offers social and community contexts as one dimension, we suggest that this needs to be considered in more detail in order to allow a dynamic and flexible form of integrative formulation. Central to this is the idea that formulation necessarily happens within social contexts (see Figure 7.1). This shapes the process in two important ways: First, formulation takes place within a background of a variety of discourses or ideologies, especially around the issue of how problems are defined (for example, as individual deficits or as manifestations of an underlying ‘illness’). There is also the cultural context

**CULTURAL CONTEXT**

**Discourse:** beliefs, expectations, social norms, views of problems

**Structure:** finance, available service, status, inequalities

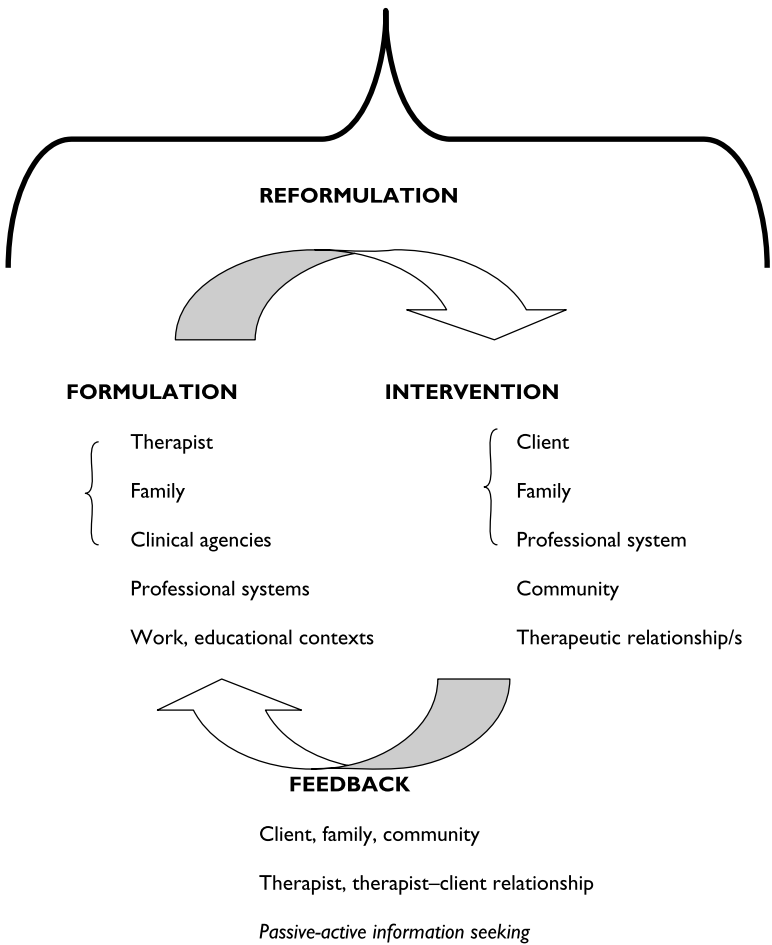


Figure 7.1 A contextual-dynamic view of integrative formulation.



of what are seen as ‘normal’, ‘legitimate’ and ‘appropriate’ forms of thoughts, feelings and actions as opposed to what is deviant and not acceptable. This wider cultural context inevitably frames the activities of therapists and counsellors since we are subject to laws and ethics of the culture in which we work, whether or not we agree with them.

Second, formulation takes place within wider structural constraints, such as the funding available for treatments and length and quality of treatments that can be financed. Also, there are structural realities about what services are available and how they are organised. For example, child services typically take 18 years of age as a cut-off point before young people have to move to adult services. In formulating about such a case we would be foolish not to take the implications of this arbitrary divide into account.

### ***Who does the formulating?***

Here, we suggest that it is important to ask who might be involved in formulations. In Figure 7.1 we can see that this may include the client, the therapist, the supervisor(s), family members, professional agencies, community/work/educational settings, professional systems and so on. The first stages of a piece of therapeutic intervention, where we collect information from a variety of sources to help us to formulate, often highlight the fact that some formulations have already been set in place. For example, many referrals to a clinical psychologist either explicitly or implicitly suggest that something like CBT is appropriate. In effect this bypasses or simplifies the formulation stage by assuming that a particular treatment is the most suitable. In this way the formulation is already partly formed, putting pressure on the therapist to go along with this rather than question its appropriateness. In NHS team contexts, a therapist or clinician who makes a habit of questioning the assumptions or rudimentary formulations of his or her colleagues may come to be seen as awkward and disruptive (Johnstone 1993).

### ***Gathering information actively***

We suggest that it is important for us to be ‘active’ rather than ‘passive’ in how we gather the information for our formulation. Arguably, this is one of the most useful contributions of Weerasekera’s matrix in that it draws our attention to areas of information

we do not have and need to seek out. It is alarmingly easy to fail to do this in busy clinical contexts. For example, we know very little about Jack's father and his side of the family. Collecting such information may be resisted, either by Jack's family or by a professional system which sees it as irrelevant. Alternatively, there may be pieces of information which are more like hearsay, such as a story that a father was an abuser. Such stories may be quite untrue: in one case known to us, inaccurate information from a man's ex-wife that the father had a conviction for sexual abuse of his children was not only untrue but had been entered into his medical records. He was told they could not be deleted. This kind of 'evidence' can obviously have a major impact on our formulation. It would be important in Jack's case to check just what the evidence is for his father's behaviour. It might be the case that the father has a very different formulation of Jack's problems and of his own contribution to them.

A useful starting point is to consider carefully what beliefs, ideas and formulations about the problems already exist within the clients and their family system and within the professionals with whom they are involved. An approach one of us (RD) typically employs is to hold an initial joint preliminary formulation meeting with the client, their family and relevant professionals. This bears some resemblance to a multi-professional case conference with the difference that the focus is specifically on what formulations are currently in place. This is drawn up as a 'formulation eco-map' in which people who have a role in the perception and construction of the meanings of the problems are mapped with those having most impact closest to the clients and family. In relation to Jack we might discover something like that shown in Figure 7.2.

All of these professionals may play a significant role in the formulation of Jack's problems. It should be noted that a substantial number of these people are likely to hold a medical view of problems; the GP, psychiatric unit staff, the CPN and perhaps the OT and psychologist as well. There may be only one or two people who are likely to introduce psychological formulation rather than diagnosis as a way of understanding Jack. It can be extremely important to discuss the implications of these different, and perhaps dominant, views with the family and if possible with other professionals. We can thus acknowledge the family's views while also recognising that these views are being shaped by the wider professional system.

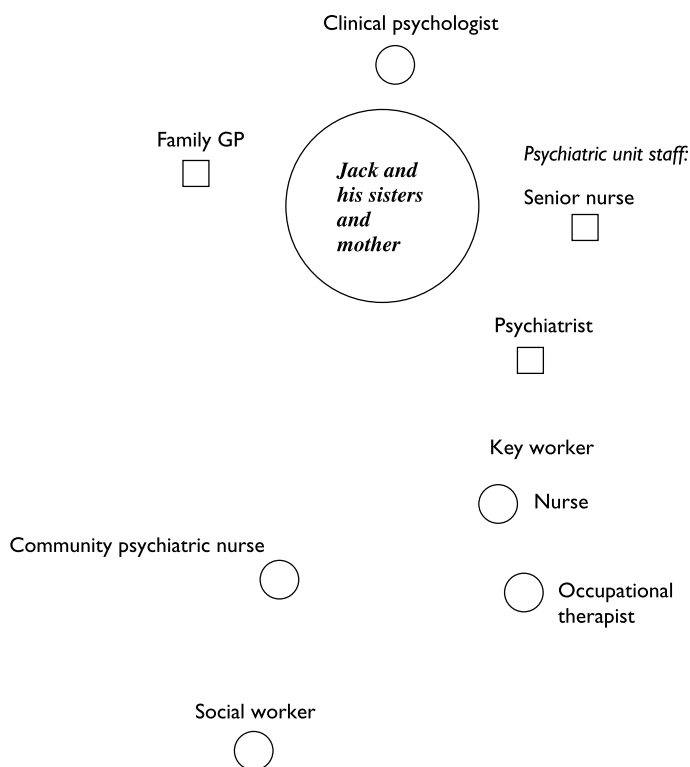


Figure 7.2 Formulation eco-map.

This can also be the starting point of a discussion about whether and how within this context it is possible to consider a more psychological formulation of problems rather than a medical diagnosis, and to get some idea of how well this is likely to be accepted. For example, it may be that both Jack and his family feel closest to medically trained staff such as his psychiatrist, his key worker in the psychiatric unit and the family GP. They are likely to continue to have substantial contact with these professionals and to gain a sense of reassurance and containment of the problems from them, and hence the formulation put forward by these professionals is likely to continue to be influential. One result is that an intervention such as family work may be seen as irrelevant or peripheral by most parties.

This kind of map can help alert us to the potential insignificance

of our own input. Even if we see Jack and his family once a week for an hour, a substantial amount of therapy time in the NHS, this may be a drop in the ocean compared to the contact they have with these other professionals. Hence it may be that our formulations and attempts to encourage a co-construction of alternative viewpoints with them may be futile unless they are accompanied by changes in the professional system.

### **Feedback**

A dynamic view of integrative formulation implies that we recognise formulation as an active process, as we suggested at the start of the chapter by the use of the verb *formulating*. This emphasises that formulation is continual rather than 'one-off'. We suggest that even the concept of reformulation may be too narrow since it implies perhaps one or two turns of the wheel before we arrive at the definitive formulation. The systemic concept of 'progressive hypothesis-ing', as discussed in Chapter 4, is a better model of the process of formulation in that it conveys the sense of a dynamic ongoing process, which arguably has no ultimate end point.

This whole process is guided by feedback about the perceived effectiveness or value of the interventions that arise from the formulations. Again, such feedback can involve a range of people. There are the client's and family's perceptions of whether things are changing and improving or deteriorating. The therapist and the team also have their own views based, for example, on observations of the family and on how the client and the family appear to be relating to them. This sense of 'how we are getting on in our relationship' is one of the most persuasive sources of information available to us. For example, comments such as 'Jack was much friendlier and more communicative with me today' can convey a sense of change and possibly confirm our psychological formulation that building trust was an important starting point for his treatment.

### **Confirming and disconfirming evidence**

There can be a danger that in obtaining feedback we will seek evidence to confirm our formulations and discount evidence that contradicts or questions them (see Chapter 9 for more discussion of this issue). In addition, different people involved may have different stakes in what information they want to seek. Not least, there may

be differences and power struggles in the professional system, which typically centre around psychological versus medical formulations. If neither psychologist nor psychiatrist, for example, wants their professional expertise to be discounted, families may feel that there is a 'formulation fight' going on around them, in which their needs become secondary to a more important interprofessional contest.

It is also the case that different contexts may offer contrasting feedback about how Jack is changing. To some extent this is to be expected, but typically Jack may be required to change in the 'unreal' situation of a psychiatric ward. Often this requires a high degree of compliance and suppression of anger. Some patients become very good at simulating compliance and hence getting even more skilful at deceiving others and possibly even themselves (Goffman 1968). We need to take such issues into account in interpreting feedback about Jack's progress. One useful way of looking at this with Jack and his family is in terms of contexts: the idea that they may all act, feel and behave differently in various situations. In narrative therapies this is described in terms of relative influence – the influence of situation and persons on the problems, and the influence of the problems on situations and persons (White and Epston 1990).

As therapists, our evaluation of feedback is influenced by our own needs. We may feel under pressure to demonstrate that our approach is valuable. More personally, Jack may trigger our own reactions, perhaps if a member of our own family has had similar problems, and we may want to play out a 'corrective script' to help us to feel hopeful about our own experiences. However, disconfirming evidence can be very informative (as in the scientific process). An important instance of this may be evidence of deterioration, anger or negativity in one or more family members when Jack shows improvement. Systemic approaches have found that it is common for family members to organise around the 'problems' such that, for example, Jack's sisters may have gained a special place in their mother's affections for being 'good girls', which might be challenged by a closer relationship between Jack and his mother. In fact, when prompted, parents will often reveal that the 'good' children have been very troublesome at times in the past and that possibly Jack was a favoured, 'delightful' child earlier on. There is some suggestion that this might be true of Jack, in that he was seen as the 'heir' to the family business which may have caused

resentment in his sisters – modern women who felt affronted by such ‘sexist’ assumptions from their parents. Possible ‘resistance’ to evidence of change would need to be aired in family meetings, or else some starkly competing family formulations may stay in place and be supported by negative examples of lack of change or deterioration.

## Summary

We have outlined one approach to integrative formulation in this chapter. Integrative formulation raises a variety of complex issues. We have outlined some reservations about Weerasekera’s model and have suggested some ideas that we think can be employed to elaborate it. We have also outlined an integrative approach which argues for the need to: consider more carefully the contexts in which formulation takes place; encourage a reflective approach in which we recognise formulation as an inherently subjective activity; and see formulation as a dynamic process in which we continually adapt and change our understandings. Finally, we have emphasised the need for integrative formulation to be a genuinely collaborative activity. We need to engage in a co-constructive process whereby we weave together the ideas, needs, wishes and theories of a wide range of people, as in Jack’s case. Most crucially, we argue that Jack needs to be regarded as a person in all this, and not an object. At the end of the day it is his formulation, of himself, his family and the world around him, that will guide how his life progresses.

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## Chapter 8

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# **Integrative formulation**

## **CAT and ANT**

*Rudi Dallos*

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### **Introduction**

In the previous chapter we looked at some general considerations about integration, illustrated by a detailed consideration of one particular integrative framework. We also suggested that attempts at integration can be located along two main dimensions: off the shelf versus idiosyncratic; and pragmatic eclecticism versus conceptual synthesis.

In this chapter we will look at two more attempts at integration. One is cognitive-analytic therapy (CAT) which offers a fully formed ‘off-the-shelf’ way to integrate a number of models, thereby becoming in effect a distinctive new approach which attempts a conceptual synthesis. The second example is attachment narrative therapy (ANT), an example of a more informal or idiosyncratic integration that may be similar to the way in which most clinicians operate, although here it is developed into a more systematic form. In doing this, there is an attempt to move towards a conceptual synthesis that is sometimes lacking in day-to-day clinical work.

### **CAT formulation**

This approach was developed by Anthony Ryle (1979, 1995, 1997) as a systematic attempt at integrated formulation that leads to an integrated treatment plan. CAT is essentially an individual therapy, though the formulation does take account of some systemic factors such as current relationships dynamics. Ryle describes the roots of his endeavour as follows:

The origins of CAT can be traced back to my involvement in

outcome research into dynamic psychotherapy and the way in which this confronted me with the inadequacies of psycho-analytic case formulation.

(Ryle 1997: 289)

His model represents an attempt to integrate a number of distinct therapeutic models into a coherent model of formulation and treatment. It also contains a number of important overarching ideas that form the basic framework of the model. These include the following:

- Formulation should be a collaborative activity, and the process of constructing and sharing a formulation with a client is in itself seen as a powerfully positive therapeutic intervention.
- Despite differences in the theoretical explanations of the different therapies that CAT draws from, there are common patterns in their application.
- Despite their differences, most therapies are based on utilising clients' reflective capacities, that is, their ability to describe the patterns of behaviours, beliefs and feelings that they wish to change.

More specifically, the approach is based on an integration of ideas from personal construct theory, object relations theory and narrative therapy, although Ryle emphasises that he is constantly revising and extending the model in the light of new ideas and emerging research.

### ***Personal construct theory (PCT)***

Ryle had originally been using personal construct theory to explore his clients' characteristics and to investigate the nature of the changes brought about in psychotherapy. Personal construct theory (Kelly 1955) is an approach which emphasises that people's choices about their lives and actions are shaped by the system of beliefs or constructs which they hold. These are seen as bipolar alternatives, such as friendly–hostile, cruel–kind, bright–stupid, which guide or construct our belief system. PCT sees the client and therapist as being on a collaborative, shared journey of discovery. They are essentially both 'scientists' who are trying to understand and predict the client's world. Hence it rejects 'expert' models of practice and

formulation in which the therapist is assumed to have knowledge and insight which is not shared with the client.

One of the most widely used techniques in PCT is the repertory grid, which is a visual representation in the form of a matrix linking the person's beliefs (constructs) about important domains of their experience (elements). The role of the therapist is to assist the client to elicit such a grid and in the process of doing so to discuss and explore it with them. Kelly argued that this process of joint exploration was in itself therapeutic and promoted change. He used the analogy of a researcher and research supervisor, but with the research being about the researcher's own life. These principles are evident in CAT's collaborative use of formulation and reformulation letters.

### ***Procedural sequence model (PSM)***

Ryle drew on PCT to develop a model of psychotherapy as based on a set of patterns linking beliefs, actions and feelings. The first of these, referred to as *dilemmas*, was a narrowing of perceived options into extreme polarised positions. Each of these options is seen by the client as intolerable: for example, the view that either I am totally controlling of others, or submissively dependent. Kelly termed this kind of thinking pre-emptive or overly rigid, a kind of cognition that has also been described as 'black and white' thinking in CBT.

Another important concept in CAT is that of patterns of self-maintaining or circular sequences in which the beliefs lead to actions which appear to confirm them. Again this is influenced by PCT, which argues that beliefs shape actions, and the perceived consequences of those actions may confirm the validity of the beliefs. Ryle calls these *snags*. As an example, the rigid belief that I am worthless may lead to attempting to please others which can lead to feeling used and hence confirm a sense of worthlessness. Another example might be when someone feels that they are not allowed to be the person they want to be because it might hurt, upset or annoy someone else. This is often seen in the 'Yes, but' type of conversation in therapy where the client finds powerful reasons why they cannot or should not change.

**Systemic theory**

Though Ryle is less explicit about the connections with systemic ideas, they are apparent in his model. This is especially the case in his definition of *snags*:

Sometimes the snags come from the important people in our lives not wanting us to change, or not able to cope with what changing means for them.

(Ryle 1997: 301)

This implies the notion of resistance to change inherent in a relational system such as a family. Ryle's transcripts of CAT sessions indicate that he is paying attention to such systemic patterns. For example, a fear of abandonment if the person does not 'put themselves out' or 'sacrifice their needs' may be maintained by actual or implied threats of abandonment by a partner or other family members.

**Object relations theory**

Object relations theory is concerned with the ways in which early experiences, especially with the mother, shape our personalities and patterns of relating to others (see also Chapter 3). Internalised representations of others are called 'objects' and are experienced by the infant as alternatively 'good' (fulfilling, available, comforting) or 'bad' (not available, not comforting, and so on). Because the young infant does not have the capacity for memory or holding the mother in mind when she is not available, something like hunger can be experienced as severe anxiety. Since the parents can never be constantly available and caring, the child will experience them as both good and bad, and a central task as he or she develops is to be able to integrate these two sets of feelings. Inability to do this may lead to 'splitting' these perceptions. Thus, because the child depends on the mother, rage may be split off in order not to threaten this central relationship. Later the child may learn to present a façade of good behaviour and appear to conform to what the parents want. However, the angry, 'split-off' feelings may be projected outwards, for example, in distrustfulness, fearfulness and hostility to others.

***Reciprocal role procedures (RRP)***

Ryle drew on object relations theory for the idea that the child learns not only how to try and elicit behaviours such as care from the parent, but also learns to anticipate how the parent will behave. The child therefore becomes able to act out the parental role, for example, when they play with other children or with pets or dolls. Importantly, the child may also turn this role onto him or herself. For example, a child may have a reciprocal role procedure of controlling–submissive; that is, they experience themselves as being submissive to the parent but have also learnt the opposite role of being controlling which they enact towards themselves or others. These patterns, which are shaped by early interactions in the family, become generalised expectations about others.

There is a connection here with attachment theory, which states that on the basis of their early interactions, the child develops an internal working model which predicts how the parents will care, or not, for them when they are distressed. This can also be understood as a transference reaction, which in psychodynamic therapy is the process of seeing, and acting (often unconsciously) towards, the therapist as if the therapist were a parent or another significant early figure.

Importantly, it is suggested the child has also learnt how to induce certain feelings in others. This has been variously described as ‘projective identification’ and also more generally as a self-fulfilling prophecy. The therapist may find themselves having strong feelings such as wanting to control the client, needing to be special and wise for them or alternatively feeling inadequate and apologetic. An important feature of CAT is a focus on these feelings and an explicit discussion of them with the client by linking them to the their reciprocal role patterns. Reflecting on the therapeutic relationship and the therapist’s use of the self are central features of the formulation and treatment.

***Narrative approaches***

CAT has also incorporated the idea that experience is essentially conversational and narrative. Vygotsky (1962, 1978) has proposed that the child learns by internalising the speech of adults around him. In addition, narrative is seen as the central way in which events are given meanings and connected over time. Bruner (1990) and

Vygotsky (1962, 1978) further argued that the parents provide 'scaffolding' to help the child to make sense of their experiences. We might speculate that this process parallels the therapeutic relationship where the therapist provides a scaffolding to help the client to reach new understandings. The child's inner world is said to be made up of conversations which later become internalised, and can include both supportive and punitive voices.

Narrative approaches also stress that it is essential that we try to form coherent stories which enable us to connect both negative and positive happenings, to consider alternative possibilities, and to allow reflection on and integration of the events in our lives. Importantly, one of the ways that we can bring this about is through writing, and in narrative therapy this is often used as a means of ordering and clarifying our stories.

In CAT, as we have noted, formulation is described as a collaborative and shared activity. Ryle in fact refers to this as a 'reformulation':

The first four sessions of CAT are explicitly devoted to the reformulation of the patient's presenting problems into a form designed to convey an understanding of the life history and the conclusions drawn from it.

(Ryle 1997: 295)

Implicit in this is an attempt to describe the person's life in terms of the procedures and reciprocal roles that have been keeping them trapped in distressing and difficult patterns. Making these patterns explicit in written prose and visual diagrams is a way of helping both client and therapist to transcend them.

### **Jack: a CAT reformulation**

One of the first steps in a CAT analysis is to identify the patterns or 'procedural sequences' of beliefs, actions and consequences which are currently making it hard for the client to change. The starting point is the referral plus any case note information, and this will be discussed openly with the client in a collaborative process of identifying patterns. There is also an exploration of the key relationship reciprocal roles in the client's life, including the ways in which we have learned to act towards others and internalise their actions towards us. Normally the first four sessions of CAT (weekly

one-hour meetings) are spent on exploring the problems and circumstances leading to the referral. This will often include the use of family genograms, life lines, sociograms (visual maps showing the closeness between ourselves and different people in our life) and other visual aids to understanding. Although the process is usually carried out in individual sessions, family members and others might be consulted to offer further information. We might sketch out the following patterns and roles for Jack. Jack has experienced a whole range of difficult and traumatic experiences: the violence by his father towards his mother and himself, his parents' divorce, harassment and burglary, and being sexually abused. As a man he may be seen, and see himself, as being like his father. This is a confusing and ambivalent state; a part of him may miss his father while another part may want to have nothing to do with him. Possibly he wants to be a 'good' and helpful son and not complain or show his sadness and distress because this will only cause more upset to his overburdened mother. In the past he has tried to be a 'good' boy by doing well at school, being popular and good at music, but this did not stop the violence and abuse to him and the people he loves. Hence he tries to control his feelings by drugs and alcohol, but this is seen as following in his father's footsteps and 'bad'. As a result he feels even worse about himself, confused, angry and misunderstood. All of this might be depicted visually as a procedural sequence (see Figure 8.1).

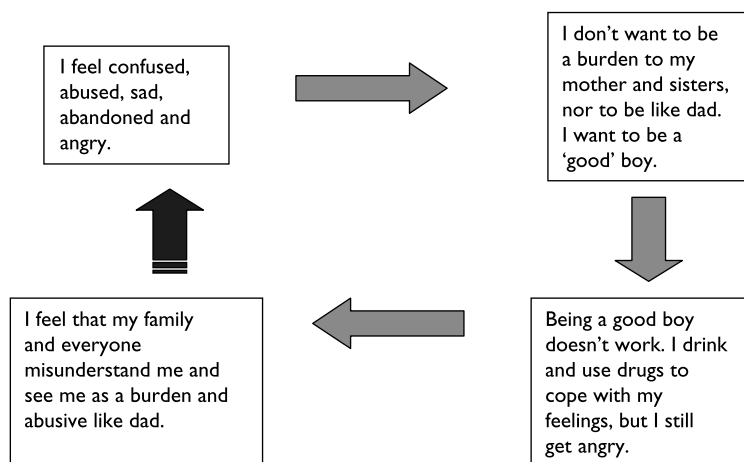


Figure 8.1 Procedural sequence for Jack.

This initial pattern would be described and discussed with Jack, along with showing how it might be linked to reciprocal roles. Consideration of the therapeutic relationship, including what feelings the therapist felt that Jack was eliciting in her, would also be part of the conversation. A core reciprocal role in Jack's case might be abused–abusive. He has experienced being abused by his father and sexually attacked by an older man, so he has a sense of being crushed, beaten and humiliated by others. Yet at the same time he has also learnt the opposite behaviour or pole, which is how to abuse. He may be turning this against himself by self-abusing with alcohol and drugs. His family also experience this as being abusive towards them. This formulation of his core reciprocal roles might be depicted as shown in Figure 8.2.

Such a visual depiction would be part of the reformulation: the statement of the problems in terms of visual depictions of sequences along with a narrative which is offered by the therapist as a summary called the *reformulation letter*. Jack's reformulation letter might look like this:

Dear Jack

You have told me about a confusing, difficult and painful childhood. At first your life in Swindon seemed to be going so well. You were comfortable, settled and well off as a family with your father running a successful business. It was even thought

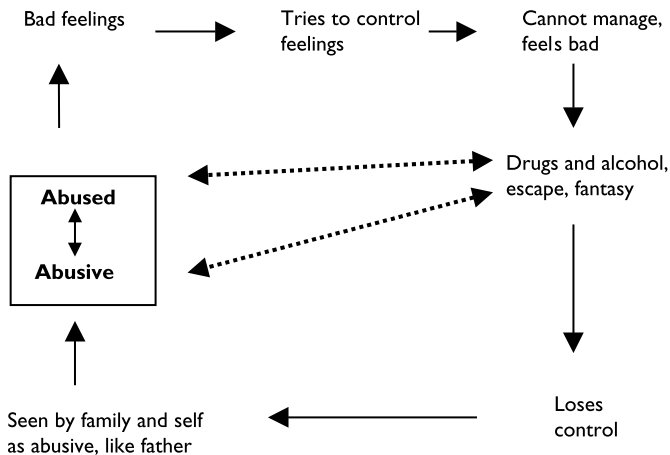


Figure 8.2 Core reciprocal roles for Jack.



that you would follow in your father's footsteps as his heir and take over the family business. But these hopes, which might once have made you proud, turned to dust and now leave a bitter taste as you remember how the business collapsed. Your father turned to alcohol and became violent towards you and your family. For a young child this must have been distressing and confusing for you. It was devastating to see the man that you had admired, and whose career path you were to follow, acting in such frightening ways and eventually abandoning your family. Maybe when you see your father's face looking back at you in the mirror this is a reminder of how close you had wanted to be to him. Now you feel sad, confused and angry when you think about him.

You told me that you have tried to conceal all these feelings from your mother and sisters. A part of you wants to find out about your father, where he is, what is he doing, and whether he ever thinks about you. At the same time you told me that these thoughts are unbearable because of all the bad things he has done, and for these you hate him. You have also been unable to tell your mother about the sexual abuse you suffered. Again, how can you burden her with this when she is so exhausted? Yet you have told me that you need to tell her, you need her to look after you and take care of you. Your mother has so many problems that you do not want to burden her with your bad feelings. But at the same time you have told me how mixed up you feel.

Perhaps what is worst for you now is that your mother and sisters have started to see you as being just like your father. Rather than understanding that you have been abused and hurt, they see you as abusive like him. When we looked at the diagrams together you said you could start to see how in a sense you have both parts inside you. One part is the abused child who has been hurt by your father and others. The other part, which you also told me about, means that you sometimes turn on yourself, abusing yourself as others have abused you. You feel abused but you also know how to be abusive to yourself. You may also feel angry about how you have been treated.

It seems that it has been difficult for you to share your feelings with your family – either because you didn't want to burden them or because your feelings just seemed too difficult to share. Our meetings can be a place where you can talk about your feelings, and we can look at how you have been affected

by what has happened in the past and how this has led you to choose certain ways of acting. We can also look at what is happening in your life right now and whether it might be possible for you to make different choices in the future.

This *reformulation*, along with the diagrams, would be shared with Jack and jointly corrected, elaborated and developed. Because Jack is said to escape into fantasy in therapy sessions, the reformulation would have to proceed slowly and carefully. The letter is a personal document which Jack can read several times, perhaps initially simply correcting factual details, but gradually becoming more connected to his feelings and experiences.

The reformulation becomes a basis for the treatment plan, which may include homework such as observational tasks, or attempts at trying new behaviours and exploring new situations. The letter may be revised in the light of the client's comments and usually there is an end of therapy letter which summarises the progress that has been made. There may also be letters at other points in the therapy. Typically a course of CAT therapy lasts for 16 sessions on a weekly basis.

## **ANT formulation**

The second integrative approach is a more informal attempt at integration that has arisen from my own work (RD), and which I am in the process of developing and elaborating. We are including this here because it falls more towards the middle of our continuum of 'idiosyncratic' versus 'off-the-shelf' integrative formulation. Clinicians may find such an approach more sympathetic because it is closer to their own idiosyncratic integrative formulations.

ANT attempts to integrate models that operate at different levels: systemic (interpersonal), individual (attachment theory), and societal (narrative theory). This is in contrast to CAT which essentially integrates approaches that all operate predominantly at the individual level of analysis (object relations and personal construct theory). Because this is a very ambitious task, ANT may necessarily be less conceptually synthesised than CAT. Again, in this way it resembles what many clinicians are attempting to do as a routine part of their work when, for example, they use combinations of systemic, cognitive and psychodynamic therapies.

As discussed in the previous chapter, most clinicians either

explicitly, or more often implicitly, evolve their own idiosyncratic versions of an integrative model of formulation and treatment (see Figure 8.3). An important step is to make these personal models more explicit and systematic. This process is apparent in the development of CAT which arose from Ryle's early attempts (1979) to incorporate objects relations theory into his use of personal construct theory. An advantage of moving towards a more formal and explicit integrative model is that it makes our work more amenable to evaluation and development. Conversely, when an integrative model remains informal, it will be harder for us to assess which parts of our treatments are effective, and in what ways.

***Integration based on the strengths and limitations of models: complementing and compensating***

The starting point for attachment narrative therapy (ANT) was an increasing awareness of deficits in the systemic and narrative models in the context of my work in the field of eating disorders. It seemed as if some of these deficits could be remedied by attachment theory, but this model also turned out to have a range of limitations.

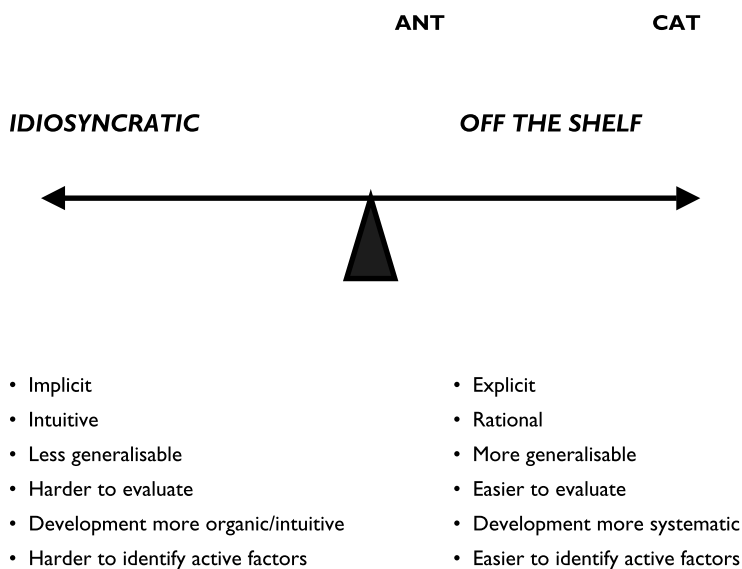


Figure 8.3 Idiosyncratic versus off-the-shelf integrative formulation.

A summary of some of these will clarify the development of the ANT integrative model.

### **Systemic therapy**

As we saw in Chapter 4, systemic formulations emphasise the inter-personal nature of problems. Specifically, the formulation assumes that the problems have a function in terms of the family dynamics. In addition, systemic formulations emphasise the ‘here and now’ current family processes that are maintaining the problems. Though there is an acknowledgement that problems may have been precipitated by historical events such as life-cycle changes, it is the current stuckness that is the main focus. This leaves systemic models with a number of weaknesses:

- 1 There is little developmental perspective to show how the problems have evolved.
- 2 It is not clear why a particular type of problem, for example, anorexia as opposed to depression or substance abuse, has developed.
- 3 It is not clear how the family dynamics shape each individual family member’s internal world, their feelings and beliefs.
- 4 Systemic formulation has less to say about the wider socio-cultural context, for example, how ideas of gender, family roles and morality shape the family processes.
- 5 We do not know why different members of a family develop different problems and ways of coping.
- 6 There is a longstanding concern that though systemic models are less blaming to the individual, they have in effect moved blame up one level to the family. Usually this means locating blame in the parents of the identified client.

Although many of these questions were of central concern to systemic family therapy at its inception, the movement seemed to take an increasingly pragmatic direction which relegated developmental considerations on the basis that they did not necessarily enhance the process of therapeutic change and might pathologise families (Haley 1976; Dallos and Draper 2005). This links with wider debates about the contrast between therapy and research, and the issue of how much we need to understand the causation of a problem to facilitate change. It also raises the important question of

the longer term progression and development of models. Models that become essentially pragmatic may eventually become formless and unclear, lacking the conceptual understanding which is necessary for development. In effect, it becomes harder to establish either the strengths or the limitations of a given model.

### ***Narrative therapies***

Narrative therapies have many similarities with systemic therapies, especially in their emphasis on the importance of communication processes in therapeutic change (Tomm 1988; White and Epston 1990; Sluzki 1992; Chapters 4 and 5). Above all, they highlight the centrality of meaning in human experience. They suggest that the meanings we give to events shape our feelings and actions. Correspondingly, if meanings shift, if we can see things in a 'new light', changes in feelings and behaviour will follow. Drawing on social constructionist ideas they emphasise that meanings are co-constructed in relationships and that language is the means whereby this occurs. In contrast to systemic approaches, the emphasis is on patterns of meanings, especially stories, rather than patterns of actions or behaviours in families.

One of the important ways in which narrative approaches complement systemic perspectives is in drawing attention to the wider socio-cultural contexts. They see language as conveying and perpetuating a range of beliefs and practices that can serve to subjugate and oppress. For example, many families are influenced by diagnostic terminology (ADHD, and so on). This invokes wider culturally shared ideas or discourses about mental illness and organic causes of problems, which are taken on by the family and come to shape its dynamics. Narrative therapy also shows how these same discourses may shape the treatment and services that are made available, such as specialist ADHD clinics. One of its key aims is to help people to resist the negative aspects of such labels which clients often come to apply to themselves. In effect, narrative therapy tries to assist individuals and families to 'reformulate' their problems in less self-denigrating ways.

These aspects of narrative therapy complement systemic approaches but also share some of the same types of deficits. For example, there is very little explanation of how particular narratives develop nor of differences between the various family members. Rather, as in the systemic model, the emphasis in formulation is on

describing dominant narratives that appear to be active, and on practical ways of altering them.

Another important question is about the nature and form of narratives. People vary in the extent to which they can link their experiences in detailed and coherent narratives. There is a growing body of research that indicates the existence of a 'narrative skill' – a complex ability which is fostered by the ways that parents talk with their children and assist them to build this ability (McAdams 1993; Habermas and Bluck 2000). Clinically this is an important question, since it is evident that narrative therapy requires a skill and sophistication with language that some people do not possess. The formulation needs to take this into account and to consider an educative or skill acquisition component to the therapy; or else other forms of therapy may be indicated until these abilities become more established.

### **Attachment theory**

John Bowlby's (1969) attachment theory incorporates a mixture of ideas from psychodynamic theory and the naturalistic observations of animals. He argued that, like other species, human beings have an evolutionarily based instinct to seek safety and comfort from their parents when confronted with danger. Parents are said to respond to their child's need for comfort in a variety of ways that shape important aspects of the child's internal world. Specifically, where parents respond in a predictable and reassuring way the child develops a sense of the world as secure and of themselves as worthy of love and comfort. Where the parents respond reluctantly or inconsistently, make the situation less safe from danger or are themselves a source of danger, infants are likely to develop a view of the world as unsafe and of themselves as unworthy and not good enough.

Attachment theory was initially based on natural observation of children who had been separated from their parents, and later on the systematic observation of structured parent-child separations in the 'strange situation' research paradigm (Ainsworth 1989). This led to the classification of attachment behaviours displayed by children into three patterns: secure, avoidant, or anxious ambivalent. The secure pattern is shown by an ability to deal with the distress caused by temporary separation from the parent by seeking and gaining comfort from the parents and then rapidly settling back to play

again. In the avoidant pattern the infant displays an apparent lack of concern or interest in the parents' absence, and appears to be shutting down their feelings about the separation. In the ambivalent/anxious pattern the child shows most distress, is slow to settle and be comforted, and is likely to oscillate between displays of anger and clingy demands for comfort. This emphasis on the detailed observation of family interactions mirrors the early research on communication in families which laid the theoretical basis for the systemic therapies (Jackson 1965; Watzlawick *et al.* 1974). It also extends this approach by offering a developmental model of how attachments evolve in families as patterns of parent-child relationships.

Recent developments in attachment theory have emphasised not only the behavioural aspects of attachment but their internal representations. Bowlby (1969) initially termed these the child's 'working models' – a set of beliefs or stories about fear, comfort, their parents and themselves (Main *et al.* 1985; Crittenden 1998). More recent research has been based on the adult attachment interview (AAI). This is a structured interview which explores and describes the stories that adults tell about their childhood attachments to their parents. The interview transcripts are subjected to detailed analysis, which has revealed that childhood attachment experiences shape not only the content but also the form of people's stories – their ability to remember and recount their experiences in a coherent way. For example, one of the effects of being exposed to a prolonged experience of a lack of comfort and caring in childhood is that memories and accounts of childhood may become excessively restricted in detail, overly rational and devoid of emotional content. In contrast, inconsistent parenting appears to lead to accounts which are overly emotive, lacking in structure, contradictory and illogical. Attachment theory therefore offers an explanation of the development of narrative skills, especially in the context of people's memories of danger, threat, abandonment and loss, which are typically the problem areas that bring people into therapy. Importantly, these 'narrative skills' have been found to shape family members' abilities to reflect on and integrate their experiences.

Attachment theory therefore fills some of the key deficits in systemic and narrative approaches in that it offers an account of the emergence of family patterns, the shaping of the child's internal world, and the development of narrative skills. However, like systemic approaches, it has little to say about the wider socio-cultural

contexts. To take an example, the development of girls and boys may differ in families due to cultural expectation of how they 'should' learn to deal with danger. Likewise, there may be broader cultural differences in what are seen as appropriate ways of expressing distress and expectations of comfort (Crittenden 1998). Attachment theory places emphasis on historical rather than current interactional processes. Arguably, patterns of attachments are maintained not just by the internalisation of past experiences with parents but also by adult ongoing relationships with them.

### **Formulating within ANT**

This involves a weaving together of the three models by taking account of their contributions to the individual, interpersonal and socio-cultural levels of analysis. It is assumed that these models are mutually compatible, since they work at different levels and thus offer the possibility of conceptual integration.

#### ***Individual level***

This includes the ways in which early experiences in the family have serve to shape emotionally coloured beliefs about the availability of others to offer support, and feelings of self-worth. Importantly this includes an emphasis on the form and structure of the stories that people hold about these experiences.

#### ***Interpersonal level***

This includes an analysis of both historical and current patterns of relating in families which shape the child's or adult's beliefs and feelings, and those of his or her parents. The shaping and maintaining of current patterns of actions and the attempts that families make to solve their difficulties will also be considered.

#### ***Socio-cultural level***

This consists of an exploration of wider culturally shared beliefs and expectations and the ways in which they influence the ideas that family members hold about 'appropriate' ways of relating and dealing with distress and conflicts.



### **Jack: an ANT formulation**

ANT formulation attempts to connect all three levels of analysis. However, the guiding focus is on the narratives, in the broader sense of stories which constitute both meanings and emotional states, and which shape our choices about actions.

#### ***Attachments and narratives***

Central to attachment theory is a consideration of the way in which families deal with danger, threat and anxiety. An attachment analysis typically starts with the patterns of actions in families, especially in relation to how family members deal with danger and threat. Jack has clearly faced many dangers, both within and outside the family. He had witnessed and also had been the victim of domestic violence. It is extremely confusing and distressing for a young child when the people who are supposed to offer comfort and support are instead sources of danger. This is likely to generate very ambivalent feelings, especially in regard to seeking protection and comfort. It is likely that Jack came to understand that his father was dangerous and his mother not available because she too was distressed and frightened. Although he might have understood his mother's situation, he would also have felt angry and resentful at not being looked after and comforted as he needed.

A typical attachment strategy in such situations is for a child to attempt to become a 'carer', to sacrifice his own needs and try to look after his parents instead. This strategy could also have helped to alleviate the guilt he felt for feeling resentful and angry towards his mother for not looking after him, even though intellectually he knew why she was unable to do this. The fact that he was such a 'good' boy at school, well liked, talented and sociable, suggests that he was superficially quite successful in covering up, to the outside world at least, the distress and fear experienced at home. This pattern of a pleasing, 'false' presentation is described as 'false affect' and is a typical component of a role reversal, 'compulsive caregiving' (Crittenden 1998). It is likely that this pattern became more deeply entrenched when Jack's father left. Jack, his mother and sisters would have been deeply worried about how they would cope emotionally and financially. In this situation the need to be a 'good' and helpful boy who did not worry his mother with his own problems might have become even more important.

Attachment theory suggests that the internal model (set of core beliefs and emotions) which is likely to develop from such family experiences might include the following:

- My family is not safe.
- I cannot rely on my parents to protect and comfort me.
- One of my parents (if not both) is a source of danger.
- I need to try to please and look after my parents, and perhaps they might argue less if I do.
- The only person I can rely on is myself.
- Talking is dangerous and leads to violence.
- I should try not to think about my parents' actions or my own needs.

These thoughts are not necessarily conscious but are likely to be manifested in how Jack behaves, including his style of talking about himself and events in his family. To categorise Jack's attachment 'style' runs the danger of oversimplification, but on the other hand it can provide us with a starting point for our thinking about his potential needs and ways of emotional coping. A formulation which includes reference to some features of attachment styles may be helpful as long as we hold these as propositions or hypotheses rather than absolutes. For example, we can see some aspects of an 'avoidant' pattern of shutting down talking and feeling, as well as signs of compulsive caregiving and self-reliance. However, this may have changed as Jack became older and experienced extreme forms of distress and abuse. Furthermore, although this strategy may have been effective earlier, it did not seem to work so well later on since it did not halt the violence, the divorce or the abuse that Jack experienced.

Taking the Saturday delivery job may have been Jack's attempt to 'care for' and help his family, but this action in itself led to further abuse. Subsequently Jack may have adopted an increasingly anxious/ambivalent attitude. At its extreme this leads to a sense of deep distrust in others which might come to embody what is labelled as a 'paranoid' style of relating and a preoccupation with the past, current and future potential dangers.

An attachment narrative approach takes this further by considering how this family constellation shapes the ways that Jack made sense of, or processed, events in his life. Specifically, Jack's 'narrative skills' may have been underdeveloped. It is quite likely that he

had little experience of his parents discussing difficult feelings, problems and dangers in a relatively calm and contained manner. Rather, he is likely to have witnessed escalating interactions, possibly with angry shouting, accusations and threats. This might have led to a sense of language and communication as untrustworthy and dangerous, particularly where difficult feelings are involved, rather than a vehicle for conveying comfort and resolving problems. Jack would therefore be less likely to communicate about such matters and also less able to make sense of events internally or to develop a reflective and coherent story about his life. During relatively safe periods of their lives youngsters may be able to function reasonably adequately with this pattern, but for Jack there were many events which were very dangerous and unsafe. His relative inability to communicate with others or to make sense of these events for himself would leave him very vulnerable, swept around by emotional currents with little opportunity to integrate and resolve conflicting feelings and events. He might stay locked in his current ways of attempting to solve his emotional problems, for example, through denial of his needs, self-destruction, paranoia and anger.

This pattern may also have made Jack vulnerable to people who appeared to show him affection and care. Possibly this is in part how the sexual abuse arose, since Jack may have learned to minimise signs of danger as a way of trying to cope within his family. Subsequently it seems that he was unable to confide in his mother. Keeping this to himself may have meant that his shame and distress increased to the points where he had to find other ways of managing them, with drugs and alcohol. For Jack, this was more about self-medication than thrill seeking.

It is interesting to note that alcohol and barbiturates have the effect of shutting down cognitive, analytical and semantic processing and leave the person, initially at least, in a kind of warm emotional glow. However, such a state is unlikely to lead to insight. A young man like Jack without the education and drive to engage in productive, integrative activities, would be left increasingly emotionally numb as he avoids the painful process of making sense of his difficulties. In contrast psychedelic drugs such as cannabis and LSD can bring troubling thoughts to consciousness more vividly. Frequently, experimentation with these is described as prompting a psychotic or paranoid reaction. An attachment narrative approach would suggest that this may be because they strip away the defensive strategy of avoiding painful thoughts of danger, abandonment,

lack of comfort and rejection. Without practice in integrating such thoughts and images they can be overwhelming and lead to terror and paranoia. If Jack experimented with such drugs it is unlikely that he was able to access comforting and reassuring conversations with his parents in order to control and make the bad images, feelings and thoughts go away.

### **Attachments and systemic processes**

Attachment theory and systemic theory share an emphasis on examining patterns of interactions in families and considering how problems are a 'functional' response to the dynamics. We can suggest that as well as individual attachment styles there are family attachment styles. This fits with systemic theory: for example, the structural family therapy concepts of enmeshed and disengaged families correspond to ambivalent/preoccupied and avoidant/dismissive attachment styles (Hillburn-Cobb 1998). Systemic approaches, though, emphasise current maintaining patterns as well as historical ones. Jack's emotional pain and patterns of reaction were not just historical. He was being cared for by mental health agencies and had been 'rejected' by his family on the grounds that he was now a danger to them. From being a child *in* danger he had apparently now become one of the *sources* of danger to the family – he was seen as dangerous. His worries about his sister, in case she had been raped by Robbie Williams, were seen not as an indication of concern but a sign of madness. His use of medication, inability to communicate about problems and uncontrollable feelings, however, are almost certainly not just *his* tendency but also an ongoing family pattern. It would be interesting to know how his sisters and mother coped with distress. It appears that his mother's solution was to use medication. Thus, the pattern of not being able to address difficult issues and feelings was continuing and arguably escalating to the point where Jack, like his father, had to leave. Difficult feelings in the family appear to be solved either by the use of medication or by leaving. A summary of some key features in the family patterns is suggested in Figure 8.4.

This analysis suggests that it is still difficult for the members of Jack's family to look after each other. It is not clear how his sisters are coping; they may have been able to find sources of support outside the family. This may be more difficult for Jack because his fear of danger has extended from his family to the outside world.

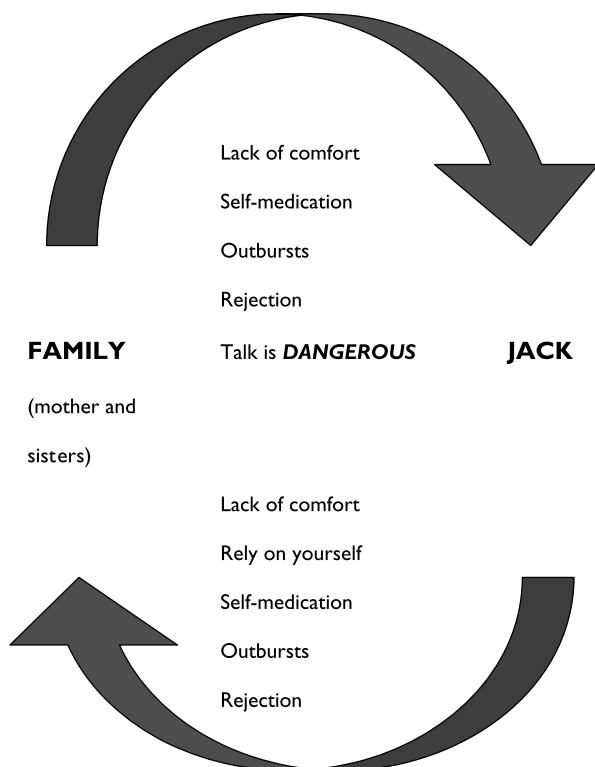


Figure 8.4 Family patterns, attachments and narratives.

However, it is likely that his sisters may also be vulnerable and may cope in similar ways to Jack in the face of major threats, losses or abandonments. In fact part of the anger towards Jack in the family may be because he is raising painful and difficult memories which in effect challenge the family style of forgetting, denying and dismissing painful events and feelings.

**Cultural contexts and narratives**

Jack's case is clearly coloured by a number of important socio-cultural factors. To start with it, it is as if his family shares a common discourse about the appropriate ways for men and women to express distress and receive comfort. These expectations are less

gender differentiated for infants but become increasingly so as they approach adolescence. Typically, boys have been expected to restrain their displays of fear and distress and to become more emotionally independent (Chodorow 1978). For many young men the process is complicated by the absence of a father from whom they can learn masculine ways of expressing their feelings. In Jack's case his father was not only absent but had himself been a source of distress and danger. Jack may have become increasingly confused about how to express his feelings in a female household. In this way the cultural imperatives may have aggravated the existing reluctance to discuss feelings and needs in the family. There may be the influence of Italian cultural norms, for example, a greater acceptance of emotional expression but within the context of a 'macho' culture. Consequently, Jack's feelings find an outlet indirectly through, for example, seeing his father's face in the mirror.

Psychiatric care may feed into these patterns by offering mainly management through medication. This reinforces the family's avoidance of feelings and locates the cause of the problems in a medical/organic discourse: Jack is suffering from an 'illness' or psychotic disorder. Jack is said to be relatively uncommunicative with his carers and is not engaging in therapy. However, he does comply with his medication which may indicate that he has accepted the powerful and prevalent discourse of a mental illness. This in turn will serve to reinforce the attachment problems that he and his family are experiencing.

### **Integration**

One of the key features of an ANT approach is that the formulation is based both on the *content* and the *process* of the dynamics and conversations in Jack's family. Access to Jack's and his family's communications is essential for formulating within this model. Some core ideas might be drawn from the kind of analysis conducted in the adult attachment interview. In its full version this involves a rigorous form of discourse analysis, but some key features could be extracted and utilised to suggest what kind of work might be appropriate with Jack. Familiarity with these techniques, including some training in AAI analysis, would be a helpful future development for therapists using an ANT approach. The transcripts can be classified into three main types which correspond to the reaction styles found in the research in infants:

- 1 *Secure*: able to use both emotional and cognitive information to make sense of past experiences; able to access memories of both positive and negative events and to reflect on and integrate these experiences.
- 2 *Dismissive*: characterised by accounts in which feelings are minimised. There is an overly rational style with little access to early memories; painful memories and parental rejections are especially hard to connect with and there may be an idealising of the parents along with a denigration of the self – ‘I am not good enough’. This corresponds to the avoidant pattern in infants.
- 3 *Preoccupied*: there is an overconcern with feelings, little ability to connect events in a coherent way, blaming of others for problems and preoccupation with the self. This corresponds to the anxious/ambivalent pattern in infants.

Although we do not know how Jack talks about his experiences, it is possible that, as suggested earlier, he had tried to cope by shutting down his own feelings and looking after other people's feelings instead. However, painful memories are still intruding. In attachment terms, Jack is using a mixed strategy in which his avoidant style of coping is breaking down, allowing frightening thoughts to come to the surface. Learning to talk about his feelings and experiences, as opposed to trying to block them off, will require considerable reassurance. At present he seems to see the only solution as turning to more extreme forms of avoidance through drugs.

In practice, the ANT formulation of Jack revolves around these three core concepts:

- 1 That his past and current attachment experiences shape how he manages distress, including his ability to place these experiences into narratives.
- 2 That the meanings he holds about these experiences are crucial, and that shifts in these can help him to think about the past, himself and the future in different ways.
- 3 That the narratives which Jack and his family hold take place within a wider social-cultural context which can include ideas about attachment and gender expectation and cultural differences about emotional expressiveness.

For example, it might be possible to help Jack and his family to

think about his father in a less negative way. It often turns out in such cases that the abuser has himself experienced abuse. This might help Jack to see his father's actions as less personally abusive towards him. A revision of his story about these events could help him to develop some different attachment narratives which might free him from his overwhelming sense of inadequacy and rejection. ANT, in short, gives a greater weight in formulation to meaning making and our power to 're-story' the past than is typically the case in attachment theory and early systemic formulations.

### ***Implications for intervention***

ANT therapy resembles systemic therapy in many ways. It can be conducted with the family and involve live supervision. In Jack's case this might be difficult initially since the family may be anxious about or resistant to meeting together. A starting point might be to meet with the women in the family and to explore their views of the problems and attachment issues, including their relationships with Jack and with his father. This might be complemented by individual work with Jack. It would be helpful if these two strands of work are integrated, possibly co-ordinating the individual sessions with the family meetings. The therapy is not time limited and follows a similar path to systemic family therapy, that is, family sessions every two to three weeks, in this case interspersed with the individual work with Jack. Typically transgeneration processes would be explored, for example, the nature of mother's own relationships with her parents, the patterns of parenting, attachments and comfort, and how these might impact on current relationships. It is interesting to note that little is known of the mother's parents and the potential source of support or aggravation of the problems that they may represent.

There may, of course, be cases where family meetings are not possible. An ANT approach could also be used in individual work with Jack, although it would be important to keep the family context in mind and discuss this during the sessions. It may also be feasible to have some contact with family members through phone, email or letters. The ANT approach encourages us to reflect on the attachments that Jack is making with the professionals who are involved. It will be important for him to form secure relationships with them in order to make the frightening journey of facing his demons, and experiment with different ways of managing his attachment needs through talking and sharing his feelings.



## Overview

In this chapter two examples of integrative models of formulations have been presented. They differ in how formal and organised the process of formulation is and also in terms of the models that they embrace. CAT is a formal organised attempt to integrate a number of models, whereas ANT is an elaborated version of the kind of integration that many clinicians often attempt in day-to-day practice. In many client groups different packages of care have evolved; for example, in eating disorders and psychosis most services offer a combination of medical, systemic and cognitive therapeutic interventions. Though clearly articulated as such, these can be seen as integrative at an implicit as opposed to explicit level. We suggest that even if clinicians do not go on to disseminate these packages as fully fledged integrative models, it can clarify both our thinking and our practice to engage in a process of considering how the different models can be used together and look at their conceptual similarities and differences. An important part of this is making explicit our implicit ideas about the connections between the various models that we employ. This may also assist us to evaluate treatments and identify the active ingredients of the various models, thus paving the way for better models of integration.

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# Controversies and debates about formulation

*Lucy Johnstone*

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### **Jack and Janet: the formulations**

The reader who has reached this point may well be feeling overwhelmed at the numerous ways of understanding Jack's and Janet's difficulties. There are certainly striking differences between the formulations: some are based on individual work with Jack and Janet, others on seeing the family; the formulation may be built primarily about their thoughts, or their feelings, or their relationships, or their social contexts, or the narratives they have woven about their lives; it may be constructed largely by the therapist, or jointly with the individual or family, or perhaps not exist in a traditional form at all; it may co-exist with a psychiatric diagnosis, or be seen as an alternative to a diagnosis, or else both the concepts of diagnosis and formulation may be regarded with suspicion; it may be an absolutely central or a very peripheral part of the underlying theoretical approach; and it may lead to very different kinds of intervention, or perhaps none at all. The two chapters on integration have, we hope, given the reader some pointers towards putting together the ideas from different models, and have also highlighted the need to work sensitively and reflectively in real-life settings.

The preceding chapters have also touched on the debates that surround the concept of formulation. We are now in a position to return to the themes of the very first chapter and explore some of the issues, debates and controversies in more detail, before coming to some tentative conclusions and finding out about how the real 'Jack' and 'Janet' have fared.

## **Formulations: a central process in the role of the scientific practitioner?**

As we saw in Chapter 1, the location of formulation within a scientific, experimental framework as 'a central process in the role of the scientific practitioner' (Tarrier and Calam 2002: 311) has been widely accepted by psychiatrists and clinical psychologists, especially those of a cognitive-behavioural orientation. As noted in earlier chapters, such assumptions are by no means universal, and the application of a positivist model of scientific enquiry to human problems and relationships is problematic in itself. However, if one does start from this position then, as Bieling and Kuyken (2003) have pointed out, formulation ought to stand up to scientific investigation into its reliability, validity and outcome.

Unfortunately 'current evidence for the reliability of the cognitive case formulation method is modest, at best' while 'there is a striking paucity of research examining the validity of cognitive case formulations or the impact of cognitive case formulation on therapy outcome' (Bieling and Kuyken 2003: 52). While the effectiveness of cognitive therapy as a whole has received support from the evidence, the same cannot be said for the heart of the approach, the individualised case formulation. For example, clinicians do not show high levels of agreement when asked about key elements of a formulation (Bieling and Kuyken 2003; Tarrier and Calam 2002); and there is virtually no research looking at the question of validity, or whether case formulations are meaningfully related to a client's presenting problems. Nor is there any clear link between case formulation and improved outcome. Kuyken (2005) has made a number of recommendations for future research into case formulation.

Recent investigations into psychodynamic formulations have been a little more productive (see summaries in Weerasekera 1996; Eells 1997; Messer 2001; Bieling and Kuyken 2003), although early attempts were unpromising (Malan 1976). One of the most extensively researched methods is the core conflictual relationship theme, in which key themes are inferred from clients' descriptions of their relationships and used to develop a formulation expressed in a standardised format (Luborsky and Crits-Christoph 1990). Interestingly, there is reasonable evidence of reliability between trained judges. There is also some limited evidence that interpretations

which are in line with the CCRT themes are positively related to therapeutic alliance and to outcome.

Kuyken (2005) suggests that this body of research can be used as a model for investigating the reliability, validity and so on of CBT case formulations as well. This raises some interesting questions. What is 'validity' as applied to a formulation, and how, if at all, could it be measured? (See Barber and Crits-Christoph 1993 and Messer 1991 for a discussion of this complex issue.) Could both CBT and psychodynamic formulations, for example, be shown to be reliable and valid for a given case? If so, which would be the 'correct' or 'true' one? Or are we actually talking about usefulness, not truth, in which case there could be a number of equally effective routes to solving the same problem?

### **Formulations: truth versus usefulness**

Butler, a clinical psychologist and author of a thoughtful overview of the subject, starts from the premise that formulation is 'the lynchpin that holds theory and practice together' (Butler 1998: 1), a broad definition that allows her to claim agreement from 'proponents of most major therapeutic traditions' including behaviour therapy, family therapy, cognitive therapy, cognitive analytic therapy and interpersonal therapy. She appears to be a little ambivalent on the question of whether formulations can be said to be 'correct' or 'true'. On the one hand she asserts that 'formulations can never be shown to be right as they are hypotheses not statements of facts . . . Like other scientific hypotheses, formulations can only be shown, conclusively, to be wrong' (Butler 1998: 20). This appears to locate the process of formulation alongside other scientific investigations which do assume that there are 'facts' and 'truths' about the way the world is, even if we can never reach a final account of them. On the other hand, she later says 'it is not necessary to believe that there is such a thing as a "correct" formulation', and quotes Messer: 'There is no one version of the truth because we largely construct our realities, which inevitably leads to multiple perspectives on that reality' (Messer 1996 in Butler 1998: 21). (Indeed, it is hard to see how any given formulation can be said to be the 'correct' one given that it is possible to formulate the same case from any number of different models – unless one assumes that some therapeutic models are 'truer' than others.) This view leans more towards a social constructionist perspective such as that

expressed in Chapters 4 (systemic formulation) and 5 (social constructionist formulation). The chapters in this book represent different positions along this continuum, from those that see the notion of a 'correct', 'true' or 'accurate' formulation as relatively unproblematic in principle (which as above usually leads to attempts to research and validate it along traditional scientific lines), to those which reject any such assumptions. The latter position would lead to a very different kind of research, more likely to be qualitative in nature and to focus on the *client's* perspective (one that is notably lacking from the investigations described above).

Although the tension between these two very different perspectives is not resolved in Butler's article, it does lead her to suggest that 'a formulation does not have to be correct, but it does have to be useful' (Butler 1998: 21). This allows us to take a step back from the debates about reliability, validity and so on outlined above. It also fits with how clinicians see the issue, according to one study: 'You know I guess I regard a formulation as *right*, if you are going to categorise it as right, if it *works*. If it doesn't work you may be as clever as you want to be . . . but if it doesn't lead to any change for the person' (Redman *et al.* 2002).

Usefulness itself has to be evaluated, of course, though perhaps according to less stringent criteria than truth, and Butler suggests that a 'useful' formulation will help to organise and clarify the information, develop an internal supervisor, and communicate with the client. She also puts forward a list of 'Ten tests of a formulation' (Butler 1998: 21):

- 1 Does it make theoretical sense?
- 2 Does it fit with the evidence? (symptoms, problems, reactions to experiences)
- 3 Does it account for predisposing, precipitating and perpetuating factors?
- 4 Do others think it fits? (the patient, supervisor, colleagues)
- 5 Can it be used to make predictions? (about difficulties, aspects of the therapeutic relationship, etc.)
- 6 Can you work out how to test these predictions? (to select interventions, to anticipate responses and reactions to therapy)
- 7 Does the past history fit? (with respect to the person's strengths as well as weaknesses)
- 8 Does treatment based on the formulation progress as would be expected theoretically?

- 9 Can it be used to identify future sources of risk or difficulties for the person?
- 10 Are there important factors that are left unexplained?

## **Formulations: useful to whom?**

### ***Useful to the client?***

To argue that a formulation should be useful immediately raises the question: 'Useful to whom?' Ideally, of course, one would hope that formulations would be useful to the client, although clients do not generally come to see us asking explicitly for formulations. Arguably, though, they do come to us asking for help in making sense of their experiences, which amounts to much the same thing. I will return to this point later. As we have seen, there is little evidence that formulations in general have a beneficial effect on outcome, which could be taken as a broad indication of whether they are useful to clients. Indeed, there is virtually no research at all on clients' views of formulations. One exception is Chadwick *et al.* (2003), who assessed the impact of case formulation on symptoms of anxiety and depression and found no significant effect. Semi-structured interviews revealed that nine clients found the formulation helpful by enhancing their understanding of their problems, and six felt reassured and encouraged. Six others reported that they found the formulation saddening, upsetting and worrying, for example: 'My problems seemed so longstanding, I didn't realise they went back to my childhood.'

As the authors note, it is not possible to draw any longer term conclusions from this; perhaps initial dismay was followed by a greater commitment to the therapeutic process, for example. Such an interpretation is supported by Evans and Parry (1996) who looked at the impact of the reformulation letter, a central feature of cognitive analytic therapy, on four 'difficult to help' clients. Reformulation did not seem to have any immediate effect on the clients' perceived helpfulness of the sessions, on the therapeutic alliance, or on individual problems, and in interview clients used words like 'frightening' and 'overwhelming' to describe its impact. However, this seemed to be related to a recognition that they had been faced with painful material that they had tried to block off, and they also commented that they now believed that the therapist had really listened to and understood them. Westcombe (2005), in a study that

reported on therapists' views of their clients' reactions to CAT reformulation letters, noted: 'A client might find the letter "hard to hear" but still feel understood. A letter could similarly be "overwhelming" *and* "containing", or "exposing" whilst also providing a feeling of being "known".' Moreover, these feelings might change over time. The therapists also commented that 'every response to the letter, as you might expect, tells you a little about the client', thus providing further material for the therapy.

This research, limited as it is, does highlight the important point that to share a formulation with a client, perhaps particularly if it is done in an expert-derived way, is a powerful action, which for this very reason may be experienced as distressing. In Chadwick *et al.*'s words: 'It raises the possibility that CF might be a point of unrecognised therapist–client distance for those clients with negative emotional reactions' (Chadwick *et al.* 2003: 675). Denman too (1995: 180) has warned that clients may find formulations 'distressing' or 'overwhelming'. The need for collaboration has been emphasised by all the authors in this book, and is a particularly strong feature of the co-constructed formulations described in Chapters 4, 5 and 6. With these, the risk of negative responses may be reduced, and client feedback can be used in an ongoing process of reformulation.

### ***Harmful to the client?***

The possibility of negative emotional reactions is even more relevant in situations where the formulation is – in the client's view – simply wrong. For example, an anonymous client reported:

My therapist simply ignored what did not fit into her theory . . .  
Worst of all, she dismissed abusive elements from my past . . .  
It's as if she has plundered my very being and soul and rewritten  
my life history according to what *she* thinks has affected me.  
(Anon quoted in Castillo 2000: 42)

Some particularly disturbing examples come from Jeffrey Masson's book *Final Analysis*:

I was fascinated by the fact that in less than one hour, a person's life was being summed up . . . And when Dr Garbin read us his summary, in the somber tone he gave it, it sounded more like a



judgement, a final judgement, than an interpretation, and I could just imagine how stunned, or stupefied, or mortified that patient would be to hear it:

‘The “truth” which dominated this patient’s life,’ he said, ‘was her discovery that she did not possess a penis and so had nothing to feel important about or to show off.’

[Masson commented] I pity that woman . . . her truth has been boxed in, sealed tight, unalterable forever.

(Masson 1990a: 67, 70)

A service user who interviewed other service users for her research made a similar point, describing ‘a man who was insulted to have been referred for any kind of psychiatric help as the disasters in his life of the last few years were quite sufficient to explain his somatic symptoms . . . Another person went for psychological problems, by his definition, and was given a social worker to work with him. He was insulted by the fact that what he had said about himself, and his idea of what the trouble was, had been ignored’ (V. Lindow, personal communication, April 2002). While it is not clear whether these clients had explicitly been offered a formulation as per the standard definitions, there was evidently a damaging clash between their own and the professionals’ broad understanding of the nature of their problems. Proctor (2002: 119) has vividly described how her therapist’s consistent unwillingness to revise her interpretations ‘had the effect of completely trapping me as someone unable to trust her own knowledge’.

A mismatch between the psychosocial understandings that service users often have of their problems and the medical model of standard psychiatric treatment that is offered to them has been widely documented (Rogers *et al.* 1993; Barham and Hayward 1995; Mental Health Foundation 1997). Disagreements between service users and professionals about *psychological* models and formulations have been much less discussed or explored. An interesting exception is Madill *et al.*’s (2001) conversation analysis of a case in which client and therapist failed to reach a shared understanding of the core problem, with the therapy ultimately having an unsuccessful outcome. This suggests that even if we cannot demonstrate that ‘correct’ formulations lead to good therapy outcomes, we may at least be able to show that ‘not useful’ formulations lead to poor outcomes.

Formulation should be an ongoing process rather than a one-off

expert pronouncement (see Chapter 7), and therefore one would hope that reformulation based on the client's feedback would ensure that unhelpful formulations are revised or abandoned. Unfortunately, this does not always happen. Dumont (1993) provides an early example of Freud's refusal to give up a general formulation that, as he himself acknowledged, met with considerable disagreement from his patients. When 3-year-old Hans's mother threatened that the family doctor would cut off his penis if he touched it again, Freud noted that he was 'obliged to infer' a castration complex, although his patients 'one and all struggle violently against recognising it' (Freud in Dumont 1993: 198).

In the same vein, Masson (1990b) provides a tragic rereading of the famous case of Dora, who determinedly resisted Freud's interpretation that she was secretly in love with Herr K, a friend of her father. In fact, as Masson shows, Dora was repelled by Herr K's advances and legitimately furious that her father had tried to promote this liaison as a pay-off for his own affair with Frau K. She ended up being betrayed not only by her father but also by Freud, who was determined to impose his own view of reality on her.

Such travesties are not confined to dead psychoanalysts. Dumont (1993: 197) argues that theories are 'mindsets that not only dispose us to select and configure the innumerable data that clients proffer over several sessions, but in subtle ways tendentially elicit those data in the first place . . . Rogerians, rational emotive therapists, Horneyans, behaviourists, existential therapists, Freudians, Gestaltists, among many others, rather consistently formulate . . . the same kinds of problems for the most diverse clients and disorders.' Having done this, they are all likely to make 'the fundamental error in problem solving . . . thinking that the "givens" of the problem are facts when indeed they are more or less fallible inferences' (Dumont 1993: 196). We tend to be extremely resistant to revising our initial explanations of phenomena, even in the face of contradictory evidence. In systemic therapy this reluctance to give up on a formulation has been termed 'marrying one's hypothesis'. While a little dating and courtship is permitted, the general advice is to be as promiscuous as possible with one's hypotheses (Dallois and Draper 2005).

Social psychology research has established that our judgements are characteristically distorted by a whole range of attributions that operate largely outside our awareness. Kuyken (2005) has summarised the biases that may affect the process of case formulation,

especially at times of uncertainty and time pressure: the tendency to interpret new information as an example of something else that we already know about (representativeness bias); the tendency to draw on information that is more easily available to us (availability bias); and the tendency to assimilate new information into a core initial hypothesis (anchoring and adjustment bias). The eleven psychologists interviewed by Redman (Redman *et al.* 2002) reported looking mainly for information that confirmed their hypotheses, with disconfirmatory information only emerging later in the process.

The general point seems to be that professionals need to maintain a difficult balance between the theory and formulations that their work is based on, and the suspension of these ideas that allows them to listen properly to their clients. Butler notes: 'Being on the receiving end of a formulation can feel like being weighed up, evaluated, or judged – like being "seen through" or "rumbled" rather than understood' (Butler 1998: 2). The examples cited above suggest that if the therapist insists on imposing a formulation that is actually wrong, or that is strongly rejected by the client, the consequences can be even more devastating. Masson notes: 'We know that even torture victims often find the fact of not being believed as painful as the torture itself' (Masson 1990b: 96). In her introduction to his book, Dorothy Rowe says: 'Whenever our own truth is denied, ignored or invalidated we experience the greatest fear we can ever know: the threat of the annihilation of our self' (Rowe in Masson 1990b: 17).

The fundamental issue here is power, and specifically, the power of one person, in an expert position, to impose their viewpoint on another. Worryingly, Westcombe (2005) found it was rare for clients to ask for changes to CAT reformulation letters: 'Even when I've made a factual mistake no one has asked me to change it.' In Rowe's words: 'In the final analysis, power is the right to have your definition of reality prevail over all other people's definition of reality' (Rowe in Masson 1990b: 16).

There is no space to repeat or explore the wider debates about power in psychotherapy here, although they are obviously relevant to formulation since it is a central process in most therapies. Viewpoints range from Masson's assertion that all therapy is inevitably abusive because it always involves an imbalance of power (Masson 1990b), to Proctor's (2002) more sophisticated analysis of the different kinds of power, both positive and negative, that may form part of the therapeutic relationship. For the purposes of this book,

we can note that formulation is less likely to be damaging if it 'is presented questioningly and collaboratively . . . It should be presented as a hypothesis, not as fact. . . . Formulation thus goes hand in hand with reformulation' (Butler 1998: 22). In other words, the tentative and provisional nature of the formulation must always be borne in mind, and it should be a joint exercise.

Rosenbaum (1996) is also aware of the dangers: 'Formulation can slide too easily into "fitting something to a known formula".' He describes his 'manifesto for avoiding formulation':

Whenever I see a client, my first step towards formulation is to take the walk from waiting room to office one relaxed step at a time. Once I get back to the office, I have the client precede me into the room while I stand outside and try to let go of everything I have ever heard, hoped for, expected or wanted – what Bion (1967) calls entering the session 'without memory and without desire'. I pause and make an active effort to cultivate compassion, kindness, acceptance, and joy for the client.

(Rosenbaum 1996: 110)

Attaining Rosenbaum's Zen-like position of detachment, although a worthy aim, is likely to be difficult or impossible for most of us. We cannot separate ourselves completely from our own assumptions and judgements and those of the culture we are part of, and it may be naive to tell ourselves that we can. This raises the question of the role of formulation for the therapist.

### ***Useful to the therapist?***

Most of Butler's (1998) 'Ten tests of a formulation' seem to apply more directly to the therapist than the client. He or she will be enabled to organise material, make predictions, identify risks, select interventions, and so on. Her 'Summary of the purposes of formulation' (see Chapter 7) is also mainly therapist focused, covering factors such as clarifying hypotheses and questions, planning treatment strategies and predicting responses to strategies and interventions.

One would hope, of course, that what is beneficial to the therapist would also be beneficial to the client. Once again, there is little experimental evidence to support this. Chadwick *et al.*'s (2003) study found that it was powerful and validating for therapists to have clients endorse a case formulation; that CF made the therapists

feel more hopeful about therapy; that it increased the therapists' sense of alliance and collaboration; that it increased therapist confidence in the choice of therapy and improved adherence to it; and that it increased therapists' understanding of the clients' problems. However, as noted above, there was no identifiable change in the *clients'* distress or alliance scores. The authors note the possibility that 'at least some of the faith therapists have in the potency of CF might be due to the impact it has for them personally' (Chadwick *et al.* 2003: 675).

Any practitioner can appreciate the feeling of relief at arriving at a formula that seems to offer an explanation and a possible way forward, in the face of the overwhelming pain and confusion that clients bring to us. In Yalom's words, our theories are 'self-created, wafer-thin barriers against the pain of uncertainty' (Yalom in Dumont 1993: 203). However, there is a danger that this is meeting our emotional or intellectual needs and not those of the client. There may be less risk of this in approaches such as systemic where, as we saw in Chapter 4, the team may generate multiple formulations, which are offered to the family and judged in terms of their usefulness to them.

### ***Useful to professions?***

There is another important way in which formulations may primarily serve the interests of the therapist rather than the client, and that is via the benefits that may accrue to the therapist's profession by adopting a formulation-based approach. As discussed in Chapter 1, formulations do not originate with and are not used exclusively by any single profession. Nevertheless, recent attempts have been made to claim this skill uniquely for clinical psychology. In answer to the question 'What makes clinical psychology special?' Peter Kinderman asserts:

Clinical psychology is a discipline and a profession based on formulation. We are unique because of the skills we have in formulation, the manner in which we do it and the approach we take to it . . . This unique approach is worthy of particular praise as an elegant application of science . . . It is my contention that the success of clinical psychology is, in fact, the success of formulation.

(Kinderman 2001: 9)

The Division of Clinical Psychology (DCP) is broadly in agreement. In a paragraph on formulation in *The Core Purpose and Philosophy of the Profession* (Division of Clinical Psychology 2001: 3) it is asserted that: 'What makes this activity unique to clinical psychologists is the information on which they draw. The ability to access, review, critically evaluate, analyse and synthesis psychological data and knowledge from a psychological perspective is one that is unique to psychologists.' Formulation is defined as one of the four core skills of a clinical psychologist (Division of Clinical Psychology 2001).

These rather grandiose claims have been greeted with scepticism by other clinical psychologists (Crellin 1998; Harper and Moss 2003). Harper and Moss (2003: 6) feel that formulation 'had a minimal influence on our development as clinical psychologists and it is perhaps testament to our profession's ability to regularly reconstruct its identity that formulation, barely heard of a decade ago, is now seen as a central defining characteristic'. Crellin argues that claims about formulation have served the key political purposes of, in the early years, achieving professional independence from psychiatry, and more recently justifying increases in grading and training places.

It would be interesting to see how clinical psychology would respond to competing claims about expertise in formulation from other professions. The word 'expertise' is itself open to deconstruction, of course. The skills involved in drawing up a systemic or narrative therapy formulation may be very different from the 'application of science' that Kinderman has in mind. Nevertheless, the defence might well lie in claims to be drawing exclusively on research and evidence as a basis for formulation – an 'elegant application of science' as Kinderman puts it, or 'the lynchpin that holds theory and practice together' in Butler's words. The DCP document similarly describes clinical psychologists as 'more than psychological therapists' because they are 'rooted in the science of psychology' and their role is to apply 'psychological science to help solve human problems' (Division of Clinical Psychology 2001: 4).

Detailed discussion of these claims is beyond the scope of this chapter (but see Bem and de Jong 1997 and Jones and Elcock 2001 for debates on the status of psychology as a science). However, Boyle (2001) has some interesting arguments to make about the possible role of formulation as an alternative to psychiatric

diagnosis (see below); a less self-interested though not unproblematic way for clinical psychologists to make political use of the concept of formulation.

### **Formulation versus diagnosis?**

The various therapeutic approaches have taken different views on whether formulation is a replacement for, or an addition to, psychiatric diagnostic systems such as DSM. As we saw in Chapter 1, early behaviour therapists, as part of establishing their credibility in relation to psychiatrists and their right to work independently from them, promoted functional analysis (subsequently developed into case formulation) as a more useful alternative to diagnosis, since it did not rely on unobservable mental entities and had clear implications for intervention (Eells 1997). Contemporary CBT therapists are more likely to see the two systems as able to co-exist (see Chapter 2). Turkat, an influential figure in the development of case formulation, argued that 'diagnosis and formulation complement each other' (Bruch and Bond 1998: 3). Tarrier and Calam, clinical psychologists and CBT therapists, argue that 'it is feasible to use case formulations within a disorder-based classification system' (Tarrier and Calam 2002: 315).

Early psychoanalysts did not include psychiatric diagnosis as part of their understanding of their patients (Eells 1997: Chap. 1) although contemporary psychoanalytic and psychodynamic clinicians may well do so (Malan 1995). According to one psychodynamic therapist, 'diagnosis and formulation have different and complementary functions'; both are said to be useful, especially in neurosis and 'personality disorders' (Aveline 1999: 199).

Some CBT therapists have reached a kind of halfway house on this issue, using psychiatric diagnostic terms such as histrionic or narcissistic personality disorder as a shorthand general formulation for certain groups of individuals who express their problems in characteristic ways. In a similar way, psychoanalytically oriented clinicians may refer to 'psychoanalytic character diagnosis', which uses diagnostic terms such as 'paranoid personality', 'depressive personality' and 'manic personality' to describe certain character structures and the typical defences and transference reactions that accompany them (Weston 1990). The intention here, again, is to provide a general formulation of certain types of psychological difficulty together with indications for therapeutic intervention.

This would be supplemented with a formulation constructed to fit the particular individual.

This is a somewhat confusing use of language. All therapists are likely to have at their disposal certain broad level formulations that describe common patterns of difficulty (for example, 'bereavement reaction' or 'trauma reaction'). These help therapists to look out for typical responses (denial, shock, flashbacks, and so on) and to suggest therapeutic interventions that are often found useful in such cases. However, it introduces an extra layer of confusion to use *medical/psychiatric* concepts in order to describe something that is actually being conceptualised in *psychological* terms. As discussed below, the two models, medical and psychological, have very different assumptions and implications.

Systemic therapists have always seen families in social and relational, as opposed to medical, terms. They start, by definition, from the fundamental assumption that difficulties never reside within one individual, as is implied by a psychiatric diagnosis. As described in earlier chapters, social inequality and social constructionist therapists, and some family therapists, are sceptical not only about diagnosis but about formulation as well. Their focus is not 'the problem' (or 'the formulation') as such; rather, it is the views of 'the problem' held by the identified client, his or her family, and by the systems in which both client and therapist live and work.

Some of the best-known writers on formulation take the view that combining psychological formulation with psychiatric diagnosis is unproblematic. Eells, for example, suggests that 'a case formulation provides a pragmatic tool to supplement and apply a diagnosis to the specifics of an individual's life. It also serves as a vehicle for converting a diagnosis to a plan for treatment' (Eells 1997: 339). Weerasekera's grid in which formulations from various models can be combined with psychiatric diagnosis to produce a comprehensive treatment plan has been described in Chapter 7. Thus, for example, 'an individual suffering from depressive and anxiety symptoms in the presence of chronic, severe marital distress may benefit from individual (medication plus cognitive behavioural therapy) and systemic (marital) therapy ... A pharmacological treatment of depression can be integrated with marital therapy, whereby the same therapist administers the medication and conducts the marital therapy' (Weerasekera 1996: 357).

It is probably not a coincidence that both these writers are psychiatrists. Indeed, their suggestions have much in common with



the multi-axial classification of DSM, whereby information about personal and social context is added onto the main psychiatric diagnosis. However, as we have seen, such views are not unique to psychiatrists. A recent debate on the subject in *The Psychologist* (Pilgrim 2000; *The Psychologist* 2000) drew supporters from both sides.

In Chapter 7 on integration it was pointed out that the professionals and institutions surrounding clients may well be working from fundamentally medical assumptions and thinking in terms of diagnosis, medication and so on, and that in Jack's case this may have both benefits and costs. For example, Jack's medication may help both him and his family to cope at present – but on the other hand, it may reinforce the message that he is inadequate and a failure. A 'formulation fight' between professionals is not going to help anyone, least of all the client, and the authors give some useful ideas about how to avoid this. However, in this chapter I want to explore the disadvantages of combining the two systems in a little more detail.

For a start, there are the many documented shortcomings of psychiatric diagnosis as a form of classification: low reliability, lack of validity of diagnostic concepts, overlap between categories, and unclear links with aetiology, prognosis and treatment. It can also have a number of other undesirable consequences such as the obscuring of personal, social and cultural contexts; the individualising of problems; stigma and disempowerment; removal of responsibility; omission of the client's viewpoint; objectification of the client; and most worrying of all, the loss of personal meaning (Kirk and Kutichins 1992; Follette and Houts 1996; Mehta and Farina 1997; Johnstone 2000; Pilgrim 2000; Honos-Webb and Leitner 2001; Boyle 2002). Formulation could, at least in principle, be seen as a possible way of reintroducing personal meaning, personal and social contexts and mutual collaboration into mental health work.

Arguing against the use of both systems concurrently, Boyle (2001) points out that if psychiatric diagnosis did what it aims or claims to do, and provided a valid, coherent and reasonably complete account of someone's difficulties with clear indications about effective treatment, then psychological formulation would be redundant. The same is also true the other way round. If a convincing formulation can be developed, meeting Butler's (1998) criteria for accounting for the facts, indicating the intervention and so

on, then an extra explanation that says in effect, 'Oh and by the way, they have a mental illness too' becomes redundant (Johnstone 1993). With a dual system, we are being offered incompatible explanations from conflicting models: 'You have a medical illness with primarily biological causes' versus 'Your problems are an understandable emotional response to your life circumstances.' In essence, a formulation says that the nature and content of your distress is *personally meaningful*, while a diagnosis says that it is *meaningless*. These assumptions cannot both be true.

Moreover, the adoption of both models at the same time leads to damaging contradictions in clinical practice, as noted in Chapter 7. With Weerasekera's anxious and depressed client, for example, the medication, unless carefully explained, carries the message that 'the problem is a biological one lying within you as an individual, and the pill will rectify it'. On the other hand, the marital therapy will not make progress unless the couple are able to accept that 'the problem is a function of the relationship you have with each other, and you both need to accept responsibility for working on it'. This is a recipe for stalemate (Johnstone 2000).

Thus formulation can, Boyle argues, be offered as a genuine alternative to diagnosis and its many shortcomings. Pilgrim agrees, asking: 'Do we not have a professional responsibility to challenge and expose the shortcomings of a diagnostic approach? . . . Surely our main duty is . . . not to shore up medical reifications, but to demonstrate why formulations about specific presenting problems in specific contexts are more useful and compelling.' He attributes the failure to do this to clinical psychology's 'ambivalent position towards psychiatry – wanting full professional independence but, at times of selective convenience, co-opting a medical knowledge base' (Pilgrim 2000: 304).

However, it is not a simple matter of jettisoning one system for the other. For a start, 'the issue is that "problem" is not an objectively identifiable natural category, and it is often not possible to see any particular behaviour or experience as inherently problematic' (Boyle 2001: 2). This is an issue that has been explored most thoroughly within systemic, social constructionist and social inequality approaches, with their willingness to ask 'Who has the problem?' and to deconstruct some of the current discourses around what is viewed as problematic behaviour (being a single parent, being a working mother, and so on).

A related danger is that formulations can be open to some of the

same criticisms as diagnosis: for example, that by uncritically accepting the view of the service user or client as the site of the problem, formulations individualise distress and ignore social context. As we have already seen, there is no guarantee that formulations will not be used in a stigmatising, objectifying, uncollaborative way as well. Perhaps the best that can be said is that such tendencies are not intrinsic to the process of formulation (and the earlier chapters have discussed a number of ways of trying to avoid this), whereas they are, arguably, an almost unavoidable consequence of psychiatric diagnosis. It may be useful to discuss these issues in more depth.

### ***Are formulations individualising?***

It is certainly true that formulations can be individualising, ignoring personal and social contexts and replicating the damage that has been attributed to psychiatric diagnosis for the same reasons. The early women's movement abounded with accounts of women whose despair at being trapped within traditional roles had been met with mystifying psychoanalytic formulations from their (male) psychotherapists:

The loss of her father when she was six was assumed to be the cause of Mrs O's depression, and her unresolved Oedipal conflict was thought to underlie her husband's complaints of her frigidity. Mrs O . . . was totally responsible for the 24-hour a day, 7-day a week care of three pre-school children. Her husband's demanding job as an air traffic controller . . . precluded any help from him. Mrs O felt trapped, tired, overwhelmed, resentful and seething with anger towards her husband. Because of her socialisation she thought she should be happy, could not acknowledge her feelings as expectable in the situation, and agreed with her doctor that she was depressed, neurotic and had sexual problems.

(Penfold and Walker 1983: 179).

Davis's (1986) detailed qualitative analysis shows how the task of reformulating a female client's initial version of her problems as stemming from her role as full-time housewife and mother into an individual deficit (she is not good at expressing her feelings) is achieved via the therapeutic conversation.

A central claim of David Smail's extensive critiques of therapy is that psychotherapies are concerned with individual internal psychological states viewed in isolation from their social and political context (Smail 1993, 1996). Another noted critic of psychotherapy, Jeffrey Masson (1990b), contends that by focusing on the individual, 'every therapy I have examined displays a lack of interest in social justice' (Masson 1990b: 285). The result of formulating social and political problems as individual pathology is mystification about the true origins of one's distress (Smail 1993, 1996) and 'an implicit acceptance of the political status quo' (Masson 1990b: 285), which for some people betrays the true purpose of the therapy industry: 'The rise of a purely psychological view of human difficulties is a handy way of mystifying social reality' (Kovel in Ingleby 1981: 73). The key question is whether formulations have to be individualising. A number of attempts have been made to avoid this danger.

Systemic therapists, by definition, seek to formulate problems from a broader than individual perspective, including as appropriate the couple, family, school, workplace, and so on. They are likely to be aware of competing views about whether there is a problem and what the problem is, from the individual, the family, agencies such as the police and social services, the school, the legal system, professionals and the wider culture (Dallos and Draper 2005). This may lead to a complex, multilayered intervention of the type described in Chapter 4.

Community psychology is a movement within clinical psychology which, as we saw in Chapter 6, aims to develop an understanding of people within their social worlds and to use this to reduce mental distress through social action. A well-known example of this comes from community psychologist Sue Holland, who has developed an approach that she calls social action psychotherapy (Holland 1992). In this, women move, as and when they are ready, from 'Step one: Patients on pills' through the various stages of person-to-person psychotherapy, talking in groups and taking action in their community. The formulation or understanding of their difficulties thus proceeds in layers, with the second step most closely resembling traditional psychotherapy and the last two adding in the social and political dimension. Holland calls this 'a progression from private symptom to public action' (Holland 1992: 5).

There have, then, been a number of attempts to integrate wider relational, social and political factors into the understanding of

people's problems, although it should be noted that simply asking the family along does not in itself guarantee such a formulation. See, for example, the family management approach to psychosis which is based on the philosophy that 'we do *not* view the family as being in need of treatment . . . our aim is to help the family to cope better with the sick member who is suffering from a defined disease' (Kuipers *et al.* 1992: 346). Nor, as Sue Holland observes, does working in the community necessarily indicate a willingness to acknowledge the role of inequality and injustice in the people's difficulties: 'The present trend towards "hospitalising the community" . . . using new means but old models . . . is a backward step' (Holland 1992: 7).

Equally, it has been argued that individual therapy need not necessarily imply an individualising formulation of the client's difficulties. Roy-Chowdhury contends that Smail draws a false dichotomy between the practice of individual psychotherapy and the acknowledgement of the social world. While 'the socio-cultural constraints of poverty and disadvantage . . . should not be psychologised away' (Roy-Chowdhury 2003: 8), there is still the possibility (although it is certainly underdeveloped in many mainstream therapies) of using the psychotherapeutic conversation to make the links between the individual and the society of which they are a part (for examples, see McNamee and Gergen 1992). This is a position that Smail himself appears to acknowledge at times when he talks of the role of individual psychotherapy as 'to side with the person rather than the social world, helping to drag out his or her *internalised* norms . . . At the very least this gives people the freedom to think and feel what they like, to examine their experience for its significance rather than simply for its "abnormality" ' (Smail 1987: 401). The implication is that even within one-to-one therapy it is possible both to challenge assumptions about the nature of the 'problem' and to construct formulations which link the person and their social context.

### **Can anyone make formulations? Do we need them at all?**

Despite the many claims made for formulation, it is not seen as essential by everyone; indeed some would dispute that it constitutes a special skill at all: 'Every time you cross a road you are formulating. It is hardly a higher skill . . . Why a person in their mid-twenties

with a postgraduate psychology qualification would be better at this than, say, a journalist, a reasonably well-read union member, a social historian or my mum, is beyond me', in the view of one clinical psychologist (C. Newnes, personal communication, April 2002).

Some therapeutic approaches explicitly reject the use of formulation in its usually understood sense, as we have seen in the chapters on social constructionist and social inequalities approaches. An interesting alternative to standard formulations is provided by the repertory grids used in personal construct therapy (Kelly 1955; Bannister and Fransella 1990; and see Chapter 8). George Kelly, its founder, argued that we all have our own versions of reality, which provide us with a more or less useful guide to living our lives. Our hypotheses about the world are described in terms of peripheral and core constructs, the latter being those that are fundamental to an individual's identity. Repertory grids are essentially a way of allowing clients to produce a picture of their own personal system of meanings, unique to that individual; their own distinctive way of formulating the world around them. No one, therapist or client, has the 'correct' or complete view, but there is always the possibility of modifying one's constructs in favour of more flexible and productive ones. Constructs can be explored through the grid, which Kelly likened to the activity of a researcher (the client) investigating their own life with the help of a research supervisor (the therapist) and making their own discoveries about it.

Carl Rogers saw formulation, or as he referred to it 'psychological diagnosis', as unnecessary and even damaging, since it implied the use of power and expertise by the therapist with the consequent danger of the client relinquishing responsibility for themselves (Rogers 1951 in Eells 1997). However, his writings make it clear that something rather similar, that is, finding the meanings of the client's experience, is a central aspect of being empathic, albeit with a very person-centred emphasis on caution, sensitivity and non-judgementalism:

It [being empathic] involves being sensitive, moment to moment, to the changing felt meanings which flow in this other person . . . By pointing to the possible meanings in the flow of his/her experiencing you help the person to focus on this useful type of referent, to experience the meanings more fully, and to move forward in the experiencing.

(Rogers 1975: 4).

The Hearing Voices network (referred to in Chapter 6 as an example of an approach that emphasises meaning and creativity) is a service-user led movement that challenges the view of voices as pathological and promotes various non-medical ways of coping with them. They have found that voice hearers develop their own ways of understanding their voices – for example, as originating from ghosts or gods, as a special gift, as guides, and so on – and that it is extremely important for professionals and helpers to respect these ‘formulations’ and not try to impose their own. ‘Accepting the experience and the belief system is a prerequisite of effective therapy’ (Romme and Escher 2000: 108). On the other hand, Romme and Escher also describe how finding a way of relating the voice to life experiences – in other words, of finding a meaning and a formulation – can bring relief from distress: ‘Our studies have shown us that there are at least three different ways of formulating the link between the voices and someone’s life history: as a historical relationship, as a psychodynamic relationship, and as a metaphorical relationship.’ They give examples, such as a woman who started hearing voices which talked about her after she lost her job; Romme and Escher suggest that this echoed the trauma of the way she had been sacked due to others spreading gossip about her (Romme and Escher 2000: 28).

It could be argued, then, that even those constructivist, humanistic or self-help approaches which reject the use of formulation as such, and strongly object to the idea of a professional producing this kind of summary, are in fact using techniques or strategies which have the aim of helping clients reach a psychological understanding, or formulation, of their distress. The key difference seems to be an overriding emphasis on respecting the client’s own views – a welcome antidote to some of the abuses described earlier in the chapter.

### **So what are formulations then?**

As noted earlier, clients do not typically come to us requesting a ‘formulation’ of their problems. In the sense suggested above, though, it can be argued that they do approach us asking for help in constructing *meaning*, a way of *making sense* of their distress. The understanding and creation of meaning is certainly not unique to therapists; indeed it is central to what it is to be human. Personal construct therapy argues that we are essentially meaning creating creatures. We are engaged in a constant process of hypothesising

about the world around us, and creating and elaborating a personal system of meanings which will enable us to survive in it. We are, in this sense, 'formulating' our experiences all the time. Thus it is not surprising if we can find examples of what could loosely be called 'formulations' in all aspects of our daily lives – including, perhaps, crossing the road – and anywhere that is concerned with exploring what it is to be human, such as novels.

Butler (1998: 2) suggests that the key assumption underlying all formulations is that 'at some level it all makes sense'. Towards the end of her review she describes formulation as 'a way of summarising meanings, and of negotiating for shared ways of understanding and communicating about them'. This may be a flag under which therapists of different persuasions and their clients can all unite – despite the other differences outlined in this chapter.

Harper and Moss make a similar point when they describe formulation as, in essence, 'a process of ongoing collaborative sense-making' (2003: 8). Although it may draw on theory – as well as on numerous other sources – this construction of what might be called a shared story does not fit comfortably within the traditional rhetoric of the scientist-practitioner and evidence-based practice. It does, however, allow for reflexivity and an awareness of all the potential pitfalls discussed above.

Is formulation, on this definition, a special skill? Could our mothers do just as well? The answer is both yes and no. We are all constantly engaged in a process of creating theories about the world and the people in it, and a great many non-professionals (as well as novelists, poets, philosophers, priests and others whose subject matter is human nature and human suffering) are extremely good at this. On the other hand, as Roy-Chowdhury (2003) has argued, we can acknowledge this without falling back into the 'therapy/formulation is no more than a chat with a friend' camp. Like the authors quoted above, he sees the core aim of therapy of all brands as 'to seek to understand and make sense of another's experience and to offer these provisional and tentative understandings to the other for consideration' (Roy-Chowdhury 2003: 8). However, his discourse analysis of therapy conversations suggests that this is a highly skilled procedure. While drawing on basic human warmth, the therapist must also 'listen not only to what is ostensibly signified in the therapee's speech but also to the hidden and disguised significations'. The therapist who is not 'tuned into the nuances of the talk, the multiplicity of discourses evoked in each sentence, who



does not seek to enter the lifeworld of the client and to communicate an understanding of that lifeworld using a language congruent with the expectations of the client' (Roy-Chowdhury 2003: 9) will risk losing the client. We might add that the therapist must also be reflective about his or her own assumptions and feelings, aware of the developing relationship with the client, and sensitive to differences in each other's formulations. He or she will bring to the relationship a body of knowledge and theory as well as accumulated 'practice-based evidence' from clinical experience, and these need to be woven into the therapeutic process in ways that respect the clients' own feelings and meanings.

## Summary

The potential criticisms and limitations of formulation echo the potential criticisms and limitations of therapy itself. This is hardly surprising if formulation is conceived, at least by most schools of therapy, as central to the process of therapeutic intervention. Both pose enormous problems for evaluation; both raise questions of truth versus usefulness; both can be damaging; both can be used for professional and political ends; both contain implicit assumptions and value judgements; both have a problematic relationship to psychiatric diagnosis; both can be individualising, ignoring social and cultural contexts; both are open to analogies about the emperor's clothes. On the bright side, both are requested and (often) found helpful by service users (if we use formulation in its 'meaning-seeking' sense); both can offer an alternative to psychiatric diagnosis and intervention with all its well-documented damage; and both, arguably, demand a high level of skill, though not one that is unique to any particular profession or indeed any particular group of human beings.

If we wish to maximise the benefits of formulations for our clients, and minimise the potential damage, the lessons seem to be that we must:

- be reflexive about our own role in the formulation and the values and assumptions we bring to it
- offer formulations tentatively
- construct formulations as collaboratively as possible
- be constantly aware of the need to reformulate
- express formulations in ordinary language

- respect and defer to our clients' views about the accuracy and usefulness of the formulation
- take systemic and social/political factors into account.

If we wish to promote the use of formulation more widely as a route to understanding and intervening in mental distress, and perhaps even as an alternative to psychiatric diagnosis, we must:

- be cautious about entering debates on the reliability and validity ('correctness' or 'truth') of formulations
- carry out more and different types of research, including qualitative methodologies and collaboration with service users, into the effects of formulation on the client, the therapist and the therapy
- abandon unsupportable claims about the uniqueness of formulation to any one profession
- be willing to speak out about the shortcomings of psychiatric diagnosis, while 'highlighting the social and moral issues which diagnosis has helped to obscure' (Boyle 2001: 5)
- include social context in formulations from all therapeutic perspectives
- be realistic, but confident, about the usefulness of formulation.

### **Jack and Janet: an update**

Jack was discharged from hospital in a slightly more settled state after a few weeks. He never really engaged in individual therapy, due to his erratic timekeeping and tendency to disappear into fantasy. A family meeting appeared to help all parties to appreciate each other's positions a bit better. Jack received a lot of practical support from a male community psychiatric nurse with whom he had a good relationship and later from an occupational therapist. A year on, he was very proud of the flat that had been found for him and had made contacts in the local community. After numerous relapses into drinking, he had finally committed himself to an access course to higher education and intended to take a degree in marketing in the future with the aim of going into the music business. He was still quite preoccupied with Robbie Williams but seemed to have decided that 'if he was going to get me he would have done so by now', and was mostly able to put these worries out of his head. Jack was in friendly contact with his mother and sisters.

Janet is doing reasonably well. She is attending school and getting on better with her mother. Although she still has anxieties about public transport, her mother is less concerned about this and believes that Janet will eventually overcome her worries. Family work seems to have helped Mary to feel more confident as a mother and less to blame for Janet's difficulties. The fact that Andrew, Janet's brother, is continuing to do well at school is a further boost to Mary's confidence as a parent. Janet has not resumed contact with her father.

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