Formulation and its use in clinical psychology

Formulation is considered to be a basic and vital therapeutic skill (Eells, 1997; Morrison, Renton, Dunn, Williams, & Bentall, 2004) but also one of the most challenging processes used by clinical psychologists to consistently underline the array of contributing factors to clients' distress (Hook, Hodges, Segal & Coolidge, 2010). Historically, the concept of clinical formulation has been difficult to define and to apply in practice (Eells, 1997); as such, Johnstone and Dallos (2006) highlighted the common elements of what constitutes a formulation and suggest it to be " a hypothesis about a person's difficulties, which draws from psychological theory" (p. 4). Whilst organizing and explaining large amounts of data (Ingram, 2006), formulations need to be sensitive, relevant, adaptive and to contain clients' strengths and evidence of resilience. Thus, whilst maintaining this definition, the aim of this paper is to review a clinical case of anxiety and depression from three different theoretical perspectives and formulate it accordingly. The models explored are Metacognitive, Cognitive-Behavioural and Psychodynamic. The case has been drawn out from the author's current caseload in an acute care adult mental health setting. All identifiable information, including names, has been altered or removed to preserve anonymity.

The client, herein referred as " Rose", is a female in her early-sixties, single, retired and mother of two. She was referred to the services about a year ago by her GP with recurring depression with associated anxiety and suicidal ideation, which deteriorated about two years ago. She described herself as a perfectionist and a worrier.

Initial assessment and presentation

A comprehensive assessment interview was performed over four sessions. Rose was presenting with sadness, “ going low”, excessive cognitive rumination, panic, lack of motivation, fear to go out alone, anxious, erratic sleep and concentration difficulties. She was appropriate and engaging in sessions, and almost “ too eager” to confide her life experiences to the therapist. She was extremely labile during the initial three sessions and often seeking reassurance about her admission to hospital.

Rose reported of frequently using “ a mask” to cover her real emotions in order “ to protect” the people she loves the most. She experienced difficulty in maintaining and forming positive relationships, and was particularly “ stressed out” with the relationship between her children. She also reported feeling hopeless about her future, which often culminated in her having recurring suicidal thoughts. She believed that by dying she would no longer be a burden to her family, in particular to her son and grandson. She feels guilty for “ letting them all down”.

Background information

Rose grew up in a working class family; however, her mother worked at home as a child-minder due to enduring agoraphobia. Rose’s father also had chronic depression but he “ never spoke about it”, giving the impression that the family would not openly discuss their mental health problems. Rose did not talk much about her childhood, blaming on her “ poor memory”. However, she did inform that she had three siblings that died very early in life. She also revealed being a “ sporty child”, swimming and running in

several school competitions at national level. She said that she “ always had to fight for everything in life” and “ things never came easily”.

Rose had a long-term relationship with a man, after she divorced the father of her children. The new partner was very abusive and gave Rose “ a black eye every few months”. About 20 years ago, he left Rose for another woman, leaving her caring for her two children and her housebound mother, whilst maintaining a full-time job. A few years later her mother died of “ sudden heart attack” and Rose was emotionally drained and physically exhausted. Afterwards, Rose’s life was relatively uneventful; her children grew up and left, and she did baby-sit her only grandchild at times. She also disclosed having a one-off sexual “ fling” with a man 20 years younger than her, who then later by sheer coincidence became her son-in-law. She felt very embarrassed about this and now worries that her daughter will find out, since they kept it a secret. Her depression started after her daughter’s engagement with this man about 5 years ago.

Furthermore, four years ago she witnessed her “ very close” brother dying and her “ world fell apart”. He was the last link to her childhood, and during the interview she burst into tears whilst looking at a picture of an old city on the wall and said: “ that picture reminds me of my brother and me when we were little”. About three years ago she retired from her long-term job and her life changed dramatically, making her life “ boring and purposeless”. About 2 years ago, during a misunderstanding, her daughter talked to Rose “ like shit” and they stopped talking for a while. This situation also involved Rose’s son who has not spoken to his sister since. Rose has resumed talking to her daughter but “ things are not the same”. Her son has become

depressed since, and Rose worries and blames herself that she is maintaining his depression. On top of all this, Rose's best friend fell out with her about 2 years ago when they were on holiday and Rose's depression " ruined their holiday". Also, recently a lump appeared in her chest and she has been finding this extremely difficult, since she has other physical difficulties, such as angina and hypothyroidism. She then attended a hospital appointment to check the lump but they did not have her name down on the list, so she experienced a panic attack, feeling " invisible" and ignored.

Due to the complexity of Rose's relational dynamics, a Genogram (figure 1) was drawn up as a visual aid based on the information provided above.

Previous therapeutic interventions

Rose has undergone several courses of ECT in previous and current admissions, and was also taking several anti-depressant and anti-anxiety medication at the time of writing this paper. She believes that she is weak and in need of a medicalised approach to distress for rapid symptomatic relief. She has contemplated very little the usage of her own cognitive skills to improve, however appeared motivated to therapy. She has never received psychological therapy before.

Resources and strengths

The assessment also explored Rose's resources and strengths, which included support from her immediate family, some close friends, and " happy-go-lucky" individual characteristics. At times, Rose has been able to experience " better days" or periods when her thoughts appear more

positive and solution-focused. She is naturally a sociable, caring and entertaining person, and finds gardening very rewarding.

Current Diagnosis

Rose met the criteria for severe depressive disorder with associated anxiety without psychotic features (American Psychiatric Association, 2000), with two key issues of suicidal ideation and relationship difficulties. Psychometric testing revealed severe depression (Beck Depression Inventory II; Beck, Steer & Brown, 1996), severe anxiety (Beck Anxiety Inventory; Beck & Steer, 1990) and severe hopelessness (Beck Hopelessness Scale; Beck, 1988) (see appendix 1 for psychometrics).

Risk Assessment

Rose reported frequent “ memory loss”, a feature related to avoidance for traumatic and emotionally challenging memories (REF here), but also connected to the amount of ECT courses she has received throughout life (REF here, e, g NICE). This is an area that needs further assessment. She also experienced thoughts of dying, but with no immediate or future plans to act upon those thoughts. She had social support from her family and this risk was being safely managed by the ward team.

A trusting therapeutic relationship between Rose and the therapist was established from the start. Rose’s difficulties and hopelessness elicited feelings in the therapist of protection and of empathy; however, at times it was felt that transferring processes of overwhelm were drawn up between Rose and the therapist.

Formulations

Using the information gathered during assessment and the definition agreed for this paper, Rose's case was formulated from three different theoretical perspectives as discussed below.

The Metacognitive Model

Overview

The metacognitive model was developed by Wells (1995, 1999) and founded in the theory of self-regulation in psychological disorder (Wells & Matthews, 1994, 1996). This model aims to clarify the function of metacognitive evaluation and worry control in the maintenance of pathological worry and anxiety (Fisher & Wells, 2008). Watkins and Teasdale (2001) have previously suggested that ruminative thinking, a feature of pathological worry, is a main component in maintaining mental health problems such as depression, but also anxiety (Segerstrom, Tsao, Alden, & Craske, 2000) and post-traumatic stress disorder (Michael, Halligan, Clark, & Ehlers, 2007). Previous influential research also demonstrated the relationship between ruminative negative thinking and long-term depression (Nolen-Hoeksema, 1991; Nolen-Hoeksema, Morrow, & Fredrickson, 1993); as such rumination is responsible for the onset and maintenance of negative responses to life events (Just & Alloy, 1997).

Within this model, metacognitition is the chief attentional process that determines the amount of consciousness that we dispense to life experiences, cognitions and emotions about those same experiences (Wells, 2009). Metacognititons influence meta-worry, or worry about worry, which can be maintained by a person's meta-belief system stored in one's long-

term memory (Wells & Matthews, 1994, 1996). This maintenance of distress activates a particular cognitive style responsible for the cyclic worry and rumination as ways of coping with danger, the Cognitive-Attentional Syndrome (CAS) (Wells et al., 2009). Coping strategies can include avoidance and suppression of thoughts and emotions, which often perpetuate the distress and prevent people from testing their faulty beliefs.

In practical terms, life experiences often trigger two major metacognitive beliefs: positive and negative. These beliefs, part responsible for activating the CAS, are respectively determining rumination and threat monitoring, and the uncontrollability and significance of feelings and thoughts (Wells, 2009). The interaction of positive and negative meta-beliefs and the activation of the CAS are maintaining the cycle of rumination, whilst keeping the person unaware of such processes and unable to terminate the cycle (Wells et al., 2009).

Metacognitive formulation for anxiety and Depression

The metacognitive formulation represents the “ here and now” of psychological disorder and is interested in its maintaining factors. The aim is to identify the faulty style of thinking through a person’s meta-beliefs and ruminating style, and address these in therapy (Wells, 2009). In the case presented here, the formulation (figure 2) contains idiosyncratic features of Rose’s anxiety and depression, and about their interconnectivity (Papageorgiou & Wells, 1999) and potential diagnostic symbiosis (Tyrer, 1990; Compton, 1998).

During assessment Rose was presenting with extreme rumination and worry about her current situation as an inpatient, family dynamics, and her physical illnesses, all of which were perpetuating her problem (Segerstorm et al., 2000). As suggested by Wells (2009), the anxiety and worry experienced by Rose are being perpetuated by thoughts of anticipated danger. Also, Rose is ruminating about her invisibility, not only to the particular situation she experienced at the hospital when she went for an appointment, but also for feeling alone, abandoned by people, and all the loss she experienced throughout life. Although this model concerns to Rose's current situation, it is taking into account that her past has influenced her meta-beliefs.

The following formulation (Figure 2) is based on Rose's most recent incident that triggered her anxiety and panic.

Rose agreed that she has always been a perfectionist and a worrier for most of her life, often a feature found in most people with anxiety (Wells, 1995; 2009). The cycle of worry becomes problematic when the activation of the Negative Meta-Beliefs leads to Type 2 worry. As such Rose will believe " I can't stop worrying", suggesting uncontrollability of affect and predicting non-improvement, thus leading to pathological worry. She then feels overwhelmed about her recycled thoughts and emotions, increasing further rumination of worries and monitoring for threats. Her reactions enter into auto-pilot, where the activation of the faulty CAS aims to cope with such distress. In reaction to this, she becomes fearful of her own beliefs, of being really " invisible" to others and a bad mother, and attempts thought suppression, avoiding speaking to family about her fears, engaging in over-dependant behaviours and reassurance seeking, and making her presence

noted so that her fear of invisibility does not fulfil itself. However, while Rose attempts to push her thoughts away from her mind, they return and her distress increases. She then becomes anxious and fearful.

While this cycle is being activated, a parallel interaction is occurring (figure 2) based on the trigger that " this is as good as it gets", thus activating meta-beliefs that she is depressive and has let her family down with her depression. A self-fulfilling cycle of depression, in turn, feeds back to the trigger of the metacognitive cycle of anxiety. These two cycles are exacerbated by Rose's maladaptive coping strategies, such as her exaggerated emotions, her avoidance of thoughts and behaviours, and her attempt to suppress her thoughts. These strategies prevent her from testing her faulty beliefs (Wells, 2009), and to look around for evidence on her invisibility. Rose's CAS is even succeeding to prevent her to look at evidence that goes against her meta-beliefs, even if such evidence is right in front of her. Rose is worrying about worry, thus perpetuating her anxiety and depression.

Cognitive-Behavioural Perspective

Overview

Cognitive-behavioural perspective originates from the idea that both biopsychosocial and cognitive phenomena play a vital role in the precipitation and perpetuation of emotional disorders (Dudley & Kuyken, 2006). At present there are many different conceptualisations to this model, with labels such as ' cognitive behavioural therapy', ' cognitive behaviour psychotherapy' and even ' cognitive therapy' (Dobson & Dozois, 2001; Whitfield & Davidson, 2007). Most of them draw from behavioural, learning,

and cognitive theories, as a way to explain and inform more positive forms of human thinking and interaction (Brewin, 1996). There is an extensive field of research to support the use of cognitive-behavioural approach for different psychiatric disorders, including depression and anxiety, and its efficacy has been supported (see Tarrier, 2005; Whitfield & Davidson, 2007) but with some criticism (see Holmes, 2002; House & Loewenthal, 2008). In the UK, this approach is also recommended by the National Institute of Health and Clinical Excellence (see nice. org. uk for updated information) and there is evidence of its usefulness in acute inpatient services (Clarke & Wilson, 2009).

The model proposes relations between thoughts, emotions and behaviours (Nelson, 1997); hence, modifying dysfunction in one of these areas it is likely to produce effect on the remaining difficulties (Whitfield & Davidson, 2007). Beck, Rush, Shaw and Emery (1979) further suggested that the content of self-defeating thoughts, caused by irrational reasoning, are often maintained by specific patterns of ‘ errorful’ thinking, such as overgeneralisation and catastrophising situations. It is generally agreed that early life events that were particularly stressful are the foundation for the creation of dysfunctional ‘ schemas’ or beliefs, and these are often reactivated later in life by similar stressful life events (Nelson, 1997; Blackburn, James & Flitcroft, 2006). These core beliefs (CBs) are described by Blackburn and Twaddle (1996) as “ deep, relatively stable cognitive structures … that determine how experiences are perceived” (p. 4). These underline the “ intermediate-level beliefs … that offer cross-situational rules for living” (Kuyken, Padesk, & Dudley, 2009: 14) or underlying assumptions (UAs), and

in turn are responsible for the surfacing of situation-specific negative automatic-thoughts (NATs) (Greenberger & Padesky, 1995). Modifying these dysfunctional cognitions is then a priority, so this approach is “ an active, directive, time-limited, structured approach used to treat a variety of psychiatric disorders (for example, depression, anxiety, phobias, pain problems, etc.)” (Beck et al., 1979: 3).

Cognitive-behavioural formulation of anxiety and depression

Cognitive-behavioural formulation often synthesises longitudinal information, vital to understand a person’s current distress and current relationship between thoughts, emotions and behaviours. For example, in depression it is accepted that early parental relationships with a child are high pretenders to the onset and maintenance of later depressive symptoms (Irons, Gilbert, Baldwin, Baccus & Palmer, 2006). As such, negative cognitions revolve around loss, inadequacy, failure and worthlessness (Clark & Steer, 1996), which often become enrooted into CBs and UAs, only to be reactivated by a later critical incident (Blackburn et al., 2006) such as abusive relationship, abandonment or death. Rose has experienced these examples of loss at different stages of her life (see figure 3a). Most importantly the feelings of inadequacy she retained from childhood that her efforts at school and through sports were never enough to gain praise from the important people in her life, have been emphasized by her loss of role after retirement 3 years ago.

Also, she was one of the two surviving children of her parents, and such loss may have also had an impact on her parents’ relationship with each other

and their children. Rose then developed a strong, perhaps parental-figure, with her brother, who was her best friend and support. Rose's sense of loss was further emphasised when her brother died, her best friend stopped contact with her, her daughter got engaged with her best friend, and with the onset of an unhealthy relationship between her own two children. She revealed a sense that the past is repeating itself in her current life and believes she has let people down and she will be alone without foreseen improvement into her condition. Rose has developed some dysfunctional assumptions of being alone, ignored and invisible to people. Her family are still a great source of support to her, and she derives most of her levels of pleasure whilst with her family, but based on their reactions to her rather than on her feelings. So, if her son is busy with another commitment she will immediately assume he is avoiding her; she then reacts to that with fear, avoidance and despair. This is congruent with her early life experiences of high expectations and avoidance of feelings in her family, which led to her developing CBs that she is a " worrier", depressive and weak. A prominent feature displayed by Rose is of pleasing others, perhaps in reaction to fear of disapproval and potential abandonment (Blackburn et al., 2006). It is interesting how these features are supported and perhaps buffered by her protective factors; however, some of these may further reinforce that she is alone, and has no one to entertain and care for (figure 3a).

Rose's NATs are clear, demonstrating the content of UAs when attributing meaning to situations. As such, " I'm invisible" and " they don't care" are a reminiscence of her desire to be noticed, wanted and needed by others; and when not able to testify for her own doubts she gets frustrated and

withdrawn, further reinforcing her solitude. Once these NATs are activated, cycles of maintenance evolve and ensue that cognitions, emotions, physiology and behaviours confirm one another in keeping Rose in perpetual distress and feeling powerless to change. These cycles (figure 3b) enrol into a symbiotic relationship, feeding from each other and from internal and external triggers (Roemer & Orsillo, 2009), maintaining anxiety and depression at bay and confirming to Rose that she is “ weak”, “ depressive” and “ abandoned” by people. A positive aspect of this model is the use of protective factors to suggest to her potential change and areas of internal/external support (Dudley & Kuyken, 2006).

Psychodynamic Approach

Overview

Psychodynamic approach evolved from psychoanalytic tradition as a briefer response to treating people in distress (Lemma-Wright, 1995; Carr & McNulty, 2006; Davis & Strawn, 2010). Although there is some variation within psychodynamic schools of thought (Lemma-Wright, 1995), these variations are more of a continuum rather than competition (McWilliams, 2004). Lemma (2003) summarised the main components of psychodynamics, as: a) people develop representations of relational dynamics very early in life through emotive patterns of relationships; b) people’s internal representations are in constant interaction, dynamic, and conflict with the external reality, and influencing each other; c) people make sense of their experiences through conscious and unconscious processes underlying cognitions, affect and behaviour (Hughes, 1999); and d) psychodynamic therapy addresses both developmental and current conflictual pathologies.

Overall, there is an assumption that a person’s internal representations, developed through early and late life experiences, play a vital role in the “ working models which provide a prototype to guide our behaviour when we encounter a new but similar situation…[so]…we tend not only to expect certain responses from other people, but even to try to elicit them” (Hughes and Riordan, 2006; 18). Thus people may even “ have expectations of how another person will behave and feel in the relationship…[and]…give verbal and non-verbal cues which invite the behaviours [on others] that we expect” (p. 66). In essence, adult relationships are often distorted mirrored images of those early relationships that had most impact on an individual and we elicit them on others, as in the cyclic words of T. S. Elliot “ time present and time past, are both perhaps present in time future, and time future contained in time past”.

Another core feature of psychodynamic approach, perhaps underlined by our internal representations, is the existence of psychological or emotional pain (Leiper, 2006). In adulthood, this pain arises through the usage of defence mechanisms developed in childhood (Storr, 1990), causing intrapsychic conflicts between conscious and unconscious information (Shemilt & Naismith, 2007). When one’s desires and conflicts, which are supposedly in the realm of the unconscious, emerge and clash causing anxiety (Gabbard, 2005). Although people seek ways to relieve and avoid such pain, through behaviours, emotions and cognitions, these strategies are often faulty and people enter into repetitive mode, since their awareness of their avoidance does not lead to effective learning to diminish psychological pain (Leiper, 2006). As such, Rose is seeking ways to preserve her psychological well-

being by activating repetitive features of herself that only serve to keep her in that same distress that she is trying to avoid. As the fundamental problem with Rose is the way she is relating to others, including her children, the dynamic of her previous experiences in relationships with her parents is leading her to relate in similar ways with other people in the present, including the staff on the ward and the therapist during sessions (Hughes and Riordan, 2006). All her overt and covert interactions with the world, although not immediately rational to her, are nonetheless meaningful and motivated by her subconscious (Leiper, 2006).

Psychodynamic Formulation

There are many ways of formulating clients psychodynamically (Leiper, 2006; Prochaska & Norcross, 2007). Since “ no form or formula can be clung to as a secure guide” (Leiper, 2006: 47), psychodynamic formulations are prototypical models of identifying a client’s psychological system and any significance in their distress, thus allowing the therapist to explore a client’s predisposing, precipitating and maintaining factors (Hughes and Riordan, 2006) and to secure a person’s life repetitive themes or conflicts in the way they relate to people, to their environment, to themselves, and to the therapist (Hinshelwood, 1991). One such formulation features the triangles “ of conflict” and “ of person” adapted by Malan (1995) as means to explain how Rose’s defences keep her hidden feelings from emerging and causing anxiety.

Malan (1995) adapted the triangles of conflict and of person from previous models (figure 5) (respectively Ezriel, 1952 & Menninger, 1958, as cited in Carr & McNulty, 2006). The triangle of conflict attempts to explain the

process that people's hidden feelings (F) lead to the activation of defence mechanisms (D) thus causing anxiety or any other dysfunctional emotion (A). This triangle " is related to the second triangle by the fact that the hidden feeling is directed towards one or more categories of the triangle of person, namely Other (O), Transference (T), and Parent (P)" (Malan, 1995: 80).

Each of these triangles suggest potential links between each of their categories; as such, in Rose's case, there is an assumption that her current problems with others (O) (e. g. her children and friends), may have originated earlier in life during her interaction with her parents or significant carers (P) (Hughes & Riordan, 2006) and such patterns are now being re-played with the therapist as Transference (T) (Leiper, 2006). Furthermore, Molnos (1984) suggested that the " triangle of conflict" can be directly linked to the triangle of person, so that each of its categories (D, A, F) can directly interact with the other three categories of the other triangle (O, T, P) (figure 6). Rose then brings to therapy her hidden feelings and also her defence and anxiety, whilst enacting in similar way to other current others just like she did many years go with her parents.

The assumption is that Rose's unconscious hidden feeling (F) is the guilt associated to jealousy and envy. This feeling arising for the loss of several needed objects (Blatt, 1998), including her brother and the friendship of the man that her daughter married with. Stone (1986) suggested that guilt for a repressed sexuality is a strong factor for anxiety, since the man who made Rose feel young again was now married to her daughter, and was taken away from her life forever. Despite being a woman with her own sexual needs she is also a mother that is meant to protect and care for her children.

She feels that if the truth comes out, since her daughter is not aware of this early relationship, this will destroy her daughter's marriage.

Her daughter also took over Rose's role with her friends, so emphasising a deep envy for those who have all in comparison to her who lost all. Rose also internalises a strong guilt for her weak humanity and for feeling envious of those who are better off that her, and shame for her inadequacy and for her emotions. She also feels guilty for the depression that her son is experiencing, and relates deeply to her motherly role as protector and carer but fails to achieve that goal. Stone (1986) suggested that this sense of ' lessness' develops through a disappointing parent, perhaps through Rose's father, since he was away for days and weeks, and when at home he was often out with friends.

Rose defends (D) herself by dissociating from reality (memory loss and perceptual difficulties), combined with suppression and repression (respectively, avoiding thoughts that cause conflict and expelling thoughts and emotions from her awareness). She further devaluates herself (being a bad mother, depressive, " it's my fault"), and often projects unto others her own feelings about herself. On an action level, she then experiences a dichotomy; on one hand she acts out by becoming very emotive, seeking reassurance, becoming over dependant and clingy; on the other hand, she becomes apathetic and rejecting people, avoiding to speak to her children, and even passive-aggressive (Gabbard, 2005; Carr & McNulty, 2006). Rose experiences deep emotions about her conflict (A), such as fear of abandonment and invisibility, of being weak and bad, of losing control of her emotions, panic, low mood, disappointment and low self-esteem.

As a child Rose may have tried to please her parents (P), being a “ sporty child” and competing in several sports to make them proud of her. She has low recollection of her father, as “ he was always away”. However, the less she spoke about her father the more she was telling the therapist (REF here). She probably felt the need to compete her father’s love with her mother (F), since someone with so little time cannot love everyone the same way. Rose created a hero figure that she still seeks out today in the males (O) of her family (brother, son and grandson) or in friends. Since her brother passed away and her son is unavailable due to his depression, Rose feels once again abandoned, feeling exhausted to fight for their love. Her grandson now is her salvation and she feels that she will miss out on his growth and to be part of his love-circle. Rose feels that her anxieties are too much (A), and the way to protect herself and others is to get away from people and push them away (D).

Interestingly enough, Rose played similar role with the therapist (T), with similar patterns of interaction as described above with the other links of the triangle of person. Rose warmed too quickly to the therapist; his gender and role perhaps represented security and knowledge, as the image of the father (P) who was absent for days only to come ‘ home’ for a few hours to give her some attention. She initially became a pleaser, wanting to be led in therapy, presenting as child-like, immature, weak and unimportant; seeking verbal and physical reassurance (D), never smiling, and where ‘ social rules’ did not take part. She never asked for personal questions, maybe she learnt “ don’t ask and you won’t be told lies”, she only seemed to enjoy whatever moment she had but crying and asking for help, as if the person in front of her was

her parent that could comfort her. The process of transference (T) had taken place in therapy, as she was coming across as the most needy of all people but also by becoming passive in therapy and withdrawn, perhaps to protect the therapist from her problems, like one protects a son. Rose's ' modus operandi' was replaying the same anxieties, defences and feelings in therapy as with other people, which she may have played with her parents in her early years. This interaction elicited responses from the therapist, or countertransferences, of reassurance giving and distancing, but equally of anxiety, sorrow and overwhelm. At times the therapist's feelings mirrored Rose's own insecurities: " will she improve?" " am I being my best?" " what will others think of me". These feelings were important to understand and clarify Rose's dynamics in therapy and with the world around her (Hughes and Riordan, 2006).

Discussion

The main aim of formulation is to make sense of client's distress and inform interventions (Ingram, 2006). The formulations explored herein each offer a conceptualisation of Rose's difficulties and are theoretically approachable to address her situation. They all attempt to explain and guide therapy, but each model and its usefulness to intervention is dependant on several factors, such as: the amount of distress experience by the client, the client's insight