

## *Formulation*

Formulation in CFT follows other, well developed models. For example Beck, Freeman & Davies et al (2003) suggest that with more complex cases, and those sometimes labelled as personality disordered, the formulation focuses on a number of central domains. These are:

- 1) Views of self and others (I am.... they are.....;)
- 2) Core and conditional beliefs about the self, world and others (e.g., I am helpless; the world is a dangerous place; I need others to help me)
- 3) Rules for living (I must succeed to make others notice and care about me);
- 4) Key fears and threats (rejection, abandonment and shame)
- 5) Basic life strategies (avoidance of conflicts, submissive behaviours or constantly try to impress others)
- 6) Domain of emotions (anxiety, dysphoria, anger)

The formulation in CFT is somewhat similar. It goes through a series of stages:

*Background and historical influences:* Here the therapist explores for basic early attachment styles and life events (e.g., neglect abuse high expectations) that illuminate issues of feeling safe and also cared for or about. These experiences will have patterned various neurophysiological systems and the co-ordination of the various affect systems. The therapist explores for key emotional memories that act a focus for self-experience and can be triggered by life events (Brewin, 2006). Some people however may have poor recall of negative events or find revealing and ‘going onto the history’ aversive. Careful history taking however can be important even if it emerges over time because it is not just ‘fact finding’ but offers key opportunities to compassionately empathise and validate people’s experiences (Leahy, 2005), and enables people to develop a coherent story and narrative to their difficulties. Therapy may be the first time people have experienced another person’s mind orientated towards them in this interested, non-judgemental, containing, empathic and caring way (Wallin, 2007).

The life history also offers ways that people can see the sources of their ‘felt sense of self and others’ - that can also be conceptualised in schema terms (Beck et al, 2003). In regard to a sense of shame and ‘feeling alone’ these can often be linked to specific emotional memories. For example, Sally could easily recall in imagery the contempt on her mothers face when she told Sally that she was ‘a stupid and ugly child.’ “It is the same horrible ‘wanting to disappear’ feelings that go through me when people criticise me” she said. When Jon felt distressed he would feel overwhelmed with feelings of ‘total aloneness’. His mother admitted to him that when he was young she was depressed and that he often cried in the night but she felt unable to go to him. Jon came to connect these early memories with the feeling of being totally alone when distressed.

*Key threat and fears:* Early background experiences can enable us to feel safe and secure or easily threatened (Mikulincer & Shaver, 2004). As Gilbert (1989) and Beck et al., (2003) note, key fears are often around archetypal and innate themes of abandonment, rejection, shame and abuse/harm. In CFT we distinguish between external threat and internal threats. External threats pertain to what the world or others might do; whereas internal threats are related to what emerges, or is recreated inside oneself. For example a person might have an internal fear and be

frightened of losing control or becoming overwhelmed by anxiety, anger or depression. Indeed it can be the fear of becoming depressed (again) that can set in motion rumination, avoidance, dread of the future and even suicide (Gilbert, 2007a)

*Safety strategies.* People will obviously develop a range of strategies to try to get safe and self-protect. These safety strategies will vary as to whether they are aimed at external threats or internal ones. Avoidance of conflicts and submissive behaviours may be aimed to ward off external threats whereas (say) distraction, dissociation and use of alcohol can be used to cope with internal threats. Safety strategies can be automatic and linked to classical conditioning or more planned and worked work. Planning to avoid going to the party because one will feel alone and anxious is a way of coping with an external threat (going to the party and rejection) *and* the internal threat of aversive feelings. Note too that people might engage in avoidance to cope with external threats but for internal threats and aversive feelings/emotions or memories they might dissociate, take drugs or abuse alcohol – so the coping strategies for an external and internal threat can differ

*Unintended consequences.* Key domains of threat and their safety strategies often lead to unintended consequences. For example, to ward off being criticised or rejected individuals may fail to develop healthy assertiveness and instead focus on submissive and appeasement behaviour, or forms of perfectionism. In consequence they may lose (or fail to develop) the competencies to articulate and actualise their own values and life goals, are constantly wary of others and become self-critical when safety strategies fail to protect them (Gilbert, 2007). Although shame and self-criticism have many sources, the therapist helps the patient to recognise and be compassionate to the consequences of understandable safety strategies.

The formulation will focus on de-shaming and helping people really focus on how much of the difficulties are not their fault or how much their anger is actually defensive and related to fear of vulnerability. Moreover that this de-shaming for can actually lead to a more open way of taking responsibility. Once people stop self blaming and shaming they will find it easier to work with their difficulties.

Here are some simple forms and procedures and worked a example. Don't worry about the details but rather focus on understanding the basic process.

## Threat/Safety Strategies Formulation

### Historical influences

### Key Fears

### Safety/defensive behaviours

### Unintended Consequences

(Emotional Memories)

Self As .... Other As ....

### Self-to-self-relating

#### Pointers: Try to stay simple to start with:

Focus on sharing and understanding together; encourage the person to reflect and develop their own formulation. Part of the focus is understanding our difficulties in 'not your fault' way.

Avoid language of cognitive *distortion* or *maladaptive* schema as this can be shaming for high shame patients.

Focus on 'your defence system has tried to keep you safe; better safe than sorry' etc. One's defences are natural efforts to adapt to challenges and threats but with unintentional drawbacks/consequences – e.g., little new learning, not able to disconfirm basic threat beliefs, few opportunities for exploration.

**Key questions:** What do you see as key background experiences to your depression? What key fears and concerns do you think these created for you (keep in mind to explore external fears and internal ones)? Looking back how you think your mind has tried to protect you (again think about protecting self from *external* threats such as rejection and also *internal ones* such as overwhelming feelings). Recognise that some people may close down on threat and may not be able to reflect on painful experiences or memories. They simply are unable to or don't want to 'go there'. Spend time enabling people to be empathic to their safety strategies as 'best efforts.' What have been the unintended consequences (disadvantages) of these safety strategies? What do you think about yourself when you run into these unintended consequences?

**Worked example 1** *Threat/Safety Strategy Formulation for Shame and Self-criticism*

