

## OCTC CLINICAL INNOVATIONS

### THE “BLOBBY” FORMULATION

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Many years ago I was building a shared conceptualisation with a patient, listening to the details of her experiences and bringing to mind the various anxiety models to inform our exploration. I teased out vicious cycles, positioned reciprocal arrows and generally constructed a diagram that showcased my theoretical knowledge combined with the patient’s clinical experiences. Voila!

Except it wasn’t “voila” for the patient it was overload and she gave me an insight that guides my practice today: “All I need to know is why me? Why now? Why isn’t the problem going away?”

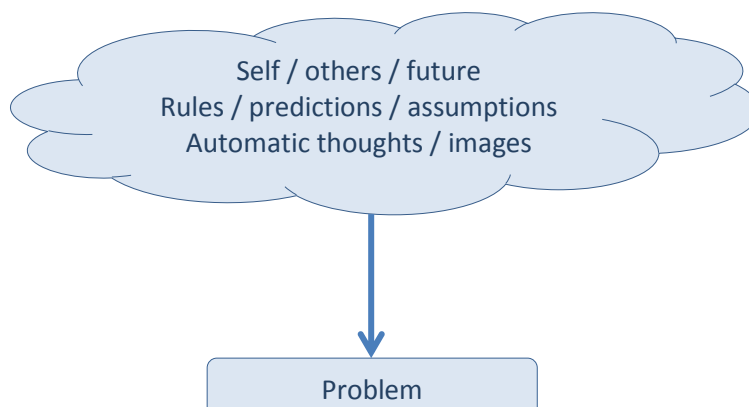
Like many of our patients, she was CBT naïve, without the advantage of studying psychological theories and models, and she needed to be introduced to a formulation at a pace that did not overwhelm her - yet she deserved to quickly have an understanding of her persistent difficulties. I began to use what is now referred to as the “Blobby Formulation”, a term reflecting its simplicity of two or three “blobs” of information and two or three arrows. It builds like this:

*Therapist: I realise that you have described your problem to others in the service but it would be helpful if you could capture, in your own words, what you struggle with so that I can hear it from you myself.*

Problem

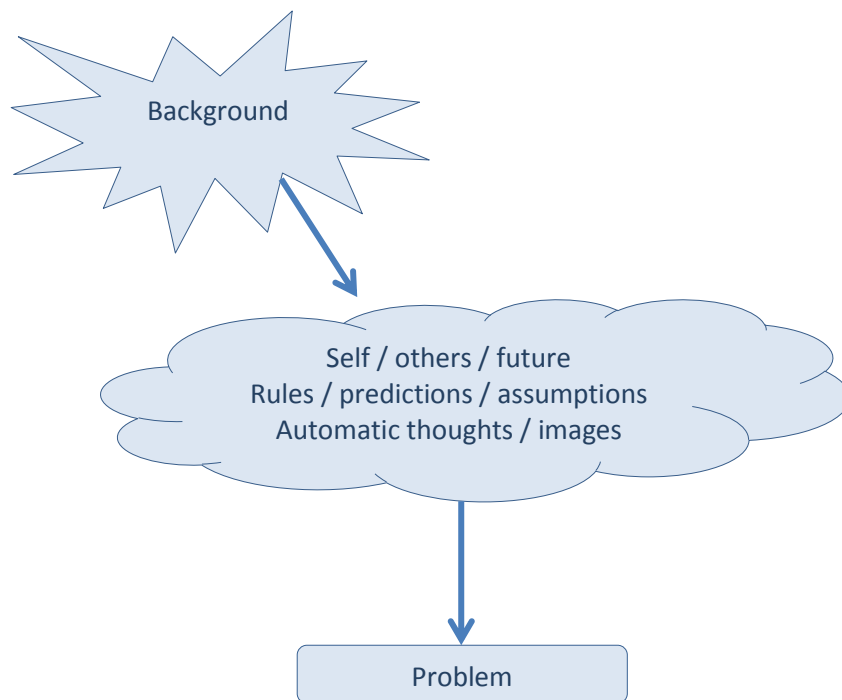
*Therapist: As a cognitive therapist. I’m really interested in the thoughts and images that help us understand where this problem comes from. Often we have predictions, fears, rules that make sense of our difficulties.....*

*.....[ Steadily building up the framework but pacing this carefully] We also tend to have a particular view of our self / ... of others / ... of the world / ... of the future that colours the way we feel and what we do.*



Now we have a simple foundation, a framework, for understanding why a person might struggle with certain difficulties. Later we can tease out core beliefs and underlying assumptions and even discuss schemata if that proves relevant - but right now the patient is trying to take on board a new concept so we keep it meaningful but extremely parsimonious. Ideally at this point our patient can begin to appreciate that “anyone who saw themselves like this and made these predictions could have these problems,” and if that happens it is often a destigmatising and therapeutic moment.

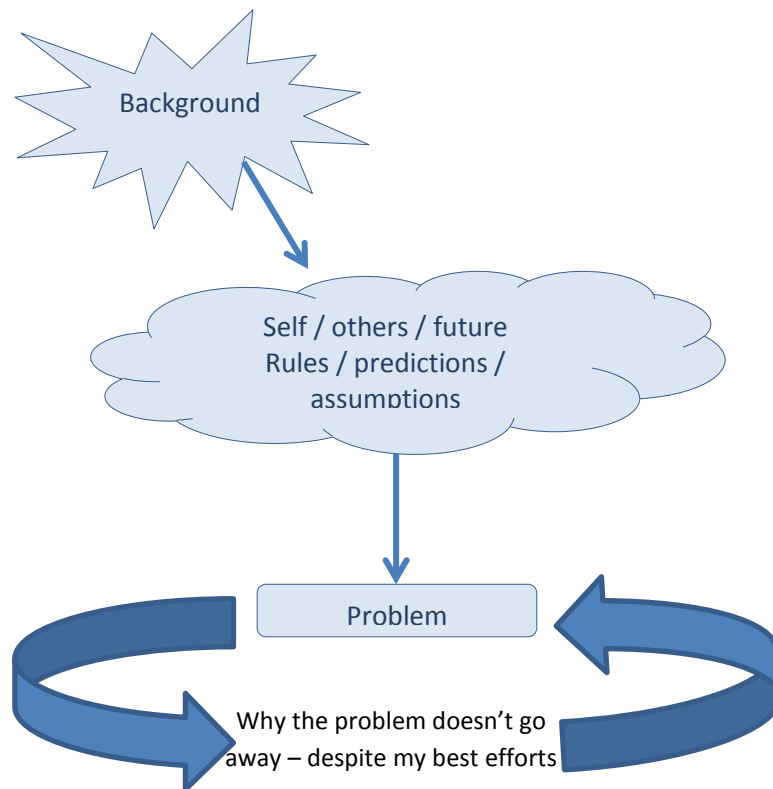
A concurrent burning question in my patient’s mind was “Why me?” and in my experience this is often the case. Again, if we can help our patients reach an “It’s no wonder...” conclusion then we can further shift self-blame or bewilderment. So we often look at enough background and developmental history (always keeping it simple) to achieve an appreciation that: “Anyone who had been through what I’ve been through / is going through what I’m going through might think like this.” The process of linking experience and cognitions can evolve from reviewing cognitions and considering what developmental factors make sense of them *and /or* from reviewing experiences and considering what cognitions likely followed. Keep it flexible so that you maximise the possibility of your patient appreciating that their problem is understandable.



This leaves us with the other burning question: “Why isn’t the problem going away?” This is the “maintenance” part of the formulation, the element of conceptualisation that gives therapists something to get to grips with, fuelling us with hypotheses concerning recovery. It can become all too easy to get bogged down in detail too soon –faster than the patient can take it on board. So once more, I tend to look for broad themes, themes that can be elaborated later as the patient becomes more converse with the constructs and concepts of CBT. Common themes are of course avoidance and withdrawal, poor problem solving, rumination and worry and so on.

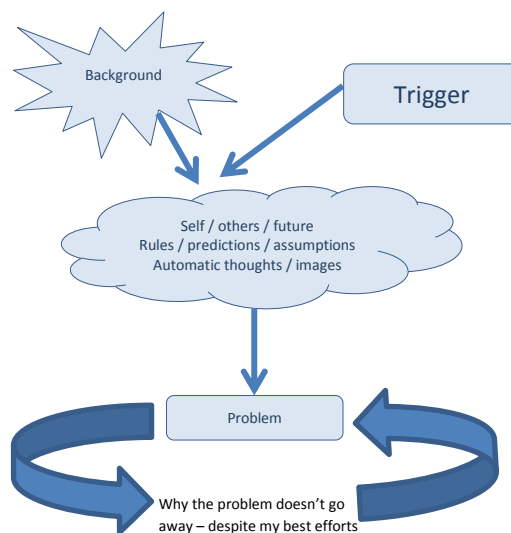
*Therapist: We seem to have begun to make sense of your difficulties and how they might have arisen so now we can consider why the problem is so persistent, why it hasn’t gone away despite your best efforts to cope. Can we look at the ways in which*

*you have been dealing with your difficulties to see if there are any strategies that we can build on, perhaps review strategies that don't work so well or even backfire? If we can do this we can start looking at alternative strategies as soon as possible.*



Once this simple conceptualisation is meaningful to the patient, we can begin to elaborate the maintaining cycles, teasing them out, identifying patterns of chronicity. I often use another beautifully parsimonious conceptualisation framework, the “vicious flower” to do this, or if the patient needs help in better understanding the links between thoughts and feelings and actions then Padesky & Mooney’s simple 5-factor heuristic is helpful (1990).

Sometimes the problems are chronic with an insidious onset but sometimes there is a clear precipitant that marks the onset and this can be easily indicated with the addition of another arrow:



Detailing maintaining cycles is essential in understanding why problems don't go away and in evolving management strategies but at this point many patients benefit from an uncomplicated snap-shot of “*Why me, why now and why is the problem not going away?*”

Having said this, it is important to ensure that patients don't feel as though we are trivialising their difficulties so some tact is required in explaining that, as therapists, we are first aiming to get an uncomplicated over-view of their problems but that this does not indicate that we don't appreciate the complexities of their difficulties.

This representation of a patient conceptualisation is a further addition to our many ways of distilling information to create a shared understanding of difficulties. It can usefully sit alongside Beck's generic formulation, the various problems-specific conceptualisations and other parsimonious depictions such as the “vicious flower”.

A final “top tip” when using this simple framework is that it can be offered as an encouraging and reassuring prelude to your assessment and formulation. I often begin assessments by saying something like:

*Therapist: As this is an assessment session, I will probably be asking more questions than I would in a typical CBT session. This is so I can understand your difficulties, how to understand them and just how you experience them. Just so you know where I am coming from and why the questions are relevant, let me sketch out the framework that guides me in appreciating your problem and why it's been so difficult to manage.*

[Draw up the blobby formulation on a whiteboard or a piece of paper that is easily seen by both therapist and patient]

*Therapist: How does that look .....does it make sense .....how do you feel when you see that....?*

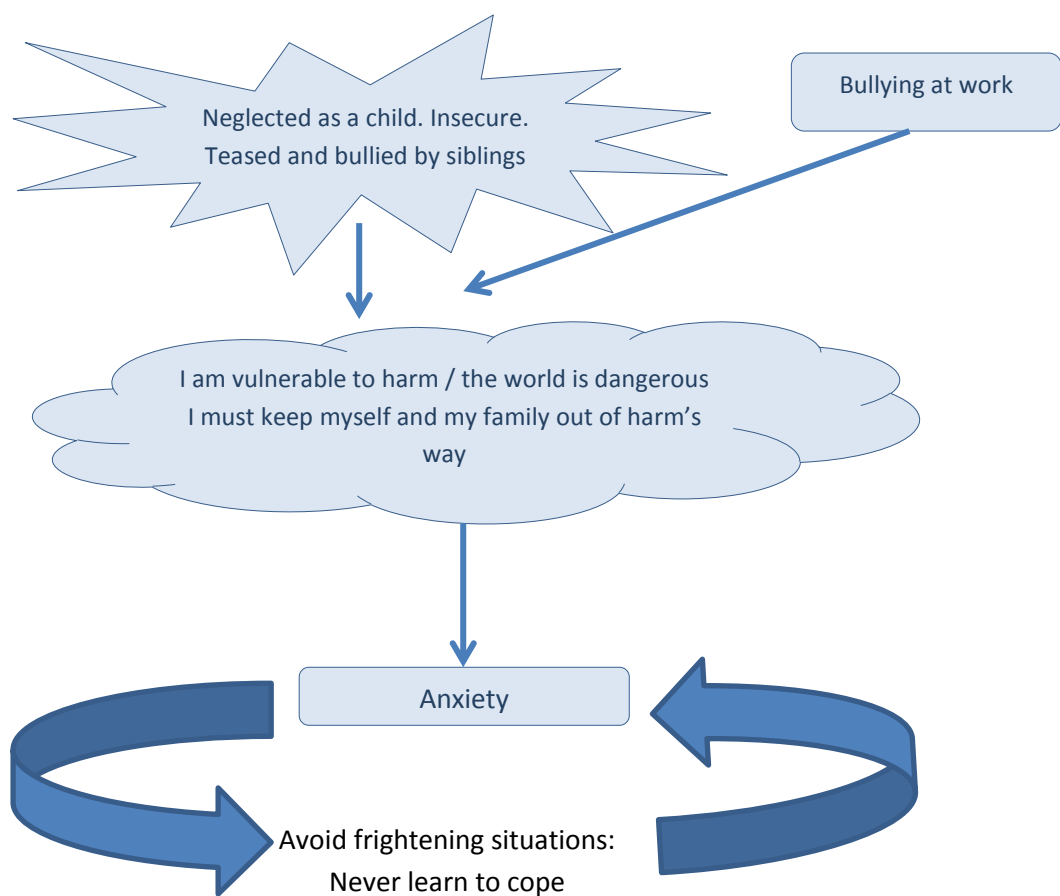
In this way we can enlist our patients as collaborators and often reduce anxieties. For example, patients who feel overwhelmed and confused by their experiences can begin to see how confusions can be teased out, explained and simplified; patients who feel hopeless can see maintaining cycles that can be targeted for change; patients who have felt exploited and manipulated in the past are assured of the transparency of the way we work together. This part of an assessment can also provide an opportunity to discuss and clarify misunderstandings about the model at the outset.

Padesky C and Mooney K (1990) *Clinical Tip: Presenting the cognitive model to clients* International Cognitive Therapy Newsletter, 6, 13-14

## Clinical Examples

**Alice** was referred for therapy in her late-20s when she had difficulty going into work after a brief period of bullying, which had been resolved within her organisation. She couldn't understand why she was still wracked with anxiety despite the incident having been dealt with professionally and to her satisfaction.

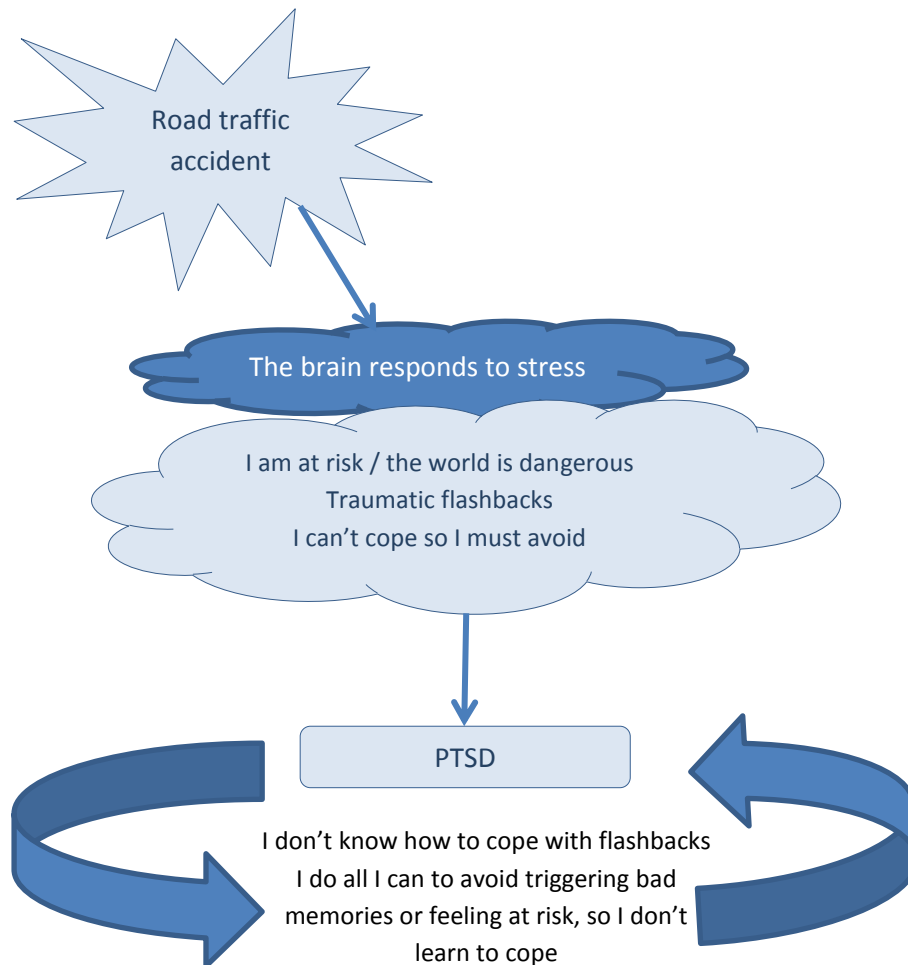
This preliminary formulation enabled her to appreciate that it was “no wonder” that she was so very sensitive following the incident and how her coping strategy was backfiring.



Once we had this preliminary “bobby” formulation, we had a simple framework that we could refer to as we teased out the details of specific vicious cycles, which we could then address using a mini-formulation for each cycle. In this way, Alice never felt overwhelmed.

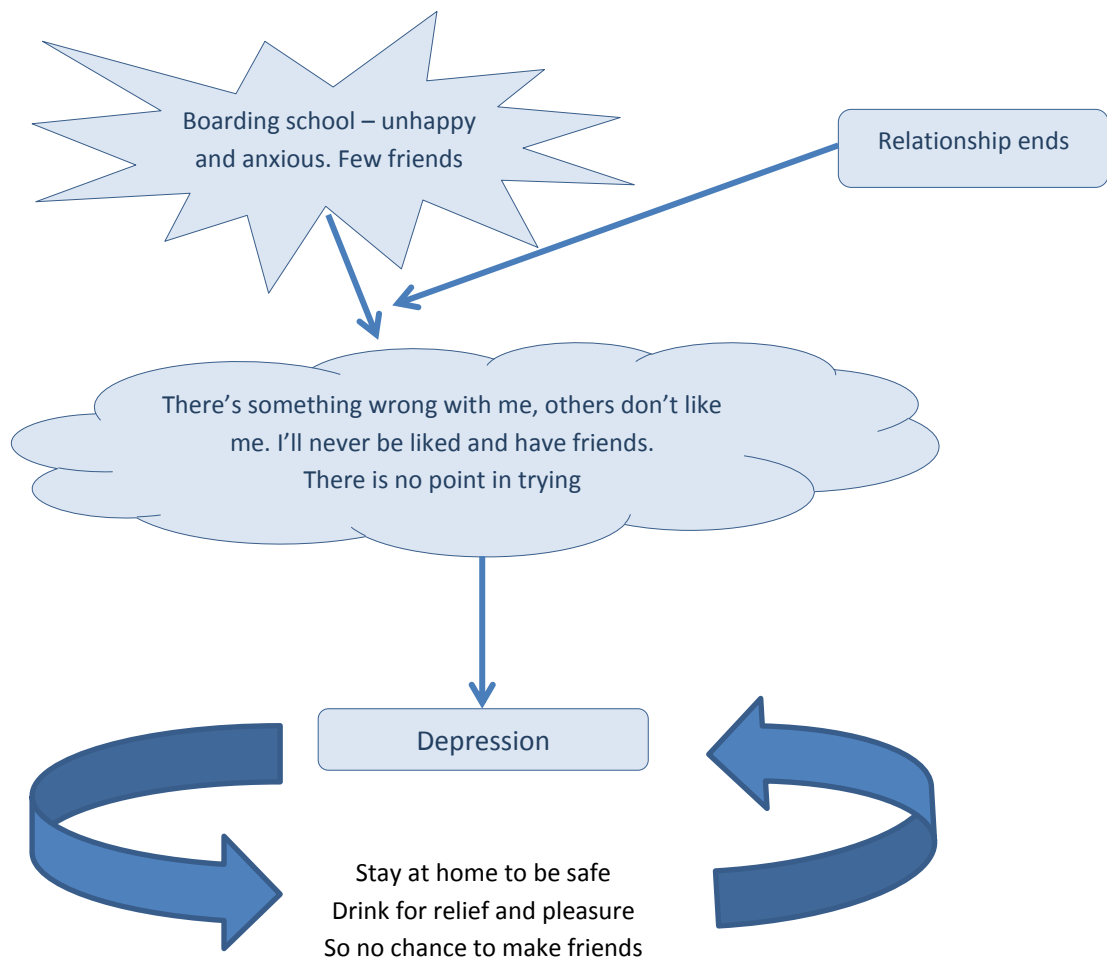
**Brendan** had always prided himself on being a “strong man” and was unforgiving of himself for now being so scared, scared even of his own thoughts. We discussed – as simply as possible – the neurobiology of flashbacks and then added an additional “blob” which simply captured the fact that “The brain responds to stress”. There was no need to overcomplicate the formulation by detailing this.

The diagram below helped Brendan to see “...it’s no wonder I get flashbacks” and in itself this was therapeutic. Brendan’s attitude towards himself changed and he was hopeful with regard to therapy.



Once we had achieved this, as with Alice, we could then tease out specific cognitive and behavioural maintaining cycles and begin to develop cognitive –behavioural plans to deal with them, all the while keeping our basic understand as clutter-free as possible.

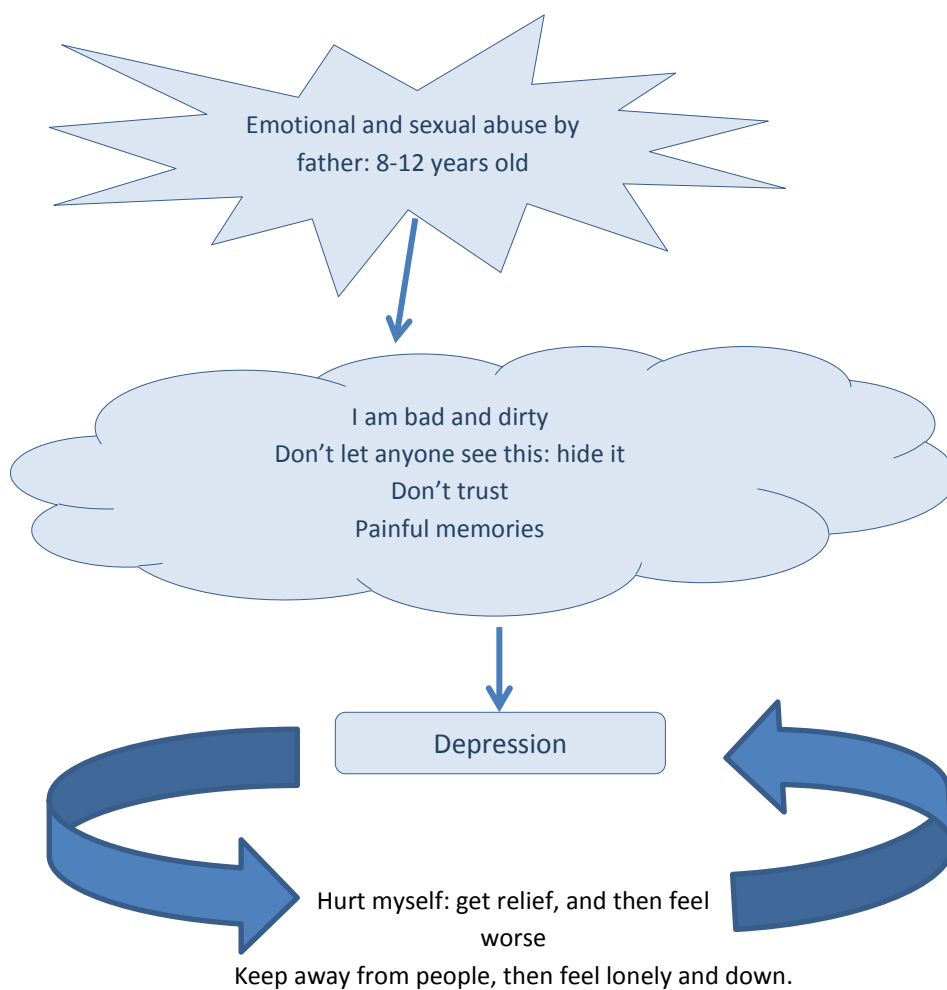
**Charlie** had recently learnt that her long-term partner was leaving her for another woman. This revived long dormant negative beliefs about herself and the future and she became depressed. By the time we met her depression was quite severe and her cognitive functioning slowed. She simply could not have taken on board a complicated formulation. The one below met the need of understanding why her depression made sense and why it wasn't going away without confusing Charlie and leaving her feeling even more incapable. The simple maintaining cycle also gave her hope that things could change.



Even complex histories and problems can be represented by the “blobby” formulation.

**Evan** had a long history of emotional and sexual abuse by his father. The abuse took many forms but we did not detail them here, partly because we aimed to keep things simple and partly because Evan found it difficult to acknowledge what he saw as the depth of his father’s depravity. Similarly, his fundamental negative beliefs were quite varied, but at this stage it was enough to gather them together as themes (“bad and dirty” / “hide” / “don’t trust”). His self-injury was also very varied but again it was sufficient to simply acknowledge that he hurt himself.

Later when he felt more resilient and when he was more familiar with the concept of psychological formulation, we could elaborate this. For now we were aiming to achieve a shared understanding of “Why me?” and “Why is the problem no going away?” Doing this helped to engage an ambivalent Evan.



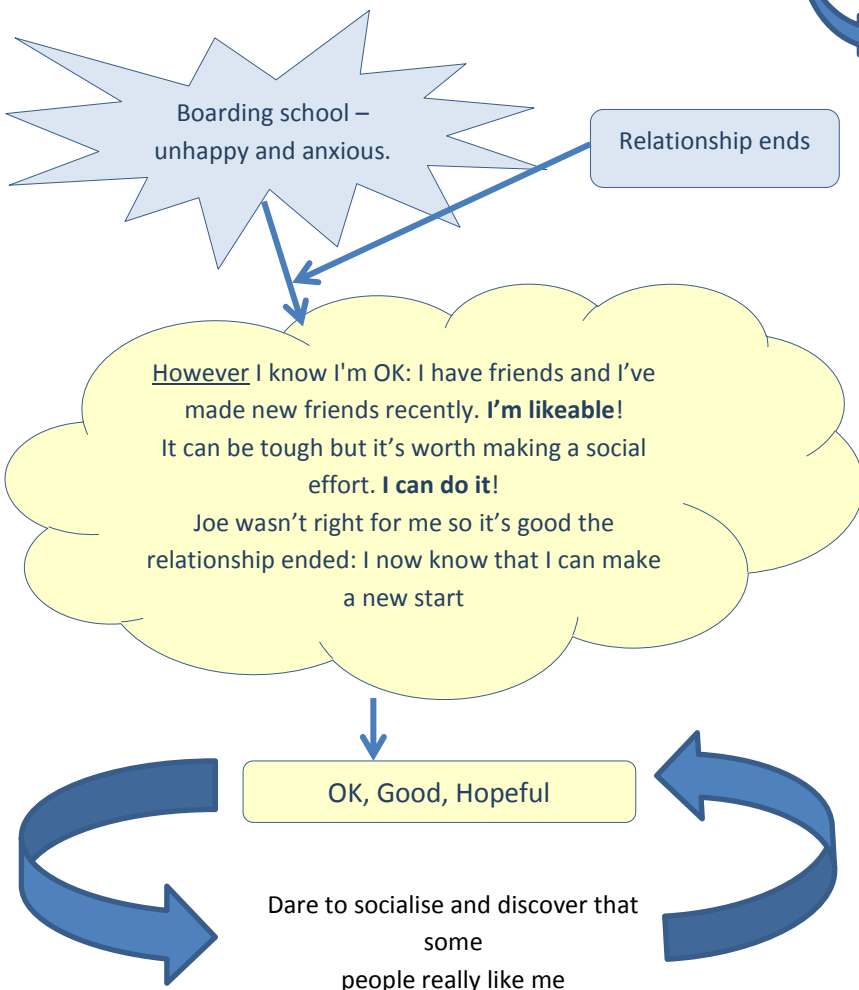
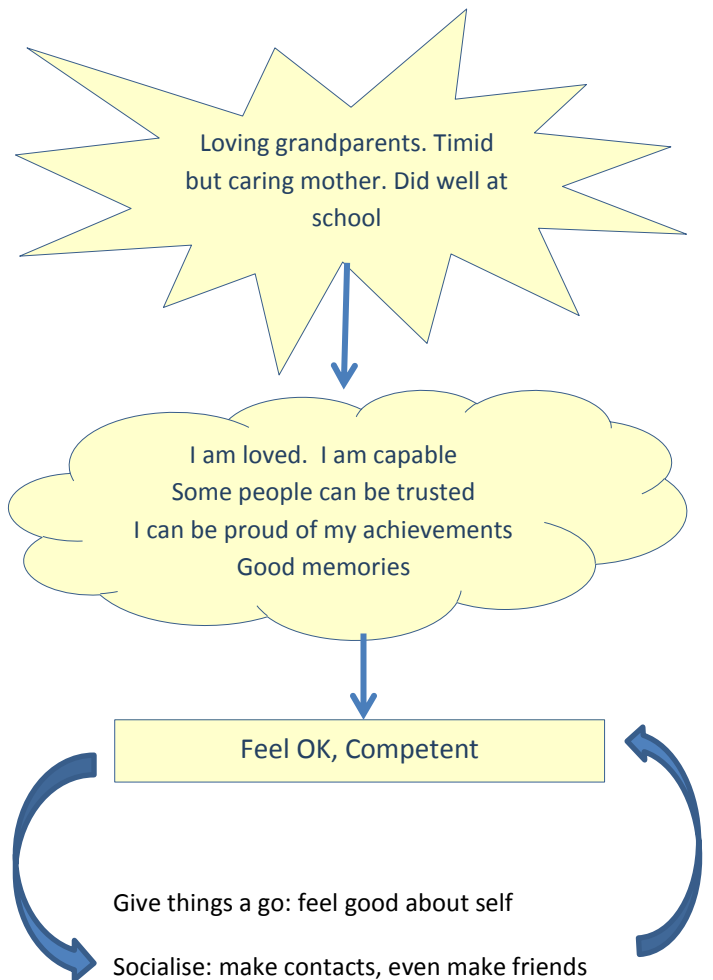


## Using Positive Formulations

This simple structure can also be used in to share positive information – information that can help patients hold on to a balanced perspective, keep in mind their strengths, see how they are building capabilities over the course of therapy and so on.

When **Evan** and I first met we also explored what had gone well in his life and where his strengths might lie.

This provided an authentic counter-balance to Evan’s more negative formulation and we kept both of them in sight during therapy as he had a tendency to minimise and overlook his strengths and achievements.



**Charlie** used a positive formulation in a different way. Initially she was reluctant to create a positive perspective as she simply didn't believe that there was one and it would have felt false. Therefore we built up a coping framework *as she made advances in her therapy*.

This captured her progress and ultimately she had a new view of her capabilities that she could recognise even though she had suffered adversity. This very much helped her in her long term coping.