CHAPTER 13

Collaborative Case Conceptualization

A Bridge between Science and Practice

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Brenda, a 34-year-old mother of two, was born in Mainland China but moved to Vancouver, Canada, with her parents and grandparents when she was only an infant. Brenda's parents became devout Christians when she was a child, so Brenda was raised in accordance with strong Christian values and traditions. In the years leading up to her adolescence, Brenda described a very close and supportive relationship with her parents and grandparents. When Brenda moved away for college, she described a resurgence of interest and pride in her cultural and religious roots.

During college, Brenda met her husband, Kelvin, and soon after graduating, they married and conceived their first child, Jon. Brenda and Kelvin separated when Brenda was 24 and pregnant with her second child, Emma. Brenda described the separation as a "difficult time" but explained that her closeness to God and her parents made the process more bearable.

At the time of her treatment, Brenda was working as a registered nurse and described a fulfilling and supportive, yet at times very stressful work environment. In the last 8 months, she had been suffering from low mood, fatigue, poor concentration, and disrupted appetite and sleep. Furthermore, Brenda described intense and recurrent thoughts of worthlessness; these feelings made it very difficult for her to resume her normal activities. For example, although Brenda had typically enjoyed an active social life, she described intense anxiety, especially in the midst of strangers. This anxiety had made it difficult for her to consider the prospect of dating, although she was open to starting a new relationship. For example, Brenda described frequent blushing and feelings of being "tongue-tied" around new romantic partners. Brenda stated that these concerns began shortly after the dissolution of a brief and recent romantic relationship. She reported that "cultural differences" between herself and her partner were the main reason for the dissolution of this relationship. Brenda's treatment goals were to increase her confidence and comfort when dating and to improve her mood.

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The central aims of scientific psychology are to describe, explain, and predict human behavior, thought, and emotion. By extension, the aims of clinical science are to describe, explain, and predict behavior and emotional responses that create psychological disorders, and provide evidence-based psychological treatments for these disorders. Accordingly, clinical scientists have developed hundreds of theories and corresponding therapies that are believed to account

for and treat various psychological disorders. However, there is a tension between attempts to explain, predict, and treat psychological disorders—and in doing so potentially reducing such disorders to theories and treatment protocols developed for populations—and missing the inescapable diversity of human experience. For example, although Brenda presented with a number of typical clinical features of depression (e.g., low mood, disruptions of sleep and appetite), she also presented with a number of unique and important factors (e.g., her religious faith and familial belonging; social anxiety symptoms). These idiosyncratic features may render standardized treatment delivery unnecessary or suboptimal.

The diversity of human experience makes clinical science not only challenging but also interesting. Researchers are now beginning to build evidence-based processes within treatment protocols to account for individual differences. As such, a one-size-fits-all approach, which may at best be unhelpful and at worst be harmful to patients, is replaced by the flexible adaptation and application of treatment protocols.

In this chapter, we define our approach to embracing the central aims of scientific psychology and the wonderful diversity of psychological problems. We define our approach—collaborative case conceptualization (CCC)—and illustrate its use to guide our description, explanation, prediction, and treatment of Brenda's presenting concerns. The conceptualization process functioned to socialize Brenda to the cognitive model, improve her engagement and buy into treatment, plan ways to dismantle negative behaviors and thoughts, and build her resilience. Treatment with Brenda spanned 17 sessions and progressed in accordance with manualized cognitive therapy for depression and anxiety; that is, the focus early in treatment was on psychoeducation and self-monitoring, and progressed to behavioral interventions, and ended with higher-order work on cognitive restructuring and challenging. Although this specific case example is fictitious, Brenda represents an amalgamation of clinical features of a number of clients we have worked with in the past. We illustrate our work with her through description, with sample transcripts from sessions and "think-aloud" sections in which we reflect on our interactions with her, and examples of completed worksheets.

What Is CCC?

Given the evidence base that supports the use of cognitive-behavioral therapy (CBT) for depression and anxiety disorders (Gloaguen, Cottraux, Cucherat, & Blackburn, 1998; Hofmann & Smits, 2008), we adopted a cognitive-behavioral approach in the treatment of Brenda's presenting issues. CBT, one of the most tested and widely adopted of all psychological treatments (Butler, Chapman, Forman, & Beck, 2006), is defined as a set of treatment approaches that emphasizes the role of cognitions (thought content, pattern, and structure) and behaviors in the onset and maintenance of abnormal responses (Beck & Haigh, 2014). For example, the "mediational" hypothesis in CBT dictates that "desired behavior change may be affected through cognitive change" (Dobson, 2010, p. 4). Accordingly, any treatment approach that devotes considerable therapeutic time to the identification and restructuring of thoughts can be conceptualized under the general CBT rubric (Blagys & Hilsenroth, 2002).

As CBT is hypothesis-driven, case conceptualization (used here interchangeably with *case formulation*) stands at the heart of this approach. Although there is some variability in the way case conceptualization is defined, most sources agree on the essential features and functions of this process in therapy. Broadly defined, *case conceptualization* is the process by which therapists "provide a clear, theoretical explanation of *what the client is like* as well as theoretical hypotheses for *why the client is like this*" (Berman, 2014, p. xi; original emphasis). Thus, case conceptualization is a hypothesis-driven process designed to describe and explain client distress. During this process, a treatment plan that maps onto these hypotheses is created in order to address current concerns and prevent reemergence of these concerns. The case conceptualization process is not unique to CBT, as many other therapeutic approaches champion the use of this process in therapy (Needleman, 1999). The case conceptualization process has been described as a core skill of CBT and other evidence-based approaches (Bieling & Kuyken, 2003; Eells, 1997).

There are a number of case conceptualization models that exist in CBT and other evidence-based treatments. However, we believe that many case conceptualization models focus disproportionately on client problems, while neglecting strengths. Moreover, case concep-

tualization in many models is often static, presented only once during therapy, and delivered in a top-down manner, with little to no collaborative input from the client. Our work on the CCC model seeks to address these limitations. CCC can be defined as "the process whereby therapist and client work collaboratively first to describe and then to explain the issues a client presents in therapy. Its primary function is to guide therapy in order to relieve client distress and build client resilience" (Kuyken, Padesky, & Dudley, 2009, p. 3). The developers of this unique conceptualization model argue that this clinical process is guided by three overarching principles (Kuyken at al., 2009): (1) levels of conceptualization, (2) collaborative empiricism, and (3) a strengths focus.

Within the CCC model, case conceptualization is a process rather than a milestone; that is, the term *levels of conceptualization* refers to the unfolding of the conceptualization process in correspondence with the understanding of the therapist and client. Accordingly, increasingly complex conceptualization models are discussed and created throughout treatment.

Collaborative empiricism stands at the heart of the CCC model. *Collaborative empiricism* is the process by which therapist and client collaboratively agree on client issues and goals of treatment. Collaborative empiricism also involves the collaborative efforts of therapist and client to design and implement tests of the client's beliefs (Beck, Rush, Shaw, & Emery, 1979; Kazantzis, MacEwan, & Dattilio, 2005; Tee & Kazantzis, 2011).

As a strengths focus is an important facet of the CCC model, definitional clarity about strength, as well as risk and vulnerability, is in order. Risk factors in psychopathology are any factors that are associated with the increased likelihood of experiencing or developing a condition (Masten & Garmezy, 1985; Rutter, 1987). Accordingly, risk factors do not necessarily play a causal role in the development of psychopathology (e.g., being female is a risk factor for depression, but it does not cause depression). On the other hand, vulnerability factors are associated with the mechanisms of a disorder and so are implicated causally in the development of a condition (Rutter, 1987). Rutter (1987) defined *resilience factors* as the dynamic, individual differences that are linked to coping successfully in response to risk and environmental stressors. *Protective factors,* on the other hand, are directly related to vulnerability. Accordingly, protective factors are believed to be associated with "amelioration of the reaction to factors that would otherwise lead to a maladaptive outcome" (Rutter, 1987, p. 317). Rutter indicated that there is a constant negotiation between risk, vulnerability, resilience and protective factors, and the outcome of this negotiation can mean the difference between health and disorder. Finally, *strengths* are defined as "any psychological processes that consistently enable a person to think and act so as to yield benefits to himself or herself and society" (McCullough & Snyder, 2000, p. 3). Accordingly, resilience factors are dynamic, whereas strengths are more stable characteristics.

Within the CCC model, there is a strong emphasis on the training and skills development of therapists. Similar to conceptualization processes in treatment, training also unfolds in a graded fashion and in accordance with the skills level of the trainee. Kuyken, Padesky, and Dudley (2009) adapted Bennett-Levy's (2006; Bennett-Levy & Haarhoff, Chapter 25, this volume) three-part model in developing case conceptualization skills. This model emphasizes declarative, procedural, and reflective learning. *Declarative learning* is defined as the acquisition of knowledge of CBT theory, techniques, and treatment structure. *Procedural learning* is concerned with the application of knowledge acquired in the declarative learning stage, while *reflective learning* is defined as "standing back" from one's practice and reflecting on experiences in order to improve skills (Kuyken et al., 2009, p. 256).

What Is the Crucible of CCC?

In chemistry, a *crucible* is a vessel used to contain chemical elements when heated. A crucible is typically made of materials capable of withstanding very high temperatures. Kuyken and colleagues (2009) liken the case conceptualization process to a crucible: a vessel used to contain the necessary ingredients of change in CBT. Specifically, these necessary ingredients include client experiences, CBT theory, research, and techniques. Accordingly, the case conceptualization process represents the vessel containing the interaction of these active ingredients. Within the CCC model, the whole of the interactions between ingredients is invariably more than the sum of their parts; that is, and much like the transformational process

that comes from heating chemical elements, the systematic "fusion" of client experiences with CBT theory and research is key in the process of therapeutic change (see Figure 13.1).

Consistent with the crucible metaphor, "heating" in the CCC model is achieved through collaboration between client and therapist (i.e., collaborative empiricism); that is, a unilateral approach—either top-down from therapist to client or bottom-up, from client to therapist—will be insufficient in producing enough "heat" to instill transformation. As such, the CCC model heavily emphasizes a collaborative approach, and indeed, this approach stands as one of the guiding principles in the current model. Kuyken and colleagues (2009) argued that this emphasis on collaboration during the conceptualization process is an extension of already extant emphasis within CBT as a whole (Beck et al., 1979).

Within the crucible, each of the guiding principles of CCC is active. The first guiding principle, namely, *levels of conceptualization,* emphasizes the evolving nature of conceptualization in CBT. To optimize utility and effectiveness, the conceptualization process must transform gradually to reflect level of therapist understanding and client readiness. Accordingly, the function and nature of conceptualizations evolve from description to explanation to prediction. *Collaborative empiricism,* the second guiding principle, highlights the need for therapist and client to work together to integrate client experiences with CBT theory and research. As such, overinvolvement of one member of the therapeutic dyad (e.g., therapist) increases the likelihood of improper integration of important elements of change (e.g., client experiences). The third guiding principle, *incorporation of client strengths,* acknowledges that most current CBT protocols focus almost exclusively on the client's problems, which is believed to reduce client engagement in treatment. As such, a strengths focus is thought to increase client's commitment to the treatment and enhance clients' sense of agency (Kuyken et al., 2009, 2015; Kuyken, Padesky, & Dudley, 2008).

Functions of CCC in CBT

Sound clinical theories (e.g., the CCC model) are intended to be useful; that is, to serve as tools to help the clinician and client. The CCC model serves 10 important functions that, as a whole, seek to alleviate distress and cultivate resilience in practice (Kuyken et al., 2009). We illustrate each of these with examples from our work with Brenda.

1. Synthesize the unique characteristics and histories of the client with relevant CBT theory and research. In Brenda's case, research on depression and social anxiety is of particular relevance. The challenge, which is made easier through the adoption of the CCC model, would be to incorporate Brenda's unique cultural and spiritual frameworks within these existing theories.

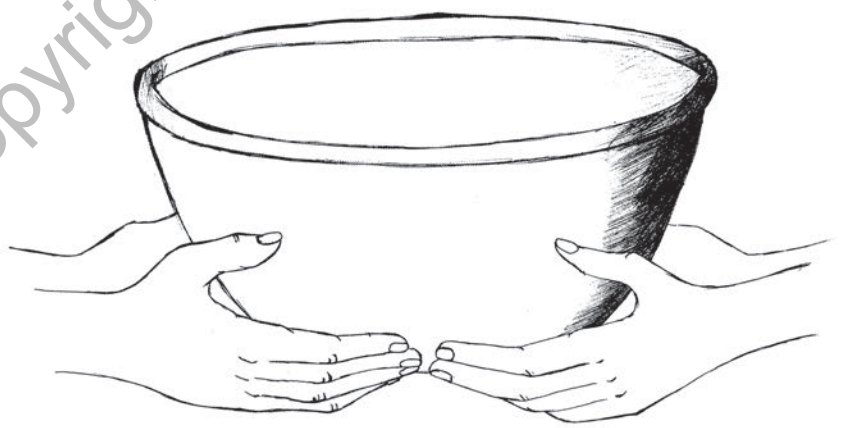

FIGURE 13.1. CCC as a crucible, with collaboration between client and therapist as "heat" source.

2. Normalize the client's presenting concerns and reduce self-stigma. Early in treatment, Brenda said, "I am afraid to tell my closest friends of what has been going on because I can't imagine anyone would understand." Accordingly, most clients are distressed about their own distress, so, in our experience, providing psychoeducation through the case conceptualization process often brings a sense of relief and empowerment.

3. Engender client engagement in treatment. Evidence suggests that engagement in CBT is a predictor of treatment success (Strunk, Brotman, & DeRubeis, 2010). As such, one of the goals of case conceptualization is to promote engagement and "buy" into the treatment. In Brenda's case, presenting a descriptive conceptualization early in treatment that closely fits her experiences (unhelpful automatic thoughts in reaction to her own emotions, which in turn generates a cascade of other negative thoughts and emotions) underscored the intuitiveness and simplicity of the cognitive model, which in turn engaged the client in the treatment.

4. Increase the manageability of the numerous and often complex presenting issues. This function serves both clients and therapists, as the process may reveal common threads that run through seemingly disconnected concerns. For example, and during the cross-sectional conceptualizations, Brenda identified her working unhelpful assumption: "If people notice my weaknesses, they will judge me." This helped Brenda and therapist to better understand the connection between most of her seemingly disconnected presenting concerns (e.g., anxiety when meeting potential romantic partners; low mood when feeling overwhelmed at work).

5. Organize, select, and order appropriate therapeutic techniques. Cognitive-behavioral therapists may feel bewildered by the dizzying array of techniques and interventions in CBT. Accordingly, the fifth function of conceptualization is to support therapists by allowing them to select techniques that map well onto agreed-upon clinical issues. As an illustration, Brenda identified that her anxiety and self-doubt around potential romantic interests was her most pressing concern. Accordingly, Brenda and her therapist selected behavioral techniques as a first therapeutic step in order to alleviate such anxiety.

6. Identify client strengths and suggest avenues for bolstering these strengths. This function is aligned with the third guiding principle of CCC and further highlights the holistic approach of the model. In the case of Brenda, her closeness with family, her Christian faith, and pride in her cultural heritage were all identified early on as potential sources of strength.

7. Maximization of cost-efficiency of treatment is now often at the forefront of academic and clinical inquiry. Case conceptualization can suggest the most cost-efficient avenue for treatment, which is prioritized more often today, as financial accountability is increasing as a function of limited resources in many settings. For Brenda, starting with behavioral techniques and ending with cognitive restructuring of faulty assumptions comprised the most cost-efficient route for treatment.

8. Anticipate and prevent problems in therapy. As dropout is a frequent problem in CBT (Shottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008), we believe that the case conceptualization process should build in mechanisms to avoid this potential concern. In Brenda's case, the conceptualization models pointed to the salience of social judgment cognitions as a *modus vivendi* for the client. As such, the therapist was careful to preempt the activation of such cognitions in the context of the therapeutic relationship; that is, the therapist was careful to point out to Brenda that "setbacks" in treatment are normal and can be framed as an opportunity for further growth.

9. Anticipate and prevent treatment nonresponse. A large minority (30–45%) of patients who complete a course of CBT do not experience a significant remediation in symptoms (Whisman, 2008). As such, the case conceptualization process is designed to anticipate this potential nonresponse and suggest alternative fruitful avenues. Conducting a collaborative conceptualization with Brenda helped the therapist anticipate lack of response due to her engagement in safety behaviors in the context of the behavioral interventions. Accordingly, the model was able to preempt such lack of response and intervene to reduce safety behaviors.

10. Allow for high-quality supervision of trainees and consultation. According to Kuyken and colleagues (2009), high-quality treatment, which describes, explains client presenting concerns, and fosters resilience, is similar to the supervision process.

Painting a Portrait: Descriptive Conceptualization

It is common for clinicians to find themselves facing the often complex, intricate, and overwhelming nature of clients' presenting issues. Brenda's therapist was no exception; he was led quickly into complicated and difficult terrain shortly after starting the session.

THERAPIST: Brenda, perhaps you could tell me what brings you here today?

BRENDA: I really don't know where to start. The last few months have just been very hard.

THERAPIST: I am very sorry to hear that. You said your life in the last few months has been very hard. What exactly has been troubling you?

BRENDA: I can hardly get out of bed. I have a job that I love, but I feel like I am not doing the best that I can. I am pretty miserable all the time, which makes me feel even worse, because I know that I have a good life in comparison to a lot of people, and I know I shouldn't really feel this way.

THERAPIST: It sounds like a lot of things are on your mind and have been affecting you lately. Anything else in particular that has made the last few months hard for you?

BRENDA: Well, I really want to find someone that I can share my life with, but I feel like I am no good to anyone. Worse yet, I feel like people judge me when I am in public; like they can see all my flaws; or that I will say something that will show how stupid I am or unworthy I am.

The goal of a descriptive case conceptualization is to render an accurate portrait of the client's presenting issues and prioritize them to pave the way for an efficient and effective treatment plan. The goal also is to normalize some of these client's struggles and engage the client early in treatment. The first task is to identify and prioritize top issues, and rate their impact:

THERAPIST: You mentioned a lot of issues that have been affecting your life in the last few months. To make treatment as useful as possible, let's make a list of these issues. How does that sound?

BRENDA: I guess we can do that. It might be a long list.

THERAPIST: That's OK. First, let's try and think of the issues that are impacting your life the most and then we will make our way down. Does that sound OK?

BRENDA: Yeah, that sounds good.

THERAPIST: So, what has been bothering you the most lately?

BRENDA: I suppose how sad I get sometimes. My low mood can get really overwhelming for me. When I feel that way, I keep thinking about how people at work may notice, and then I have trouble concentrating and feel like I am doing a lot of mistakes.

THERAPIST: Let's jot that down in our list. (*Hands Brenda a structured form on which she can list issues and strengths in descending order of impact/importance*)

> **Think-Aloud:** It was important that the therapist encourage Brenda to write down simple presenting issues and their behavioral impact on her life. For example, if Brenda had only identified "low mood" as her top presenting issue, the therapist would have prompted Brenda, in order to uncover the specific impact of low mood on her functioning: "What things does your low mood get in the way of?"

In our experience, it is unlikely for patients to report their strengths spontaneously. Accordingly, it is important that the therapists ask clients directly about what they view as strengths and resilience factors:

THERAPIST: We talked a lot about some of the issues that have been impacting your life of late. Let's talk about the other side of the coin: things that you do particularly well, or things that are going right for you at the moment, and effective ways you've learned to deal with your stress.

BRENDA: Not sure if there is much going right for me at the moment. Everything feels like its falling apart.

THERAPIST: I know it may feel that way, but even in our short time together here, I have noticed that despite all the issues that have been impacting you lately, there seems to be a lot of things you're getting right. Our job is to bring those things to light and together help strengthen them over the course of treatment. For example, one thing I noticed is that you seem to get a lot of pride and strength from your family and heritage,

and both seem to help you deal with stressful situations in your life. Am I getting that right?

Brenda: I suppose you're right. My parents can sometimes be a source of stress for me, but overall, they have been really supportive toward me and the kids. I am also really proud of being Chinese. Sometimes when I feel like I don't even know who I am any more, I start thinking about where I come from and feel like I am connected to something. I also have a lot of people that care about me at the church that I go to. I've called on them to support me before and they were happy to help. They always remind me that no matter how I feel about myself, God still loves me. It's a nice feeling.

Think-Aloud: Note how the therapist uses words like *our* and *together* to stress the collaborative nature of treatment. Also note how the therapist in this example uses self-disclosure: When he noticed that the client was "stuck" on presenting issues and their impact, he prompted her to think of her strengths by informing her of what he had noticed during their brief interaction.

In addition to identifying and prioritizing presenting issues, it is important that therapists contextualize these issues in the descriptive level of the conceptualization process. The five part model (Padeskey & Mooney, 1990) is a popular method of contextualizing presenting issues, and pictorial models of conveying this information are often helpful means of introducing the cognitive-behavioral framework by stressing the relationships between cognitions, behaviors, emotions, and physiological responses (see Figure 13.2). As can be seen in Brenda's five-part model, the therapist and client worked together to identify how environmental diatheses may have interacted with existing vulnerabilities to produce some of the presenting complaints.

More than the Sum of the Parts: Cross-Sectional Conceptualization

Cross-sectional conceptualization refers to the level of conceptualization that links theory with particular client experiences. This level works on a "higher level" (Kuyken et al., 2009, p. 172)

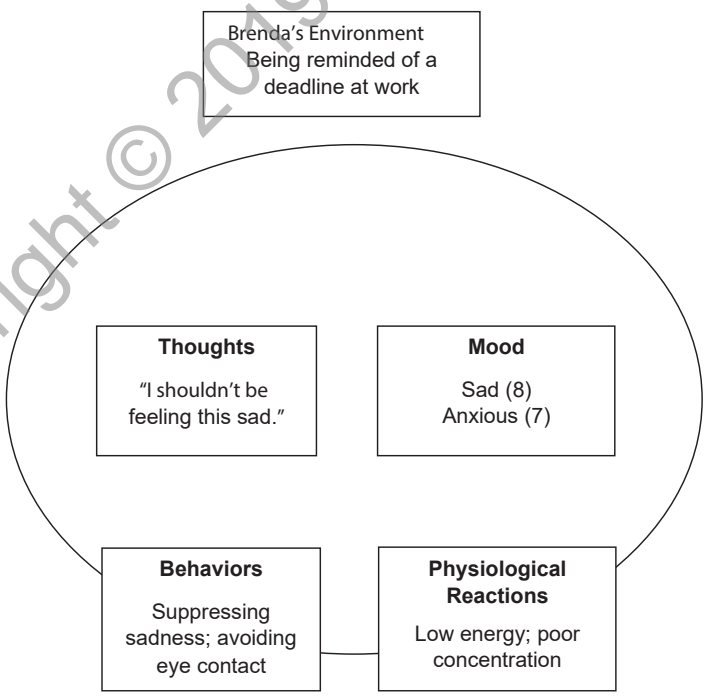

FIGURE 13.2. Brenda's five-part model.

by identifying key cognitive and behavioral mechanisms that maintain or exacerbate presenting concerns. The first goal of the cross-sectional conceptualization is to help clients identify proximal vulnerability factors unique to them and develop interventions that disrupt this cycle of vulnerability. The second goal of this level of conceptualization is identifying common threads that run across the patient's presenting issues. Kuyken and colleagues (2009) recommend a four-step process to establish a cross-sectional conceptualization, as described below. Note that although we do not discuss session details between the construction of the descriptive and cross-sectional conceptualizations, this work is foundational for appropriate progression in treatment. Important milestones after the descriptive conceptualization include appropriate self-monitoring and introduction to some early behavioral techniques (e.g., exposure; activation). The first step in this process is to gather recent examples of the patient's top concerns. In doing so, the therapist can also help the patient establish mechanisms related to the client's distress. Brenda had identified "low mood" and "poor concentration" as top priorities in her treatment. Accordingly, the therapist and Brenda worked together to uncover as many recent examples in her life as possible when these issues occurred, and to identify whether there were similarities among these seemingly unconnected occurrences.

THERAPIST: We have been talking about your mood and the fact that you notice your mood dip from time to time. You mentioned that last week you noticed that you felt sad at work. Do you remember any other instances when your mood was that low?

BRENDA: On Monday last week, I was grocery shopping, and then I started feeling sad. It felt completely out of the blue, but I almost broke down in tears in the middle of the store.

THERAPIST: That sounds really hard, Brenda. Maybe we can try to find a link between these two situations during which you felt this way. Let's look back at your five-part model that we put together a few sessions ago. I notice here that you identified the thought "I shouldn't be sad" and an associated physical reaction of being out of energy and having poor concentration. Am I getting that right?

BRENDA: Yeah, that sounds right.

THERAPIST: If you think back, what were the thoughts and the physical sensations that went along with your low mood that time when you were in the grocery store?

BRENDA: Now that I think about it, I did have a wave of fatigue that hit me. I also remember thinking, "Here it comes again. I won't even have energy to finish shopping for the kids. This is not normal and unacceptable."

Think-Aloud: Assuming Brenda was engaged with homework related to self-monitoring of thoughts, emotions, behaviors, and physical sensations, discussions such as the one we just presented work to further solidify observations made in, and hypotheses generated by, the descriptive conceptualization.

After the identification of a number of recent examples when Brenda felt low and sad, the therapist and client worked to develop a model of triggers and maintenance factors to help account for her top presenting issues:

THERAPIST: From the list of examples we wrote down, can you see a pattern that connects these different situations together?

BRENDA: I see that my mood is almost always connected with thoughts about how I shouldn't feel a certain way or that people will notice and will judge me. My low mood seems to also be connected with how tired I feel.

THERAPIST: I am seeing this, too. What do you make of all of this?

BRENDA: I am starting to see that my depression is making me question myself as a nurse and a mother. I guess the more I think that way, the more fatigued I feel and harder it is for me to concentrate on what I am doing, and less likely for me to get what I need done. It's kind of like a self-fulfilling prophecy.

THERAPIST: That seems like it fits with what has been going on. If you could, how would you connect your thoughts, feelings, behaviors, and physical sensations across these different situations, then?

BRENDA: If I had to guess, across these situations, I probably start noticing something about my depression, like my sadness or how tired I am, and then I start thinking about how I shouldn't feel this way or that people will think less of me if they know, and that makes me even more sad and tired. I always remember the thought "I have to hide this," because

I can't imagine anyone understanding what is happening to me. The thought that I have to hide it doesn't help with my concentration.

THERAPIST: It sounds like you may be on to something here, Brenda.

Think-Aloud: Here, the therapist challenges Brenda to think about her own thinking and generate her own hypotheses that function to link thoughts, behaviors, and emotions across time and situations.

As we can see, together with the therapist, Brenda was able to devise a working model of her low mood: Physical primes of her low mood and fatigue may lead to negative thoughts about her need to "hide" the symptoms, which lead to intense feelings of sadness and fatigue, which then make it less likely for her to carry out her duties (e.g., work-related deadlines) and may reinforce the original unhelpful thoughts ("This is not normal"; "I shouldn't feel this way"). In the coming sessions, Brenda and her therapist uncover a potential unhelpful underlying assumption that may work to maintain her low mood: "If people notice my moments of weakness, they will judge me." Brenda and the therapist then work together on a brief conceptualization of this hypothesized model (Figure 13.3).

In the next step of cross-sectional conceptualization, Brenda and the therapist identify targeted interventions to disrupt this hypothesized cycle of vulnerability. During this step, Brenda also identifies how her resilience and strengths, namely, the support of her parents and friends, can help break the cycle. For example, Brenda indicated that she would solicit help from her parents around the house during instances when she is feeling extremely fatigued. She also agreed to solicit help from her coworkers when she is feeling particularly sad or in need of a short break while on the job. In soliciting this kind of support, Brenda also began to modify her underlying assumption: "Even if I cannot always be strong, I know I can still get support from people around me, and they will not judge me."

In subsequent sessions, the therapist and Brenda began developing another maintenance model surrounding Brenda's social anxiety:

THERAPIST: I know that one of your other concerns was how anxious you get around others. I am curious if you think your mood and anxiety are connected somehow?

BRENDA: Now that I think back, every time I get really anxious around strangers is when

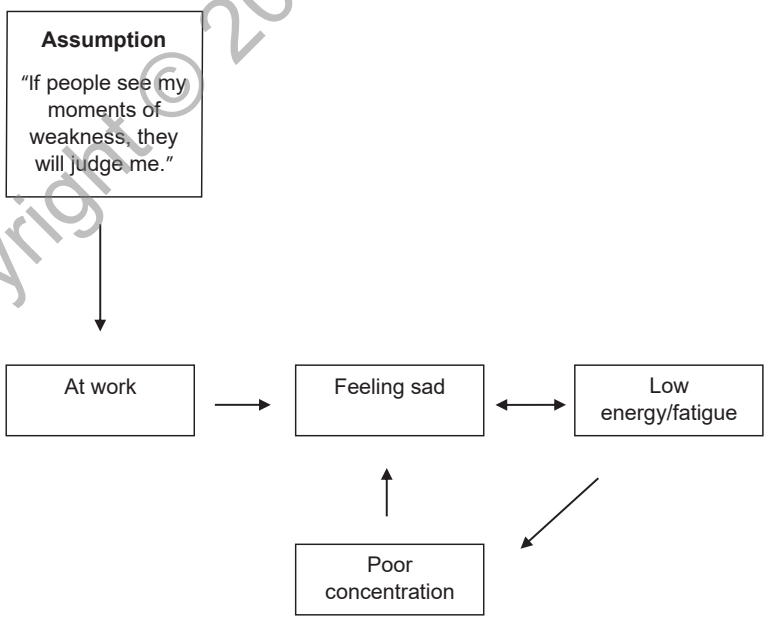

FIGURE 13.3. Cross-sectional conceptualization.

that thought pops back in my head: "People can't see me sad," "Feeling this way is not normal," or "I will be judged." As soon as I have these thoughts, I start feeling like there is something wrong with me and that people will see it and judge me.

Related to the underlying assumption that triggers and maintains her low mood, Brenda identified that she "feels judged" when she does not maintain an appearance of energy and excitement around others. Accordingly, she becomes anxious in the company of her romantic interests, which works to increase her fatigue and poor concentration, and maintain the cycle of anxiety.

During last stage of the cross-sectional level of conceptualization, the therapist and Brenda revised and expanded the original maintenance model. For instance, Brenda noticed that at times, she preempts feeling judged by others and starts acting with hostility and defensiveness around them, which makes her feel guilty later. Note that the models created in this and other levels of the conceptualization process are tentative in nature. Thus, all models are subject to revision when evidence that is unsupportive of such models arises.

From Then to Now and Beyond: Longitudinal Conceptualization

In the longitudinal level of the conceptualization process, Brenda and her therapist explore key developmental events that may have contributed to formation of unhelpful underlying assumptions and schemas. Together, they connect her life history to her present struggles. As is argued by Kuyken and colleagues (2009), a longitudinal conceptualization may not always be necessary, especially when treatment goals have been met during the cross-sectional conceptualization stage. However, if progress seems volatile and/or if more pervasive clinical issues have been identified, a longitudinal conceptualization is recommended. Accordingly, the goals of a longitudinal conceptualization are to address causes of unstable remission and to elucidate why patients may continue to experience symptoms across varying environmental circumstances. Finally, longitudinal conceptualizations are intended to predict and prevent future relapse and mobilize protective factors when vulnerability factors have been activated.

Longitudinal conceptualizations comprise two stages. In the first stage, the patient and therapist use CBT theory to establish a connection between current issues and developmental experiences. In the second stage, patient and therapist use the conceptualization to develop and select interventions that may break this association. As with other stages in the conceptualization process, movement between these two stages is driven by how well the conceptualization fits with the evidence.

The assessment phase of Brenda's treatment revealed two important developmental events. Brenda reported being ridiculed by other children for her ethnicity in middle school. She reported feeling "different," and that she worked hard to "blend in" with the other children. Also, in her late adolescence, Brenda reported developing a romantic interest in a boy at her church. She reported that her Youth Pastor became aware of this relationship and voiced his disapproval of this interest on religious grounds.

THERAPIST: Brenda, I noticed on your thought records from last week you had the thoughts "It's awful if they know what's really going on" and "I shouldn't be feeling this way." Do these sound familiar to you?

BRENDA: I guess I had similar thoughts a couple weeks ago. Now that I think about it, I had really similar thoughts a few weeks before then, too.

THERAPIST: Yeah, I noticed that, too. What do you make of this?

BRENDA: I am not sure.

THERAPIST: I remember when we were talking about your history in the first couple of sessions and you had mentioned something about your experience of being bullied in middle school.

BRENDA: That's right. Kids were awful to me just because I didn't look the same or because I showed up with a different lunch than most of them. That year didn't do my self-esteem very good.

THERAPIST: I also remember that the low mood and other issues you came to treatment with started shortly after you and your most recent boyfriend broke up because of how close you are with your parents.

BRENDA: That's right. He just didn't understand that this is how it is for me and how it will always be. He just couldn't accept that fact.

THERAPIST: Do you see a connection there?

BRENDA: Do you mean both are about my culture?

THERAPIST: Yes, there's that. But I am also curious to know how you perceived these events then and now?

BRENDA: Well, I usually feel very confident about where I come from, but in both of these instances, I guess I felt a bit of shame or that I need to be like everyone else, which is ridiculous.

Here, Brenda discovered that there may be a connection between her being bullied in middle school and the events that led to the dissolution of her most recent romantic relationship. The therapist then used Socratic questioning to bring this possible connection to light. Brenda confirmed that she experienced similar thoughts and symptoms as a reaction to both events. Later, the therapist and Brenda make another connection between her current "need" to be strong around others and her experience of intense sadness when she perceives her strength or the appearance of it as wavering (e.g., when she is unable to concentrate at work).

Subsequently, Brenda and her therapist devise a working longitudinal conceptualization connecting her developmental history with her current functioning (Figure 13.4). In addition to the conceptualization of vulnerability, Brenda and her therapist developed a "resilience" longitudinal conceptualization (Table 13.1). As we mentioned in the opening section of this chapter, there is continual negotiation between risk and resilience factors, and the relative strengths and weight of each of these factors may dictate long-term remission or relapse. As such, we believe it is important to develop a resilience model, as tapping into resilience and protective factors may help dismantle the effects of vulnerability factors, even if the latter set of factors are not dealt with in a direct manner.

The Science of Case Conceptualization: What Does the Evidence Say?

Despite the stated importance of case conceptualization and formulation in cognitive therapy (Butler, 1998), few studies to date have examined the effects of conceptualization on treatment outcome per se. Initial research efforts in this area examined the level of interrater agreement on different aspects of the conceptualization process (Dudley, Park, James, & Dodgson, 2010). This research revealed that although there was higher agreement on the descriptive aspects of conceptualization, more inferential elements produced only modest inter-clinician agreement (Kuyken, Fothergill, Musa, & Chadwick, 2005; Mumma & Smith, 2001).

Several lines of research have found that training and expertise function to improve the validity and utility of case conceptualizations in treatment. Evidence suggests that clinicians with more experience and specialized training produce more reliable conceptualizations (Kuyken et al., 2005, 2015; Persons & Bertagnolli, 1999). For example, clinicians with more experience were more likely to agree on the same patients' underlying cognitive schemas than those with less experience. Furthermore, therapists with greater expertise were found to produce higher quality (Mumma & Mooney, 2007) and more parsimonious (Bieling & Kuyken, 2003) conceptualizations. For example, experienced clinicians' schema conceptualizations were more predictive of patients' distress than those of novice clinicians (Mumma & Mooney, 2007).

Investigations that attempted to examine the effects of quality of formulation on treatment outcome are scant, and existing studies have generated mixed results (Chadwick, Williams, & Mackenzie, 2003). That said, there is emerging evidence of its importance in treatment. For example, in a recent trial, Abel, Hayes, Henley, and Kuyken (2016) found that therapists who demonstrated higher CCC competence also displayed sudden gains in CBT with clients who suffer from treatment-resistant depression. Sudden gains in this trial were associated with a more stable and long-term remission. CBT case conceptualization may function to improve outcome by enhancing other process-related variables. For example, Tee and Kazantzis (2011) found that use of a collaborative approach in treatment improved clinicians' understanding of their clients' viewpoints and enhanced the therapeutic alliance. This was replicated in a recent study by Nattrass, Kellett, Hardy, and Ricketts (2015) in a sample of patients with obsessive–compulsive disorder. Furthermore, some researchers have hypothesized that adopting a strengths and resilience approach in treatment will function to improve outcome (Padesky & Mooney, 2012; Slade, 2009); however, most of

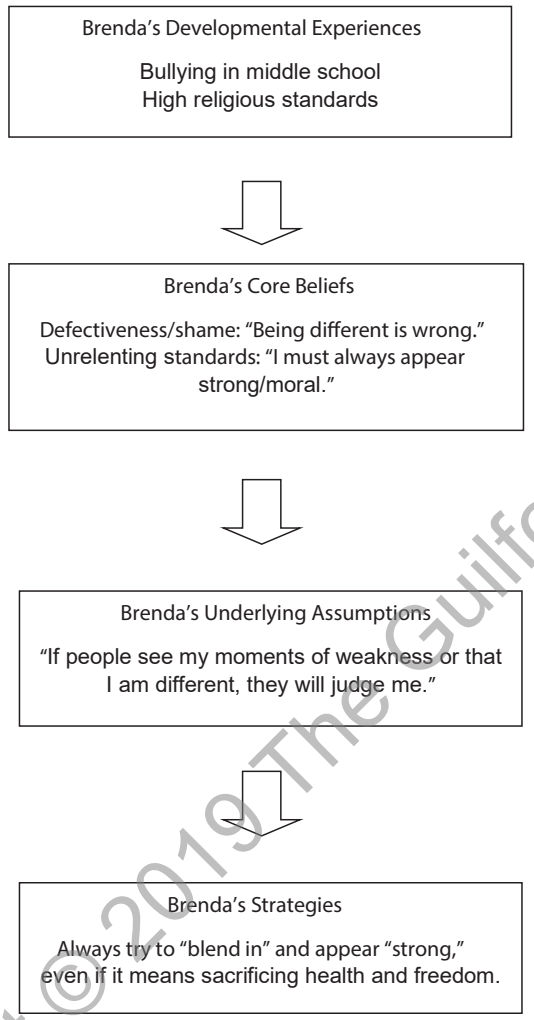

FIGURE 13.4. Brenda's top longitudinal case conceptualizations.

these hypotheses have not been empirically validated. In addition, Persons, Roberts, Zalecki, and Brechwald (2006) found that the use of case conceptualization was significantly associated with outcome in effectiveness trials. Finally, Kuyken and colleagues (2015) found that clinician scores on the Collaborative Case Conceptualization Scale (CCC-RS) were significantly and positively correlated with CBT competence in general, as assessed by the Cognitive Therapy Scale (CTS).

Considering the entirety of the evidence base, there are few studies that have directly examined the effects of case conceptualization on therapy outcome, and such early studies are supportive of the use of case conceptualization to improve outcome, especially for comorbid diagnoses or complex presentations (e.g., Persons et al., 2006); however, much work remains to be done. Our interpretation of the extant literature suggests that (1) case conceptualization may be enhanced through training; (2) case conceptualization may improve other process-related factors (e.g., therapeutic alliance), which may in turn produce favorable outcomes; and (3) some elements of the CCC model (e.g., strength focus and collaborative approach) may overall be therapeutically beneficial.

TABLE 13.1. Brenda's Resilience Model

Development	Core beliefs	Assumptions	Strategies
Strong familial connection	"I am loved."	"If I am ever in need, I can count on those around me."	Solicit help from others.
Sense of pride from Chinese heritage	"I belong."	"If I am ever lost, I can look to my culture for answers."	Use wisdom of culture in explaining everyday experiences and struggles.
Religious upbringing	"God loves me."	"Even if I am different or not always strong, I am still loved."	Use spirituality to feel accepted even in the midst of adversity or personal struggles.

Although the results of these preliminary studies are suggestive, more research is needed to support the role of conceptualizations in CBT. For example, future studies should directly examine whether the quality (e.g., reliability and validity) of case conceptualizations predicts outcomes later in treatment. Furthermore, and given the recent development of a rating scale of CCC skills in CBT (Kuyken et al., 2015), future studies should directly examine the relationship of such skills with outcomes in treatment. Finally, the utility of many elements of the CCC model specifically (e.g., the levels of conceptualization) has yet to be empirically tested; therefore, we encourage researchers to examine the incremental value of such elements in CBT.

Summary

Decades of careful clinical research have generated useful theories about the human condition and the nature of distress. Importantly, this research has revealed that these theories do not always apply, or they do not apply in the same manner to all sufferers. For this reason, a reflective, deliberate, and flexible approach to alleviating distress is necessary. The CCC approach in CBT is a blueprint for how to effectively use clinical theories built on solid evidence in a flexible manner that is respectful of human complexity and diversity; that is, both our clients and psychological science bring to therapy useful, rich theories to help describe and explain the human condition and how distress is caused and maintained. They also provide ways to describe and explain resilience. The CCC approach in CBT provides a crucible in which these personal and psychological theories come together, with the therapist and client collaboratively building an understanding that can help the client move toward his or her treatment goals. For Brenda and her presenting issues, history, strengths, and faith are all part of the conceptualization in the service of both helping her to not only address her mood and relationship problems but also lead a happy and fulfilling life.

In using the CCC model, we hope that mental health practitioners can appreciate and embrace the richness and complexity of clinical practice. Furthermore, in writing this chapter, we also hoped to emphasize to practitioners the value of collaboration in the context of treatment; rather than a practitioner-led approach to treatment, the work is a partnership. Many therapists have said that this is a relief, as responsibility is fully shared with the client. Finally, and through use of and proficiency in the CCC model, we hope that practitioners are able to better identify and build on patients' strengths and work not just to address patients' vulnerability but very explicitly develop their resilience.

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