Chapter 1

The Procrustean Dilemma

The mythological character Procrustes was a host who invited guests to his house, claiming that all visitors, whatever their size, would fit the bed in his guest room. Such a grand and magical claim attracted a lot of attention. What Procrustes did not tell his guests was that he was willing to either cut off his guest's legs or stretch them on a rack to make them fit the bed. The story of Procrustes could be a cautionary tale for psychotherapy clients. Although there are many empirically tested models for understanding psychological distress, few clients want to see a therapist who cuts off or distorts client experience in order to fit preexisting theories.

Clients present with complex and comorbid presentations for which no single approach is a 100% fit. This book teaches therapists how to become skilled in methods of case conceptualization that offer custom-made hospitality for clients seeking help. Readers learn how to shape case conceptualizations that synthesize individual aspects of a given case with relevant theory and research without the need to resort to Procrustean measures.

As a case illustration, Steve is a single 28-year-old man referred to an outpatient clinic for cognitive-behavioral therapy (CBT). The referral notes that Steve experiences difficulties adjusting to his enjoyment of cross-dressing. At the assessment Steve confirms that cross-dressing is something he wants to discuss in therapy but it is a greater priority to talk about having been "terrorized in the city where I lived until recently … and … I'm having a lot of trouble getting over it even though I have relocated." Steve suffered repeated violent physical attacks in the city where he used to live and he moved because there was no sign that these attacks

would stop. Steve is slight in build, soft-spoken, and unassertive. In the diagnostic work-up Steve meets criteria for posttraumatic stress disorder (PTSD), major depressive disorder, and agoraphobia with panic. In terms of Axis II there is some evidence of avoidant personality traits. His therapist hypothesized that Steve's slight build and soft-spoken, unassertive style led the bullies in his neighborhood to victimize him. His PTSD was a reaction to repeated physical assaults that he felt powerless to prevent. Withdrawal to his apartment exacerbated the PTSD symptoms and contributed to Steve's becoming depressed and agoraphobic.

Steve and the therapist agreed to begin therapy by focusing on Steve's PTSD symptoms. In the sixth session Steve disclosed that neighbors had seen him the previous year in his home dressed in women's clothing. Word quickly spread through the neighborhood that Steve was a cross-dresser. With this revelation, a group of youths began a campaign of violence against him. Repeated physical assaults led to Steve's decision to relocate.

The issues Steve's therapist faced are similar to the issues therapists face with each client at the beginning of therapy:

- "Given the various presenting issues and Axis I and/or II diagnoses, what should be the primary focus for the work?"
- "Do I address Axis I or Axis II problems, or both? If both, in what order?"
- "How do Steve's presenting issues relate to one another, if at all?"
- "What CBT protocol do I use here? What do I do when no particular protocol seems appropriate?"
- "How should I work with his cross-dressing?' How do I do this without exacerbating his fear?"
- "How do I work collaboratively with Steve to weave his priorities and my clinical judgment into our decision making about therapy?"
- "How do I work with my own beliefs, values, and reactions if these are sometimes different than my client's?"

In short, Steve's therapist is faced with the question that faces all therapists at the beginning of therapy: "How do I best use my training and experience along with evidence-based therapy approaches to help these particular issues presented by this person?" This book answers this question by showing how skillful case conceptualization provides ways to work collaboratively with clients to (1) describe presenting issues, (2) understand them in cognitive-behavioral terms, and then (3) find constructive ways to relieve distress and build client resilience.

WHAT IS CASE CONCEPTUALIZATION?

We define CBT case conceptualization as follows:

> *Case conceptualization is a 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.*

We use the metaphor of a crucible to emphasize several aspects of our definition (Figure 1.1). A crucible is a strong container for synthesizing different substances so that they are changed into something new. Typically, heating the crucible facilitates the process of change. The case conceptualization process is like that insofar as it synthesizes a client's presenting issues and experiences with CBT theory and research to form a new understanding that is original and unique to the client. CBT theory and research are essential ingredients in the crucible; it is the integration of empirical knowledge that differentiates case conceptu-

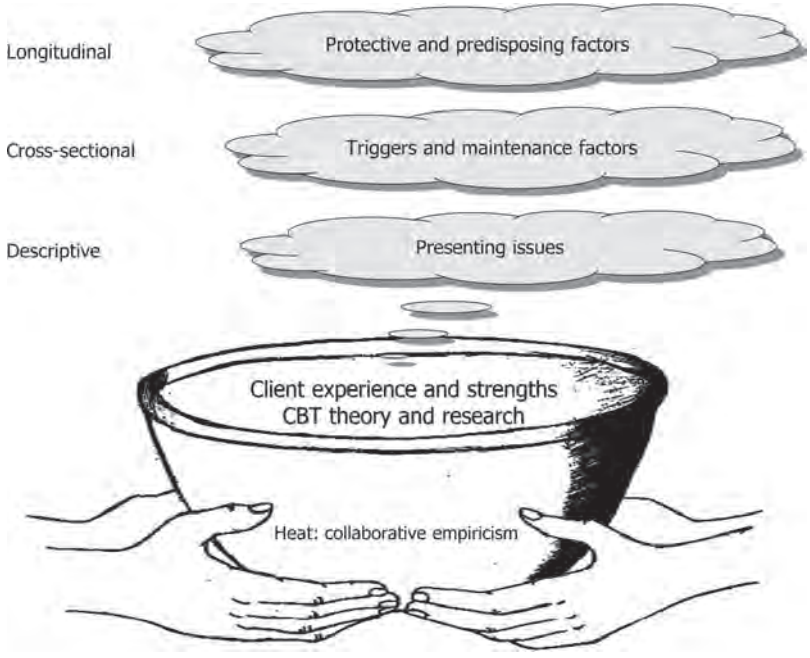

Figure 1.1. The case conceptualization crucible.

alization from the natural processes of deriving meaning from experience in which people engage all the time.

The crucible metaphor further illustrates three key defining principles of case conceptualization developed in detail throughout this book and shown in Figure 1.1. First, heat drives chemical reactions in a crucible. In our model, collaborative empiricism drives the conceptualization process. The hands in Figure 1.1 represent collaborative empiricism between therapist and client; they generate the heat that encourages transformation within the crucible. Collaboration helps ensure that the right ingredients are mixed in a useful way. The perspectives of therapist and client combine to develop a shared understanding that fits, is useful to the client, and informs therapy. Empiricism is a fundamental principle in CBT (J. S. Beck, 1995). It refers to the empirical research and relevant theory that grounds therapy as well as to the use of empirical methods within day-to-day practice. An empirical approach is one in which hypotheses are continually developed based on client experience, theory, and research. These hypotheses are tested and then revised based on observations and client feedback.

Second, like the chemical reaction in a crucible, a conceptualization develops over time. Typically, it begins at more descriptive levels (e.g., describing Steve's problems in cognitive and behavioral terms), moves to include explanatory models (e.g., a theory-based understanding of how his posttraumatic stress symptoms are maintained), and, if necessary, develops further to include a historical explanation of how predisposing and protective factors played a role in the development of Steve's issues (e.g., incorporating Steve's developmental history into the conceptualization).

Third, new substances formed in a crucible depend on the characteristics of the materials put into it. A client's experiences along with CBT theory and research are key ingredients in a conceptualization. Traditionally, the emphasis has been on client problems. Rather than simply look at these, our model incorporates client strengths at every stage of the conceptualization process. Regardless of their presentation and history, all clients have strengths that they have used to cope effectively in their lives. Incorporation of client strengths into conceptualizations increases the odds that the outcome will both relieve distress and build client resilience. As illustrated in Figure 1.1, client strengths are part of the crucible's mix.

This book responds to the Procrustean dilemma by proposing a new approach to case conceptualization that joins theory and research with the particularities of an individual's life experience. Three principles guide this approach: (1) collaborative empiricism, (2) levels of conceptualization that evolve over time from the descriptive to the explana-

tory, and (3) incorporation of client strengths. Each chapter in this book offers specific "how-to" guidelines for the development of case conceptualizations that can improve therapy's effectiveness.

In this opening chapter we suggest that case conceptualization has become central to CBT practice because it serves the 10 key functions outlined below. However, we also go on to consider some important empirical challenges to the centrality of case conceptualization in CBT practice. These challenges have been important in shaping the case conceptualization approach proposed in this book.

FUNCTIONS OF CBT CASE CONCEPTUALIZATION

We propose that therapy has two overarching goals: (1) to alleviate clients' distress and (2) to build resilience. There is an emerging consensus that CBT case conceptualization helps achieve these two goals when it fulfills the following 10 functions (see Box 1.1; Butler, 1998; Denman, 1995; Eells, 2007; Flitcroft, James, Freeston, & Wood-Mitchell, 2007; Needleman, 1999; Persons, 2005; Tarrier, 2006).

1. *Case conceptualization synthesizes client experience, relevant CBT theory, and research*. As articulated in our definition, a primary function of case conceptualization is to meaningfully integrate client experiences with relevant CBT theory and research. In Steve's case CBT theories of PTSD (Ehlers & Clark, 2000), depression (Clark, Beck, & Alford, 1999), anxiety (Beck, Emery, & Greenberg, 1985), and personality (Beck et al., 2004) can all usefully inform the case conceptualization. These theoretical ideas are integrated with related research and key aspects of Steve's personal history, current life situation, beliefs, and ways of coping to create a unique case conceptualization. Evidence-based theory and research ensure that the best available knowledge informs our emerging understanding of the presenting issues.

2. *Case conceptualization normalizes clients' presenting issues and is validating.* Many clients worry that their presenting issues are stigmatizing, set them apart from others, and make them somehow "abnormal." Clients sometimes say, "I thought I was crazy," or "I am so ashamed to have these problems." Case conceptualization describes problems in constructive language and helps clients understand how problems are maintained. While there still is real social stigma regarding many mental health problems, the process of collaborative case conceptualization can helpfully validate and normalize client experience. As Steve said later in therapy, "There are other people like me and I am not a freak. I know I am not the only person who cross-dresses, and I don't need

Box 1.1. Functions of Case Conceptualization in CBT

1. Synthesizes client experience, CBT theory, and research.
2. Normalizes presenting issues and is validating.
3. Promotes client engagement.
4. Makes numerous complex problems more manageable.
5. Guides the selection, focus, and sequence of interventions.
6. Identifies client strengths and suggests ways to build client resilience.
7. Suggests the simplest and most cost-efficient interventions.
8. Anticipates and addresses problems in therapy.
9. Helps understand nonresponse in therapy and suggests alternative routes for change.
10. Enables high-quality supervision.

to blame myself or expect to be attacked." Normalization of the issues clients present in therapy can instill hope, help clients see the personal relevance of the cognitive model, and provide a platform for change.

3. *Case conceptualization promotes client engagement.* Engagement with CBT is a prerequisite for change. Case conceptualization often generates curiosity and interest, which lead to client engagement. Most clients enjoy case conceptualization because it offers a sense of mastery over difficulties and suggests pathways for reaching goals. Even when struggles persist, clients experience mastery when situations unfold in expected ways: "Just as we discussed last week, when my daughter began to whine I found my chest tightening and I felt ashamed. Even though I couldn't stop myself from this reaction, for once it made sense to me. I didn't feel so crazy. And that felt really good!"

Occasionally, clients begin therapy with beliefs that affect therapy engagement negatively. This was the case with Steve, who avoided revealing relevant information about his cross-dressing to the therapist. Once Steve chose to disclose more of his history, the therapist used this as an opportunity to uncover beliefs that might interfere with engagement:

THERAPIST: Thank you, Steve, for being honest with me—this will help us work together better. (*Steve looks uncomfortable and afraid. The therapist uses this nonverbal information as a prompt to ask*): What do you think will happen now that you have told me how the victimization started in your last neighborhood?

STEVE: (*hesitantly and avoiding eye contact*) You will despise me and not want to work with me any more. I feel so ashamed. (*Looks afraid and begins to sob.*)

This example illustrates how an unanticipated problem in therapy is used to sharpen the case conceptualization, clearing the way for greater therapy progress and client engagement. When handled well, moments like this can be a real breakthrough because important client beliefs, emotions, and behaviors are uncovered and integrated into a conceptualization. His therapist helped Steve understand that feelings of shame and fear surrounding cross-dressing were understandable in the context of his previous experiences and associated beliefs. As a child, his mother supported Steve when he expressed a desire to cross-dress, yet his father reacted violently, threatening to throw him out of the house unless Steve stopped. Later neighborhood harassment and violent attacks affirmed his father's perspective. These experiences were linked with his fear that the therapist would despise him if his behavior was revealed. Collaboratively constructing this case conceptualization with the therapist dissolved many of Steve's fears regarding engagement in therapy.

4. *Case conceptualization can make complex and numerous problems seem more manageable for clients and therapists.* Clients, particularly those with complex and long-standing difficulties, can feel overwhelmed by the sheer number of issues they face. Steve's list of presenting issues and comorbid diagnoses exemplifies this phenomenon. Therapists also can feel overwhelmed when faced with clients' complex and long-standing problems. When done skillfully, case conceptualization can help problems become more manageable for clients *and for therapists*. One therapist described it as the process of "making the soupy mess into something more palatable." A client described it as, "All these bits of the puzzle fit together now."

5. *Case conceptualization guides the selection, focus, and sequence of interventions.* Arguably the most important function of case conceptualization is to inform the therapy. The number of CBT interventions that are potentially appropriate with any given client is large and expanding (J. S. Beck, 1995, 2005). Moreover, it is not always obvious which protocol to select for those clients with comorbid presentations or for those presentations that do not fit a particular model. How does a cognitive therapist choose from this vast array of choices? Case conceptualization helps the therapist select, focus, and sequence interventions. It helps clients understand why they are doing what they are doing, emphasizes the need for change, and provides a clearer therapy focus.

Once the therapist and client have a working understanding of the

presenting issues, they can begin to consider which concern(s) to address first. CBT involves numerous choice points for therapists and clients. Case conceptualizations provide explicit rationales for making particular choices. When therapist and client agree on a conceptualization, a clear rationale can be made for following particular therapeutic approaches. Furthermore, a shared case conceptualization allows clients to fully participate in making decisions about the prioritization of presenting issues and therapy choice points.

For example, the most pressing issues for Steve at the beginning of therapy were his fear of revictimization and terrifying daily flashbacks to the violence he had experienced. In the early stages of conceptualization it became clear that Steve's cognitive and behavioral avoidance were maintaining his fear. This led Steve and his therapist to focus initially on the PTSD symptoms. However, as this work progressed Steve disclosed that he had not taken enough care to ensure the privacy of his cross-dressing in the neighborhood where he lived, thereby risking negative reactions from others. At this juncture the therapist decided to develop a fuller description and understanding of Steve's cross-dressing behavior. The emerging conceptualization led to a better description and understanding of his cross-dressing so that Steve could be supported in safe expressions of this behavior.

This process of sequencing interventions continues throughout therapy. Evolving case conceptualizations provide the road map to help the therapist and client decide together on the best routes toward therapy goals.

6. *Case conceptualization can identify client strengths and suggest ways to help build client resilience*. Conceptualization that attends to client strengths and uses a resilience lens to understand how clients respond adaptively to challenge has a number of advantages. It provides a description and understanding of the whole person, not just problematic issues. A strengths focus broadens potential therapy outcomes from alleviation of distress and resumption of normal functioning to improvement of the client's quality of life and bolstering client resilience. Discussion of client strengths often enhances a positive therapeutic alliance and can lead to the incorporation of positive client values into therapy goals.

7. *Case conceptualization often suggests the most cost-efficient interventions.* There are many drivers toward cost-effectiveness in health care delivery. Clients and other parties paying for CBT want a cost-effective approach. A case conceptualization approach can provide this by helping therapists and clients select the most efficient way of working toward therapy goals. It may be that a particular cognitive or behavioral mechanism is a linchpin that connects the client's main issues. Drawing out, loosening, and remediating this mechanism could, rather like a stone dropping into

a pond, ripple out to other areas of a client's life. For example, someone who is depressed, has stopped working, and no longer answers the phone or door has greatly diminished opportunities for mastery or pleasure. For such a person, behavioral activation reintroduces reinforcing contingencies that can lead to other positive changes (e.g., sense of self-efficacy) that in turn might lead to further changes (e.g., the confidence to engage in more reinforcing activities).

8. *Case conceptualization anticipates and addresses problems in therapy.* Therapeutic impasses and difficulties provide opportunities to test or develop the conceptualization. A good conceptualization offers an understanding of therapeutic difficulties as well as ways to address them. Ideally, every conceptualization enables a therapist to hypothesize issues that are likely to arise in therapy. For example, a client assessed for group CBT who suffers from depression and comorbid social phobia can be expected to have beliefs and fears that may interfere with participation in group therapy. Possible beliefs include "Group therapy won't help me because I am less capable than others," "People in the group will see how inadequate I am," or "I will get so anxious I will want to escape." Assessment of these beliefs as part of an initial conceptualization allows the therapist to address these client concerns, making group therapy accessible for someone who might otherwise avoid a group or drop out after a few sessions.

9. *Case conceptualization helps us to understand nonresponse to therapy and suggests alternative routes to change*. CBT outcome research studies report that a significant proportion of cases respond either partially or not at all (Butler, Chapman, Forman, & Beck, 2006). At best, a case conceptualization suggests ways to address partial or nonresponse by targeting the cognitive and behavioral mechanisms that maintain clients' problems. For example, residual depressive symptoms are excellent predictors of depressive relapse (Judd et al., 1999), and CBT innovations are beginning to inform our practice of working to prevent relapse (Hollon et al., 2005). However, there will always be cases that are not successful. For these, a case conceptualization should provide some understanding of nonresponse. Nonresponse could, for example, be a result of stable hopelessness or entrenched avoidance (Kuyken, Kurzer, DeRubeis, Beck, & Brown, 2001; Kuyken, 2004). The case conceptualization crucible provides a framework for therapists and clients to explore the various factors that might explain nonresponse in terms of the client's presentation and history, relevant theory, or research (Hamilton & Dobson, 2002).

10. *Case conceptualization enables high-quality supervision and consultation*. During case conceptualization we begin to understand what triggers, maintains, and predisposes the client's presenting issues. We also

begin to understand the factors that protect clients and foster resilience. Just as these realizations unfold in therapy, there is a parallel process in supervision and consultation. Case conceptualization structures supervisor and supervisee thinking and discussion. The collaborative conceptualization process between supervisor and supervisee can be a tremendous learning experience because it provides a model for curiosity and guided discovery that the supervisee can emulate in therapy with the client. Treatment plans, therapy progress, outcomes of particular interventions, therapeutic impasses, and therapist reactions are discussed in supervision. Each of these supervisory discussions can be viewed through a case conceptualization lens to test its "fit," better understand what has occurred, and then plan a way forward.

Like many therapists, we are drawn to CBT because of the creative dialogue that exists between clinical experience, theory, and research. Our clinical experience resonates with the mainstream position (cf. Eells, 2007) that case conceptualization can indeed function in the 10 ways just described. But the existing research tells a less certain story. The following sections review the evidence base for CBT case conceptualization and the challenges it raises. In Chapter 2, we describe why we believe our model resolves the key challenges posed by both research and clinical practice.

WHAT THE EVIDENCE FOR CASE CONCEPTUALIZATION TELLS US

The case conceptualization research literature has been reviewed comprehensively elsewhere (see Bieling & Kuyken, 2003; Kuyken, 2006). This synopsis highlights important challenges to the claim that CBT case conceptualization is "evidence based."

Can Case Conceptualization Be Subjected to Research?

Some therapists maintain that case conceptualization cannot be subjected to research. In psychodynamic psychotherapy there is a compelling repost to this critique that comes in the form of a research program that examines a particular case conceptualization framework, the Core Conflictual Relationship Theme (CCRT; Luborsky & Crits-Christoph, 1998). To illustrate that case conceptualization can be evidence based we present a synopsis of this research program.

Patients' descriptions of their relationships are used in the CCRT method to infer core themes in relationship conflicts (i.e., wishes toward the self, wishes toward others, responses from others, and responses

from the self). The authors (Luborsky & Crits-Christoph, 1998) make explicit links to underlying psychodynamic theory and have developed a systematic and transparent scoring methodology.

The CCRT has proven reliable. A review of eight studies examining judges' agreement about patients' core relationship themes found agreement in the moderate to good range (kappa = .6–.8; Luborsky & Diguer, 1998). Reliability was better for some aspects of the CCRT than for others, and more skilled and systematic judges tended to show higher rates of agreement with one another. Evidence of test–retest reliability has been established from the assessment to early treatment phase (Barber, Luborsky, Crits-Christoph, & Diguer, 1998). In studies of validity, pervasiveness of core conflictual relationship themes have been associated in predicted ways with defensive functioning (Luborsky, Crits-Christoph, & Alexander, 1990). Furthermore, changes in CCRT pervasiveness have been associated with symptom changes during therapy (Crits-Christoph, 1998), although the size of changes in CCRT pervasiveness was small (especially for wishes toward self or others) and the size of the association modest. The CCRT has been linked to therapy outcome. Accurate interpretations based on CCRT-derived case conceptualizations have been associated with patient improvements in a study of 43 patients in brief psychodynamic psychotherapy (Crits-Christoph, Cooper, & Luborsky, 1988).

Thus the CCRT appears to be a case conceptualization method that is reliable, valid, and related to improved outcomes. In summary, the CCRT method suggests that a systematic and coherent case conceptualization approach used by well-trained and skilled therapists can be evidence based.

Is There an Evidence Base for CBT Case Conceptualization?

Is CBT case conceptualization evidence based in the same way as the psychodynamic CCRT? Peter Bieling and Willem Kuyken set out criteria to evaluate whether case conceptualization deserves its emerging mantle as "the heart of evidence-based practice" (Bieling & Kuyken, 2003, p. 53), "the lynch pin that holds theory and practice together" (Butler, 1998, p. 1), and a key principle underpinning cognitive therapy (J. S. Beck, 1995). As set out below, the criteria for evidence-based case conceptualization can be broadly classed as top-down and bottom-up:

Top-down criterion

- Is the theory on which the conceptualization is founded evidence based?

Bottom-up criteria

- Is conceptualization reliable? That is,
  —Is the process of conceptualization reliable?
  —Can clinicians agree on the conceptualization?
- Is the conceptualization valid? Does it triangulate with the client's experience, any standardized measures, therapist and clinical supervisor's impressions?
- Does the conceptualization improve the intervention and the therapy outcomes?
- Is the conceptualization acceptable and useful to clients and therapists?

Top-Down Criterion for Evidence-Based Conceptualization

The top-down criterion is satisfied by affirmative responses to two questions: "Is the theory from which case conceptualization is derived based on sound clinical observation?" and "Are the descriptive and explanatory elements of cognitive theory upheld by research?" To consider these two questions we briefly describe the elements of cognitive theory and the evidence base for CBT theories of emotional disorders.

Since its inception CBT theory has been appreciated for its systematic descriptions and explanations of emotional difficulties. While CBT was developing between the late 1950s and the late 1970s, the dominant accounts of emotional disorders were biological and psychoanalytic. Pioneers such as Aaron T. Beck and Albert Ellis were trained in psychoanalytic therapy but discovered that when they tried to apply these theories to their clients it proved to be Procrustean. To make psychoanalytic theory fit they had to disregard the ways people described their depression and anxiety. This mismatch led Aaron T. Beck to articulate a model of emotional disorders that was grounded in how people described their distress (Beck, 1967) and which continues to evolve (Beck, 2005). The current model recognizes modes of information processing (Barnard & Teasdale, 1991; Power & Dalgleish, 1997) as well as two levels of belief: core beliefs and conditional underlying assumptions (Beck, 1996, 2005; J. S. Beck, 1995, 2005). The strategies that people use in various situations are assumed to be linked to the operating mode and activated beliefs and assumptions. Modes, core beliefs, underlying assumptions, and favored behavioral strategies are linked to one another and to a person's developmental history. Finally, automatic thoughts describe the thoughts and images that spontaneously arise in the mind moment to moment.

Modes

Modes are the broadest of these concepts. Modes describe whole patterns of information processing that help people adapt to changing demands. They become activated when orienting schema identify these demands. A classic example of a mode in action is when a person *instantaneously* orients and selectively attends to threat, bringing on line finely attuned cognitive processes (e.g., where, who, what, how bad), emotional reactions (e.g., fear), physiological states (e.g., autonomic arousal), and behavioral reactions (e.g., freeze, fight, or flight).

The content of modes is organized around core themes and mirrors the themes associated with particular emotional disorders. Loss, defeat, and deenergizing are associated with depressive disorders. Threat, fear, and energizing are associated with anxiety disorders. A person in the depressive mode conserves resources; in anxiety, immediate safety seeking is emphasized. In this sense some modes are "primal" and are experienced as reflex reactions to stimuli (e.g., threat triggers escape behavior). Other modes are more differentiated (e.g., hostility and prejudice) and associated with more complex behavioral reactions.

Core Beliefs

Core beliefs are central beliefs a person holds about the self, others, and the world. Unlike modes, which represent whole patterns of information processing and response, core beliefs refer to specific cognitive constructs or content such as "I am lovable" or "People can't be trusted." Core beliefs are often formed at an early age. Most people will form paired core beliefs such as "I am strong" and "I am weak" (Padesky, 1994a). Only one of these paired core beliefs is activated at a time. When anxious, the core belief "I am weak" is likely to be activated. In less threatening circumstances, the core belief "I am strong" may be activated. When activated, core beliefs are experienced as absolute truths; as such, they are typically affectively charged.

Sometimes people do not develop paired core beliefs in all domains. Whether due to adverse developmental circumstances, traumatic events, or biological factors, some people hold strongly developed core beliefs that are not balanced by an alternative core belief (Beck et al., 2004). For example, people diagnosed with personality disorders or those with chronic depression and anxiety often hold highly emotionally charged core beliefs that generalize unconditionally across situations and moods. A person with histrionic personality disorder is likely to view others as "needing to be entertained" and the self as "dull and unlovable," even under conditions of safety. Thus one way to detect the presence of a core

belief is to notice thoughts that are accompanied by intense emotion and that do not shift in the face of contradictory evidence.

Underlying Assumptions

Underlying assumptions are intermediate-level beliefs that (1) maintain core beliefs by explaining life experiences that otherwise might contradict the activated core belief, (2) offer cross-situational rules for living that are consistent with core beliefs, and (3) protect the person from the negative affect associated with activation of core beliefs. They are called intermediate because they lie between core beliefs, which are absolute, and automatic thoughts, which are situation specific. Box 1.2

Box 1.2. Case Examples Linking Modes, Core Beliefs, Underlying Assumptions, and Strategies

	Suzette: "I'm always acting."	**Bob: "You have to take care of number 1!"**
Modes	Hyperarousal	Fight mode
Core beliefs	"I am dull and unlovable."	"I am powerful and superior."
	"Others need to be entertained."	"Others exploit me and deserve to be exploited."
Underlying assumptions	"If I entertain people, then they will find me interesting/love me."	"As long as I stay on top of other people, they won't be able to take advantage of me."
	"If I am not special and different, then no one will find me interesting or lovable."	"If I don't exploit people first, they will exploit me."
Strategies	Act, entertain, charm, and seduce.	Manipulate and lie.
	When this isn't met with appreciation, self-injury, and suicide attempts.	Vigilant to others' behavior.
Automatic thoughts	Thought: "I'm not special."	Thought: "My boss is just using me."
	Image of herself disappearing into a crowd.	Image of himself telling a story to colleagues and seeing them being "won over" by him.

illustrates the links among modes, core beliefs, underlying assumptions, and strategies for two people, Suzette and Bob.

Cognitive therapists offer a variety of terminology to describe underlying assumptions. Judith S. Beck (1995) calls them associated beliefs and distinguishes between assumptions (e.g., "If I am not special and different, then no one will find me interesting or lovable"), rules for living (e.g., "The 'show' must go on"), and attitudes (e.g., "Only people who are entertaining are likeable"). Padesky uses the term *underlying assumption* to highlight that these beliefs operate beneath the surface of automatic thoughts and behaviors (Padesky & Greenberger, 1995). She makes the case that it is helpful whenever possible to state underlying assumptions as "if … then …" conditional beliefs. Her reasoning is that beliefs stated in an "if … then …" form are predictive and thus can be more easily tested in therapy via behavioral experiments. Also there can be many different reasons for a particular rule for living. The "'show' must go on" rule could just as likely result from the underlying assumptions "If I am not special and different then no one will find me interesting or lovable," or "If people fail to entertain me, they are not worth my attention." Stating underlying assumptions in an "if … then …" form fleshes out beliefs more clearly.

Whether they are called underlying assumptions, associated beliefs, or conditional assumptions, these beliefs form a network of generally consistent beliefs that support related core beliefs. Core beliefs are a primary way of construing the self, others, and the world; underlying assumptions support this primary construal. Even so, core beliefs do not predict which specific underlying assumptions a person will hold because there are a variety of assumptions that can sustain a core belief.

Strategies

Strategies describe what the person does when modes, core beliefs, and underlying assumptions are activated. They are closely linked to modes and the content of core beliefs and underlying assumptions. For example, in a primal threat mode, the strategy may be fight or flight. In a more differentiated paranoid mode, the behavioral reaction may be withdrawal and hypervigilance. Strategies can be both cognitive and behavioral, and their range is enormous; what is important is that they are understandable when we understand a person's modes and beliefs.

Even highly unusual strategies become understandable reactions once mode, core beliefs, and underlying assumptions are identified. For example, Suzette, one of the people conceptualized in Box 1.2, cut her wrist when a coworker warmly reassured her, "You are just like everyone else in this company." For Suzette, this inclusion in normality was

devastating because she held an underlying assumption, "If I am not special and different, then no one will find me interesting or lovable." Her colleague's comment that Suzette was normal activated a high level of distress that she managed by cutting.

Strategies are activated by an affective thermostat; a person reacts cognitively or behaviorally when his/her internal state becomes deregulated. These reaction patterns often strengthen over time through processes of operant or classical conditioning. Strategies that become reflexive over time often seem dysfunctional until their origins are examined. It can be normalizing for clients to see how the unhelpful strategies they use now were highly adaptive at an earlier point in their lives.

Automatic Thoughts

Automatic thoughts describe thoughts and images that arise for everyone in the course of the day. They are called "automatic" because they arise routinely for people as they make sense of their experience. People are typically more aware of their emotional reactions than of the thoughts and images that precede or accompany them. Automatic thoughts are the focus of conceptualization when they explain the link between a situation and an emotional reaction. In the example above, Suzette's automatic thought when her colleague said, "You are just like everyone else in this company" was "I'm not special," with an associated image of herself disappearing into a crowd.

Since the publication of the seminal book *Cognitive Therapy and the Emotional Disorders* (Beck, 1976), Beck and his colleagues have developed formulations of a broad range of problem areas grounded in carefully listening to clients' accounts of their beliefs, emotions, and behaviors. Each CBT theory posits particular belief sets along with information-processing styles that describe and explain the disorder. The cognitive model of depression emphasizes negativity, specifically in relation to the self (Clark et al., 1999), and cognitive models of anxiety emphasize an overdeveloped sensitivity to threat (Beck et al., 1985). Cognitive models of personality disorder emphasize the beliefs and strategies associated with different personality disorders (Beck et al., 2004), with Suzette and Bob illustrating people with histrionic and antisocial traits, respectively (Box 1.2). Perhaps because cognitive-behavioral theories have their origins in careful observations from clinical practice, these theories tend to provide good descriptive accounts of emotional disorders that have high face validity with clients and are well supported in research. As shown in Box 1.3, there is a substantial empirical basis for cognitive theories of many Axis I and II disorders as well as growing empirical support for cognitive models of psychosis and more recently models of resiliency.

However, supporting research for the explanatory hypotheses con-

Box 1.3. Primary CBT Protocols and Evidence Summaries

Problem area	*Protocol*	*Summary of evidence*
Depression (unipolar)	Beck et al. (1979)	Clark et al. (1999)
Depression (bipolar)	Newman, Leahy, Beck, Reilly-Harrington, & Gyulai (2002)	Beynon, Soares-Weiser, Woolacott, Duffy, & Geddes (2008)
Anxiety disorders	Beck et al. (1985)	Butler et al. (2006); Chambless & Gillis (1993)
PTSD	Ehlers, Clark, Hackmann, McManus, & Fennell (2005)	Harvey, Bryant, & Tarrier (2003)
Personality disorders	Beck & Rector (2003)	Beck & Rector (2003), but see Roth & Fonagy (2005)
Substance abuse and dependence	Beck, Wright, Newman, & Liese (1993)	No summary to date, but see Roth & Fonagy (2005)
Eating disorders	Fairburn, Cooper, & Shafran (2003)	No summary to date, but see Roth & Fonagy (2005)
Relationship problems	Beck (1989); Epstein & Baucom (1989)	Baucom, Shoham, Mueser, Daiuto, & Stickle (1998)
Resilience and health	Seligman & Csikszentmihalyi (2000); Wells-Federman, Stuart-Shor, & Webster (2001); Williams (1997)	No summary to date
Psychosis	Beck & Rector (2003); Fowler, Garety, & Kuipers (1995); Morrison (2002)	Tarrier & Wykes (2004)
Hostility and violence	Beck (2002)	R. Beck & Fernandez (1998)

Note. Several seminal reviews examine the empirical status of CBT across problems areas (Beck, 2005; Butler et al., 2006; Roth & Fonagy, 2005).

tained within CBT theories is more mixed. For example, the cognitive theory of panic disorder has solid research support for both the general model and many of its explanatory hypotheses (Clark, 1986). On the other hand, although there is substantial supporting research for the broad cognitive model of generalized anxiety disorder (GAD), there are fewer studies supporting its explanatory hypotheses; in fact, there are

competing explanatory hypotheses. More specifically, the broad model is that persons with GAD overestimate dangers and underestimate their ability to cope with these threats (Beck et al., 1985). Of the models competing to explain the development and maintenance of GAD, Riskind postulates a "looming cognitive style," a specific danger schema that gives rise to worry and avoidance (Riskind, Williams, Gessner, Chrosniak, & Cortina, 2000). Wells offers a cognitive model of GAD that proposes maladaptive metacognitions, such as negative beliefs about worry (Wells, 2004). Borkovec (2002) suggests that an inflexible focus on the future might be a central cognitive problem in GAD. Each of these differing models has some empirical support. Therefore, clinicians looking for an evidence-based model to conceptualize a client's GAD-based worry have several different CBT models to consider as well as empirically supported behavioral models (e.g., Ost & Breitholtz, 2000).

In short, according to the top-down criterion for evidence-based case conceptualization, general cognitive theory provides a solid basis for working with clients to develop conceptualizations. Additional research is needed to examine the explanatory elements of cognitive theories of depression (Beck, 1967; Beck, Rush, Shaw, & Emery, 1979; Clark et al., 1999), anxiety (Beck et al., 1985; Clark, 1986; Craske & Barlow, 2001), and personality disorders (Beck et al., 2004; Linehan, 1993; Young, 1999). However, these theories already offer rich frameworks for therapists' use. Cognitive theories provide an evidence-based foundation for describing clients' presenting issues and generate testable hypotheses about triggers, maintenance, predisposing, and protective factors. We consider CBT theory a vital ingredient in the case conceptualization crucible because it is derived from grounded clinical observation and has extensive research support. When therapists have a robust theory with which they are familiar, they are much better equipped to integrate theory seamlessly into their conceptualization practice.

Bottom-Up Criteria for Evidence-Based Conceptualization

The remaining criteria for evaluating case conceptualization's evidence base are described by Bieling and Kuyken (2003) as "bottom up," referring to the process, utility, and impact of case conceptualization in clinical practice. A case conceptualization meets bottom-up criteria if it is reliable, valid (i.e., relates meaningfully to clients' experiences and can be cross-validated with other measures of clients' experiences and functioning), meaningfully and usefully affects the process and outcome of therapy, and if it is viewed as acceptable and useful to clients, therapists, and supervisors. Is there evidence that CBT conceptualizations meet these bottom-up criteria? In this section we provide a summary of evidence to date.

Is CBT Case Conceptualization Reliable?

Reliability studies answer one or both of these questions:

1. Is the process of case conceptualization reliable?
2. Can therapists agree with one another on the conceptualization for a given case?

To answer these questions, researchers presented CBT therapists with case material and a framework for conceptualization and asked them to formulate a case to see whether therapists agreed on key aspects of the conceptualization (Kuyken, Fothergill, Musa, & Chadwick, 2005; Mumma & Smith, 2001; Persons et al., 1995; Persons & Bertagnolli, 1999). These studies converge in suggesting that therapists generally agree on the descriptive aspects of the conceptualization (e.g., clients' problem list) but reliability breaks down as more inference is required to hypothesize underlying explanatory cognitive and behavioral mechanisms (e.g., key beliefs and associated strategies).

Higher rates of agreement on underlying cognitive mechanisms are achieved with more systematic case conceptualization frameworks although, even then, reliability is not high. In a study by Kuyken and his colleagues (Kuyken, Fothergill, et al., 2005), 115 therapists attending a 1-day workshop on case conceptualization formulated a case using J. S. Beck's (1995) Case Conceptualization Diagram. Judith Beck formulated the same case also using her diagram. Rates of agreement between her prototypical conceptualization and workshop participants' conceptualizations were high for descriptive information (e.g., relevant background information), moderate for easy-to-infer information (e.g., compensatory strategies), and poor for difficult-to-infer information (e.g., dysfunctional assumptions). Agreement was higher for more experienced therapists.

We propose that a systematic approach, focused training, and therapist experience will improve conceptualization as it moves from more descriptive levels to explanatory levels, which require much greater theory-based inference. More recent studies offer some support for this view (Eells, Lombart, Kendjelic, Turner, & Lucas, 2005; Kendjelic & Eells, 2007; Kuyken, Fothergill, et al., 2005).

Is CBT Case Conceptualization Valid?

The next bottom-up criterion asks "Is the conceptualization valid?" While reliability is normally a prerequisite for validity, there is value in considering validity in its own right, at least for more descriptive levels of conceptualization, where reliability has been established. Unlike with

the dynamic CCRT approach reviewed earlier, evidence bearing on this criterion is only recently emerging. In a study varying the information available to therapists over time and asking them to account for changes in clients' distress, the clinicians with expertise in case conceptualization explained, on average, twice the proportion of variance in the distress variables (Mumma & Mooney, 2007). In a similar finding, when the quality of therapist-generated CBT conceptualizations are judged by outside raters, more experienced or accredited CBT therapists are judged to produce higher-quality conceptualizations (Kuyken, Fothergill, et al., 2005). Across therapy approaches, therapist expertise is consistently related to higher-quality conceptualizations in terms of their being more comprehensive, elaborated, complex, and systematic (Eells et al., 2005). A recent study (Kendjelic & Eells, 2007) demonstrates that training aimed at improving therapists' use of a systematic approach to conceptualization led to improvements in overall quality of conceptualization as well as improvements along dimensions of elaboration, comprehensiveness, and precision.

In summary, the paucity of data bearing on the validity of case conceptualization within the context of CBT is striking, although the emerging data suggest that high-quality conceptualizations require a high level of therapist expertise.

Does CBT Case Conceptualization Improve Therapy and Outcomes?

The next criterion is whether case conceptualization improves therapy interventions and outcomes. If case conceptualization does not satisfy this criterion, its utility for clinical practice is questionable. Clinical lore maintains that individualized case conceptualizations enhance the process and outcome of CBT because they guide interventions and help predict issues that need to be addressed in therapy (Flitcroft et al., 2007). There is a growing body of research that examines whether case conceptualization enhances the process and outcome of CBT. Most of this research posits that an individualized approach should outperform a manualized approach because the therapy is being tailored to the particular needs of a client.

A series of studies of behavior therapy, CBT, and cognitive-analytic therapy have consistently failed to provide support for this basic idea (Chadwick, Williams, & Mackenzie, 2003; Emmelkamp, Visser, & Hoekstra, 1994; Evans & Parry, 1996; Ghaderi, 2006; Jacobson et al., 1989; Nelson-Gray, Herbert, Herbert, Sigmon, & Brannon, 1989; Schulte, Kunzel, Pepping, & Shulte-Bahrenberg, 1992). A seminal early study by Dietmar Schulte and his colleagues (Schulte et al., 1992) randomly assigned 120 people diagnosed with phobias to either manualized behavioral therapy, individualized therapy (based on a functional

analysis of the problem behaviors), or a yoked control in which they were offered a treatment package that had been tailored for someone else. Although the three groups differed significantly, the authors do not report pairwise comparisons even though the means suggest that the manualized approach outperformed the other two conditions. The individualized and yoked controls did not differ from each other.

We ran post hoc *t* tests comparing the standardized and individualized arms. The results suggest that the manualized arm was superior to the individualized arm on the anxiety reaction questionnaire ($t = 2.14$, $p < .05$) and the clients' own global ratings ($t = 2.39$, $p < .05$), and there was a trend for the fear thermometer ($t = 1.63$, $p = .1$). Taken at face value, these results suggest that conceptually individualized therapy (based on a functional analysis) conferred no advantages in terms of therapy outcome, was not significantly different from the wrong individualization, and on two dimensions was inferior to the manualized treatment! On the other hand, the authors' own post hoc analyses of the integrity of the individualized and manualized therapy arms suggest significant evidence of individualization in the manualized arm; that is, therapists adapted the manual for their clients and thus the manualized treatment was not identical across clients (Schulte et al., 1992).

In a more recent study involving a series of single-case designs applying CBT for psychosis, case conceptualization had no discernible impact on outcomes or client-rated process measures such as the therapeutic relationship (Chadwick et al., 2003). The only discernible effect of case conceptualization was for the therapist, who felt that the alliance had improved following the session in which the case conceptualization had been shared with the client. However, clients did not rate the alliance as being improved.

There are some exceptions to this general trend of findings (Ghaderi, 2006; Schneider & Byrne, 1987; Strauman et al., 2006). For example, in a small randomized controlled trial for clients reporting depressive symptoms, a tailored intervention (self-system therapy) specifically addressing clients' self-discrepancies and goals proved particularly effective with clients for whom these concerns were central to the presenting issues (Strauman et al., 2006). In another study, Ghaderi (2006) compared individualized and manualized approaches for clients with bulimia nervosa. Although there were few differences between conditions, some outcome measures favored the individualized condition and the majority of nonresponders were in the manualized condition.

These few studies offer promising preliminary evidence that theory-driven individualized treatment models can enhance outcomes. However, this promise is accompanied by two cautionary observations. First, differences between manualized and individualized conditions tend to emerge only in a small subset of the outcome measures, and the effect

sizes for significant differences tend to be small. Second, the assessors doing the follow-up assessments have typically not been blind to treatment condition. In summary, studies that examine the relationship between case conceptualization and therapy outcomes offer little definitive support for the benefits often claimed for case conceptualization. We concur with other commentators (e.g., Eifert, Schulte, Zvolensky, Lejuez, & Lau, 1997) that individualized and manualized treatment are not mutually exclusive. In addition, we propose that manuals be used in a flexible, theory-driven fashion, guided as far as possible by an empirical approach to clinical decision making. Moreover, our model proposes that conceptualizations co-created with clients are more likely to provide compelling rationales for therapy interventions.

Is CBT Conceptualization Considered Acceptable and Useful?

The final bottom-up criterion for judging the evidence base of case conceptualization in CBT asks whether case conceptualization is helpful for CBT clients and is regarded as useful by therapists, supervisors, and clinical researchers. A few small-scale studies are beginning to address this question with fascinating results (Chadwick et al., 2003; Evans & Parry, 1996). Client reactions to case conceptualizations are both positive (led to better understanding, felt more hopeful) and negative (made me think I was "crazy," overwhelmed). This work is salutary because mainstream CBT typically describes case conceptualization as beneficial (as we do, above) and rarely mentions its potential negative impact. Negative reactions to a case conceptualization might impede therapy or, as Evans and Parry (1996) speculate in a post hoc way from the perspective of cognitive analytic therapy, motivate clients and facilitate change.

From the perspective of therapists, case conceptualization is increasingly viewed as a core aspect of CBT (Flitcroft et al., 2007). Basic and advanced CBT training programs typically include case conceptualization as a core skill. While a decade ago only a very small handful of empirical papers on case conceptualization existed, research in this area is growing steadily. The growth of commitment to case conceptualization suggests that therapists find case conceptualization helpful as a method for individualizing CBT manuals for particular clients. On the other hand, there is little evidence that clients experience case conceptualization as a core part of CBT.

Should We Eliminate Case Conceptualization from CBT?

Even though CBT therapists and training programs are very committed to case conceptualization, the evidence challenges the claimed

roles of case conceptualization in CBT. We cannot strongly advocate existing case conceptualization approaches as an alternative to protocol-based approaches just because protocol-based approaches are sometimes not effective with comorbid or complex presentations. We argue, however, that the research to date is not cause for abandoning case conceptualization; rather, we believe it challenges us to develop models that are more likely to meet evidence-based standards.

From a top-down perspective, cognitive theories are based in careful clinical observation, have a strong evidence base, and offer many testable hypotheses. A good CBT therapist uses cognitive theories to plan and navigate therapy. However, unlike the evidence base for the psychodynamic CCRT case conceptualization approach, CBT therapists currently do not appear to use case conceptualization in a principle-driven and empirical way.

This text teaches an approach to CBT case conceptualization that bridges theory and practice, informs therapy, and potentially will stand up to empirical scrutiny. We believe it takes a step toward resolving some of the challenges presented by the research studies examining CBT case conceptualization. In the following chapters we present our model of CBT case conceptualization, provide a rationale for why therapists should follow it, and explain in detail how to apply it. We next examine the model's three foundation principles: evolving levels of conceptualization (Chapter 2), collaborative empiricism (Chapter 3), and incorporation of client strengths (Chapter 4). We then bring these three principles to life by showing how one particular client's case conceptualization evolves over the course of treatment and guides it (Chapters 5–7). Case conceptualization requires higher-order skills that can be developed through training and supervision; Chapter 8 offers ideas for both learning and teaching case conceptualization skills. In Chapter 9 we draw these themes together and suggest future directions for research on case conceptualization. By explicitly describing the processes and principles of case conceptualization we hope this book encourages CBT therapists to approach case conceptualization as a journey that is exciting, creative, dynamic, rewarding, and best enjoyed with the clients' full participation.

Chapter 1 Summary

- Case conceptualization is a process like that in a crucible; it synthesizes individual client experience with relevant theory and research.
- Collaborative empiricism is the "heat" that drives the conceptualization process.

- Conceptualization evolves over the course of CBT, progressing from descriptive to increasingly explanatory levels.
- Conceptualizations incorporate not only client problems but also client strengths and resilience.
- CBT case conceptualization serves 10 key functions that describe client-presenting issues in CBT terms, improve understanding of these presenting issues, and inform therapy.
- Case conceptualization helps achieve the two overarching goals of CBT: to relieve client distress and build resilience.
- The evidence base for CBT case conceptualization presents important challenges. This book responds to these challenges by providing a framework for how to conceptualize.

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