Cognitive Behaviour Therapy Case Studies

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SAGE

Los Angeles | London | New Delhi
Singapore | Washington DC

First published 2012

SAGE Publications Ltd
1 Oliver's Yard
55 City Road
London EC1Y 1SP

SAGE Publications Inc.
2455 Teller Road
Thousand Oaks, California 91320

SAGE Publications India Pvt Ltd
B 1/I 1 Mohan Cooperative Industrial Area
Mathura Road
New Delhi 110 044

SAGE Publications Asia-Pacific Pte Ltd
3 Church Street
#10-04 Samsung Hub
Singapore 049483

Library of Congress Control Number: 2044929629

British Library Cataloguing in Publication data

A catalogue record for this book is available from the British Library

ISBN 978–0–85702–075–8
ISBN 978–0–85702–076–5 (pbk)

Typeset by C&M Digitals (P) Ltd, Chennai, India
Printed and bound by CPI Group (UK) Ltd, Croydon, CR0 4YY
Printed on paper from sustainable resources

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Mandy Drake is a senior lecturer in mental health at the University of Chester. She qualified as a mental health nurse 20 years ago and the majority of her career has been spent in the community, working primarily with people experiencing common mental health problems. She has worked in the field of CBT for the last 12 years, the more recent of which have been dedicated specifically to brief and minimal interventions. Mandy has an interest in increasing the accessibility of psychotherapeutic interventions to both those wishing to train in the field and to those wishing to engage with the therapy, and this has led her to develop a Masters programme in multi-method therapy. Mandy maintains her clinical practice as an associate practitioner within the university counselling service where she provides a CBT clinic.

Janice Lamb is a principal psychotherapist and a sexual and relationship psychotherapist accredited by both the UKCP and COSRT. She has also completed a PG Dip in forensic sexology and is a COSRT accredited supervisor. Janice currently works in psychology services within an acute NHS hospital trust but she has had a varied career since qualifying as a mental health nurse in 1984. For the past 15 years, however, her clinical practice has drawn heavily on CBT, particularly within her psychosexual work. Janice has a particular interest in working with women experiencing sexual dysfunctions, including those with a history of gynaecological problems.

Ian W. Ross is a qualified psychologist, counsellor, clinical supervisor and cognitive behavioural therapist, accredited by the BABCP. He has extensive experience as a lecturer at the University of Chester and the Open University, with both undergraduate and postgraduate students. Ian is a strong proponent of an integrated approach to psychotherapy and has worked with a range of clients in the NHS, GP settings, occupational health and private healthcare. He also manages an independent CBT clinic in North Wales.

Mike Thomas is Professor of Eating Disorders at the University of Chester. He has spent nearly 30 years in clinical practice and academic life and has worked with clients experiencing eating disorders since 1990. As a consultant psychotherapist he currently runs two separate clinics, one specialising in severe and enduring conditions and the other in differential diagnoses. His current research interests are the impact of family therapy for adults experiencing eating disorders and in exploring physiological aspects which influence chronicity of mental health conditions. He also works with clients diagnosed with personality disorders and PTSD and is a clinical supervisor for CBT therapists working in both the NHS and the independent sector. Mike acts as a consultant/adviser for clinical provision and is actively engaged with ex-Forces personnel, supporting medically discharged servicemen and women to gain new careers in civilian life.

Dennis Turner is a senior lecturer in mental health nursing at the University of Chester. He has more than 38 years' experience of working in the NHS and higher education. His current interests include mental health care within BME communities and cognitive behavioural interventions with this client group. He maintains links with clinical practice by spending time with the local Primary Care Mental Health Team where he is involved in working with clients with mild to moderate mental disorders using cognitive behavioural approaches. Dennis is also an associate practitioner within the university counselling service where he provides a CBT clinic with Mandy.

Preface

There are several textbooks available covering the subject of cognitive behavioural therapy (CBT) and it is no revelation to discover that the reason is because CBT is the dominant approach to psychotherapeutic interventions in most clinical services. In fact the approach has gained such popularity that many cognitive behavioural principles are now applied in areas outside its normal practice environments of health and education. Proponents can be found in areas such as sports and executive coaching, and similarly many commercial and public organisations use CBT principles in their management and leadership programmes. In our everyday lives we can see CBT influences around us, in business, marketing, advertising and the media; it has even gained the interest of politicians and economists. We can see its application as consumers; for example, when we are influenced by cognitive techniques in marketing to develop product loyalty, which forms conditional responses through repeated purchasing and generalises our good-will so we go on to buy different products from the same source – an adaption of positive maintenance principles. Modern politics is beginning to understand that people don't significantly change by being hectored or through crude propaganda; there are better and arguably more honest techniques to modify or strengthen underlying assumptions or core beliefs for the benefit of the community.

Yet this social application of clinical application and the popularity of cognitive behavioural principles has not occurred suddenly, even though it may appear to have done so. It has taken nearly 60 years for CBT to reach its current status and it has its beginnings in psychoanalysis and educational learning approaches as well as advancements in early cognitive and behavioural techniques. Many people perhaps forget that Aaron Beck, one of the most significant figures in the development of CBT, was trained as a psychoanalyst, and it was his attempts to include analytical theories in his behavioural treatment clinic that acted as a catalyst for what became his theories of cognitive behavioural therapy.

CBT is, however, criticised for its instrumental, almost mechanical approach to clinical conditions and it has difficulty shaking off a reputation for being aloof and a bit cold. This may be because it has been the subject of more clinical research studies than other forms of psychotherapy, and the constraints of research paradigms, particularly relating to objectiveness and applying validated

measuring instruments, does it no favours in this regard. Yet from early proponents such as Beck, Ellis, Gelder and others, to more modern practitioners, there has been an emphasis on developing trust and empathy within CBT and there is a growing view with developments such as compassionate and mindfulness-based CBT that practitioners could do more to highlight these aspects of therapy.

It is no surprise either that CBT has grown significantly from its earlier clinical and educational roots; research studies repeatedly demonstrate that the approach is efficient and effective. In other words it is good value for the use of time, resources and money, and produces results which are consistent, repeated and measurable across a range of different presenting conditions and services. CBT is a very adaptable therapy; it can be applied in community settings, residential and in-patient services or in the home through guided self-help, psycho-educational approaches and computerised CBT (c-CBT). Therapeutic interventions can be as brief as 6–12 one-hour sessions or last longer for chronic and severe conditions, and individuals can have 'top-up' sessions to prevent relapse. This has led to another debate amongst CBT practitioners: some suggest that the values underpinning CBT are more than just reductionist economic applications and that the quality of therapy is being compromised by utilitarianism; others argue that it is a professional and even ethical responsibility to offer the best quality at the lowest cost.

Nevertheless such efficiency and effectiveness has ensured that the National Institute for Clinical Excellence (NICE) suggests the use of cognitive behavioural therapy as a clinical intervention across a wide range of clinical presentations. This has led to a debate amongst CBT practitioners regarding the application of clinical methods such as conceptualisation and formulations. As the increase in protocol-driven formulation and treatment models for specific clinical conditions continues some practitioners argue that they should displace the case and individualised formulation planning approach; others suggest there is room for all three to be accommodated in practice.

CBT is also flexible; it has no school of theoretical rigidity, although there may be a number of orthodox CBT practitioners who would like to establish such a school, and it has grown to encompass more traditional humanistic approaches such as mindfulness-based CBT. The current 'third wave' of cognitive behavioural psychotherapies also includes couples and family therapy as well as trans-cognitive and multi-modal principles and early research findings suggest that CBT is continuing to develop and adapt new applications.

All this has ensured that CBT is often the most common therapeutic option offered by service providers and the chances of a mental healthcare professional not encountering CBT provision today is unusual. More practitioners are also engaging with CBT practices in their own professional fields,

such as general mental health practice, nursing, psychology, psychiatry, social work, occupational therapy, dietetics and physiotherapy, to name just a few. Yet out of the many books available regarding cognitive behavioural therapy there are fewer covering case studies than there are theories or principles, and unfortunately feedback and evaluation from our own students, clients and fellow-practitioners suggest that sometimes the presentation of CBT principles applied to practice is too dense, jargon-filled, aimed at the specialist, or all a bit confusing.

This is therefore a general textbook aimed at the individual specifically interested in the application of CBT in practice and covering some of the most commonly encountered clinical conditions. Its aim is to further the understanding of theory-application and can be used by students, practitioners, service-users, carers and lecturers to support and develop their interest in cognitive-behavioural therapy. It is not a specialist text covering theory in great detail or a diagnostic manual – there are no 'exemplar' treatment interventions based on hypothetical clients – but a book highlighting individuals with clinical presentations and the realities of clinical life when applying cognitive behavioural psychotherapy. For example, some of the case studies demonstrate good progress through treatment interventions; others show clients struggling with the dilemmas faced when developing counter-conditioning strategies or with behavioural experiments that challenge their normal avoidance-strategies to disconfirm their negative beliefs. Such varied and different case studies hopefully reflect the individuality of clients and therefore the cognitive behavioural therapy best suited to their individual needs.

Mandy Drake and Mike Thomas

1
Principles of Cognitive Behavioural Therapy

Mandy Drake and
Mike Thomas

Learning objectives

By the end of this chapter you should be able to:

Discuss the historic development of CBT
Describe the Stepped Care model
Explain the principles of CBT
Outline the therapeutic process

This chapter will cover some of the background to cognitive behavioural therapy (CBT) principles using the device of common questions and answers. Perhaps one view that needs to be challenged right at the beginning of the text is the invidious belief that CBT is an instrumental approach lacking the degree of human contact and empathy which are often highlighted in other therapeutic approaches. This is not a new criticism and this continuing negative perception of CBT may, in part, be due to the protocol-driven case formulations which are increasingly used in practice. These are tested formulations with proven effectiveness which are applied to specific conditions or problems and have pre-set guidance, even down to a specific session's content, and can be observed in the Improving Access to Psychological Therapies (IAPT) programmes currently in vogue. This text demonstrates the application of some

protocol-driven formulations, particularly when engaging in maintenance therapy, but we have also attempted to present generic and idiosyncratic case formulations (idiosyncratic referring to bespoke and more appropriate formulations based on clients' multi-problem or complex presentations).

CBT exponents have had to constantly emphasise the compassionate and humanistic elements of the therapy. As far back as 1989, Gelder noted that CBT was concerned with the thoughts and feelings of the individual and was therefore an important bridge between the then more dominant behavioural approaches and the dynamic therapies. In 1995 Judith Beck emphasised the empathetic skills required of the CBT practitioner and the need for them to be authentic and genuine in their commitment and interest towards the client as an individual. By 1996 Salkovskis had argued against the mechanical application of CBT whilst Padesky (1996) had highlighted the need for skilled psychotherapeutic application to prevent a prescriptive approach. More recently, Thomas (2008) pointed out that the founder of CBT, Aaron Beck, originated from a psychoanalytical background and that it was his attempt in the late 1950s and early 1960s to bring psychoanalytical principles into behavioural approaches that first gave him the origins of what became CBT. More recently Westbrook, Kennerley and Kirk (2011) have acknowledged that, despite repeated refutation, CBT still has the reputation of being a mechanical application of techniques and as such they have argued that CBT is in fact a therapy of understanding (see below). This approach supports the work of Leahy (2008), who argues that the therapist who demonstrates understanding of the clients' suffering increases the chances of a successful therapeutic outcome.

This book continues to argue that CBT has a humanistic aspect in that therapeutic interaction cannot be adequately practised without a good, sound level of communication skills, empathy and understanding for, and of, the client. It also demonstrates that case formulation and assessment require the establishment of trust and confidence in both the therapy and the therapist and that this cannot occur without sound and skilful interpersonal interaction. In fact one could posit a view that CBT treatment interventions without the necessary understanding and empathy are not actually CBT but an artificial application of CBT principles, often based on an economic model of cost effectiveness rather than a genuine, authentic interest in the plight of those seeking support. That is perhaps where the mechanistic, instrumental approach lies; with those practitioners who claim to practise CBT but do not grasp the level of interpersonal techniques and skills required to support clients through difficulties.

This constant drive to retain and highlight the compassionate elements of CBT as a reaction to those who promote the recipe models may explain

the 'third wave' of CBT techniques now gaining popularity with more emphasis on mindfulness-based cognitive therapy, integrated meta-cognitive approaches, schema-focused therapy and the assimilation of brief, group and family therapy techniques into CBT practices.

One of the aims of this book is to demonstrate through case studies the reality of practising CBT with clients who have myriad difficulties and who seek compassion, trust and skilful intervention to support them as they deal with the intricacies of their daily lives. Thus, the reader will not find exemplars here, as clients with simple, single-issue presentations may well be suited to the theoretical application of CBT but unfortunately tend not to exist in the realities of practice. Instead we have attempted to demonstrate the application of CBT to cases that are reflective of the real issues found in clinical practice, thus better representing the complex clinical world experienced by many CBT practitioners.

Some background reading may be useful, and certainly having access to the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edn – *Text Revision* (DSM-IV-TR; APA, 2000) and the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10; WHO, 2007), would enhance understanding of the diagnostic criteria for each presented clinical problem. There are also several excellent CBT texts available which provide ample background knowledge of theory and principles in more depth than we go into, and it is our assumption that readers will draw on these to complement the case-study approach taken here.

Yet a text on CBT cannot be presented without some acknowledgement of the principles of CBT and this chapter begins with one of the most common queries.

Why CBT?

CBT appears to meet three conditions which have helped it to gain popularity as a treatment of choice in many clinical environments and more recently within the wider social world. These include the strong evidence base for its effectiveness, its cost benefits in terms of resource use, particularly with the advent of guided self-help, psycho-educational and e-CBT approaches, and its flexibility in application in relation to the number and duration of sessions, the level at which treatment can be aimed and the growing number of conditions to which it can be applied.

Gelder (1989) noted that it was during the 1970s and 1980s that CBT gained popularity, stating that this is when it was found to be more amenable to clinical trials and was thus considered to be more scientific in its approaches than the other approaches of that era. The range of conditions to which it

could be applied was demonstrated by Hawton and colleagues (1989), who listed panic, generalised anxiety, phobias, obsessions, eating disorders, sexual dysfunctions, relationship problems, somatic problems and depression among those where CBT was effective.

Beck, Freeman and Associates (1990) went on to apply CBT with individuals presenting with personality disorders and not many years later Haddock and Slade (1997) demonstrated CBT to be effective with individuals experiencing psychosis. Since then Murray and Cartwright-Hatton (2006) have looked at CBT interventions in the field of child and adolescent mental health, Free (2000) has used it in group settings and Crane (2010) has applied it in a mindfulness context. Lazarus (1997) and Curwen, Palmer and Ruddell (2008), have emphasised its use in a brief therapy setting and Robinson (2009) has observed that CBT is being incorporated into family therapy interventions. Westbrook et al. (2011) suggests that CBT has increased in popularity over the last 30 years because its roots lie in scientific psychology and therefore it has taken an empirical approach which allows practitioners and researchers to provide more evidence for its use more rapidly than other therapies. Alongside such efficacy studies it has also consistently demonstrated an improved economic model compared to other therapies, particularly with its emphasis on 6–12 sessions.

CBT has been shown to be effective in many evidence-based studies, with reduced negative symptoms for clients and more positive health outcomes and changes in their daily living. For the health economist, the service managers and the politicians this indicates less need for health intervention and therefore less utilisation of health resources; for as well as demonstrating effectiveness CBT also demonstrates efficiency. This makes it a treatment of choice for the independent sector, the privately funded single-practitioner therapist and the NHS, particularly if there are time-limited sessions of around 6–12 sessions. Its effectiveness and efficiency has gained CBT the attention of the National Institute of Clinical excellence (NICE) which has produced a series of guidelines specifying CBT as the recommended treatment therapy. CBT therefore meets government objectives (of whatever political persuasion) of managing public funds (Thomas, 2008).

CBT also has the flexibility to be included in the Pathways to Care (Stepped Care model) widely implemented in mental health settings in the United Kingdom. In this model there are a number of steps representing different intensities of treatments and interventions. Each step therefore provides an increasing level of support and the client can be referred out of the Pathway or upwards or downwards as their condition deteriorates or improves. Clients can also access a step without necessarily completing lower steps, depending on their level of need and severity of presenting symptoms.

Step 1, Watchful Waiting, is used when clients do not want any health interventions or when the practitioner believes that they may recover without any interventions, and is generally viewed as a sub-clinical situation. Step 2 is aimed at individuals presenting with mild to moderate conditions and involves guided self-help, CBT utilising psycho-educational interventions, e-CBT and exercise-on-prescription or sign-posting towards local voluntary or self-help groups. Step 3 is for clients presenting with moderate conditions and this is where CBT becomes more intensive. The emphasis, however, is on briefer therapies where possible, sometimes coupled with psycho-pharmaceutical interventions. Step 4 is for individuals experiencing moderate to severe conditions, involves chronic or severe disorder management and may involve assigning a case manager to work alongside the client. The case manager in turn, usually supported by a specialist mental health worker liaises with the client's general practitioner and other significant carers, co-ordinates case conferences, and maintains contact with the client on a regular basis. Interventions may involve brief CBT, psycho-pharmaceutical input or longer-term CBT for up to 16 to 20 sessions. The final stage of the Care Pathway, step 5, is for clients experiencing chronic, severe or enduring problems, is offered by specialist mental health services and aims to support clients who have failed to improve in the previous steps or who have such severe problems that those interventions in steps 1–4 are inappropriate. Treatment usually means inpatient care providing complex psychological and psycho-pharmaceutical interventions.

In summary, CBT has spread widely over the last four decades. It has demonstrated its effectiveness and efficiency in two ways: across different clinical services and clinical conditions using evidence-based studies; and in its cost effectiveness in terms of resource allocation. It is therefore recommended by NICE as a treatment intervention in many clinical conditions, and as such has become the most advocated intervention in the Stepped Care model which is integral to current mental health service delivery.

What is the aim of CBT?

CBT heralds primarily from the work of Aaron Beck who first published in this area in the 1960s and 1970s. It aims to provide a problem-orientated framework within which a cognitive-behavioural assessment and resulting case formulation can be conducted and compiled (Hawton et al., 1989).

Originally the aims of the assessment and formulation were to provide an individualised treatment programme for clients presenting with a variety of clinical problems, but CBT has developed so that it is now applied in a variety of non-clinical settings, including education, sport, business, politics and the media.

This book, however, focuses on its application in the clinical setting. Persons (1989) stated that the aim of therapy was to differentiate between the client's overt difficulties, in other words the real problems presented by a client, and the underlying psychological mechanisms which underpin or cause the overt problem, often based on irrational beliefs about the self. The therapist should therefore support the client in exploring the overt problem and the relationship with underlying psychological mechanisms in order to alleviate the underlying causative factors.

However, CBT has never been a 'school' of therapy and there are many different philosophical and practical views regarding its theoretical basis and implementation. As mentioned above, Westbrook, Kennerley and Kirk (2011) suggest that the aim of CBT is to gain understanding: understanding of the clients' own individual situation and problems and understanding of CBT principles, the aim being that the two together would provide the most appropriate clinical treatment. Trower, Casey and Dryden (1996) give a slightly different view by pointing out that CBT teaches clients to recognise their own maladaptive thinking and to become aware of those thoughts, feelings and situations that trigger negative automatic thoughts (NATs). Once this has been accomplished, CBT aims to clarify whether the client actually wants to change their current problems, which is an interesting perspective and perhaps one that is often forgotten in the 'rescuing' principles found in many therapies. Only when the client wants to change is the next aim of CBT instigated; namely for the client to learn how to modify maladaptive thoughts. This is reflected in Thomas's (2008), view which states that CBT is a structural therapy which aims to modify dysfunctional thinking, behaviour or assumptions. Therapy is focused on the client learning to recognise their own NATs, and by subsequently identifying the triggers for such thoughts and evaluating their impact on their life the client can then modify their responses, thus preventing unwelcome symptoms and gaining a better quality of life. Kinsella and Garland (2008) add that another aim of CBT is to achieve agreed outcomes or goals which will improve the clients' emotional state, and they propose that decreasing negative thoughts and behaviours should be undertaken within a time-limited structure using evidence-based interventions.

What are the theoretical bases of CBT?

CBT is based on a series of principles starting perhaps with Beck's Cognitive Triad (1976) which states that an individual may be prone to negative thinking about the self, the world and the future. The model has been elaborated many times since his early work, but Beck basically suggested that thinking

is underpinned by attitudes (termed assumptions) which are based in early childhood experiences and later life events. For many people such assumptions support adaptation to the world around them and motivate activity to develop and maintain wellness. Everyone has a predisposition to react in certain ways in certain situations and this is based on genetics, environment, early upbringing and life events.

Some life events can, however, be traumatic or at the very least disappointing and can precipitate negative thinking and lower mood states. Low mood in turn heightens the probability of more negative thinking, which reinforces the mood state and in time forms a negative circle which begins to influence day-to-day living. This generalisation of negative thinking is sometimes referred to as cognitive distortion. The person therefore develops a negative view of *themselves*, their current experiences in *the world* and about their *future*; hence the cognitive triad.

One of the problems for the individual with the development of the cognitive triad is that they develop selective attention to only those incidences which confirm their negative view of themselves, the world or their future and this can be difficult to alter. For example they may avoid any situation which may cause a different way of thinking, especially if they think that any attempts at change are doomed to failure anyway. Their mood or cognitive condition may worsen as change begins to happen, causing the individual to think the treatment is not working and reinforcing the sense of failure. Physical symptoms may worsen (an area often neglected in therapy generally) and maintenance strategies may be disturbed such as the family dynamics or relations at work. These negative effects may cause the individual to take avoidance measures such as not attending therapy sessions, not participating in out-of-session activities or leaving therapy altogether. Changing the way that the individual sees the triad from a negative to a more positive position is not always easy and the process is sometimes referred to as the process of cognitive restructuring or cognitive reframing.

Cognition itself was viewed by earlier Beckian CBT practitioners as having three levels, and all three were influenced by two other factors, mood and behaviour. The deepest level of thinking or cognition is often referred as the Core Belief level. These beliefs are supported with a structure which helps link together thoughts, past events and current experiences and additionally assimilates new experiences into existing beliefs. This structure is referred to as the schema although many practitioners and theorists use the terms schemas and core beliefs interchangeably.

Core beliefs support a second, intermediate level of thinking, originally called attitudes but over many years the term assumptions has become the preferred word. In turn these assumptions (both functional and dysfunctional) support automatic thoughts which are immediate, sometimes sub-conscious,

responses to events or issues in a person's life. Beck took the view that disturbances in a person's core beliefs caused dysfunctional underlying assumptions and supported negative automatic thoughts, known commonly as NATs.

In CBT the therapist works with the client to identify which level of cognition is viewed as the main problem and therapy focuses on interventions at that level. Because NATs are normally immediate problems they can be the quickest to respond to treatment and consequently there is a greater interest in CBT working at this level, as sessions may produce results within 6–12 sessions. Working at the intermediate level takes longer whilst working at core level can be complex and will often take many sessions. A similar view is taken within the Stepped Care model where intervention at the NATs level can usually be carried out at steps 2/3, intermediate interventions at steps 3/4 and core level interventions at steps 4/5. Although core level work takes longer there is benefit, as interventions at NATs and intermediate level tend to occur when working at core level as a reframing of core beliefs' impact on dysfunctional assumptions and NATs in a positive way. Similarly, work aimed at NATs can undermine an individual's assumptions and core beliefs but the effect is less immediate.

Both the cognitive triad model and the three levels of cognition have been the mainstay of CBT principles, but other models do exist and Beck's early work has been elaborated since the 1970s. One of the most popular models is one espoused by Padesky and Mooney (1990) which incorporates the three levels of thinking in Beck's work and in addition places import on the areas of physiological state, mood, and behavioural and environmental aspects of the person. This model is known as the five aspects of life experience, and assessment takes into account all five areas of a person's life with equal scrutiny, recognising how the thinking at either NATs, intermediate or core level interconnects with mood, behaviour, physical well-being and the environment. Therapeutic intervention may be at NATs level, intermediate or core, and simultaneously work may be done with problems identified in one or more of the other four areas of physical reactions, behaviour, mood and environment.

Other models have developed alongside Beck's original triad. Meichenbaum (1975), for example, developed a form of self-help approach to stress management which focused on core beliefs, dysfunctional assumptions and the physiological aspects of stress as areas where interventions could provide good outcomes. Ellis (1977), with his rational-emotive therapy model has been an important influence on the development of CBT as he emphasised the ABC model. In this approach A refers to an activating event, B to the beliefs associated with the event, and C to the thinking, emotional and behavioural consequences. Ellis himself was interested in the way predisposing and precipitating factors influenced a person's responses. Persons (1989), preferred cognition,

mood and behaviour, with an additional modality of the problem itself, as the basis for a case formulation approach, whilst Lazarus (1997) practises a form of multi-modal brief therapy underpinned by seven modalities rather than the five popularised by Padesky and Mooney (1990).

How is CBT applied in practice?

CBT interventions can best be described as occurring in phases starting with socialisation, assessment and case formulation, moving into treatment interventions and ending with evaluation.

Socialisation is important yet is often an aspect of CBT which is taken for granted. It refers to the early phase of the therapeutic process in which the CBT approach is explored by the client. In our view the role of the therapist in socialisation is to explain the principles of CBT, its evidence-based findings, how and why assessments are important, the method by which the case formulation model is contextualised and the potential interventions available to the client. In other words explain in a suitable manner the therapy itself and emphasise the elements of choice and control available to the client. It is akin to gaining informed consent for the therapy to continue and it seems entirely reasonable therefore that the potential client should be in a position to decide whether it is the right type of therapy for them at that particular time.

Some therapists talk through the socialisation aspects, others employ educational materials to assist information-giving and others provide demonstrations during therapy sessions to highlight the links between the cognitive triad or to show how thoughts, feelings, behaviour, physical symptoms and the environment interact. Some practitioners incorporate the socialisation phase with the formulation presentation itself; for example Wells (1997) and then later Cooper, Todd and Wells (2009: 96) state that socialisation involves 'selling the model' and includes educating the client about CBT, discussing the patient's role in treatment and presenting the formulation. Many therapists also use this phase to provide information to the client on the clinical diagnosis itself. It remains surprising how many clients know that they have a diagnosis and the name given to their symptoms but lack any details about the condition itself.

Therapy takes a certain amount of courage, the client is being asked to open up with some of their closest thoughts and feelings, within a short time of meeting, to someone who, at first, is a stranger. There is not much time to gauge each other's attitudes or reactions before therapy sessions concentrate on the problems. Achieving the trust of the client is a major aspect of the therapist's responsibility and involves skilled interpersonal awareness. Therapy is also hard work; one hears and reads about the therapeutic effects on the

therapists but little regarding the therapeutic effects on the client; yet if therapy is to be successful it requires time, effort and commitment from the client while they struggle with the problems that first brought them to therapy, as well as seeing to all the other tasks that must be accomplished on a daily basis. Beck (1976) discussed the draining effects when change is being attempted, and the therapist plays an important role in ensuring that clients have enough strength to continue the change process. In our experience future therapy is made more difficult when past therapy has been abandoned.

Socialisation is therefore a good point to discuss therapeutic agreements, sometimes referred to as therapeutic contracts, which involves discussing issues such as confidentiality, trust, boundaries for the therapy and the role the therapist may play in a multi-disciplinary team or in liaising with other healthcare professionals. The collaborative aspect of CBT can also be explored with discussions focusing on the client's input regarding activities, assessments, feedback and evaluation.

Despite the different approaches to socialisation there is a general agreement amongst CBT practitioners that socialisation increases the likely benefits of therapy (Roos and Wearden, 2009). For instance, the therapeutic alliance formed in socialisation can have a demonstrable effect on treatment outcome. Daniels and Wearden (2011) found that outcomes had higher success rates if socialisation led to the client and the therapist having agreed treatment goals. Additionally, where there was higher understanding of treatment, there was improved collaboration, which supports the earlier findings of Martin, Garske and Davis (2000), who concluded from a meta-analysis of the literature that a collaborative approach to treatment increased the success of the therapeutic relationship.

Assessment is the process used to gather data in order to develop ideas regarding the presenting problems. The information derived from assessment is used to inform treatment, one example of which is whether the problems experienced are at the immediate, intermediate or core level. Assessment data also provide information about the severity of the problems; whether they are mild, moderate, severe, complicated by comorbidity and so on. It is from the assessment data that clients start to gain an understanding of the CBT principles such as the cognitive triad and the interaction between the modalities of thoughts, feelings, behaviour, physical sensations and environmental influences. The initial assessment can take up to two hours, either in one session or two, but in the new briefer therapies the time available may be one hour or less, whereas for clients with severe or complex problems this could be extended to three or four.

Assessment gives a structure to information gathering and thereby develops conceptualisation and thereafter the presentation of findings in the formulation itself. Assessment is an ongoing process and certainly where measures are used re-assessment is undertaken at set times throughout treatment, usually

the beginning, middle and end of therapy to monitor progress and demonstrate outcomes. This is particularly useful if standardised instruments or tools are used, as the results can provide a before-and-after comparison.

For ease of explanation we propose that assessments can take two forms: comparative – matching the results against validated pre-set data scores; or exploratory – gaining further information about a specific problems or events. For example, a diagnostic comparative assessment would have the aim of comparing the results with existing data such as found in the DSM-IV-TR (APA, 2000) or the ICD-10 (WHO, 2007) to confirm whether the client matched the criteria for specific conditions such as anxiety or depression. Another example would be mood scores, where results are matched with validated pre-set data to assess the level and risk to the client. In this book there are examples demonstrating comparative assessments for specific clinical diagnosis, for example using the DSM-IV-TR or ICD-10.

The exploratory assessment is used to find new information in relation to the client's symptoms and as such is individualised and aimed specifically at developing a picture of the client's day-to-day lived experience. The clinical interview is the most common form of exploratory assessment, which starts with asking the client to outline their reason(s) for attending and how they see their presenting problems. The interview aims to elicit the duration of the problem for the client, any known precipitating factors, onset, impact and level of intensity. It can also cover significant life experiences, relationships, employment status, current living situation, hobbies, interests, medication, physical condition and past and present healthcare input.

A further aspect of the assessment is an examination of the client's mental state. This takes into account, amongst many things, the potential for self-harming, suicidal intent, mood state, symptoms of psychosis or physically based disorders such as early onset of dementia, alcohol misuse or disordered eating.

To complement the clinical interview, CBT assessment tends to draw on a variety of measures, often taking the form of global symptom questionnaires (e.g. PHQ-9; Kroenke et al., 2001) or more specific records and diaries such as a panic diary. The latter tend to be developed by the therapist and individualised to the client's presenting problems, and a range of such measures can be found in the Appendices of this book.

Case formulation are the next stages in therapy but it seems from reviewing the literature that there is some confusion about these as there are frequent references to case conceptualisation or case formulation as the same thing. Indeed, Westbrook et al. (2011) state that formulation is sometimes referred to as case conceptualisation and Grant et al. (2010) use the terms interchangeably. However, we would argue that they are different and that case conceptualisation is the *initial* stage before formulation itself.

Conceptualisation involves identifying, through a variety of assessment means, the origins, development and maintenance of the problem, whilst formulation is usually the *presentation* or demonstration of the conceptualisation using pictorial or diagrammatic form. The form is most often a model which may be generic or specific to the difficulties experienced by the client. Models tend to represent the theoretical stance of the originator(s) and provide a valuable method of demonstrating connections or patterns that describe or illustrate dysfunctionality. They may examine domains such as thinking, feeling, behaviour, physical/bodily effects and the environment, or may highlight the connections between immediate perceptions, underlying dysfunctional assumptions and belief frameworks.

The other area of potential confusion is with the types of formulations which are commonly grouped into one of three different types: protocol-based – tested in practice and problem-specific; generic – as in Padesky and Mooney's (1990) five aspects model; or idiosyncratic – a combination of generic or problem-specific-based models in conjunction with the client's particular or complex presentation. Protocol-based formulations are also referred to as problem-specific formulations, whilst some authors use the term case formulation to indicate generic or idiosyncratic formulations.

There is much discussion in the literature about which type of formulation should be used, and over recent years there has been a drive for the adoption of those that are protocol-based. This is because such formulations come with a treatment package attached which directs the therapist through a standardised set of interventions, often having been proven effective and efficient in research trials. Due to this evidence base some practitioners argue that therapists have an ethical and professional duty to utilise protocol formulations (Grant et al., 2010), whilst others have been noted to view such formulations as inferior to generic and idiosyncratic ones, stating that in the reality of the clinical situation the latter better support clients who present with complex, co-morbid, chronic, severe or enduring conditions (Kinsella and Garland, 2008). We share the view of Kinsella and Garland (2008) that protocol-driven formulations are a good method of learning CBT skills (being based on good CBT principles), and that they can also be useful for short-term CBT interventions, but we also believe that the generic or idiosyncratic formulations are more bespoke and better able to accommodate additional aspects of the clients' problems that often co-exist in practice. We also value the flexibility of general and idiosyncratic formulations as they give more freedom for clinical decision-making which can not only be based on the individual experience of the therapist but can also assimilate the individual experience of the client.

It may therefore be that the less experienced therapist learns the trade, so to speak, through the use of protocol-driven formulations and that with more

experience they gain the skills and knowledge to utilise more generic models. Thereafter, with even more clinical experience, they might go on to develop idiosyncratic models, allowing them to draw on their own clinical decision-making abilities and to individualise the treatment to the specific needs of their client.

Finally, there are also terms such as maintenance formulations and longitudinal formulations which one could argue strictly on definitional terms are not formulations but *principles for* formulation models. The former focus on the problems that are immediate and present and on what is maintaining them in the here and now. It introduces the client to the vicious cycle, a commonly used term in CBT to describe the interrelated nature of the different modalities (thoughts, feelings, behaviours, physical sensations and environment). Maintenance formulations tend to be utilised where therapeutic intervention is short to medium term, with the focus therefore normally being on NATs and assumptions. This approach is most commonly reflected in protocol-driven and generic formulations. Longitudinal formulations, on the other hand, focus on core beliefs that have been formed by environmental and early life experiences, and, as a result, therapeutic intervention tends to be longer. Longitudinal formulations are most commonly idiosyncratic in nature. This view accords with that taken by Kuyken, Padesky and Dudley (2008), who suggest that longitudinal factors should be considered when developing a formulation that may involve predisposing factors, whilst a presentation of the maintenance cycle should be considered where the focus is on more immediate triggers and impact.

In summary, a case formulation is therefore the process by which the identified, presented client problems (conceptualisation) are linked with existing CBT principles so that both the client and the therapist have enough information to devise an agreed treatment plan. There is a variety of forms and models of formulation, a selection of which are demonstrated within the chapters of this book.

Treatment interventions are implemented following the outcome of discussions from the formulation presentation. For problem-specific or protocol-driven formulation there is usually a pre-designated plan of intervention which can be discussed with the client, whilst for generic or idiosyncratic formulations the therapist outlines the most appropriate type of interventions. For this general text covering CBT interventions the treatment interventions tend to follow the generic and idiosyncratic approach, rather than being protocol driven, and these are subsequently differentiated as follows: the level at which intervention takes place within the Stepped Care model and the focus of cognitive intervention as being either NATs, dysfunctional underlying assumptions or core beliefs. In turn these are designated as follows: NATs as

immediate interventions, dysfunctional underlying assumptions as intermediate interventions and core belief as core or schematic interventions. For example, a client with mild depression who is referred to a practitioner working in the community is offered intervention based at step 2 of the Care Pathway with CBT treatment following a generic, guided self-help approach where cognitive interventions are aimed at the immediate (NATs) level. Another client presenting with a severe and enduring eating disorder is seen by a practitioner working within a specialist inpatient unit, therefore the intervention is at step 5 of the Care Pathway, formulation is idiosyncratic and interventions are based on cognitive reframing at the schematic (core beliefs) level.

The goal of treatment is to teach the client new ways of coping, thinking or approaching their perceived problems in such a way that they have an increased ability to cope. If the situation cannot be changed or a condition is chronic and enduring then techniques such as mindfulness support more of an acceptance approach to the issues. What is important for intervention strategies to be effective is to have pre-set objectives or outcomes which are realistic and achievable, and not too generalised. Sometimes the objectives may be set at certain points throughout the therapy and sometimes they are set as end goals. Therefore the formulation should provide signposts towards prioritising the problems to be addressed first, and logically these should be the ones causing the most immediate concern for the client.

To progress towards the identified goal the therapist has a myriad of strategies available to them, and rather than discuss these as theoretical premises we have chosen in this text to demonstrate the strategies through their application to the cases presented.

Evaluation of the treatment intervention tends to happen within the last two sessions of therapy and normally takes the form of revisiting the original objectives or goals and evaluating whether these have been met. Evaluation can sometimes be quite quick and relatively simple but in other situations it can be quite complicated and involve referring onwards, planning maintenance strategies, contacting local voluntary groups or managing a situation where the client does not want to leave therapy.

The use of standardised measuring tools is very useful in the evaluation phase of therapy as the client can see the difference in scores or performance and the results also act as reinforcers for further commitment to continue new ways of thinking or to support maintenance of new coping strategies. This approach is sometimes referred to as the case experiment design because it gathers data for wider research regarding the validity and reliability of standardised measuring tools, provides a more scientific basis of knowing whether therapy has been useful to the client and can provide some useful evaluation of the service itself.

Evaluation sessions are also an opportunity to discuss relapse prevention. Whilst this would normally be a consideration throughout therapy, the evaluation stage