

Assessment and Case Formulation in Cognitive Behavioural Therapy



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ONE Introduction and Orientation to the Current Status of CBT

Sarah Corrie, Michael Townend and Adrian Cockx

Learning objectives

After reading this chapter and completing the learning activities provided you should be able to understand:

- The aims of this book.
- How competence is defined and understood in cognitive behavioural therapy.
- The increasingly complex contexts in which CBT is now commissioned and delivered.
- How to use this book to best meet your learning and development needs.

Introduction

The aim of this book is to help you understand the philosophies, principles, methods and techniques that can inform the effective assessment and case formulation of your clients' needs and, in doing so, assist the development of your mastery of cognitive behavioural therapy (CBT).

Assessment and case formulation, within the context of a co-constructed therapeutic relationship, lie at the heart of effective CBT. Conducting a thorough, theoretically and relationally informed assessment and using the information obtained to devise a case formulation that can assist intervention planning are clinical activities that have been consistently identified

as forming the backbone of CBT (Grant and Townend, 2008; Corrie and Lane, 2010). However, knowledge of the optimal ways of carrying out these activities remains lacking. Despite some laudable attempts to provide clearer guidance (see for example, Butler, 1998; Kuyken et al., 2009; Corrie and Lane, 2010), the lack of consensus about how to assess and formulate clients' needs disadvantages those practitioners who seek to develop a rigorous and systematic approach that can take account of developments in the field, respond to the demands of different service contexts and remain attentive to the unique characteristics of the individual client.

The lack of definitive guidelines on how best to assess and formulate clients' needs is perhaps not surprising when we consider the terrain that must be navigated. Contemporary CBT is a broad, emerging therapeutic landscape that encompasses a range of concepts, theories, models and styles of working, rather than a single, unified discipline (Gilbert, 2008; Grant et al., 2008; Westbrook et al., 2011). What constitutes effective assessment and case formulation within one 'school' of CBT may, therefore, look somewhat different in another and may also alter with the passage of time as advances in the field occur.

Although certain fundamental assumptions may be shared (for example that cognition plays an important role in distress and is amenable to intervention) the range of problem-specific formulation models and disorder-specific constructs guiding assessment and intervention planning has increased exponentially. As noted by Grant and Townend (2008), the amount of content that needs to be absorbed can feel overwhelming until the theoretical assumptions shared across models become clear.

Experienced practitioners who are confident that their knowledge of models and protocols remains current will also encounter challenges at least some of the time. Indeed, navigating a constantly changing theoretical and empirical landscape whilst holding in mind our clients' self-told stories arguably *should* be a challenge. Clients do not always present with neatly packaged difficulties that can be swiftly or easily categorized according to therapists' preferred classification schemes. Even where clients appear to have relatively uncomplicated needs or clearly do meet diagnostic criteria for a particular disorder, the way in which therapy unfolds will depend on a wide variety of factors including the skillfulness of the therapist in engaging, understanding, conceptualizing and responding to emergent issues on a moment-by-moment and session-by-session basis. As Padesky (1996a) observes, competence requires both knowledge of cognitive and behavioural theory and an ability to apply this knowledge in a systematic fashion to the material encountered in the consulting room. This was echoed more recently by the Improving Access to Psychological Therapies (IAPT) initiative (see www.iapt.nhs.uk/about-iapt/website-archive/competencies-and-national-occupational-standards/cognitive-behavioural-therapy-competences-framework) where it is noted that although a structured therapy, CBT:

...works best if therapists consistently maintain a sense that clients need to understand themselves through a process of 'guided-discovery', so that they find out about themselves for themselves... CBT should help clients learn skills which enable them to cope with future adversity in a more effective way.

Individuals with the same diagnosis or problem of living are not a homogeneous group and when working with clients, therapists face an unending series of choices about which direction to take. Therapy will always need to be tailored to the individual client even where what is being offered is a manualized intervention.

Contextual factors shaping the delivery of CBT

At the same time as having to negotiate an evolving scholastic and clinical terrain, CBT practitioners also need to embrace the shifting demands and expectations of their services. In the past 50 years or so, the ways in which psychological therapies are mandated, organized and practised have changed radically (Lunt, 2006). The development and delivery of CBT is couched within a broader political, social and economic climate characterized by unprecedented levels of unpredictability, complexity and volatility. This evolving and uncertain climate has a number of implications for the knowledge and skills that CBT therapists are expected to acquire, the clinical problems with which they need to be equipped to work and the training routes available to facilitate the development of their competence.

A first implication of this rapidly changing professional climate is that in recent years the professions themselves have come under greater scrutiny and control (see Lo, 2005; Lane and Corrie, 2006, for a review of these debates). This has contributed to the increasing professionalization and regulation of the psychological therapies including CBT, as well as the need for more objective standards to guide policy. Both the demonstrated efficacy of cognitive and behavioural therapies for a diverse range of mental health problems and the commitment to ongoing refinement through the accumulation of a robust evidence-base have enabled CBT to secure an advantageous position with government and other funding bodies who seek evidence of efficacy as a basis for commissioning (McHugh and Barlow, 2010). In the context of a health care climate organized around empirically-supported interventions, CBT is likely to remain a desirable commissioning choice.

A second major, and related, development has been the advent of the UK government's initiative for England, *Improving Access to Psychological Therapies* (IAPT; Department of Health, 2008a), funded and developed to improve the psychological well-being of the population through more rapid and consistent access to evidence-based therapies. IAPT has resulted in the emergence of a new CBT workforce to deliver routine and first-line stepped care interventions – a workforce created to support Primary Care Trusts in

implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders. The ability of this workforce to deliver on the targets specified requires skill in the implementation of empirically-supported interventions which in turn depend upon well-honed knowledge of how to assess and formulate clients' needs within the context of protocol-guided practice. Thus, through IAPT, CBT has become uniquely placed within the government's mandate to increase the availability of psychological therapies.

A third implication is that there are now in the UK established pathways through which individuals can become formally 'accredited' as CBT practitioners, based on their ability to evidence sufficient levels of clinical experience, knowledge, skill and professionalism. As the lead organization for CBT in the UK, the British Association for Behavioural & Cognitive Psychotherapies (BABCP, 2012) specifies the 'Minimum Training Standards' for eligibility for accreditation. These standards outline the number of CBT cases which must be completed, the number of clinical practice hours to be accrued and the amount and type of supervision that must be received to support this practice. Additionally, written submissions are required demonstrating both theoretical and clinical understanding of a spectrum of client presentations. IAPT therapists in particular are offered employment contracts on the basis of completing a rigorous training that maps on to these requirements and follows a specific curriculum.

As protocols are developed to target the unique cognitive and behavioural profiles of specific disorders, issues of adherence (i.e. whether the therapy is delivered according to the protocol) and competence (whether the therapy is delivered with sufficient skill) become vital to ascertain. However, this gives rise to questions about the nature of competence itself – in particular, what does 'competent' CBT look like, what is the knowledge and skill-base that needs to be acquired and how can competence be reliably and accurately measured?

Muse and McManus (2013: 485) have defined competence in CBT as, '... the degree to which a therapist demonstrates the general therapeutic and treatment-specific knowledge and skills required to appropriately deliver CBT interventions which reflect the current evidence base for treatment of the patient's presenting problem'. In their work aimed at identifying the activities that typify proficient CBT for clients with depression and anxiety disorders, Roth and Pilling (2007) have devised a map of competences which provides important clarification of the knowledge, skills and attitudes required. Through reviewing the efficacy of therapeutic approaches demonstrated in controlled trials, and studying the associated treatment manuals, Roth and Pilling have identified over 50 competences that appear central to the delivery of effective CBT for depression and anxiety disorders. The authors note that given the number and levels of competences outlined, the framework should not be used in a prescriptive way but rather seen as an aid to decision-making, competence development and assessment of therapist skill.

The identified competences have been organized into five domains each of which comprises a range of activities which in turn consist of a set of specific skills. These are as follows (see also www.ucl.ac.uk/CORE):

1. Generic (the so-called 'common factors' of effective therapy such as knowledge of mental health problems and the ability to form positive working alliances with clients).
2. Basic CBT competences (such as a working knowledge of common cognitive distortions, the ability to structure therapy and how to explain to clients the rationale for homework).
3. Specific behavioural and cognitive techniques (e.g. the principal methods and techniques that are employed in most CBT interventions such as exposure and response prevention and guided discovery).
4. Problem-specific competences (those CBT interventions and procedures adapted to specific disorders. The competence framework details these for specific phobias, social phobia, panic disorder, obsessive-compulsive disorder, generalized anxiety disorder, post-traumatic stress disorder and depression).
5. Metacompetences (those 'higher order' skills of thinking and procedural knowledge that enable a therapist to implement and adapt, pace and time specific interventions in response to client need).

Assuming that competence can be defined, described and identified in practice, how do we assess our own and others' progress towards it? In their review of the methods currently available for assessing proficiency in CBT, Muse and McManus (2013) identify examples of both transdiagnostic CBT rating scales (that is, those assessing the general CBT competences demonstrated in a particular session) and disorder-specific measures (i.e. assessing the competences required to deliver a particular treatment protocol for a given disorder). An example of the former would be the Cognitive Therapy Scale – Revised (Blackburn et al., 2001), whereas an example of the latter would be Cognitive Therapy Scale – Psychosis (Haddock et al., 2001). There can be challenges with implementing disorder-specific measures of assessment in routine clinical services (Muse and McManus, 2013). Nonetheless, competence frameworks, generic and disorder-specific measures of therapist competence and the available evidence-base all point to an emerging clarification of what proficient CBT comprises, the knowledge, attitudes and skills to which novice CBT therapists need to aspire, and the abilities that supervisors and trainers should inculcate in their students.

The above factors represent just some of the enabling and constraining factors which CBT therapists must understand and negotiate in order to provide an optimally effective service to their clients. What is also evident is that within these rapidly evolving professional contexts, practitioners are increasingly required to take responsibility for their professional development, to be able to synthesize insights from theory, research and practice

to inform their work with clients, and to see themselves as lifelong learners so that their knowledge and skills remain fit for purpose (we address this in more detail in Chapter 17). Indeed, there is an argument that professional 'survival' is tied to our commitment to remain informed and justify our practice (Guest, 2000). This book speaks to this agenda and in the chapters that follow we have attempted to provide information, offer guidance and acquaint you with the necessary skills that can serve to enhance the quality of your CBT practice and aid your endeavours as lifelong learners.

The second edition of this book: the vision behind the content

Knowledge of clinical presentations is never static and since the first edition, scholarly activity, professional expertise and changes in diagnostic classification have taken collective understanding of clients' difficulties and needs in new directions, a process that will undoubtedly continue. In this second edition we have sought to retain the essence of what made the first edition so influential and popular, whilst also remaining abreast of developments in the field as well as standards in professional practice and the diverse contexts in which CBT therapists now deliver their services.

We have sought to capture some of the many ways in which CBT is practised by including a series of case studies describing the adaptation of CBT assessment and case formulation for different clinical presentations. As noted previously, there is no single model of therapy that is 'CBT' and it will become evident from reading the different chapters that our contributors (and indeed ourselves as the authors of this text) do not adhere to identical understandings of what precisely CBT is or how it is optimally delivered. This diversity is intentional as we believe that any text seeking to do justice to such a rich discipline needs to reflect at least some of the perspectives that now characterize the field.

As Clark (2014: xv) asserts, the task for therapists is always one of needing to '...tailor CBT methods whilst remaining true to the core principles'. Our contributors have, we believe, achieved this admirably, demonstrating how they have adapted their approach to engage and work effectively with their clients while remaining committed to the core principles that define the field. What our contributors share is (1) a commitment to empirically underpinned and theoretically informed approaches to the therapeutic relationship and to assessment and formulation; (2) an ability to provide a contemporary perspective on their area of expertise; and (3) a first-hand knowledge of how rewarding (but at times challenging and even bewildering) therapeutic practice can be.

The brief we gave our contributors was to hold in mind information and guidance that would support CBT practitioners in working towards

mastery of a particular application of CBT assessment and formulation, as well as reflective exercises to support readers' further engagement with the topic. Additionally, we wanted to avoid the 'polished' case studies that can sometimes attract criticism from (especially novice) readers that they are too remote to feel entirely accessible. In practice, there is often a need to balance accuracy and helpfulness. Decisions are always context-dependent and involve an understanding of what is possible in the settings in which we work (Lane and Corrie, 2012). How precisely CBT assessment and case formulation are undertaken will be impacted by a variety of factors. These include case management concerns (e.g. risk assessment) and service constraints (some services may 'cap' the number of CBT sessions provided at a level which falls below that recommended by NICE guidelines for a particular disorder) and will at times incorporate clinical decision-making that involves cross-disciplinary input.

As such, although our contributors have presented their clinical reasoning very clearly, they have focused on what works when attempting to make sense of clinical dilemmas in the messy 'real world' settings in which therapy is often delivered, rather than on how therapeutic outcomes ideally look when confounding factors are removed. We were delighted that our authors supported this vision and are enormously grateful to them for sharing their knowledge and expertise. As is often the case, editing the case studies has enabled us to grow in our knowledge and understanding of how to work effectively in a rapidly changing field.

Who is this book for?

Our aim is to support the learning and development needs of CBT therapists at all stages of their careers so that regardless of their baseline level of competence and service setting, readers can become increasingly skilled in undertaking CBT assessments and developing case formulations. We hope, therefore, that this book will be useful for a wide range of practitioners including:

- CBT therapists at the start of their careers who are grappling with the complexity of clinical material for the first time.
- Newly qualified CBT therapists who are seeking to refine their core skills in key areas.
- More experienced professionals wishing to hone their approach and wanting a helpful CPD text.
- CBT supervisors wanting systematic and effective ways of helping their supervisees make sense of their clients' needs as the clinical picture emerges.
- Trainers who wish to expand their repertoire of approaches for introducing students to the fundamentals of assessment and case formulation in CBT.

We also hope that this book will be a useful source of information for clinical leads, service managers and others involved in the professional development and mentoring of CBT practitioners in a wide variety of training and professional practice contexts.

About the book

The book is divided into three parts. In Part 1, the reader is introduced to the fundamental and more advanced technical and procedural aspects of cognitive behavioural assessment and case formulation. Specifically, Chapter 2 examines both nomothetic and idiographic assessment and offers guidance on how to approach this. The therapist's ability to understand and adapt to the internal world of the client is of critical importance. The meanings attributed to self, others and the world that the client inhabits (including enabling and disabling environments, and personal history) and the contexts in which certain beliefs and behavioural repertoires have developed, are all part of the terrain with which the therapist must become acquainted.

Of central importance to the collaborative nature of the approach, CBT relies upon the relationship between therapist and client, and the ability of the therapist to manage the therapeutic process. In addition to the technical requirements of assessment and formulation attention must, therefore, be paid to the collaboration formed with the client from the earliest stages of engagement. Chapter 3 examines the process and relational aspects of CBT assessment. There is a paucity of research (and indeed training opportunities) in this area relative to other areas of CBT practice. Moreover, given the outcome orientation of many services in which CBT is delivered, and a variety of caseload and other service-related pressures, there can be a tendency towards time-efficient models of service delivery that prize task-focused over process-oriented elements – a criticism which has been levied at the field of CBT historically (see for example, Safran and Muran, 2000). Appreciating how process and relational factors can be understood by the theories and research that inform CBT practice is, therefore, a vital contribution to enhancing therapist effectiveness. This chapter offers the reader an opportunity to broaden their practice and better understand the intricacies of both the opportunities and challenges that can arise in aiming to develop a collaborative working relationship with clients.

Chapter 4 examines the fundamentals of case formulation. Kuyken et al. (2009) have argued that case formulation in CBT requires higher-order skills and propose the need for 'focused training' particularly as therapists use clinical data to move from the descriptive to the more explanatory levels which require more theory-driven inferences. Chapter 4 provides some frameworks that can help you make sense of the data gathered and offers guidance on how to systematically improve your skills in case formulation, building on the ideas presented in Chapters 2 and 3.

Finally, Chapter 5 attends to what has been termed a 'transdiagnostic' approach, considering more integrative models of assessment and case formulation. In recent years, much of the research within CBT has been dominated by a disorder-specific outlook, with approaches to assessment, formulation and intervention adapted for the needs of a particular psychological difficulty or diagnostic classification. However, as noted by Harvey et al. (2004), there are marked similarities in cognitive and behavioural processes across clinical presentations. This has given rise to an interest in those processes that appear to be 'shared' across disorders. As an important development within the field of CBT, Chapter 5 considers the implications of this for our approaches to CBT-focused assessment and formulation so that readers can have a working knowledge of this perspective, even if they choose to work using a disorder-specific approach.

In Part 2 we explore the application of CBT assessment and formulation further through a series of case studies drawn directly from our contributors' clinical work. This enables readers to appreciate how the material of Part 1 can be applied to clients with different needs and presenting concerns.

The case study chapters are divided into two sections. In the first section, the reader can learn how to approach their CBT practice with potentially more straightforward clinical presentations. We have grouped under this category those chapters describing work with clients who are experiencing panic disorder and agoraphobia; depression (using a traditional Beckian approach and then in the following chapter a contemporary behavioural approach); health anxiety; generalized anxiety disorder; and social anxiety. In the second section, we have grouped together those chapters that describe work with clients whose clinical presentations are potentially more complex, namely obsessive-compulsive disorder (OCD); post-traumatic stress disorder (PTSD); physical health problems; borderline personality disorder; and psychosis. It should be noted here that the distinction between 'simple' and 'complex' case studies is somewhat arbitrary and used principally for ease of organizing the material. It is not meant to imply that the case studies in the first section describe 'easy' clinical presentations or indeed that the second section details work with clinical presentations that will be inevitably complex to conceptualize and challenging to work with. Nonetheless, as complexity increases, therapists often find themselves needing to make adaptations that can accommodate the specific difficulties with which clients are grappling, and which take the work beyond the boundary of the existing evidence-base. The direction that these adaptations may take is addressed by our contributors through the recommendations and guidance they provide, based on their extensive experience of the clinical presentation described.

Finally in Part 3, a shorter section, we offer some concluding comments and recommendations for the field as a whole. We reflect on progress in assessment and formulation over the last few years, identify potential trends, opportunities and challenges for the future, and offer some final thoughts

on developing competence in CBT assessment and case formulation. We conclude the book with a reflective practice task for you to use for yourselves (or with your supervisees and students if you are in a training role) to inform the ongoing development of your learning and any next steps that you might wish to take in enhancing your CBT-related knowledge and skills.

How to use the book

This book can help you structure your clinical thinking more effectively and systematically and we would encourage you to personalize your reading to your own learning and development needs. It is, therefore, worth spending some time considering what your primary learning needs might be and how you can use the book to best advantage. Are you, for example, at the start of your career and seeking to establish a framework that you can use to support the development of your practice? Or are you seeking to hone your assessment and formulation skills in the context of a specific disorder (you may feel relatively confident working with depression, but somewhat mystified by OCD). Or as an experienced practitioner do you suspect that with the passage of time there has been some 'therapist drift' (Waller, 2009) and that you have slipped into bad habits which you would like to rectify? Alternatively, you may be a supervisor or trainer wanting to find helpful ways of introducing key concepts and approaches that can support your work as a mentor to junior members of the profession. Not all of the contents will be equally relevant to your professional requirements, so feel free to skip over any chapters which do not apply to you at this point in your career.

You will also find it helpful to give some thought to what you might need to support you in your learning. You may, for example, want to try out one or two of the frameworks on offer and make notes of your results in a learning journal. A growing area of interest in the CBT literature is the development of the professional self of the practitioner (see Bennett-Levy et al., 2015; Corrie and Lane, 2015) and we embrace this here, encouraging you to interact with the material, ponder its implications for your work and your effectiveness and where appropriate to experiment with the ideas presented. Although we do our best to signpost key debates within the field as they relate to matters of CBT assessment and formulation, it is beyond the scope of this book to review broader conceptual, professional and political issues in detail. If questions arise, you will find it helpful to refer to the additional reading lists provided as well drawing on the networks of professional development that are available to you.

However you decide to support your learning, we hope that by engaging with the material and the recommended exercises, you are challenged to think about your practice in new ways. This may feel exciting or unsettling and you may find yourself confronting questions that are most suitably

followed up in supervision or in a training environment. From our point of view, if you find that the material leads to further dialogue we will be well pleased. Given that there is no single uniform approach called CBT, different approaches within this broad family of therapies *will* assess and conceptualize client material in different ways and this provides much opportunity for reflection, discussion and debate.

A final comment

A variety of theoretical, empirical and professional contributions have greatly advanced our understanding of psychological disorders and emotional difficulty. Alongside these developments, the increasing recognition of what CBT has to offer has resulted in a growing demand for well-trained professionals who can think and practice in ways that are consistent with cognitive and behavioural theory. However, therapeutic practice will never be a precise science and gaining, as well as maintaining and enhancing, competence is neither an easy nor a guaranteed outcome. No matter how long we have been practising, we can never become complacent that our knowledge and skills remain fit for purpose.

Regardless of the contexts in which you deliver CBT and the reasons you are choosing to read this book, we hope that you will enjoy the chapters which follow and benefit from the topics addressed. Although it is important to be aware that this book is not in any way intended to be a substitute for CBT training or supervision, we hope that it will be a useful companion in your attempts to develop your knowledge and skill, and that it might complement other forms of professional learning and development that are available to you. Above all, we hope that this new edition of *Assessment and Case Formulation in Cognitive Behavioural Therapy* might support the development of your clinical skills and prove to be a worthy companion as you undertake this complex task known as CBT. We welcome feedback and look forward to your comments.