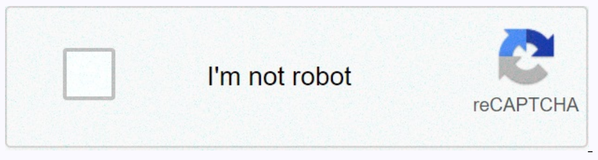

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Cbt formulation example

For the first section, Environment, we are interested in all the factors of the situation that seem to cause or are present during the problem. These can range from very broad life events to directly related triggers, examples of which range from bereavement, childbirth, financial problems, health issues, interpersonal difficulties, work stress – just about any factors associated with the problem can be registered in this context. Then we want to identify what kind of thinking is special about the problem. This can take the form of a thought, e.g., I can't deal with that or think I'm useless, or, as we'll discover in later articles, it could be related to a certain useless style of thinking, such as mind reading, or destruction. Sometimes it can take a while and practice (see thought files) to get used to identifying the thinking that exists in the problem, but if we write exactly what goes through our minds when the problem happens then that's good enough for now. Then we want to determine what emotion we experience during the problem. Usually a feeling can be summed up in a word like anger or sadness. Often people report emotional state as the most easily accessible, as this is the element that often leads them to seek help. It is important to recognize at this stage that you need to write down whatever feelings you feel in relation to the problem, regardless of whether or not you think it is directly related to the general issue of our depression. People often experience other emotions alongside depression and there is evidence to suggest that for men in particular, the feeling of anger is itself a characteristic of depression. We then want to identify which behaviours are involved in the problem. Typical changes in behavior in depression can be decreased levels of activity, for example less social contact or physical activity, and increased avoidance. Sometimes we may also see behaviors such as increased alcohol use or self-harm. Again, take some time to think about how your particular problem represents itself behaviorally and write it down. Ask yourself, what do others see when I deal with this problem? The term upper-class behaviors is associated with mental behaviors such as anxiety and melancholy (or brooking) which, although they take place mentally, are behavioral in the sense that we can choose to participate in them through trying to solve a problem. Again, if anxiety or melancholy are behavioral characteristics of your particular problem, then it down to your composition. Finally, we distract in the physiology box. This relates to any and all changes we experience physically in relation to the problem. In depression, typical physiological changes will include decreased appetite, changes in sleep sleep decreased libido, lethargy. Further, as anxiety can often be found alongside depression, you may experience physical changes that include physical tension, changes in breathing rate and increased heart rate. Central to the successful use of CBT is the development of a formulation (sometimes known as a conceptual case): a personalized image that helps us understand and explain a customer's problems. This chapter describes the role of preparations, the evaluation process used to develop a formulation, how preparations are manufactured and some of the common pitfalls at this stage of treatment. The wording in CBT definitions and approaches differs, and there is no right way to make formulations (see for example, Persons, 1989; Bruch & Bond, 1998; Butler, 1998? Kuyken, Padesky & Dudley, 2009). However, most approaches share key characteristics (Bieling & Kuyken, 2003). Therefore, our definition of a CBT formulation is that a CBT formulation uses the CBT model for development: a description of the current problem(s); an account of why and how these problems could have evolved; analysis of the basic conservation procedures used to maintain the problems. Some of the benefits of taking a formulation like this are: The formulation helps both the client and therapist understand the problems so that what they may present as a tangled collection of random symptoms moves from chaotic confusion to something that makes sense. This process can begin to combat the discouragement that is common to clients during initial presentation (and sometimes to therapists when they face difficult and complex problems). The formulation acts as a bridge between CBT theories regarding problem development and maintenance and the individual customer's experience. It's Lynch's Pin That Keeps Theory and Practice Together (Butler, 1998). CBT theories are necessarily pitched on a general level: describe typical clients who have panic attacks, or depression, or whatever; and describe the processes involved in each disorder in general and at a somewhat abstract level - as appropriate for scientific theories. But to apply these theories to an individual in a clinical setting, we need to move from these generalizations to that person's specific experience in front of us. An important function of the wording is to bridge this gap. The formulation provides a common sense and guide to the treatment that may follow. If we have a reasonable understanding of the processes that cause and maintain the of a customer, then we can more easily see which interventions could be useful to overcome these problems. A good formulation therefore makes it easy to determine what treatment should do, at least in general, and helps clients understand why specific strategies can be useful. The wording starts the process of opening new new thinking - a key part of CBT - giving customers a different way of understanding their symptoms. Many customers come to the initial assessment by assessing their problems, which is either threatening, or self-critical, or both. For example, in OCD, customers often see the fact that they have unpleasant thoughts as meaning that they must be evil or immoral; or health stress, they may see physical symptoms that indicate they are seriously ill. The process of constructing a formulation can be a first step in examining alternative views of symptoms and can free customers to see different ways of dealing with them. Finally, synthesis can help the therapist understand, or even predict, difficulties in treatment or in the therapeutic relationship. For example, if low self-esteem and self-critical thoughts are important elements in the formulation, we can predict that this client may have difficulties in doing his homework, because he will be concerned about not doing it well enough or worrying that the therapist will disapprove of his thoughts. Taking these predictions into account from the wording, we may be able to avoid difficulties or manage them better. Wording: art or science? Although the benefits described above may seem obvious, the scientific status of the wording in CBT is in fact far from clear. For example, there is a relative lack of research evidence to indicate whether the formulations are reliable, i.e. whether different therapists agree on a formulation for the same client (Bieling & Kuyken, 2003); and there is also little evidence as to whether synthesis-based therapy is more effective than purely time-consuming therapy (i.e. treatment administered in a standardised manner, so that all patients with a particular problem receive essentially the same treatment). In fact, there is a fascinating study showing that behavioral therapy based on a single formulation can sometimes lead to worse results than completely standardized therapy (Schulte, Kuenzel, Pepping & Schulte, 1992), although another more recent study found some evidence of superiority for CBT based on an individual synthesis in nervosa bulimia (Ghaderi, 2006). It is not our intention to investigate these disputes in detail, but we believe it is worth describing our position on some of them. First, as mentioned above, one of the roles of phrasing is to act as a bridge between CBT theories and the experience of an individual client. In fulfilling this role, it seems inevitable to us that the process of formulating somewhere in the land of no man between science and art (or at least art). On the one hand, we try to use empirically validated and documented CBT models, derived from scientific principles, to help our customers. On the other hand, we need to apply these theories to the unique people we work with, work with, therefore we must work with their idiosyncratic thoughts and feelings. Such a process cannot be fully described in objective and general terms: the ideal wording is not only true from a scientific point of view, it must also make sense to the client in terms of subjective importance – and this is a work that includes both art and science. Secondly, even the most rigid treatment protocol needs some personalization: no treatment manual can or should prescribe every word of the therapist. There is therefore a need to translate the general guidelines into what is appropriate for this client at the moment, which is one of the roles of wording. Finally, clinical practice inevitably brings us clients who do not fit the protocols, clients for whom an intervention does not work according to protocol, or clients for whom there simply is no clearly recommended protocol (either from CBT or from any other form of treatment). In such cases, the only thing we can do - other than abandon - is to build an individual formulation and develop a course of treatment based on this formulation. Therefore, our view is that CBT professionals should start assessing whether there is an established treatment protocol that has proven effective and, if any, then they should use it to update the formulation and as a basis for treatment. But they should always apply the protocol as part of a formulation that can guide its application to the individual customer, and they should also know when to leave the protocols behind and develop an idiosyncratic processing plan. An individual formulation is the best tool we have to achieve both of these goals. Focus on maintenance processes The main focus for CBT formulations and treatment plans is usually on current maintenance processes. Several linked beliefs contribute to this focus: Processes that initiate a problem are not necessarily the same as the processes that maintain it. Once a problem has begun, maintenance procedures can take a life of their own and keep a problem going, even though the root cause has long since disappeared. It is generally easier to get clear data on current procedures than it is for the root causes, which may have happened many years ago. It is easier to change the maintenance processes that are happening here and now than to change the development processes, which by definition belong to the past. In any case, if the events of the past continue to have important results, then they have to do so through some current psychological process. Thus, cbt's main focus, most of the time, tends to be the here and now, and the main objective of evaluation and formulation tends to be the same. One customer described the key role of maintenance procedures in relation to the original causes in one of the authors so: Imagine that you walk walk a crumbly and unstable cliff top. While walking near the edge, a seagull flies down and lands near your feet, and the weight of the seagull is enough to make the edge of the cliff crumble. You fall over the edge, but you manage to catch a branch 20 feet down, so you're hanging there, clinging to the branch. Now, if you're hanging in there, and you want to get out of this situation and get safely back to the top of the cliff... Then there's no point in looking for the seagull! A more prosaic analogy that makes the same point is that if you want to put out a fire then you have to better deal with what goes on - heat, fuel, oxygen, etc. - instead of looking for the fight that started the fire. This does not mean that history or development are irrelevant. We're talking about what's usually the main focus of CBT, not what's always the only focus. There are several reasons why developmental history can be important. Information about the past is necessary to answer the question 'How did I get here?', which is often important for customers. They want some understanding of what led to their problems, and it's important to try to help them to that goal (though it's not always possible in practice - sometimes the developmental causes of a problem remain mysterious despite our best efforts). It may be useful to identify the root causes in order to prevent them from working again in the future. Following the above analogy, once the fire is out then it may well be a good idea to find out where the fight came from, so that we can avoid future fires from the same cause. There are some difficulties where a significant part of the problem is inherently about the past. PTSD, or the consequences of childhood trauma, are obvious examples where it is clear that past events may need to be the focus of treatment. Another area is shape-based therapy for people with personality disorders or other complex problems. But even in these areas, the main focus is often on how the past works in the present. Thus, CBT evaluation and treatment cannot and should not exclude the exploration of past events and their effects, but cbt's main focus is usually more biased at the moment than in the past, and towards specific examples rather than general rules. The evaluation process The objective of the CBT assessment is primarily to come up with a formulation that has been agreed to be satisfactory by both the client and the therapist, and which will serve the purposes described above.1 The assessment in the context of the it is not a simple matter to note a symptom checklist or complete a typical life history. Instead, it is an active and flexible process of repeatedly building and testing cases. Figure 4.1 illustrates this circle. The therapist constantly tries to make sense of the information that comes from the and creating tentative ideas about which processes may be important in formulation. Subsequently, further evaluation is aimed at testing these cases. If further evidence seems to support the case, it may become part of the wording; if not, then the case should be amended and further evidence will be sought. This process continues until the therapist feels that there is enough of a phrasing to start discussing it with the client. Eventually a draft wording work is agreed. But even after this point, further information that emerges during treatment can lead to modifications or additions to the formulation. Most of the time such modifications will be small tweaks, but sometimes new information will emerge that require a major recast of the problem. Figure 4.1 The evaluation process When assessing current problems According to the central nature of maintenance procedures in CBT, relatively more time tends to be spent exploring details of current experience than in some other treatment approaches. This is an aspect of CBT that principled therapists often find uncomfortable, perhaps in part because it involves an unknown degree of structured interrogation. Information about history and problem development can be obtained from a fairly ordinary narrative. However, the type of information and level of detail about the current problems we need for a CBT formulation cannot usually be obtained without careful, sometimes exploratory and repetitive, interrogation during the interview (and perhaps from other sources of information as well, as discussed in the next chapter). Of course it is vital to also pay attention to building rapport and a constructive therapeutic relationship (see below). Problem Description The first step is to expand a description as a list of problems. Your goal is to get a clear picture of the exact nature of the problem, at the level of specific patterns of thoughts, behavior, etc. Note that a problem with this concept is not a diagnostic label. Terms like depression or social anxiety may be useful shorthand, but they are not enough on their own for our purposes. We need to be more specific and break by presenting problems or diagnostic labels in four systems, consisting of: Knowledge, i.e. words or images that go through the customer's mind when he has the problem. A good question to get to them is: What goes through your mind when...? (for example'... when you feel anxious or ... when you feel low'). It can also be watch out for changes in emotions during a session and ask: What went through your mind just now? Such hot thoughts, i.e. thoughts approached while producing strong emotions, are often much more informative than thoughts reported at quiet moments days or weeks later. Thought Thought as part of the work can also be useful here. Remember that not all knowledge is verbal, and it's always worth checking if customers have upsetting mental images. Emotions or influence, i.e. the emotional experience of the client. It is not uncommon for customers to have difficulty distinguishing between thoughts and emotions. The distinction is not reinforced by the fact that in English we often say I feel that ... when what we really mean is I think .... A general rule of thumb is that generally a feeling can be described at least bluntly with a single word: depression, anxious, angry and so on. If what he is trying to express needs much more than one word – e.g. I felt like I might have a heart attack – then it is probably a thought, not a feeling. Behavior, that is, what the customer does, actions that are externally visible. Useful questions to ask are: What are you doing now because of the problem you didn't ask? (e.g. safety behaviours – see later); and, What have you stopped doing as a result of the problem? (e.g. avoiding situations that cause fear). Physiological changes or physical symptoms, e.g. symptoms of self-stimulation in anxiety, such as increased heart rate, sweating, a pains and pains, nausea, etc.; or loss of sexual interest and appetite for eating in depression. A good strategy is to ask the customer to go through the most recent case they can remember when they encountered the symptoms of the problem. Having identified that time, you can then take the customer through what happened, any moment, starting with any change you first noticed: maybe a dip in mood, maybe an alarming physiological symptom, or maybe a scary thought. To distract what happened to each of the four systems: What went through your mind when this happened? How did you feel? Did you notice any changes in the bodily sensations? What did you do? And what was the next thing that happened... and so on. Triggers and modifiers Another area of the investigation is to determine the factors that currently affect the problem, in two areas: Triggers, i.e. which factors make the problem more or less likely to arise. Modifiers, i.e. what contextual factors make the difference in how serious the problem is when it occurs. As a simple example, a spider phobia by definition will be caused by seeing a spider, but it can also be caused by seeing images of spiders, seeing anything in the environment that even vaguely looks like a spider, or even from the word spider (some customers compose different terms for spiders because the word itself is so for them). When phobia is caused by such situations, the severity of fear is likely to be altered by other factors: e.g. the size of the spider, its speed, how close it is to the person, if he thinks he can escape, and so on. Be aware that many factors can act as triggers or modifiers. Among those considering are: Status variables. Are there specific situations, objects or places that make a difference? Social/interpersonal variables. Are there any specific people who make a difference? The number of people around? Specific kinds of people? Cognitive variables. Are there specific types or topics of thought that tend to cause problems? Behavioral variables. Does the problem occur when the client or other people do specific activities? Normal variables. Is the problem affected by taking alcohol or drugs? Are problems more likely when the person is tense, tired or hungry? Does a woman's menstrual cycle affect the problem? Emotional variables. Is a problem worse when the person is depressed, bored or upset? Some customers may react badly to any kind of strong feeling, even positive feeling, because it makes them feel out of control. Some clients will respond to this line of questioning by saying they are always anxious or depressed and nothing makes any difference. That's almost never true. Such an answer often arises because the customer has become so distressed and overwhelmed by the problem that he has lost the ability to go out and think about it objectively. Careful, gentle questioning will usually bring out a few factors that make a difference. One question that may begin to offer some clues is to ask the customer what situation would be his worst nightmare. By noting which dimensions the client uses to describe this worst situation, you may receive indications about which variables are important. Another useful approach is to use self-control work to identify differences that the client cannot remember in the interview. Information about triggers and modifiers is useful in two ways. First, it begins to give the therapist useful clues about possible beliefs and retention processes, looking at what topics might lie behind the variables discovered. If one is particularly anxious in situations where his behavior could be observed by others, perhaps there is some element of fear of negative evaluation; if he is particularly depressed when he perceives others as his rejection, there may be some beliefs to be unlovable or unworthy. These indications can then prompt further questions that may help confirm or refute initial speculation. Later will give you ideas about the type of beliefs that are often found in different disorders. The second benefit of this information is that it can be useful in treatment. It can be useful for identifying treatment goals (e.g. if the customer feels anxious in restaurants or supermarkets, these may be areas he wants to work in) or in planning interventions (e.g. when planning a behavioral experiment about what happens in the event of a customer panic, it is useful useful know that they are more likely to panic in crowded shops and less likely to panic if accompanied by a trusted person). Consequences The last important area of today's problems is to look at what is happening as a result of the problems. This can be explored in four main aspects: What impact has the problem had on the customer's life? How did his life change because of the problem? How have important others (friends, relatives, doctors, work colleagues, etc.) responded to the problem? What coping strategies has he tried, and how successful has he been? Does he use either prescription drugs or other substances to help him cope? The first question here is important to get a picture of what the customer has lost (or, occasionally, won) as a result of having the problem. The following questions may give you important clues about maintaining procedures. Many retention processes result from perfectly reasonable common sense efforts by the customer or others to address the problem. Unfortunately, such answers can sometimes serve to maintain the problem. For example, it is almost universal of human nature to avoid or escape from a situation that is considered threatening – indeed, it is a completely functional response in many cases (for example, if threatened with physical assault). It just so happens that escape and avoidance can also serve to maintain unnecessary fears. Similarly, if your partner is worried about something and asks for reassurance about it, then it is an absolutely natural reaction to give them the assurance they want; again it is just an unfortunate fact that this can at best be ineffective and at worst can exacerbate the problem. There are many other examples where such physical responses to a problem prove useless in the long run. Note that this does not necessarily mean that either customers or other people are in no way motivated (even unconsciously) to keep the problem (see notes on potential problems, p. 93 below). Another reason for exploring coping is that sometimes customers have developed quite good coping strategies. With a bit of framing - perhaps being more consistent or taking things further - these coping efforts can provide effective treatment strategies. It's always worth asking customers about what they think helps: they often have good ideas! Maintenance of procedures A critical focus of evaluation and formulation is the effort to identify maintenance standards, i.e. psychological processes that maintain a problem Evolution. These are often in the form of vicious cycles, or feedback loops: cycles in which initial thinking, behavior, emotional or physiological reaction causes effects that eventually feed back to the original symptom, so as to maintain or even worsen. In later chapters we will look at some of the specific processes that CBT theories suggest may be important in different disorders. In In section summarize some of the most common vicious circles that you will encounter repeatedly in many different disorders. This should serve as a guide to some of the things to look for during an evaluation. Figure 4.2 Safety behaviours Safety behaviours The concept of safety behaviour has become central to many current theories of anxiety disorders since it was outlined by Salkovskis (1991). Anxious customers often take steps to do something they believe protects them from any threat they fear. For example, someone who is afraid to collapse in a supermarket can cling tightly to the shopping trolley so they don't fall over; someone who is afraid to be seen as boring and disliked can take care not to reveal anything about himself. People are endlessly inventive, and no matter how many customers you see, they still come up with security behaviors you've never come across before. Although this type of behavior is easily understood, it can have an unnoticed and unintended side effect. It prevents threat beliefs from being disconfirmed, because when nothing happens, the lucky escape is attributed to the success of security behavior, rather than leading to a reduced perception of the threat (see Figure 4.2). There are several popular stories that reflect this concept to customers. One concerns a man who meets a friend standing in the street waving his hands up and down. When he asks the friend what he's doing, the answer is, Keeping the dragons away. But there are no dragons around here, the man replies. To which his friend says, You see, it works so well! Stories like this can naturally lead to therapeutic strategies, helping clients think about how the dragon-fearing man could learn that there are actually no dragons. Most customers will easily find the answer that he needs to stop shaking his hands so that he can see that there are no dragons yet. They can then be asked to consider whether this could have some lessons for their own problems and therefore rely on wording (see also chapters 13 and 14 on anxiety disorders). Figure 4.3 Escape/avoidance/avoidance Avoidance (or escape) can be considered as a highly common form of safety behaviour. However, it is worth identifying avoidance separately, partly because of its almost universal prevalence of anxiety problems and partly because its disuse is immediately clear to customers in a way that may not be other safety behaviors. This is perhaps due to the fact that the concept is part of 'popular psychology', as in the advice that if you fall off a horse, the best thing to do is to get straight back into it (see Figure 4.3). Note that avoidance is not necessarily as obvious as running away when one encounters a condition that causes anxiety. For example, someone who gets nervous in social situations accurately states that it does not avoid such situations. However, careful exploration can reveal that although he speaks to people, he never looks them in the eye, or never speaks for himself. In other words, there is more subtle avoidance despite the lack of obvious avoidance. Figure 4.4 Decrease activity Decrease activity This retention process, illustrated in Figure 4.4, is as common in depression as avoidance is in anxiety. Low mood leads to decreased activity, which then leads to the loss of most of what is used to give positive feelings of pleasure, achievement or social acceptance. The lack of positive rewards in turn keeps the mood low. Destructive misinterpretation Originally conceived by Clark (1986) as the central cognitive process in panic disorder, this cycle (Figure 4.5) can also be important in clients with other problems, such as health anxiety or OBSESSIVE COMPULSIVE DISORDER. The central idea is that physical or cognitive changes – most often symptoms caused by stress, such as increased heart rate, breathing difficulties or other signs of self-stimulation – are interpreted as a sign of some immediate and serious threat: that I am going to have a heart attack, or stroke, or that I am going crazy. Of course, such a thought causes even more anxiety, and therefore more symptoms, which seems to confirm the imminent threat ... and so it goes around. Figure 4.5 Destructive Misconception Scan or Hypervigilance This procedure is common in health stress and is also observed in other problems such as PTSD. Figure 4.6 shows how the concern that someone may have a serious illness leads to scanning or checking for symptoms that one believes indicate the disease. This scan, and the increased salience of symptoms due to their health importance, leads someone to notice what can actually be perfectly normal physical symptoms. These symptoms are then interpreted as confirmation of one's fears. In some cases, control behavior can even cause worrying symptoms. For example, a client who feared that her throat would close and drown frequently and persistently would try to clean her throat with a loud Ahem. As a result, it produced unpleasant feelings in her throat, which she then took as confirmation that there was indeed something wrong. A useful metaphor to highlight this type of process is to ask customers to remember a time they have been thinking about buying a particular model of the car. They may have noticed that in such moments it seemed like the streets were absolutely full of this kind of car. What can we do with it? Most customers will readily admit that it is unlikely that the owners' club for this particular car has decided to follow them around. These cars were always there, they just weren't noticed until they became important. Now that they have important, they see them everywhere. Figure 4.6 Scanning or Hypervigilance Self-Fulfilling Prophecies This refers to a process through which people with negative beliefs about the attitude of others towards them may provoke reactions that seem to confirm these beliefs. Figure 4.7 illustrates this process for two examples: socially anxious and hostile behaviour. In the first case, the expectation of rejection by others leads to withdrawal from social interactions: e.g. reducing invitations to social events, or not participating in conversation attempts. Over time this behaviour can lead to others cease to make such social approaches - which naturally serve to prove to the person that other people do not like them. A similar pattern can be seen in some forms of hostile or aggressive behavior. expectation of hostility from others can lead to aggressive behavior, for example in order to show that one should not be intimidated. Aggression can then provoke hostile behavior from others, thus confirming the prediction of one's hostility. Performance anxiety This pattern (Figure 4.8) is common in social anxiety, male erectile dysfunction and some less common problems, such as people who are unable to urinate in public toilets (paruresis or bladder syndrome). You worry that someone is not going to be able to perform adequately (talk consistently, or maintain an erection, or urinate) leads to anxiety, which in turn can actually disrupt performance, resulting in hesitant speech, erectile difficulties, inhibition of bladder release, etc. This, of course, reinforces negative beliefs about performance. Figure 4.7 Self-fulfilling prophecies Figure 4.8 Performance Anxiety Figure 4.9 Fear of Fear Fear of Fear Although apparently simple, fear of fear can be difficult to deal with. This process, illustrated in Figure 4.9, occurs when people find the experience of anxiety itself so aversion that they develop superstitious fears to become anxious again. These fears then produce the very anxiety of which they fear. The difficulty in treatment stems from the fact that this cycle can be so disconnected from external influences that there is nothing tangible to focus on: some clients are able to say much more than they consider stress intolerable. Sometimes, however, you will be able to find an external feared consequence – perhaps that stress will lead to madness or a physical problem. Such external consequences can give you a way, for example by doing experiments to check the reality of these fearful consequences (see Chapter 9). Perfectionism A common standard in customers with negative beliefs about their own ability or value is the cycle that includes perfectionism shown in Figure 4.10. The desire to prove himself is not completely worthless or incompetent leads to such high standards that can never meet them consistently, and therefore the sense of worthlessness is maintained rather than diminished. Figure 4.10

Perfectionism Figure 4.11 Short-term reward Short-term rewards We end with one of the most basic conservation processes, going right back to the days of learning theory and air conditioning operant. Figure 4.11 shows the behavioural process maintained by rewarding short-term consequences, despite negative long-term consequences. This process occurs because humans – indeed, all animals – have evolved to be more strongly shaped in their behavior by short-term consequences than long-term ones. The importance of this process is evident in many problems such as substance abuse, certain forms of eating disorder, aggressive behavior, escape and avoidance behavior and so on. Note that all of the above circles are intended as general outlines of possible processes and not as universal laws: use them as ways to start your thinking and customize them as needed for an individual customer. Evaluating the history of the past and the development of problems Having examined common current maintenance standards, we proceed to examine the past: the history of the customer and the development of the problem. This part of the evaluation aims to identify vulnerabilities, acceleration-causing factors, and modifier factors. Vulnerability Factors Under this title, we are looking for anything in the person's story that could make him vulnerable to developing a problem, but which in itself does not necessarily mean that he will develop a problem. For example, we know from Brown and Harris's classic work (1978) that factors such as the loss of a parent in childhood make a person vulnerable to depression, but that doesn't mean that everyone who has lost a parent will inevitably become depressed. To develop depression, other events need to come into play (in Brown and Harris's model, serious life events - or what we've called precipitators below). From CBT's point of view, the main factor believed to contribute to this vulnerability is the development of specific beliefs, either in the form of assumptions or basic beliefs (see Chapter 1). A multitude of such beliefs may be relevant, and their exact form is highly idiosyncratic to specific clients, but common examples are: I have to succeed in what I do; If you are good to others, then you should be good to you; I can only cope with life if I have a partner to help me; Or I'm useless. Although a pervasive sense of worthlessness is quite obvious many of these beliefs can allow a person to function well for long periods of time. Only when faced with a situation that resonates with faith in a useless way that can drive problems: in the above examples, when they do not achieve, or do not get the respect they crave, crave, They don't have a partner. Later chapters will examine certain beliefs that are usually believed to be associated with specific problems. The events or situations that really cause a problem are known as the catalysing ones. The standard model of cognitive therapy is also known as critical incidents. Precipitations are factors that seem to be closely related to the actual occurrence of a problem or to a significant deterioration of a long-term problem. Although there may be only one major event that hastens a problem (perhaps most obviously in PTSD), it is often the case that there is no single event, but rather a number of more minor highlights, each of which the person could have encountered, but which overwhelm the person when they occur together in a relatively short period of time. When there is only one fact, in addition to the serious trauma that leads to PTSD, then we often find that the event somehow matches a pre-existing belief: for example, the person who feels it is necessary to be in a relationship loses an important relationship, or the person who believes that they should always be confronted and control is confronted with something uncontrollable. People sometimes get confused between the abuses (which cause the appearance of a problem, as defined above) and the triggers (which cause a problem now, as described above in p. 70). Both refer to factors that cause a problem, but the differences are: the during-hours occurred by default in the past, while triggers continue to work in the present; the during-hours usually happened once, or at least a limited number of times, while impulses can occur several times a day. So, for example, think of someone who has developed a fear of driving in cars. Then the cliff for this fear could have been a car accident, or a near miss, five years ago: the cliff happened once, and it happened in the past. On the other hand their fear can now be triggered at any time they have to go to a car, and perhaps also when they watch TV programmes or other media that show dangerous driving: impulses happen now, and can happen relatively often. Modifiers Just as we are looking to modify the factors in the current problems, so it may also be useful to look at modifying the factors throughout the year. Customers often report that problems have only slowly worsened, but sometimes careful exploration reveals that there have been times of improvement or rapid deterioration. Common modified factors include in relationships. important role transitions, such as leaving the home, marriage or leaving the home; and changes in responsibilities, such as promotion at work or having a child. The order of assessment data In which order should you explore these different aspects of customer problems? We don't believe there is way to do this, for the simple reason that both clients and therapists vary. Some clients have little idea of what to expect from a psychological evaluation and no strong preferences on how to proceed and are happy to follow a structure largely determined by the therapist. Other clients can be put into telling their story in chronological order, from birth to the present day. However, others may at first want nothing more than a space to express their anguish. Therapists must respond to these differences. That said, all other things are equal, our preference is to start an evaluation by investigating the current problems. Starting from here is relatively easy for most clients, and helps to orient the therapist in later stages of evaluation. You know enough about the problem and therefore have some assumptions about the type of area it may be important to explore when considering problem development and personal history. At first, you may prefer to take a structured approach to evaluation, keeping the focus tight enough on one field at a time. Later, as you gain experience and the structure becomes second nature, you may find that you can relax and allow the conversation to wander around more while keeping in your mind the structure and how different aspects of the problem fit together. Non-specific factors and the therapeutic relationship We observed in Chapter 3 that one of the common myths about CBT is that it has little interest in the therapeutic relationship, and we hope it is clear that this is not true. While CBT does not generally give the therapeutic relationship a central therapeutic role, it still sees the relationship as a key means of change. This is particularly important during the evaluation, in the creation of this relationship. Although we have talked about some of the technical aspects of evaluation, we want to make it clear that attention to the human relationship between client and therapist is just as important – indeed, perhaps even more important. If you forget to ask a specific question you can always return to it later, while if you do not respond with warmth and humanity to your customers, you may not come back at all! Therefore, it is vital not to be so engrossed in the pursuit of information that it will really stop listening to what the customer is saying or fail to notice and respond to distress. Newcomers to CBT sometimes worry that asking questions that require a CBT rating should automatically mean that the customer feels harassed and harassed. The our is that this is not usually so. If questions are asked with warmth and empathy, in a true spirit of curiosity and desire to understand, most customers will see evaluation as a positive experience with someone who cares, and wants to understand, their way in the world. A good technique, throughout the treatment, but perhaps especially during evaluation, is to pause often to summarize your understanding of what the client has told you and ask for their feedback on whether you are right. This has many benefits. It gives you time to reflect and think about where to go next. It helps reduce the risk of misunderstanding by giving the customer the opportunity to correct the differences between your summary and what they wanted to convey. And the request for feedback conveys the message that the client is an active partner and that the therapist is not necessarily all-wise and all-knowing. Making preparations is not too fast; not too slow The evaluation and formulation process is worth spending time on, because developing a good formulation will bear fruit in more effective and focused treatment. But how long? You may feel two opposite pressures. Sometimes, there is an urge to hang and get into treatment as soon as possible. On the other hand, therapists sometimes feel that they cannot come up with a satisfactory formulation until they know absolutely everything about their client's history, from the time of birth to the present day. The best answer is probably somewhere in the middle. In general we would recommend a two-meeting evaluation, at least until you become familiar with the CBT approach. In the first session, aim to get as much information as you can. Then you have the time between sessions to try to make sense of the information and develop a phrasing. The attempt to construct a wording will very quickly highlight any significant gaps in the evaluation. You can then go to the second session with a clear idea of what else you need to know and, in most cases, develop the wording in conversation with the client by the end of the second session. That's not a hard and fast rule. In some cases, perhaps with very complex problems or with clients with whom you find it difficult to form a relationship, the evaluation process may take longer. On the other hand, as you become more experienced at CBT you will probably find that with customers with simple problems you can develop at least one draft in one session. But the two session approach works well for most beginners most of the time. Diagrams The best way to communicate preparations is through diagrams, not words. There are two common approaches to preparation of preparations. Many CBT therapists have a table in their office and use it to draw preparations. Others just pull them on paper. The table has advantage that it is larger and therefore easier to see and also easier to scrub out as changes are made. On the other hand, doing the wording on paper means it's easier to make a photocopy for the customer to take away. In both cases, it is useful to the process of drawing up a formulation as collaborative as possible. Don't just produce a beautiful formulation like a rabbit from a hat. Include your client in the process, asking him what should go where: From what we've discussed so far, what do you think could lead to the onset of the problem?, What do you think the result is when you do that?, and so on. Kuyken et al.'s (2009) book is a really useful source of ideas about what the term 'collaborative case conception'. Figure 4.12 shows a possible pattern for formulations. This is not meant to be restrictive. There are many different ways to display formulations, and you'll probably develop your own style. This is only a possible approach, which gives at least a clear picture of the most important elements in any formulation. An alternative model that is sometimes useful is what is known as a vicious flower model, in which the central core and various maintenance processes look a bit like a flower with petals - hence the name (Salkovskis, Warwick & Deale, 2003; Butler, Fennell & Hackmann, 2008: 78-80). This model is especially useful when there is some basic concern that drives many different vicious cycle maintenance processes; the model allows you to bring together various aspects of a complex problem in a way that facilitates back and forth movement between the general basic problems and the specific examples of how the problem occurs (see Figure 4.13 for example). Moorey (2010) has also recently unveiled a useful vicious flower model aimed at capturing key processes in depression. Sample composition Figure 4.14 shows an example of composition for a client who exhibited the fear of becoming fecal incontinence while driving. This had led to him being able to drive more than a mile or two from home. This was just far enough to continue getting to work, but was only achieved by designing a complicated route that kept him within easy reach of a public toilet. The relevant information summarised in the wording is as follows. Figure 4.12 A standard composition Figure 4.13 Example of vicious flower wording Vulnerability Two factors seemed important. First, that he had been brought up in a family where bowel function was more than average concern: in his words, his family was obsessed with the intestines. He recalled that as a child he would be asked every day if he had opened his bowels and, if he didn't, they would have given him laxatives. Secondly, and perhaps most importantly, he remembered with some anguish an incident when he was 11 or 12 years old, when, while he had stomach bug, actually had incontinence on the school bus on the way home. Not surprisingly, he remembered this as an extremely shameful and humiliating experience. Beliefs This hypothesis that these previous experiences had led to beliefs that his bowels were likely to malfunction, and that, if they did, the results could be devastating. Perhaps related to this, he said he had always felt a slight relationship between bowels and anxiety: when he felt anxious, he tended to want to go to the toilet, and when he felt an urge to open his bowels, there was some degree of anxiety. Figure 4.14 An example of Precipitants phrasing The history of this client is an interesting illustration of the previous point about the settlement between precipitators and pre-existing beliefs. A few years before the incident that started the presentation problem, the customer had suffered what would have seemed a much more traumatic experience when he had hit someone in his car and the person had died as a result. The accident was not his fault – the other person had run down the road in front of him and had no chance of avoiding them – but it was obviously embarrassing. However, despite significant temporary discomfort, it did not lead to persistent problems. What led to the presentation problem seems a much more trivial occurrence, but because it is linked to his beliefs, it proved more powerful as precipitation. The incident occurred at a time when he was under a lot of pressure at work because of the conflict within the company. During this time, while driving to work and feeling a little under the weather, he had a sudden urge to open his bowels and became very worried that he would lose control. Nothing catastrophic happened. He found a place to stop, went behind a fence and then continued driving to work. However, this immediately led to further concern, which increased steadily in the following months. The problems became anxious at the thought of driving more than a short distance from home (feeling). He had typical anxiety symptoms, including increased heart rate, muscle tension, feeling hot and so on, but especially a fickle stomach (physiology). He believed that if he didn't reach a toilet within minutes of getting an urge to open his bowels, he would lose control (cognitive function). He avoided driving almost entirely except to get to work and faced that only by his safety behavior of staying inside the row of public toilets. He also focused a lot of attention on his gut, checking both before and during any trip if he had to go to the toilet and always trying to open his bowels before he started (behavior). Maintenance Three main maintenance procedures have been identified. First, avoiding driving outside areas was a safety behavior that prevented any test of his beliefs about the lack of control of his intestines. Second, his anxiety created gut symptoms that were interpreted as evidence of a lack of control. And, finally, the continuous control of the his bowels constituted a scan, which led to noting gut sensations that were really perfectly normal. Suitability for CBT A common question from the beginning therapists are: Who is suitable for CBT? The truth is that there isn't a lot of solid evidence of how you should match clients with treatments – either CBT or any other treatment. Safran and her colleagues developed a set of widely discussed criteria, and two studies have found that these predict better results in short-term CBT (Safran, Segal, Vallis, Shaw & Samstag, 1993; Myhr, Talbot, Annable & Pinard, 2007). A customer will do better (on average) if: can they access NAT during the session? knows and can differentiate different emotions. is well related to the cognitive model. accepts responsibility for the change; can form a good collaborative therapeutic alliance (using data from previous relationships); has problems of relatively acute appearance and history; does not present useless 'security operations', i.e. efforts to control stress to such an extent that treatment is difficult; shows the ability to work on one topic at a time in a relatively focused way; is quite optimistic about the treatment. However, these factors are not well established and the strength of the link to the result is not great, so use them as a guide and not as a rigid set of criteria. In addition, they were designed to assess suitability for short-term CBT – one may be able to overcome less positive factors in long-term work. Faced with a lack of evidence on suitability, many therapists offer clients a trial period - perhaps five or six sessions - during which both the client and therapist can assess how well CBT fits for this individual. Although five or six sessions may not be long enough to solve customer problems, it's usually long enough to get an idea of whether CBT seems to be helpful. If it is, then treatment can continue. If not, you can consider other editing plans. Of course, the decision to discontinue treatment needs careful discussion, so as to avoid upset for the client as much as possible. Possible problems during the evaluation As mentioned earlier, a common difficulty for beginners in CBT gets sufficient detailed information about the problems. This may be due to therapist or client difficulties. Problems for the therapist For therapists, the difficulty may lie in part in not yet knowing which are important. With more experience with a number of psychological problems, you will develop a sense of what areas are likely to be important in specific problems. You should also read about CBT models so that you know what theorists consider important (hopefully the rest of this book will help!). One of the skills that experienced therapists demonstrate is not so much always asking the right questions, but quickly acknowledging where they are wrong question and quickly move on to try a different angle. It is important to try to feel your way between giving up too easily and insist too long. In most cases, if your client fails to tell you much about an area of interrogation, it is worth persevering for at least a while and trying different approaches. Customers often find one question easier to answer than another, and what initially seems a completely fruitless line of inquiry can suddenly open up in a more productive way. However, don't be so persistent that the client feels like it's an interrogation rather than an evaluation! In general, our experience is that when you first learn it is worth persevering slightly beyond the point that it feels completely comfortable for you; will usually be acceptable to the customer. Problems for the customer For customers, there may be several difficulties that make it difficult for them to answer your questions. In each particular case, it is important to understand what causes the difficulty, but there are two common classes: those where the customer really does not know the answer to your question; and those where he knows, but is reluctant to answer. Common reasons for customers who don't know the answers include: The customer has become so accustomed to the problem (or so discouraged by it) that they no longer notice the factors you're trying to evaluate. Often, further mild interrogation can begin to cause variations and thus reveal more information. Another useful technique is self-monitoring (see Chapter 5), either done near the time of emotional disorders, so as to increase the accessibility of thoughts or becomes hourly to get fluctuations in mood. Avoidance or other safety behaviors have become so widespread or so effective that the customer no longer experiences negative thoughts and thus cannot report them. A useful metaphor for understanding this is the reaction of an experienced driver seeing a red light. He wouldn't consciously think 'I should have stopped better, because if I didn't make it a car coming the other way could crash into me, and that would be very unpleasant'. It just brakes automatically seeing the red light. On the other hand, if he put his foot on the brake and nothing happened, then his negative thoughts and feelings would be easily accessible! Therefore, a useful strategy may be to test a small behavioural experiment (see Chapter 9), which is used as an evaluation strategy. If the customer is willing to see what will happen if he does not avoid or perform the usual behavior then thoughts and feelings are likely to become much more apparent. The client is among this small percentage of people who simply find it very difficult to access or report thoughts and feelings. Some people get better with the practice, so it's worth sticking with for a while, for example through work as above. Some people people get comfortable with thoughts and feelings. In such cases, a more traditional behavioral approach may prove more fruitful. Examples of knowledge of the answers but reluctance to report them include: Fear of the therapist's reactions. For example, the customer may think that they will disapprove of his thoughts or behavior, or find his symptoms silly, or laugh at him. Always try to find out the reason for the customer's reluctance before trying to do anything about it. Most customers will be able to gradually talk about blocking thoughts, even if they don't yet feel able to talk about their initial thoughts. It may also be useful to offer the client suggestions on the kind of concerns other clients have reported, so that he realizes that the therapist has heard this kind of thing before (but without putting words in the customer's mouth). Other feared consequences of reporting symptoms openly. A client may fear being diagnosed as crazy and locked away, or a client may think that the therapist will contact the police or social services and arrest her or take her children away. With some problems there may be quite idiosyncratic fears. Some people with obsessive compulsive problems say they fear that their protective rituals, especially those involving magical thinking, will no longer work if they reveal the full details, thus putting themselves or others at serious risk. Again, it may be useful to offer clients examples of common fears and also perhaps clarify the differences between different types of mental health problem (for example, that OCD is different from schizophrenia). Possible problems in the production of formulations Effect is not purpose It is important to avoid the assumption that customers or their relatives necessarily intend (even unconsciously) the consequences of their behavior. The fact that one of the results of a market-phobic client's behaviour is that her husband must always accompany her does not prove in himself that she behaves in this way to always have her husband with her. Similarly, the husband of an idealistic client reassures her in a way that seems to maintain the problem does not indicate that she is doing this to keep her obsession. This does not mean that such incentives (sometimes called secondary profit) do not exist; only that it is not universal. Some independent evidence is necessary, beyond the simple result, to prove that it is relevant in each particular case. Freud himself is supposed to be the only one who's going to be the one who's going to he said in relation to Freudian symbolism: Sometimes a cigar is just a cigar. We could maybe extend this to most of the time a cigar is just a cigar. Most customers and their families want to get rid of their problems: they are simply trapped in patterns of thought and behaviour that do not help them achieve this goal. Censorship Censorship Phrasing Therapists sometimes ask if there is any element of a formulation that should not be shared with the client. As a general rule, the answer is No. As part of CBT's collaborative approach, the wording should be open. One possible, but rare, exception to this is whether the full wording would contain some element that could threaten the therapeutic relationship. Discussions on the wording will usually occur quite early in the relationship, when there may not yet be sufficient confidence and confidence to contain conflicts. An obvious example would be if you thought you had sufficient evidence to assume a secondary profit as part of the wording (see above). Even with strong evidence for this type of procedure, the client may be offended by such a suggestion early in treatment. It would perhaps be wise not to become part of the wording until the relationship has been strengthened and such issues can be discussed openly. Spaghetti crossover It is not necessary for a working formulation to contain every piece of information you have about a customer. Including too much in a formulation can lead to a nightmare of crucify lines and boxes that are confusing rather than clarifying. Remember, the goal of the wording is to make sense of the information collected by the customer and explain the basic processes involved. A degree of filtering and simplification is necessary and desirable to make the formulation easy enough for both the client and the therapist. A good motto is the saying attributed to Einstein: Everything must be made as simple as possible - but not simpler. Tunnel vision Sometimes we can fix very early in a case and then get 'stuck', paying attention only to information that confirms the case and not looking for other information (Kuyken, 2006). It is important to remember that, in order to adequately test a case, we need to look for evidence to refute this case, not just evidence to support it. We can also sometimes try to force customers to install the wording, instead of making the wording appropriate to the customer. It is important to respond to what customers tell you and that the wording is idiosyncratic for your customer. Formulations must make sense A common problem is a formulation that has boxes and interlocking arrows that look nice but which, and on closer examination, make no logical sense. This can happen as a result of careless use of the simple four-system diagram sometimes called the hot cross bun (Padesky & Mooney, 1990: see 4.15). Although this model is popular and can be very useful as a simple reminder of the multiple interfaces between the four systems, it needs to be made more specific if it is to form the basis of a useful wording. Used without enough attention, can lead to summation various thoughts in a box; placing equally different piles of behaviours, emotions and physical changes in other boxes; drawing arrows between frames. and then sits back, satisfied that the problems have been explained. But they don't, because the arrows don't represent any understandable process. Instead of being specific about what behavior is associated with what thought or what feeling is, we only have a big arrow that connects all thoughts to all behaviors, all emotions, and so on. Although each of these links may make sense when taken individually, they make no sense at all when they are all together. As a result, the therapist (not to mention the client) is likely to struggle to explain how these supposed connections work. Always think critically about your formulations and ask yourself what psychological process the arrows and boxes represent. Make sure you explain how a thought in a box leads to a behavior in another box, or how that behavior affects a particular belief. In short, make sure your formulations make sense. Figure 4.15 Preparations with hot cross should be used It may seem obvious that a composition cannot help if not used, but can be forgotten. Having constructed the formulation, the therapists sometimes file it off as a work completed and never think about it again. Remember that the point of phrasing is to guide both therapist and client throughout treatment. Try to get the habit of referring back to the wording often: How does this experience fit the wording?? What would our wording suggest could be a good way forward here?? Is this work [in session or as a task] going to make a difference in an important conservation process? Basic Beliefs and Schematics Finally, a note of caution about the transition from formulation to treatment plans. There is sometimes a belief that if your composition contains basic beliefs or schematics, then (a) these should be the primary goals for treatment, because they are more fundamental or deeper than NAT or behavior; and (b) you should therefore start by amending them. That's rarely the case. Basic beliefs and shapes are certainly broader in their applicability than a typical NAT, but this does not necessarily make them more important or more fundamental and certainly does not mean that working with negative thoughts and behaviours is superficial. On the contrary, almost all the data currently available on the effectiveness of CBT are mainly based on work at the level of specific thoughts and related behaviours. There is also evidence that working at this level really leads to changes and a broader level of belief (see, for example, Jacobson's fascinating 'dissolution' study, etc., 1996). Our approach is to keep things things going. simple as possible and work with more general beliefs and assumptions only when clearly necessary because we have reached as far as we can with more specific thoughts and behaviors. Summary CBT formulations aim to provide a brief description of the basic characteristics of a problem, how it started and what continues. CBT assessments are used to collect information and test the basic assumptions of a CBT formulation, so we come up with a evidence-based model that makes sense to both the client and the therapist. The preparation should, whenever possible, be based on an established treatment model based on evidence of its effectiveness. when patients do not fit easily into an established model, then you should develop a synthesis by applying the basic CBT theory to your individual client. CBT formulations focus mainly (but not exclusively) on current maintenance processes. In addition to helping both the client and the therapist understand important procedures, they provide the foundation for treatment plans (which usually aim to disrupt localized maintenance processes). Formalities can take different forms, but often take the form of diagrams, so as to make clear the vicious circle of maintenance procedures. Learning Exercises Review and Reflection: What do you do from the comparative lack of research evidence to show that formulation-based therapy has some advantage over fully standardized therapy? Does this mean that we have to abandon the formulations, or does it show that research so far is very limited? How could we learn more about the scientific status of the wording? What kind of evidence is necessary to conclude that 'secondary profit' works in a particular case? If there is such evidence, how would you discuss it with your client? Going forward: Try to draw up a phrasing chart for a couple of your customers and see how far you can go. What's wrong with you? How could you overcome these problems? Take these formulations to supervision and discuss with your supervisor how well they work and what you could do to check if they are accurate. Practice drawing up the wording in collaboration with your customers and provoking their reactions. Did any of your customers find the wording useless? If so, how? Further reading Grant, A., Townend, M., & Mill, J. (2009). Evaluation and formulation of cases in cognitive behavioral therapy. London: Sage. Contains interesting discussions on some of the key theoretical empirical controversies surrounding the formulation of the case, but it also has fascinating extensive narratives of individual clients and their formulations. Kuyken, W., Padesky, C., & Dudley, R. (2009). Collaborative case arrest. New York: Guilford Press. A creative and inspiring book on different types of case-making (e.g. formulation of and how to use them in collaboration with clients at all stages of treatment. 1 Of course, in many service contexts, an assessment may have other, more general, purposes, such as risk assessment, urgency assessment or testing for specific treatments. However, we will not look further at these assessments.