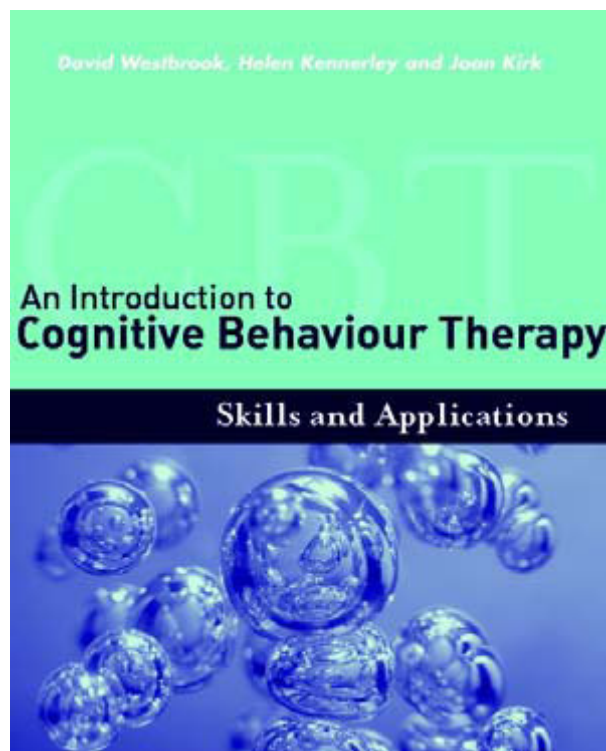


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4

Assessment and Formulation

Central to the successful use of CBT is developing a *formulation* (sometimes known as a *case conceptualisation*): an individualised picture that helps us to understand and explain a client's problems. This chapter describes the role of formulations, the assessment process that is used to develop a formulation, how to construct formulations and some of the common pitfalls in this phase of treatment.

Formulation in CBT

Definitions and approaches differ, and there is no one 'correct' way of doing formulations (see for example Persons, 1989; Bruch and Bond, 1998; Butler, 1998). However, most approaches share core features (Bieling and Kuyken, 2003). Our working definition of a CBT formulation is therefore that a CBT formulation uses the CBT model to develop:

- a description of the current problem(s);
- an account of why and how these problems might have developed;
- an analysis of the key maintaining processes hypothesised to keep the problems going.

Some of the benefits of making a formulation like this are:

- The formulation helps both client and therapist understand the problems, so that what may present as a baffling collection of random symptoms moves from chaotic confusion to something which *makes sense*. This process can begin to combat the demoralisation which is common in clients at initial presentation (and sometimes in therapists, when faced with difficult and complex problems).
- The formulation acts as a bridge between CBT theories about problem development and maintenance and the individual client's experience. It is 'the lynch pin that holds theory and practice together' (Butler, 1998). CBT theories are necessarily pitched at a general level: they describe typical clients who have panic attacks, or depression, or whatever; and they describe

the processes involved in each disorder in general terms and at a somewhat abstract level – as is appropriate for scientific theories. But to apply those theories to an individual in a clinical setting, we need to move from these generalisations to the specific experience of *this* person in front of us. One important function of the formulation is to bridge this gap.

- The formulation provides a shared rationale and guide for the therapy which may follow. If we have a reasonable understanding of the processes causing and maintaining a client's problems, then we can more easily see what interventions might be useful to overcome those problems. A good formulation therefore makes it easy to establish what therapy needs to do, at least in broad terms, and helps clients understand why particular strategies may be useful.
- The formulation begins the process of opening up new ways of thinking – a key part of CBT – by giving clients a different way of understanding their symptoms. Many clients come to the initial assessment with a view of their problems which is either threatening, or self-critical, or both. For example, in OCD, clients often see the fact that they have unpleasant thoughts as meaning that they must be evil or immoral; or in health anxiety, they may see bodily symptoms as indicating that they are seriously ill. The process of constructing a formulation can be a first step in considering alternative views of the symptoms and can free clients to see different ways of tackling them.
- Finally, the formulation can help the therapist to understand, or even predict, difficulties in therapy 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 homework, because he will be worrying about not doing it 'well enough' or worrying that the therapist will disapprove of his thoughts. By taking account of such predictions from the formulation, we may be able to avoid difficulties or manage them better.

Formulation: art or science?

Although the benefits described above might seem obvious, the scientific status of formulation in CBT is actually far from clear. For example, there is a relative lack of research evidence indicating whether 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 about whether treatment based on formulation is more effective than purely protocol-driven therapy (i.e. therapy given in a standardised way so that all clients with a particular problem get essentially the same treatment). In fact, there is one fascinating study which suggests that behaviour therapy based on an individual formulation may sometimes result in *worse* outcomes than completely standardised therapy (Schulte et al., 1992), although another more recent study found some evidence of superiority for CBT based on an individual formulation in bulimia nervosa (Ghaderi, 2006). It is not our intention to explore these controversies in detail, but we think it is worth describing our position on some of them.

First, as noted above, one of the roles of formulation is to act as a bridge between CBT theories and the experience of an individual client. In fulfilling this role, it seems to us inevitable that the process of formulation lies somewhere in the no-man's land between science and art (or at least craft). On the one hand, we are attempting to use empirically validated and evidence-based CBT models, derived using scientific principles, to help our clients. On the other hand, we have to apply these theories to the unique individuals with

whom we are working, and we therefore need to work with their idiosyncratic thoughts and feelings. Such a process cannot be completely described in objective and generalisable terms: the ideal formulation is not just 'true' in a scientific sense, it must also 'make sense' to the client at the level of subjective meaning – and that is a task which involves as much craft as science.

Second, even the most rigid treatment protocol needs some individualising: no treatment manual can or should prescribe the therapist's every word. There is, therefore, a need to translate general guidelines into what is appropriate for *this* client at *this* time, which is one of the roles of the formulation.

Finally, clinical practice inevitably brings us clients who do not 'fit' the protocols, clients for whom an intervention according to the protocol does not work, or clients for whom there simply is no clearly recommended protocol (either from CBT or any other form of treatment). In such cases, the only thing we can do – other than giving up – is to build an individual formulation and develop a course of therapy based on that formulation.

Our view is, therefore, that CBT practitioners should start by assessing whether there is some well-established treatment protocol which has been shown to be effective and, if there is, then they should use that to inform the formulation and as a basis for treatment. But they always need to apply the protocol within the framework of a formulation that can guide its application to the individual client, and they also need to know when to leave the protocols behind and develop an idiosyncratic treatment plan. An individual formulation is the best tool we have for achieving both those ends.

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:

- The processes that start a problem are not necessarily the same as the processes that keep it going. Once a problem has begun, maintenance processes can take on a life of their own and keep a problem going, even if the original cause has long since disappeared.
- It is generally easier to get clear evidence about current processes than it is about original causes, which may have happened many years ago.
- It is easier to change maintenance processes that are happening here and now than to change developmental processes, which by definition are in the past. In any case, if past events are indeed still having important effects, then they must be doing so through some current psychological process.

Thus, the main focus of CBT, most of the time, tends to be on 'the here and now', and the main focus of assessment and formulation tends to be the same. A client described the key role of maintenance processes versus original causes to one of the authors thus:

Imagine you're walking along a crumbly and unstable cliff-top. Whilst you're walking near the edge, a seagull flies down and lands near to 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 just manage to grab on to a branch 20 feet down, so you're left hanging there, clinging

to the branch. Now if you're dangling there, and you want to get out of this situation and get safely back up to the top of the cliff ... then it's no use looking for the seagull!

A more prosaic analogy which makes the same point is that if you want to put out a fire then you had better tackle what keeps it going – heat, fuel, oxygen, etc. – rather than look for the match that started the fire.

This is not to say that history or development are irrelevant. We are talking about what is *usually* the *main* focus of CBT, not about what is *always* the *only* focus. There are several reasons why developmental history can be important.

- Information about the past is essential if one is to answer the question 'How did I get here?', which is often important to clients. They want some understanding of what led to their problems, and it is important to try to help them in that goal (although not always possible in practice – sometimes the developmental causes of a problem remain mysterious despite our best efforts).
- It may be useful to identify original causes in order to prevent their operating again in the future. Following the analogy above, once the fire is out then it may well be a good idea to find out where the match came from, so that we can avoid future fires from the same cause.
- There are some difficulties where an important 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 might need to be a focus of therapy. Another area is 'schema-focused' therapy for people with personality disorders or participatory complex problems. But even in these areas, the main focus is often on how the past is operating in the present.

Thus, CBT assessment and therapy neither can nor should *exclude* the exploration of past events and their implications, but the main focus of CBT is typically more biased towards the present than the past and towards specific examples rather than general rules.

The process of assessment

The aim of CBT assessment is primarily to arrive at a formulation which is agreed as satisfactory by both client and therapist, and which will serve the purposes outlined above.¹ Assessment within this framework is not a simple matter of ticking off a checklist of symptoms or completing a standard life history. Rather, it is an active and flexible process of repeatedly building and testing hypotheses. Figure 4.1 illustrates this cycle.

The therapist is constantly trying to make sense of the information coming from the client and building up tentative ideas about what processes might be important in the formulation. Further assessment is then aimed at testing those hypotheses. If further evidence seems to support the hypothesis, it may become part of the formulation; if not, then the hypothesis will need to be modified and further evidence will be sought. This process continues until the therapist feels that there is enough of a formulation to begin discussing it with the client. Eventually a working draft formulation is agreed. But even after that point, further

1. Of course, in many service contexts, an assessment may have other, more generic, purposes as well, such as risk assessment, establishing urgency, or screening for particular treatments. However, we shall not consider such assessments further here.

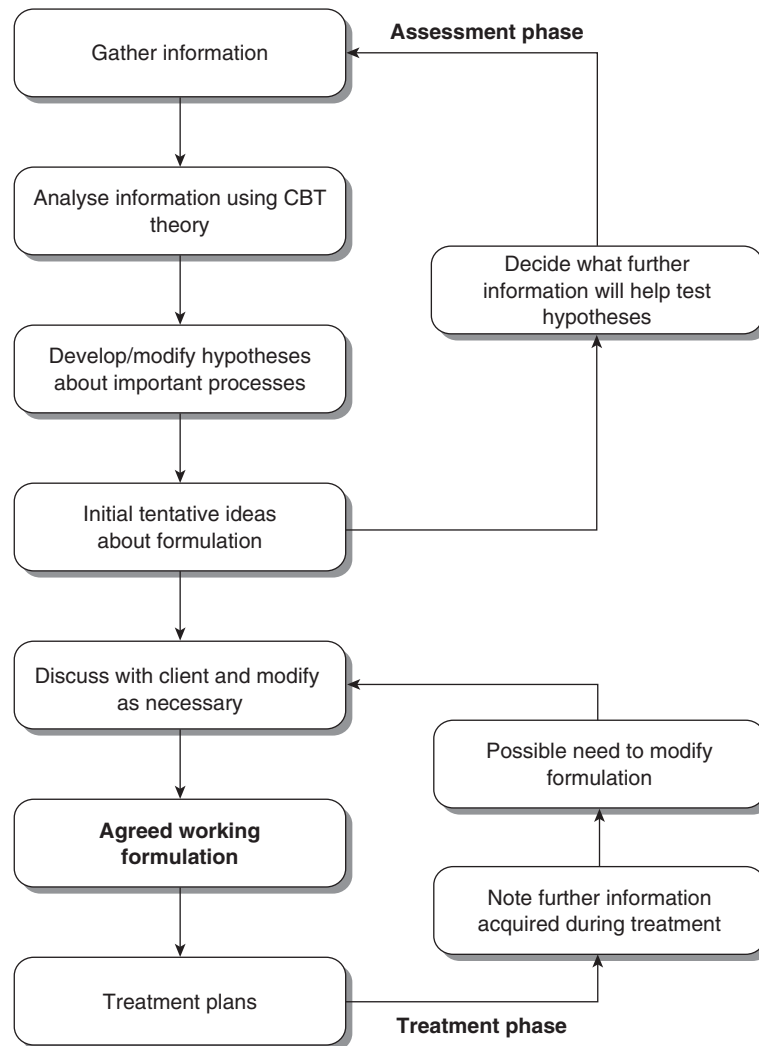


Figure 4.1 The process of assessment

information which emerges during treatment may lead to modifications or additions to the formulation. Most of the time such modifications will be minor ‘tweaks’, but sometimes new information will emerge which demands a significant reformulation of the problem.

Assessing current problems

In keeping with the centrality of maintenance processes in CBT, relatively more time tends to be spent on exploring details of current experience than in some other approaches to

therapy. This is an aspect of CBT which beginning therapists often find uncomfortable, perhaps partly because it involves an unfamiliar degree of structured questioning. Information about history and problem development may be obtained from a fairly ordinary narrative. However, the kind of information and level of detail about current problems which we need for a CBT formulation cannot usually be obtained without careful, sometimes probing and repetitive, questioning at interview (and perhaps from other sources of information as well, as discussed in the next chapter). Of course it is crucial that you also pay attention to building rapport and a constructive therapeutic relationship (see below).

Problem description

The first step is to develop a description in the form of a problem list. Your aim is to get a clear picture of the exact nature of the problem, at the level of specific patterns of thoughts, behaviour, etc. Note that a problem in this sense is not a diagnostic label. Terms such as 'depression' or 'social anxiety' may be useful shorthand but are not enough in themselves for our purposes. We need to be more specific and break presenting problems or diagnostic labels into four 'systems', consisting of:

- *Cognitions*, i.e. words or images that go through the client's mind when he has the problem. A good question to get at these is: 'What goes through your mind when ...?' (for example '... when you're feeling anxious' or '... when you're feeling low'). It can also be useful to look out for changes of emotion during a session and to ask: 'What went through your mind just now?' Such 'hot thoughts', i.e. thoughts accessed whilst they are generating strong emotions, are often much more informative than thoughts reported in calm moments days or weeks later. Thought records as part of homework can also be useful here. Remember that not all cognitions are verbal, and it is always worth checking whether clients have upsetting mental images.
- *Emotions or affect*, i.e. the client's emotional experience. It is not uncommon for clients to have difficulty in distinguishing between thoughts and emotions. The distinction is not helped by the fact that in English we often say 'I feel that ...' when what we really mean is 'I think that ...'. A rule of thumb is that in general an emotion can be at least crudely described in just one word: 'depressed', 'anxious', 'angry' and so on. If what he is trying to express needs significantly more than one word – e.g. 'I felt that I might have a heart attack' – then it is probably a thought, not an emotion.
- *Behaviour*, i.e. what the client does, actions which are outwardly visible. Useful questions to ask are: 'What do you now *do* because of the problem which you did not used to do?' (e.g. safety behaviours – see later); and, 'What have you *stopped doing* as a result of the problem?' (e.g. avoidance of fear-provoking situations).
- *Physiological changes or bodily symptoms*, e.g. symptoms of autonomic arousal in anxiety, such as increased heart rate, sweating, aches and pains, nausea, etc.; or loss of sexual interest and appetite for food in depression.

A good strategy is to ask the client to go through the most recent occasion he can recall when he experienced the problem symptoms. Having identified the time in question, you then take the client through what happened, from moment to moment, starting with

whatever change he first noticed: perhaps a dip in mood, perhaps a worrying physiological symptom, or perhaps a frightening thought. Elicit what happened in each of the four systems: 'What went through your mind when that happened? How did it make you feel? Did you notice any changes in bodily sensations? What did you do? And what was the next thing that happened . . .' and so on.

Triggers and modifying factors

Another area of questioning is to establish the factors currently affecting the problem, in two areas:

- *Triggers*, i.e. what factors make the problem more or less likely to occur.
- *Modifiers*, i.e. what contextual factors make a difference to how *severe* the problem is when it does occur.

As a simple example, a spider phobia by definition will be *triggered* by seeing a spider but may also be triggered by seeing pictures of spiders, by seeing anything in the environment that looks even vaguely like a spider, or even by the word 'spider' (some clients make up different terms for spiders because the word itself is so distressing to them). When the phobia is triggered by such situations, the severity of the fear is likely to be *modified* by other factors: e.g. the spider's size, its speed, how close it is to the person, whether he thinks he can easily escape, and so on.

Be aware that many factors can operate as triggers or modifiers. Amongst those to consider are:

- **Situational variables.** Are there specific situations, objects or places that make a difference?
- **Social/interpersonal variables.** Are there particular people who make a difference? The number of people around? Particular kinds of people?
- **Cognitive variables.** Are there particular kinds or topics of thought which tend to trigger problems?
- **Behavioural variables.** Does the problem occur when the client or other people are doing specific activities?
- **Physiological variables.** Is the problem affected by taking alcohol or drugs? Are the problems more likely when the person is tense, tired or hungry? Does a woman's menstrual cycle affect the problem?
- **Affective variables.** Is a problem worse when the person is depressed, bored or upset? Some clients may react badly to any kind of strong emotion, even positive emotion, because it makes them feel out of control.

Some clients will respond to this line of questioning by saying that they are *always* anxious or depressed and nothing makes any difference. This is almost never true. Such a response often arises because the client has become so distressed and overwhelmed by the problem that he has lost the ability to 'step outside' and think about it objectively. Careful, gentle questioning will usually bring out some factors which do make a difference. One question which may begin to offer some clues is to ask the client what situation would be

his worst nightmare. By noting what dimensions the client uses to describe this worst situation, you may get clues as to what variables are important. Another useful approach is to use self-monitoring homework to spot differences that the client may not recall at interview.

Information about triggers and modifiers is useful in two ways. First, it starts to give the therapist useful clues about possible beliefs and maintaining processes, by considering what themes might lie behind the variables discovered. If someone is especially anxious in situations where his behaviour might be observed by others, perhaps there is some element of fear of negative evaluation; if he is particularly depressed when he perceives others as rejecting him, perhaps there are some beliefs about being unlovable or unworthy. These clues can then prompt further questions which can help to confirm or refute the initial guesses. Later chapters will give you ideas about the kind of beliefs which are frequently found in different disorders.

The second benefit of this information is that it can be useful in treatment. It may be helpful in identifying targets for treatment (e.g. if the client feels anxious in restaurants or supermarkets, those might be areas he wants to work on); or in planning interventions (e.g. when planning a behavioural experiment on what happens if the client panics, it is helpful to know that he is more likely to panic in crowded shops and less likely to panic if accompanied by a trusted person).

Consequences

The last major area of the current problems is to look at what happens as a result of the problems. This may be explored in four main aspects:

- What impact has the problem had on the client's life? How has his life changed because of the problem?
- How have important others (friends, family, doctors, work colleagues, etc.) responded to the problem?
- What coping strategies has he tried, and how successful has he been?
- Is he using either prescribed medication or other substances to help him cope?

The first question here is important to get a picture of what the client has lost (or, occasionally, gained) as a result of having the problem. The next questions may give you important clues about maintaining processes. Many maintaining processes arise from perfectly reasonable 'common-sense' attempts by the client or others to cope with the problem. Unfortunately such responses may sometimes serve to maintain the problem. For instance, it is almost a universal of human nature to avoid or escape from a situation perceived as threatening – indeed, it is an entirely functional response in many situations (for example, if threatened with physical attack). It just happens that escape and avoidance may also serve to maintain unnecessary fears. Similarly, if your partner is worried about something and asks for reassurance about it, then it is a perfectly natural reaction to give them the reassurance they want; again it is just an unfortunate fact that this can be at best ineffective and at worst can exacerbate the problem. There are many other examples where such

natural responses to a problem turn out to be unhelpful in the long run. Note that this is *not* necessarily to suggest that either clients or other people are in any sense motivated (even unconsciously) to keep the problem (see notes on possible problems, p. 60 below).

Another reason for exploring coping is that sometimes clients have developed quite good coping strategies. With a bit of shaping up – perhaps being more consistent or taking things further – these coping attempts can provide effective treatment strategies. It is always worth asking clients about what they think helps: often they have good ideas!

Maintaining processes

A crucial focus of assessment and formulation is trying to identify maintenance patterns, i.e. the psychological processes which keep a problem going. These are often in the form of vicious circles, or feedback loops: cycles in which the original thought, behaviour, affective or physiological response gives rise to effects which ultimately feed back to the original symptom so as to maintain or even worsen it. In later chapters we will look at some of the specific processes which CBT theories suggest may be important in different disorders. In this section we summarise some of the most common vicious circles which you will meet repeatedly in many different disorders. This should serve as a guide to some of the things to look for during an assessment.

Safety behaviours

The concept of safety behaviour has assumed a central place in many current theories of anxiety disorders since it was outlined by Salkovskis (1991). Anxious clients frequently take steps to do something which they believe protects them from whatever threat it is that they fear. For example, someone who fears collapsing in a supermarket may cling tightly on to the shopping trolley so as not to fall over; someone who fears being seen as boring and dislikeable may take care not to reveal anything about himself. People are endlessly inventive, and no matter how many clients you see, they will still come up with safety behaviours that you have never met before. Although this kind of behaviour is easily understandable, it can have an unnoticed and unintended side effect. It blocks the threat beliefs from being disconfirmed, because when nothing happens, the ‘lucky escape’ is attributed to the success of the safety behaviour instead of resulting in a decreased perception of threat (see Figure 4.2).

There are several popular stories which illustrate this concept to clients. One concerns a man who comes across a friend standing in the street waving his arms up and down. When he asks the friend what he is doing, the answer is ‘Keeping the dragons away’. ‘But there are no dragons around here,’ he replies. To which his friend says, ‘See, that’s how well it works!’

Stories like this can naturally lead on to therapeutic strategies by helping clients to think about how the dragon-fearing man might learn that actually there are no dragons. Most clients will easily come up with the answer that he needs to stop waving his arms so that he can see that there are still no dragons. They can then be asked to consider whether that might have any lessons for their own problems and thus build on the formulation (see also Chapters 13 and 14 on anxiety disorders).



Figure 4.2 Safety behaviours

Escape/avoidance

Avoidance (or escape) can be considered as a particularly common form of safety behaviour. However, it is worth identifying avoidance separately, partly because of its near-universal prevalence in anxiety problems and, partly, because its unhelpfulness is immediately clear to clients in a way that those of other safety behaviours may not be. This is perhaps because the notion is part of 'folk psychology', as shown in the advice that if you fall off a horse, the best thing to do is to get straight back on it. (See Figure 4.3.)

Note that avoidance is not necessarily as obvious as running away when one meets an anxiety-provoking situation. For example, someone who gets anxious in social situations might accurately report that he does not avoid such situations. However, careful exploration might reveal that although he talks to people, he never looks them in the eyes, or he never talks about himself. In other words, there is more subtle avoidance despite the lack of obvious avoidance.

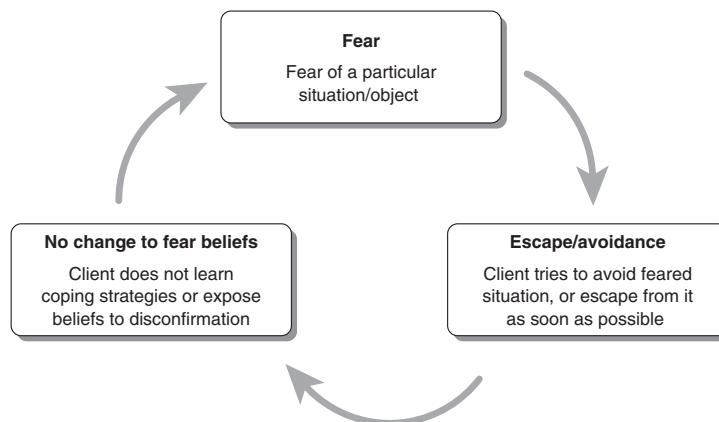


Figure 4.3 Escape/avoidance

Reduction of activity

This maintaining process, illustrated in Figure 4.4, is as common in depression as avoidance is in anxiety. Low mood leads to reduced activity, which then leads to the loss of most of what used to give positive feelings of pleasure, achievement or social acceptance. Lack of positive rewards in turn maintains low mood.

Catastrophic 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 OCD. The central idea is that bodily or cognitive changes – most often symptoms caused by anxiety, such as increased heart rate, breathing difficulties or other signs of autonomic arousal – are interpreted as indicating some immediate and serious threat: that I am about to have a heart attack, or a stroke, or that I am ‘going mad’. Naturally enough, such a thought causes yet more anxiety, and hence more symptoms, which seems to confirm the imminent threat ... and so it goes round.

Scanning or hypervigilance

This process is common in health anxiety and is also seen in other problems such as PTSD. Figure 4.6 shows how the worry that one might have a serious illness leads to scanning or checking for the symptoms that one believes indicate the illness. This scanning, and the increased salience of the symptoms due to their significance for health, leads one to notice what may actually be perfectly normal bodily symptoms. Those symptoms are then interpreted as confirmation of one’s fears. In some cases, the checking behaviour may even *produce* worrying symptoms. For example, a client who feared that her throat would close up and she would choke would frequently and strenuously try to clear her throat with a loud ‘Ahem’. As a result, she produced unpleasant feelings in her throat, which she then took as confirmation that there was indeed something wrong.

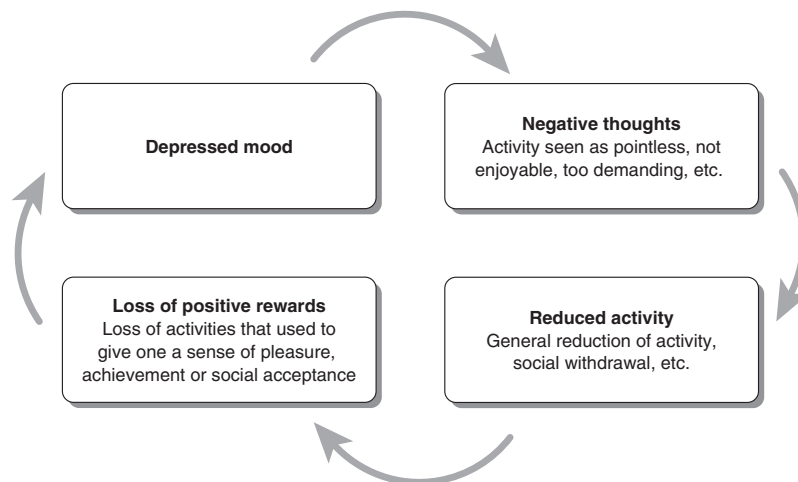


Figure 4.4 Reduction of activity

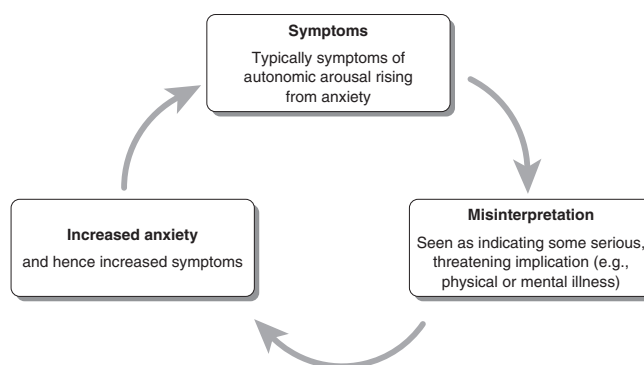


Figure 4.5 Catastrophic misinterpretation

A useful metaphor to illustrate this kind of process is to ask clients to remember a time when they have been thinking about buying a particular model of car. They may have noticed that at such times it seemed as if suddenly the roads were absolutely full of that kind of car. What can we make of this? Most clients will readily concede that it is unlikely that the owners' club for that particular car has decided to follow them around. Those cars were actually always there, it's just that they were not noticed until they became important. Now that they have become important, they see them everywhere.

Self-fulfilling prophecies

This refers to a process through which people with negative beliefs about others' attitudes towards them may elicit reactions which appear to confirm those 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 withdrawing from social interactions: e.g. declining invitations to social events, or not joining in attempts at conversation. Over

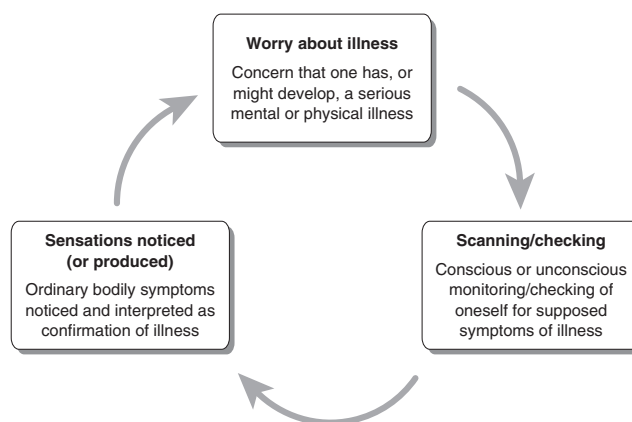


Figure 4.6 Scanning or hypervigilance

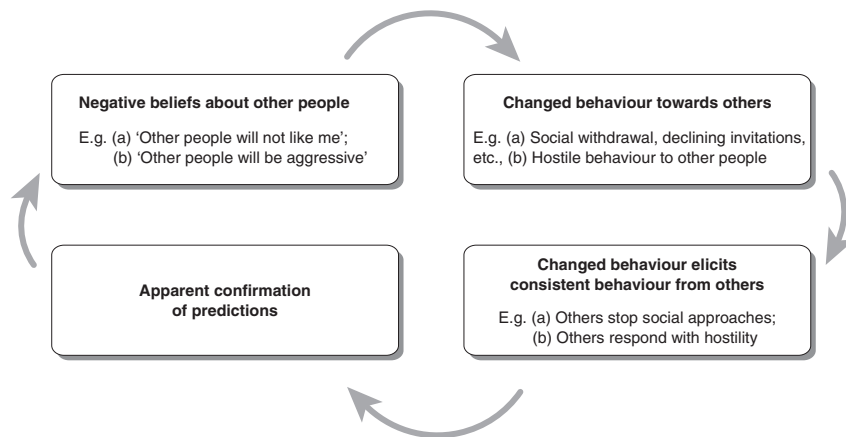


Figure 4.7 Self-fulfilling prophecies

time this behaviour may lead to others ceasing to make such social approaches – which of course proves that other people do not like me.

A similar pattern can be seen in some forms of hostile or aggressive behaviour. The expectation of hostility from others can lead to aggressive behaviour, for example in order to show that one is not to be intimidated. The aggression may then elicit hostile behaviour from others, thus confirming one's prediction of hostility.

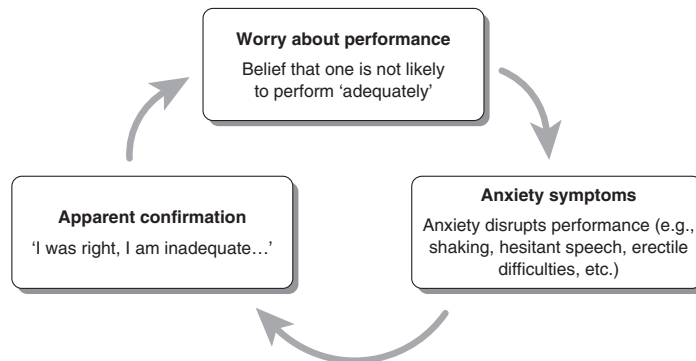


Figure 4.8 Performance anxiety

Performance anxiety

This pattern (Figure 4.8) is common in social anxiety, in male erectile dysfunction and in some less common problems such as people who are unable to urinate in public toilets (*paruresis* or 'shy bladder syndrome'). Worry that one is not going to be able to perform 'adequately' (talk coherently, or maintain an erection, or urinate) leads to anxiety, which in turn may indeed disrupt performance, resulting in hesitant speech, erectile difficulties, inhibition of bladder release, etc. This, of course, strengthens the negative beliefs about performance.

Fear of fear

Although apparently simple, fear of fear can be difficult to treat. This process, illustrated in Figure 4.9, arises when people find the experience of anxiety itself so aversive that they develop anticipatory fears about becoming anxious again. These fears then produce the very anxiety of which they are afraid. The difficulty in treatment stems from the fact that this cycle can become so detached from outside influences that there is nothing tangible to focus on: some clients are unable to say much more than that they find the anxiety intolerable. Sometimes, however, you will be able to find an external feared consequence – perhaps that anxiety will result in madness or a physical problem. Such external consequences can give you a way in, for example by doing behavioural experiments to test the reality of these feared consequences (see Chapter 9).

Perfectionism

A common pattern in clients with negative beliefs about their own capacity or worth is the cycle involving perfectionism shown in Figure 4.10. The desire to prove oneself not completely worthless or incapable results in such high standards that one can never meet them consistently, and, therefore, the sense of worthlessness is maintained rather than reduced.

Short-term rewards

We end with one of the most basic maintaining processes, going right back to the days of learning theory and operant conditioning. Figure 4.11 shows the process of behaviour being maintained by rewarding short-term consequences, despite negative longer-term consequences. This process occurs because humans – indeed, all animals – have evolved to be more strongly shaped in their behaviour by short-term consequences than long-term ones.

The importance of this process is obvious in many problems such as substance abuse, some forms of eating disorder, aggressive behaviour, escape and avoidance behaviour, and so on.

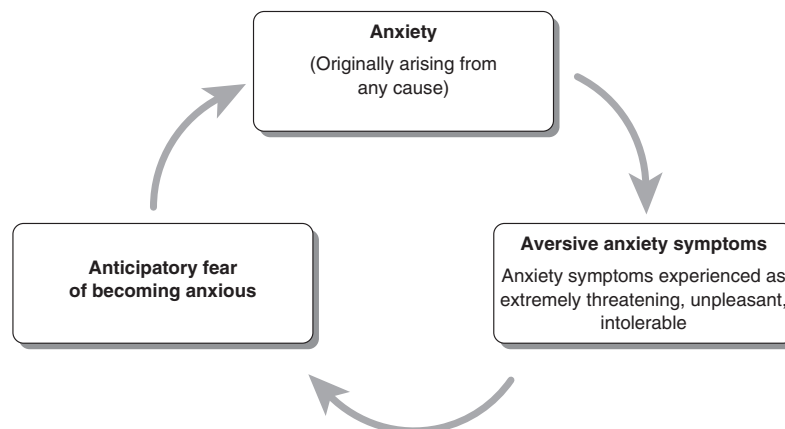


Figure 4.9 Fear of fear

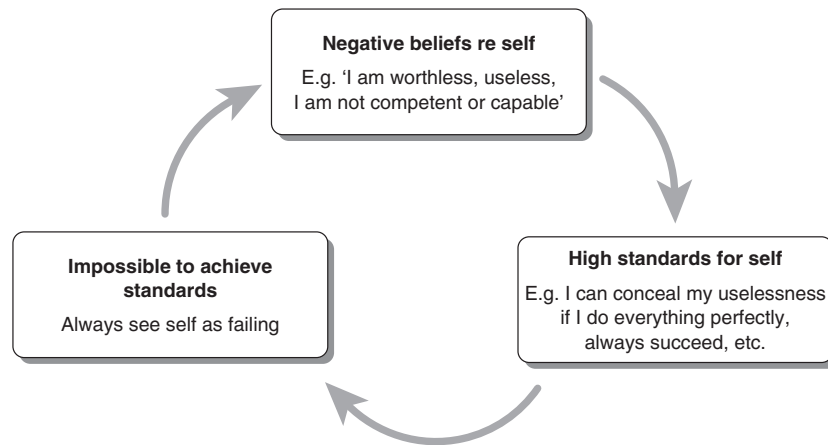


Figure 4.10 Perfectionism

Note that all the above cycles are intended as general outlines of possible processes, not universal laws: use them as ways to start your thinking and adapt them as necessary for an individual client.

Assessing past history and problem development

Having considered common current maintenance patterns, we move on to looking at the past: the client's history and the development of the problem. This part of the assessment aims to identify vulnerability factors, precipitating factors and modifying factors.

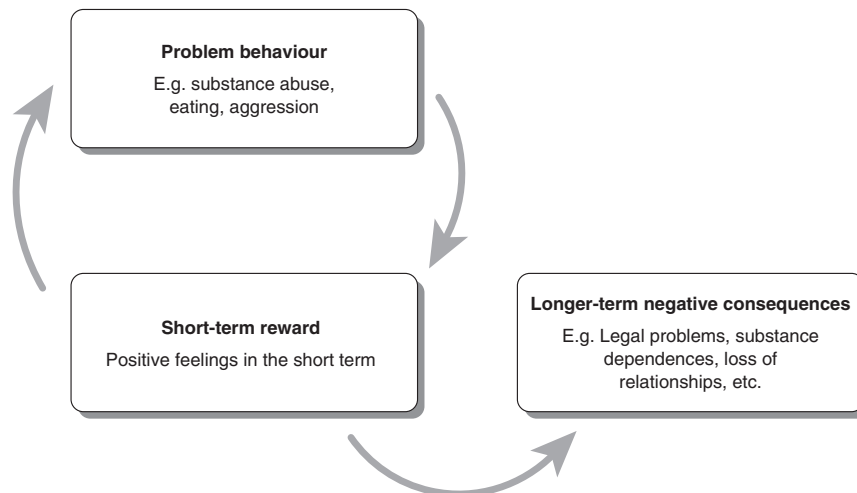


Figure 4.11 Short-term reward

Vulnerability factors

Under this heading, we are looking for anything in the person's history which might have made him vulnerable to developing a problem, but which does not by itself *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 does not mean that *everyone* who has lost a parent will inevitably become depressed. For depression to develop, other events need to come into play (in Brown and Harris's model, 'severe life events' – or what we have called 'precipitants' below).

In CBT terms, the main factor believed to contribute to such vulnerability is the development of particular beliefs, either in the form of assumptions or core beliefs (see Chapter 1). A multitude of such beliefs may be relevant, and their exact form is highly idiosyncratic to particular clients, but common examples are: 'I must succeed at everything I do'; 'If you are nice to others then they ought to be nice to you'; 'I can only cope with life if I have a partner to help me'; or 'I am worthless'. Although a pervasive sense of worthlessness is fairly obviously unhelpful, many of these beliefs may enable a person to function well for long periods of time. It is only when they come up against some situation that resonates with the belief in an unhelpful way that problems may result: in the above examples, when they do not succeed, or do not get the respect they crave, or do not have a partner. Later chapters will look at some beliefs commonly thought to be linked to particular problems.

Precipitants

The events or situations which actually provoke the onset of a problem are known as the precipitants. In the standard cognitive-therapy model they are also known as 'critical incidents'. Precipitants are factors which seem to be closely associated with the actual onset of a problem or with a significant worsening of a long-standing problem. Although there may be a single significant event which precipitates a problem (perhaps most obviously in PTSD), it is often the case that there is no single event, but rather a series of more minor stresses, any one of which the person might have coped with, but which overwhelm the individual when they occur together in a relatively brief time. When there *is* a single event, other than major trauma leading to PTSD, then we often find that the event in some sense 'matches' a pre-existing belief: for example, the person who feels that it is essential to be in a relationship loses an important relationship, or the person who believes he must always be coping and in control comes up against something uncontrollable.

Modifiers

Just as we look for modifying factors in the current problems, so it may also be useful to look at modifying factors across time. Clients often report that the problems have just slowly grown worse, but sometimes careful exploration reveals that there have been times of improvement or of rapid worsening. Common modifying factors include changes in relationships; major role transitions such as leaving home, getting married or having one's children leave home; and changes in responsibilities such as a promotion at work or having a child.

The order of assessment components

In what order should you explore these different aspects of the client's problems? We do not believe there is any one 'right' way of doing this, for the simple reason that both clients and therapists vary. Some clients have little idea of what to expect from a psychological assessment and no strong preferences about how to proceed and are happy to follow a structure largely set by the therapist. Other clients may be set on telling their story in chronological order, from birth to the present day. Yet others may at first want nothing more than a space to express their distress. Therapists need to be responsive to these differences.

That said, all other things being equal, our preference is to begin an assessment by exploring the current problems. Starting here is relatively easy for most clients, and it helps to orient the therapist in later stages of the assessment. You know quite a bit about the problem and, therefore, have some hypotheses about what kind of area may be important to explore when looking at problem development and personal history.

At first, you may prefer to take a structured approach to assessment, keeping the focus fairly tightly on one area at a time. Later on, as you gain experience and the structure becomes second nature, you may find that you can 'loosen up' and allow the conversation to wander around more, whilst still retaining in your mind the structure and how different aspects of the problem fit together.

'Non-specific' factors and the therapeutic relationship

We noted 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. Whilst CBT does not generally give the therapeutic relationship a central curative role, it still regards the relationship as an essential vehicle for change. This is particularly important during the assessment, when that relationship is being established. Although we have talked about some of the technical aspects of assessment, we want to make it clear that paying attention to the human relationship between client and therapist is just as important – indeed, probably even more important. If you forget to ask a particular question you can always come back to it later, whereas if you fail to respond with warmth and humanity to your clients, they may not come back at all! It is therefore crucial not to get so absorbed in the pursuit of information that you stop genuinely listening to what the client is saying or fail to notice and respond to distress.

Newcomers to CBT sometimes worry that asking the number of questions that a CBT assessment demands must automatically mean that the client feels harassed and intruded upon. Our experience is that this is not usually so. If questions are asked with warmth and empathy, in a genuine spirit of curiosity and desire to understand, most clients will see the assessment as a positive experience with someone who is interested in, and wants to understand, their way of looking at the world.

A good technique, throughout therapy but perhaps especially during assessment, is to pause frequently to summarise your understanding of what the client has told you and to ask for their feedback on whether you have got it right. This has several benefits. It gives

you time to reflect and to think about where to go next. It helps reduce the risk of misunderstanding, by giving the client a chance to correct differences between your summary and what they meant 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 formulations

Not too fast; not too slow

The process of assessment and formulation is worth spending time on, because developing a good formulation will pay dividends in more efficient and focused therapy. But how much time? You may feel two opposing pressures. Sometimes, there is an urge to ‘get stuck in’ and get into treatment as quickly 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 moment of birth to the present day. The best answer is probably somewhere in the middle.

In general we would recommend a two-session assessment, at least until you are familiar with the CBT approach. In the first session, aim to get as much as you can of the necessary information. You then have the time between sessions to try to make sense of the information and develop a formulation. Trying to construct a formulation will very quickly highlight any important gaps in the assessment. You can then go into the second session with a clear idea of what else you need to know and, in most cases, develop the formulation in discussion with the client by the end of the second session. This is 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 process of assessment may take longer. On the other hand, as you become more experienced in CBT you will probably find that with clients with straightforward problems you can develop at least a rough formulation within one session. But the two-session approach works well for most beginners most of the time.

Diagrams

The best way of communicating formulations is through diagrams rather than words. There are two common approaches to drawing formulations. Many CBT therapists have a whiteboard in their office and use this to draw up formulations. Others just draw them onto paper. The whiteboard has the advantage of being larger and therefore easier to see and also easier to rub out as changes are made. On the other hand, doing the formulation on paper means that it is easier to make a photocopy for the client to take away.

In either case, it is helpful to make the process of drawing up a formulation as collaborative as possible. Don’t just produce a beautiful formulation like a rabbit out of a hat. Involve your client in the process, asking him or her what should go where: ‘From what we have discussed so far, what do you think might have led to the problem starting?’ ‘What do you think the effect is when you do that?’ and so on.

Figure 4.12 shows a possible template for formulations. This is not meant to be prescriptive. There are many different ways of showing formulations, and you will probably develop your own style. This is just one possible approach, which does at least give a clear picture of the most important elements in any formulation.

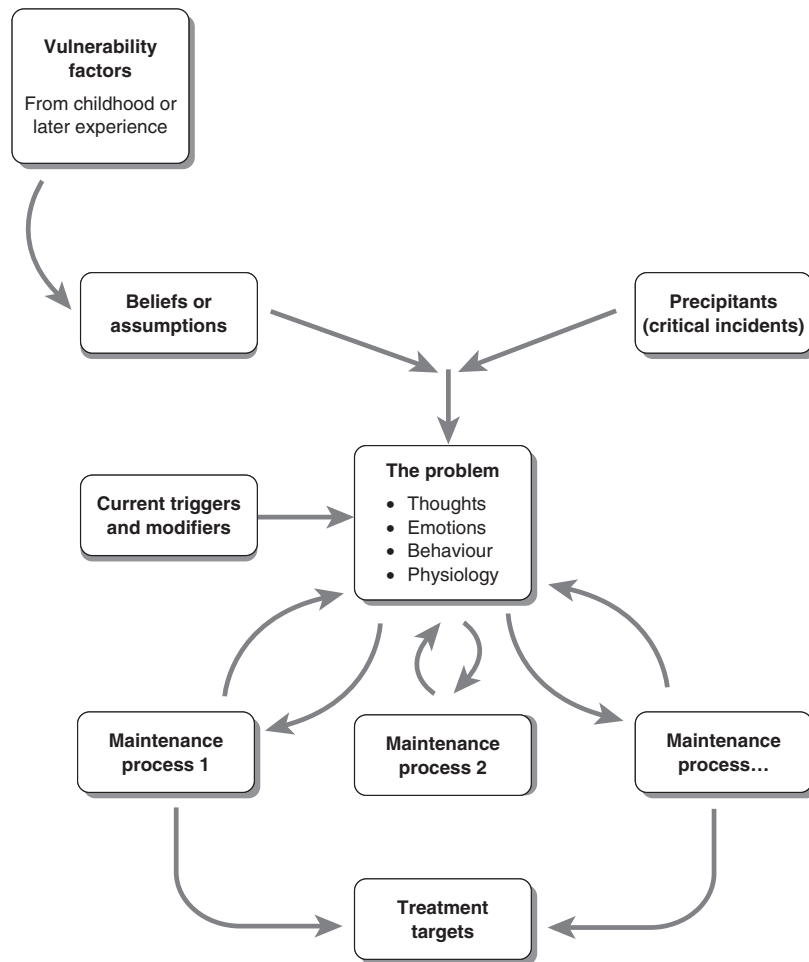


Figure 4.12 A template formulation

Sample formulation

Figure 4.13 shows an example of a formulation for a client who presented with a fear of becoming incontinent of faeces whilst driving. This had led to his being unable to drive more than a mile or two from home. That was just far enough for him to continue to get to work but was only achieved by plotting an intricate route that kept him in easy reach of a public toilet. The relevant information summarised in the formulation is as follows.

Vulnerability

Two factors seemed important. First, that he had been brought up in a family where bowel functioning was of more than average concern: in his words, they were 'obsessed by

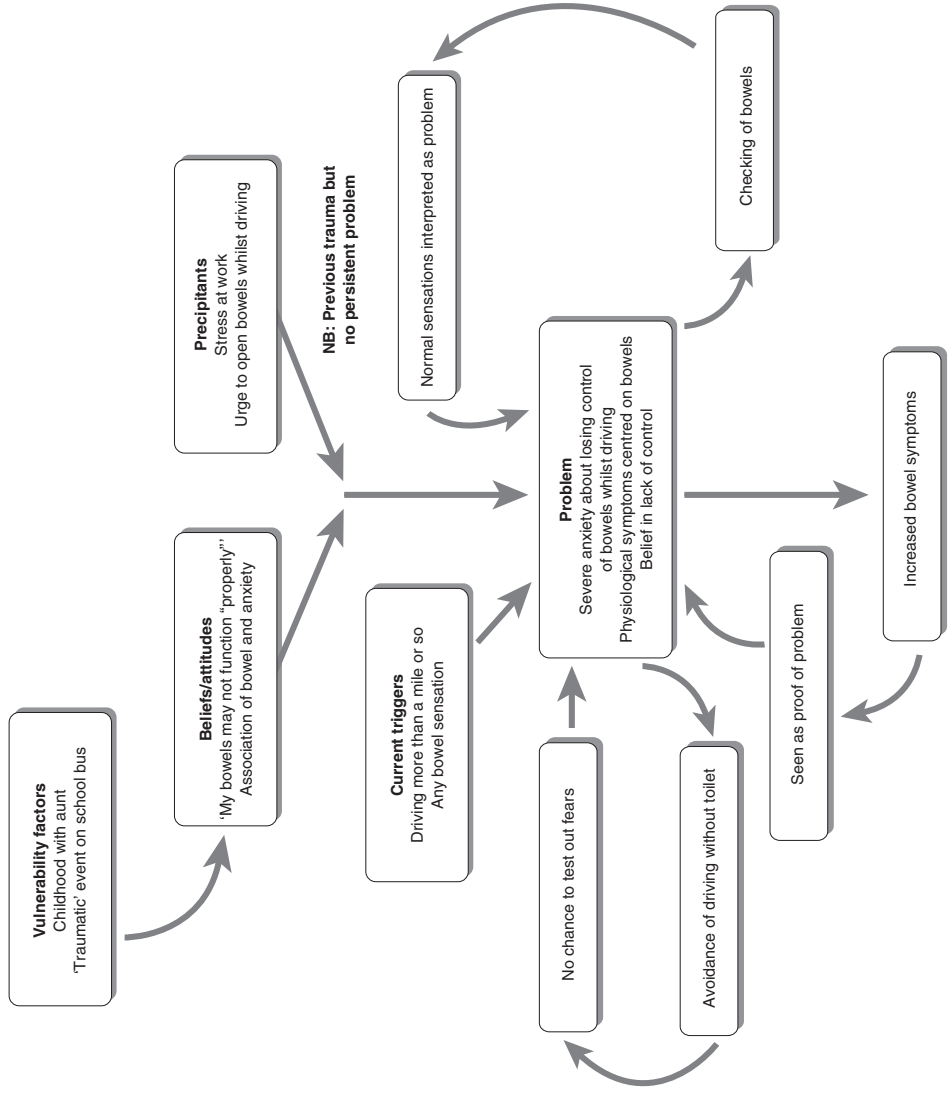


Figure 4.13 An example formulation

bowels'. He recalled that as a child he would be asked every day whether he had opened his bowels and, if he had not, he would be given laxative medication.

Second, and probably more important, he recalled with some distress an incident when he was eleven or twelve when, whilst he had a stomach bug, he had in fact been incontinent on the school bus on the way home. Not surprisingly, he remembered this as an extremely shameful and humiliating experience.

Beliefs

It was hypothesised that these earlier experiences had led to beliefs that his bowels were liable to malfunction, and that if they did the results could be catastrophic. Perhaps related to this, he reported that he had always felt a slight association between bowels and anxiety: when he felt anxious, he would tend to want to go to the toilet, and when he felt an urge to open his bowels, there was some degree of anxiety.

Precipitants

This client's history is an interesting illustration of the earlier point about the 'fit' between precipitants and pre-existing beliefs. Some years before the incident which started the presenting problem, he had suffered what would seem a far more 'traumatic' experience, when he had hit someone in his car who had died as a result. The accident was not his fault – the other person had run out into the road in front of him and he had no chance to avoid them – but nevertheless it was obviously upsetting. However, despite significant temporary distress, it did not lead to persisting problems.

What did lead to the presenting problem seems a much more trivial incident, but because it linked with his beliefs, it proved more powerful as a precipitant. The incident occurred at a time when he was under a great deal of stress at work, due to conflict within the company. During this time, whilst driving to work and feeling a bit under the weather, he had a sudden urge to open his bowels and he became very anxious that he would lose control. Nothing disastrous actually happened. He found a place to pull over, went behind a hedge and carried on to work. However, this immediately led to further anxiety, which increased steadily over the next few months.

The problems

He became anxious at the thought of driving more than a short distance from home (*emotion*). He had typical anxiety symptoms, including increased heart rate, muscle tension, feeling hot and so on, but particularly an unsettled stomach (*physiology*). He believed that if he did not reach a toilet within a few minutes of getting an urge to open his bowels, he would lose control (*cognition*). He avoided driving almost entirely except for getting to work and coped with that only by his safety behaviour of staying within range of public toilets. He also focused a great deal of attention on his bowel, checking both before and during any journey whether he needed to go to the toilet and always trying to open his bowels before he set off (*behaviour*).

Maintenance

Three main maintenance processes were identified. First, his avoidance of driving outside 'safe' areas was a safety behaviour that blocked any testing of his beliefs about his lack of

control of his bowels. Second, his anxiety created bowel symptoms which were interpreted as proof of lack of control. And, finally, his constant checking of his bowels constituted 'scanning', which led to his noting bowel sensations which were actually perfectly normal.

Suitability for CBT

A common question from beginning therapists is: 'Who is "suitable for CBT?"' The truth is that there is not much solid evidence about how we should match clients to therapies – whether CBT or any other therapy. One study that has been widely quoted (but not replicated) is Safran et al. (1993), which suggested better outcome in short-term CBT if the client:

- can access NATs in session;
- is aware of, and can differentiate, different emotions;
- relates well to the cognitive model;
- accepts responsibility for change;
- can form a good collaborative therapeutic alliance (using evidence from previous relationships);
- has problems of relatively acute onset and history;
- does not show unhelpful 'security operations', i.e. attempts to control anxiety to such a degree that therapy is difficult;
- shows ability to work on one issue at a time in a relatively focused way;
- is reasonably optimistic about therapy.

These factors are not well established, so use them as a guide rather than a rigid set of criteria. Furthermore, they were devised to assess suitability for short-term CBT – one may be able to overcome less positive factors in longer-term work.

Faced with the lack of evidence about suitability, many therapists offer clients a trial period – perhaps five or six sessions – during which both client and therapist can evaluate how well CBT fits for this individual. Although five or six sessions may not be long enough to resolve the client's problems, it usually is long enough to get an idea of whether CBT seems to be useful. If it is, then the therapy can continue. If not, you can consider other treatment plans. Of course, the decision to discontinue treatment needs thoughtful discussion so as to avoid upset to the client as far as possible.

Possible problems during assessment

As previously noted, a common difficulty for beginners in CBT is getting 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 partly in not yet knowing what information is important. With more experience with a range of psychological problems, you will develop a sense of what areas are likely to be important in particular problems. You should also read about CBT models, so that you know what theorists see as important (we hope that 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 recognising quickly when they are asking the *wrong* question and rapidly moving on to try a different angle.

It is important to try to feel your way between giving up too easily and persisting too long. In most cases, if your client is not managing to tell you much about an area of questioning, it is worth persisting for at least a while and trying different approaches. Clients often find one question easier to answer than another, and what initially seems a totally fruitless line of enquiry may suddenly open up in a more productive way. However, do not be *so* persistent that the client feels as if it is an interrogation rather than an assessment! In general, our experience is that when you are first learning it is worth persisting slightly beyond the point that feels completely comfortable to you; it will usually be acceptable to the client.

Problems for the client

For clients, there may be several difficulties that make it hard for them to answer your questions. In any particular case, it is important to understand what is causing the difficulty, but there are two common classes: those where the client genuinely does not know the answer to your question; and those where he does know, but is reluctant to answer.

Common reasons for clients not knowing the answers include:

- The client has become so used to the problem (or so demoralised by it) that he no longer notices the factors you are trying to assess. Often, further gentle questioning can begin to elicit variations and thus reveal more information. Another useful technique is self-monitoring (see Chapter 5), either done close to the time of emotional upsets so as to increase the accessibility of thoughts or done hourly to pick up variations in mood.
- Avoidance or other safety behaviours have become so widespread or so effective that client 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 traffic light. He would not consciously think 'I had better stop, because if I don't a car coming the other way might crash into me, and that would be very unpleasant.' He would just automatically brake on seeing the red light. On the other hand, if he put his foot on the brake and nothing happened, then his negative thoughts and emotions would be easily accessible! A useful strategy, therefore, can be to try a small *behavioural experiment* (see Chapter 9), used as an assessment strategy. If the client is willing to see what happens if he does not avoid or does not perform his usual safety behaviour, then the thoughts and emotions are likely to become much more apparent.
- The client is amongst that small proportion of people who simply find it very difficult to access or report thoughts and emotions. Some people get better with practice, so it is worth persisting for a while, for example via homework, as above. A few people never do get comfortable with thoughts and feelings. In such cases, a more traditional behavioural approach may prove more fruitful.

Examples of knowing the answers but being reluctant to report them, include:

- Fear of the therapist's reactions. For instance, the client may think that you will disapprove of his thoughts or behaviour, or find his symptoms 'silly', or laugh at him. Always try to discover the reason for the client's reluctance before trying to do anything about it. Most

clients will be able gradually to talk about the obstructing thoughts, even if they do not yet feel able to talk about the original thoughts themselves. It may also be helpful to offer the client suggestions about the kind of worries other clients have reported, so that he realises that the therapist has heard this kind of thing before (but without putting words into the client's mouth).

- Other feared consequences of reporting the symptoms openly. A client may fear she will be diagnosed as 'mad' and locked away or think that the therapist will contact the police or social services and have her arrested or have her children taken away. With some problems there may be quite idiosyncratic fears. Some people with obsessive-compulsive problems report fearing that their protective rituals, particularly those involving 'magical thinking', will no longer work if they reveal the full details, thus putting the client or others at serious risk. Again, it can be helpful to offer clients examples of common fears and also perhaps to clarify the differences between different kinds of mental-health problem (for example that OCD is different to schizophrenia).

Possible problems in making formulations

Effect is not purpose

It is important to avoid the assumption that clients or their relatives necessarily *intend* (even unconsciously) the consequences of their behaviour. The fact that one of the effects of an agoraphobic client's behaviour is that her husband always has to accompany her does not by itself prove that she is behaving like that *in order* to have her husband always with her. Similarly, an obsessional client's husband reassuring her in a way that seems to maintain the problem does not show that he is doing that *in order* to keep her obsessional. This is not to say that such motivation (sometimes called *secondary gain*) does not exist; just that it is not universal. Some independent evidence is needed, beyond the mere effect, to show that it is important in any particular case. Freud himself is supposed to have said in relation to Freudian symbolism, 'Sometimes a cigar is just a cigar.' We might perhaps extend this to '*Most of the time* a cigar is just a cigar.' Most clients and their families want to get rid of their problems: they just get trapped in patterns of thought and behaviour that do not help them to achieve that goal.

Censoring the formulation

Therapists sometimes ask whether 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 the collaborative approach of CBT, the formulation should be open. A possible, but rare, exception to this is if the full formulation would contain some element that might threaten the therapeutic relationship. Discussions about the formulation will typically happen fairly early on in the relationship, when there may not yet be sufficient trust and confidence to contain conflicts. An obvious example would be if you thought you had sufficient evidence to assume secondary gain as part of the formulation (see above). Even with strong evidence for that kind of process, the client might be offended by such a suggestion early on in therapy. It might be wise not to make it part of the formulation until the relationship has strengthened and such issues can be openly discussed.

Spaghetti junction

It is not necessary for a working formulation to contain *every* piece of information you have about a client. Including too much in a formulation can result in a nightmare of criss-crossing lines and boxes that is confusing rather than clarifying. Remember, the aim of the formulation is to make sense of the information gathered from the client and to explain the key processes involved. A degree of filtering and simplification is necessary and desirable to make the formulation reasonably easy for both client and therapist to grasp. A good motto is the saying attributed to Einstein: 'Everything should be made as simple as possible – but no simpler.'

Tunnel vision

Sometimes we may fix too early on a hypothesis and then get 'stuck', only paying attention to information that confirms the hypothesis and not looking for other information (Kuyken, 2006). It is important to remember that in order to test a hypothesis adequately, we have to look for evidence that would *refute* that hypothesis, not just evidence that supports it.

We can also sometimes try to force clients into fitting the formulation, rather than making the formulation fit the client. It is crucial that you are responsive to what clients tell you and that the formulation is idiosyncratic to your client.

Formulations need to make sense

A common problem is the formulation that has boxes and interlinking arrows which look fine but which, and on closer examination, make no logical sense. This can happen as a result of careless use of the 'hot cross bun' (Padesky and Greenberger, 1995: see Figure 4.14).

Although this model is popular and can be very useful as a simple reminder of the multiple interconnections between the four systems, it needs to be made more specific if it is to form the basis of a useful formulation. Used without enough consideration, it can lead to lumping together miscellaneous thoughts in one box; putting equally disparate piles of behaviours, emotions and bodily changes in other boxes; drawing arrows between the boxes; and then sitting back, satisfied that the problems have been explained. But they have

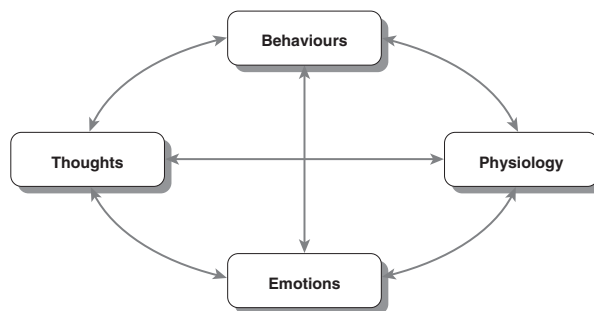


Figure 4.14 The hot cross bun

not, because the arrows do not represent any comprehensible process. Instead of being specific about what behaviour is linked to what thought or what emotion, we just have one big arrow linking all thoughts to all behaviours, all emotions, and so on. Although each one of these links might make sense when taken individually, they make no sense at all when they are all lumped together. As a result, the therapist (not to mention the client) is likely to struggle to explain *how* these supposed links operate.

Always think critically about your formulations and ask yourself what psychological process the arrows and boxes represent. Make sure you can explain *how* a thought in one box leads to a behaviour in another box, or *how* that behaviour has an effect on a specific belief. In short, make sure your formulations make sense.

Formulations need to be used

It may seem obvious that a formulation cannot help if it is not used, but it can be forgotten. Having constructed the formulation, therapists sometimes file it away as a task completed and never think about it again. Remember that the point of the formulation is to guide both therapist and client throughout treatment. Try to get into the habit of referring back to the formulation frequently: 'How does this experience fit with the formulation?'; 'What would our formulation suggest might be a good way forward here?'; 'Is this work [in session or as homework] going to make a difference to an important maintaining process?'

Core beliefs and schemata

Finally, a note of caution about the transition from the formulation to treatment plans. There is sometimes a belief that if your formulation contains core beliefs or schemata, then (a) those must be the primary targets for treatment, because they are more 'fundamental' or 'deeper' than NATs or behaviour; and (b) you should therefore begin by modifying them. This is rarely true. Core beliefs and schemata are certainly broader in their applicability than a typical NAT, but that does not necessarily render them more important or more fundamental and certainly does not imply that working with negative thoughts and behaviours is 'superficial'. On the contrary, almost all the evidence currently available for the effectiveness of CBT is based on working primarily at the level of specific automatic thoughts and their associated behaviours. There is also evidence that working at that level actually results in changes at the wider belief level as well (see, for example, the fascinating 'dismantling' study of Jacobson et al., 1996). Our approach is to keep things as simple as possible and work with more general beliefs and assumptions only when it is clearly necessary because we have got as far as we can with more specific thoughts and behaviours.