Introduction

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The representation of a single theoretical background is increasingly hard to find in our contemporary cognitive behavioural communities. This book is no exception and readers will discover our theoretical and empirical allegiances, commonalities and differences, as the text unfolds. A common strand throughout is our fundamental commitment to empirically underpinned and grounded cognitive behavioural psychotherapy (Moorey, 2007; Salkovskis, 2002; Scrimali and Grimaldi, 2004).

Historical and contemporary writers in cognitive behavioural psychotherapy have tended to take a disorder-based approach to formulation, or have used variations of the original clinical models of the emotional disorders or depression developed by Beck and Colleagues (Alford and Beck, 1997; Beck et al., 1979). Whilst we are influenced by traditional Beckian cognitive therapy and traditional behaviour therapy (Marks, 1987), when supported by evidence, we are also influenced by other, more recent and integrative developments and revisions in our knowledge and practice field. These include the postmodern turn in cognitive therapy (Hammack, 2003; Lyddon and Weill, 1997; Ramsay, 1998; Safran and Messer, 1997) and related client-led textual representation (Chase Grey and Grant, 2005; Short, 2005); the compassion paradigm (Gilbert, 2005); transdiagnostic (Harvey et al., 2004) and multi-level approaches to assessment and formulation (Barnard and Teasdale, 1991; Brewin et al., 1996; Power and Dalgleish, 1999); the role of creativity (James et al., 2004; Mahoney, 2003; Mooney and Padesky, 2000); the influence of positive psychology (Cheavans et al., 2006; Ingram and Snyder, 2006); classic and contemporary therapeutic relationship issues (Gilbert and Leahy, 2007) and, finally, self-practice, reflective development and clinical supervision in cognitive behavioural psychotherapy (Bennett-Levy and Thwaites, 2007; Bennett-Levy et al., 2001; Townend et al., 2002).

Each of the above developments is reflected in this text, and their application to assessment and formulation is detailed in a unique synthesis of contemporary ideas for the cognitive behavioural practitioner, supervisor and educator.

SOME KEY ISSUES AND ASSUMPTIONS

Assessment as a collaborative enterprise

The keys to effective therapeutic interventions in cognitive behavioural psychotherapy are the development of a therapeutic relationship, a detailed and systematic assessment
and a formulation to guide practice. Curiosity and hopefulness are two vital attributes for a cognitive behavioural psychotherapist in this endeavour. This is especially so when assessing the motivations for the client in seeking therapy during an initial assessment interview, which according to Sanders and Wills (2005), ought to include:

- What are your exact goals at this time?
- What other solutions have you tried to help you overcome your problems?
- How hopeful are you that therapy can help you currently?

In addition to the above, we have become increasingly aware in our work of the need to carefully assess any fears that clients may have around change. These might well be about the therapy process, the emotions they are likely to experience, and how therapy might impact on them, their family and relationships with others. It may also be that clients fear the closeness of a therapeutic relationship if they have a history of abusive relationships or have had difficulty in forming appropriate relationships with others.

In order to engage clients in the therapeutic process from the outset, it is important that therapists role model curiosity and hopefulness to encourage a ‘possibility focus’ in clients. It is equally important for assessment to be a focused and collaborative process where the client is invited to make a contribution to initial, and subsequent, agenda setting and management of the therapeutic process as a whole. The aim is neither to 'label' nor 'diagnose' the client, but to reach early and provisional agreement around the nature of the current difficulties and pathways to change and recovery, and therefore what needs to be worked on in therapy. This is a two-way process, in that the therapist assesses the client in a way that demonstrates compassion and empathy for his or her distress while remaining sensitive to his or her thoughts and feelings about engagement in therapy. Such an approach explicitly invites the client to consider if the cognitive behavioural approach and the psychotherapist are right for them at this time and helps to identify any resistance or doubts that the client may have.

The assumption behind collaborative assessment is to build a comprehensive picture of the client’s difficulties and goals, both in terms of how the difficulties arose, how they affect the client currently, and emerging future-directed strategies to help the client work towards overcoming them. Sanders and Wills (2005) stress that the outline of assessment is not intended to be fixed and immutable, but, rather, a series of ‘coat hooks’ on which to hang gradually assimilating information from the client’s meaning-making through the utilisation of guided discovery as the basis of collaboration between therapist and client.

The client’s personal meaning-making

Centrally important in the collaborative enterprise that characterises contemporary CBT assessment is the personal meaning-making of the client and the need for the therapist to adapt to this. The therapist takes the position that the focus is both at the phenomenological level, the client’s inner life world (Alford and Beck, 1997) and of equal importance is the client’s perception and experiences of the external world, such as conflicts at home, within relationships, experiences at work, and the coping behaviours used in these contexts.
The relational approach to case formulation

Within such a phenomenological focus on the internal and external worlds, therapists need to be mindful that they will be part of the client’s interpersonal and external worlds and vice versa. So, just as the interpersonal issues and difficulties that the client has in her life are likely to be played out in the therapy session, the cognitive behavioural psychotherapist may well process interpersonal information in a distorted way at times of ‘therapeutic alliance rupture’. In the words of Robert Leahy (2001: 5), ‘in the therapeutic relationship, both patient and therapist are patients’. Because of this, in our view, all interventions – including assessment – make sense only in relational and co-constructional forms (Gilbert and Leahy, 2007; Safran, 1997; Safran and Segal, 1996). Essentially, the therapeutic alliance between client and therapist should be seen as a psychosocial laboratory, within which:

Both patient and therapist struggle to sort out how much they can accommodate to the other’s views about treatment tasks and goals, without compromising themselves in some important way. (Safran, 1997: 459)

Interpersonal meaning-making and case formulation

Table 1.1 overleaf illustrates the need for both client and therapist to accommodate to each other’s viewpoint in order to help the client work through difficulties. This is likely to involve rule and core belief affirmation and violation for both parties in the therapeutic relationship (Haarhoff, 2006; James et al., 2004; Leahy, 2001, 2007; Rudd and Joiner, 1997), and may often be transferential in character (Miranda and Andersen, 2007). It is therefore important that cognitive behavioural psychotherapy is viewed as a relational rather than a simple technical or mechanistic endeavour. Therapists will thus need to pay close attention to the activation of their own cognitions throughout the process of therapy and seek to make sense of this within the developing therapeutic process and evolution of the formulation.

THE STRUCTURE OF THE BOOK

In exploring the above further, this text is divided into three parts: Part I introduces the reader to fundamental and advanced technical and process knowledge in cognitive behavioural assessment and case formulation. Part II provides practical illustration of aspects of the preceding discussion, in diagrammatic and narrative form, using eight case studies. These are drawn directly from the authors’ recent clinical work and cover helping individuals with the following difficulties: obsessional compulsive disorder; borderline personality disorder; post-traumatic stress disorder and related difficulties; family difficulties; low self-esteem; psychosis; health anxiety and, finally, chronic depression. The last part of the book explores a long overdue issue in our cognitive behavioural communities – specifically around leadership and related scientific
paradigm awareness – and highlights the need for a future text to develop and clarify this and other professional development concerns.

A range of blank case formulation templates that we have found helpful are provided in the Appendices at the end of the book for the reader to use within their own practice.

### Table 1.1

<table>
<thead>
<tr>
<th>Level of thought</th>
<th>Focus of thought</th>
<th>As applied to the therapeutic relationship for client</th>
<th>As applied to the therapeutic relationship for therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core belief</td>
<td>Self</td>
<td>Possibility of core belief accommodation with therapist's core beliefs. Possibility of core belief violation by therapist.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td></td>
<td>Possibility of core belief accommodation with client's core beliefs. Possibility of core belief violation by client.</td>
</tr>
<tr>
<td></td>
<td>World</td>
<td></td>
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<tr>
<td>Rules for living (underlying assumptions)</td>
<td>Self</td>
<td>Possibility of rule accommodation with therapist's rules. Possibility of rule violation by therapist.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Others</td>
<td></td>
<td>Possibility of rule accommodation with client's rules. Possibility of rule violation by client.</td>
</tr>
<tr>
<td></td>
<td>World</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Automatic thoughts (ATs)</td>
<td>Self</td>
<td>Possibility of AT accommodation with therapist's ATs. Possibility of AT violation by therapist.</td>
<td></td>
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<tr>
<td></td>
<td>Others</td>
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<td>Possibility of AT accommodation with client's ATs. Possibility of AT violation by client.</td>
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