Cognitive-Behaviour Therapy Case Conceptualisation and Psychotherapeutic Practice - The Practitioner's Perspective.

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ABSTRACT

Cognitive Behaviour Therapy (CBT) is the most-widely utilised therapeutic approach in New Zealand; with case conceptualisation identified as “the heart”, or “cornerstone”, of CBT practice. Yet, there is limited empirical support for CBT case conceptualisation; and an identified paucity of research regarding its real-world use. As such, the present study investigated the real-world, case conceptualisation practices, attitudes and experiences of 48 New Zealand CBT practitioners; with the primary aim of exploring CBT case conceptualisation within the context of the practitioners’ subjective perspective.

The data set consisted of responses to a purpose-built survey, while data analysis took the form of a descriptive analysis, which in turn, informed a thematic based review of the themes within the data. The descriptive results revealed that almost all respondents are utilising CBT-specific, case-level conceptualisations in their practices; they appear to have a good understanding of the various components of case conceptualisation, and appear to mirror the recommended theory in both their theoretical understanding, and practical use of conceptualisation. Utilising the descriptive results as a context, a thematic analysis was used to identify the main and sub-themes embedded in the responses.

“Conceptualisation as a Highly Valued Therapeutic Process” was identified as the single main theme. The first sub-theme, “The Indicators that respondents value case conceptualisation”; included the following additional sub-themes: The high level of conceptualisation use among respondents; the pursuit of further education about case conceptualisation; the use of conceptualisation-compatible therapeutic tools; and the qualities that respondents attributed to conceptualisation; and informed the overall theme of conceptualisation as a valued process. The second sub-theme, “The practitioner-perceived benefits of conceptualisation”, contained three sub-themes,

each examining the benefits of CBT case conceptualisation to either the practitioner, the client, or, the therapeutic process; was informed by the main theme, and explores *why* respondents value conceptualisation. These findings; together with the limitations, implications and future directions, of this study are discussed in the context current literature and the research aims.

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And finally, to Roan... This year, and this process tested many things; but amidst the chaos three things never wavered: Your support, even when you were under just as much pressure; your belief in me, even when I had lost complete faith in myself; and your love. Simply put, without you there really would be nothing. Thank you.

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Introduction

Case conceptualisation (or formulation) is a core psychotherapeutic skill, that has been defined as a dynamic set of hypotheses about a client, that aim to integrate the unique experience of the individual with a relevant theoretical perspective in order to promote understanding and inform treatment; thus providing a link between theory and practice. This chapter aims to briefly explore case conceptualisation; including the historical influences on conceptualisation; and the contributions of the various psychotherapeutic models to conceptualisation. Furthermore, this chapter provides an overview of the remaining thesis chapters.

Case Conceptualisation

Case conceptualisation involves elements of diagnosis, treatment, theory, practice, science, art, etiology and description; and aims to identify the predisposing, precipitating, perpetuating, presenting and protective factors pertinent to a client's problems (Eells, 2007). A true understanding of the individual client provides a platform for therapeutic change; through the effective use of individualised "client–specific" techniques. Furthermore, a collaboratively formulated case conceptualisation synthesises the client's experience with the relevant theory; which assists in normalising and validating the client's experiences; thus making them more likely to engage in therapy (Kuyken, Padesky, & Dudley, 2009). Conceptualisation is not a uniform process; as each theoretical perspective follows a different process and utilises different content in order to formulate a workable and theory driven case conceptualisation; which in turn guides treatment and directs the therapeutic process (Eells, 2007; Eells, Lombart, Kendjelic, Turner, & Lucas, 2005; Eifert, 1996; Haarhoff, 2008; & Persons, 1989).

Furthermore; every case will have inherent complications that the practitioner will have to negotiate in order to formulate an effective conceptualisation. These include finding a balance between the need for an immediate conceptualisation which ensures no time is wasted on issues that are not relevant; and the need to ensure the conceptualisation is fully comprehensive and therefore covers all the client's issues, potential obstacles, and future treatment options. The conceptualisation will need to be complex enough to cover all client components, but not overly complex that it is misunderstood or confuses the client; this will only detract from the therapeutic process and make it less likely to stand up to tests of reliability and validity (Eells, 2007). Finally as in all therapeutic activity, the practitioner must always be aware of their own clinical bias within the conceptualisation process; which may impair their ability to be objective.

Historical Influences on Case Conceptualisation

According to Eells, historically, psychotherapeutic case conceptualisation has been influenced by a variety of factors; these include: The medical model of examination and case history; the various models and classifications of psychopathology; the use and quality of psychometric assessment; new research on case conceptualisation; and the various models of psychotherapy used; each of these is discussed below:

The medical model of: Examination and case history.

Psychotherapeutic case conceptualisation embraces the qualities of logic, reason and objectivity found in the medical model (Eells, 2007). It has also embraced the empirical practice of experimentation and observation as a means to new understanding and learning; as well as the practice of detailed documentation leading to individualised client case histories (Eells, 2007; Morgan & Morgan, 2001; & Stiles, 2003).

The various models, and classifications of psychopathology.

Individual clinicians from different schools of thought will frequently identify different "psychopathological" components of a specific client's case; and will often subscribe to a specific set of assumptions about whether something constitutes psychopathology and how the psychopathological state, developed, is maintained, and organised (Eells, 2007). The most common divides in the way that psychopathological states are classified include: etiological versus descriptive; categorical versus dimensional; and normality versus abnormality models (Blashfield, 1984; Kendell, 1975; Millon, 1996).

The use, and quality of psychometric assessment.

The construction of reliable and valid psychometric tests; as well as the standardisation of administration and construction of said tests has added to our ability to formulate more accurate and universally understood case conceptualisations (Eells, 2007).

The various models of psychotherapy.

A practitioner's theoretical grounding will have the greatest influence on the type of conceptualisation developed (Leahy, 2008). Individual practitioners will emphasize different dimensions in their conceptualisations based upon their chosen psychotherapeutic approach. The theoretical grounding of the conceptualisation will determine the way the practitioner evaluates and assigns the client's symptoms within the conceptualisation (Persons, 2008). Each psychotherapeutic approach has been informed by different methods and protocol for formulating and assessing case conceptualisations; and each method has contributed to, or influenced, our overall understanding of case conceptualisation in the following ways:

Psychoanalytic theory.

Freud's psychoanalytic theory has contributed much to our current understanding of psychology; but three components of psychoanalysis, in particular, have influenced case conceptualisation (Eells, 2007). Psychoanalysis has always had an emphasis on the case study as a means of interpreting and explaining psychoanalytic concepts; this has elevated the social and scientific standing of the case study (Eells, 2007; Pigman, 1995). Psychoanalysis also improved and expanded the clinical interview; providing a wealth of additional verbal information, as well as incorporating non-verbal information that can assist the practitioner in determining underlying issues (Eells, 2007; Hergenhahn, 2005; Hothersall, 1995). Most importantly, it was Freud who developed the first working models of personality and psychopathology; which developed our understanding of normal and abnormal human behaviour (Hergenhahn, 2005).

Humanistic therapy.

Humanistic therapy views case conceptualisation as potentially harmful to the client; specifically when it is utilised as "psychological diagnosis". The primary concern of humanistic practitioners is that conceptualisation places the practitioner in a position of authority (or leadership) which can limit the client's ability to take responsibility for their own problems and lead them to become dependent on therapy. This concern caused a review in the way conceptualisation was carried out; specifically an emphasis on the need to see the client as a person, rather than a set of symptoms or disorders was identified and collaborative case conceptualisations encouraged (Eells, 2007; Rogers, 1951).

Behavioural therapy.

Behavioural Practitioners utilise a functional analysis approach to case conceptualisation; which involves identifying particular client characteristics, behaviours, and environmental re-enforcers; and targeting them with behavioural

interventions. The functional analysis has made a contribution to our overall understanding of conceptualisation in the following three ways (Eells, 2007; Hayes & Follette, 1992): A focus on identifying and treating symptoms in order to reduce distress as quickly as possible; a focus on identifying and modifying environmental sources of distress; which is less stigmatizing for the client (Eells, 2007; Greenberger & Padesky, 1995); and a focus on the use of experiments, demonstrations and measures to support clinical findings, and allow the conceptualisation to be utilised as a record to mark any change in symptoms (Eells, 2007).

Cognitive-Behaviour Therapy (CBT).

CBT has contributed to our understanding of case conceptualisation by providing us with a new psychotherapeutic theory that places importance on cognitions as an underlying explanatory factor; as well as a set of manualised, general conceptualisations about a variety of psychopathologies. Case conceptualisation is considered a core component of the Cognitive-Behavioural approach, and is frequently described as central to; or "the heart of" CBT (A.T. Beck, Rush, Shaw, & Emery, 1979; Eells, 2007; Eells et al., 2005; & Persons, 1989). Given the nature of this thesis, CBT case conceptualisation will be discussed in greater detail in the following chapters.

In summary, many mental health practitioners regard case conceptualisation as an important or even critical process within psychotherapeutic practice (Eells, 2007). However, despite practitioner's favourable view of case conceptualisation there is currently limited research regarding the real-world use of case conceptualisation in psychotherapeutic practice (Beiling & Kuyken, 2006); with even less research conducted on a New Zealand sample. The purpose of this research is to bridge the identified gap between the recommended theory and actual therapeutic practice. This is to be achieved by evaluating the current practices of New Zealand based, CBT practitioners.

Overview of Chapters

Chapter two provides a review of the theoretical aspects of CBT case conceptualisation. This includes the Cognitive model; the levels of conceptualisation; and the content and process required in the development of a CBT case-level conceptualisation.

Chapter three provides a review of the current research conducted on case-level conceptualisation; with a specific focus on CBT case conceptualisation.

Chapter four describes the methodology of this study.

Chapters five and six present the results of the study. Chapter five presents the descriptive data; whilst chapter six presents the results of the thematic analysis.

Chapter seven provides a discussion regarding the overall findings of this study. The implications and limitations of the study are also discussed, and directions for future study identified. Then (in line with the underlying hermeneutic methodology of "researcher as co-learner"), the author provides an account of her subjective learning experience and findings. Finally, the study is concluded with the presentation of the research conclusions.

Case Conceptualisation within Cognitive-Behaviour Therapy

In order to provide a background and context to the study this chapter reviews the theoretical components of CBT case conceptualisation. It begins by discussing CBT, and the CBT model. The role and importance of case conceptualisation within CBT is then discussed, before the levels within CBT conceptualisation are explored; with special attention paid to individualised case conceptualisation. The review ends with a discussion regarding the content and process required to construct an individualised conceptualisation.

Cognitive-Behaviour Therapy

CBT is a goal orientated and problem focused therapeutic approach that encourages a strong therapeutic alliance (with collaboration and active participation emphasised); as well as a sound empirical base that is open to modification; therefore CBT utilises an approach of "collaborative empiricism", that encourages a continual (and collaborative) testing of hypotheses within structured sessions (Kuyken et al., 2009). The core principle underlying the CBT model is that thinking, or cognition, plays a role in the development and maintenance of behaviour; that these thoughts or cognitions can be monitored and altered; and that behavioural and emotional change can be attained through the alteration of these cognitions (A. T. Beck et al., 1979; J. S. Beck, 1995; Hollon & A. T. Beck, 1994). The emphasis is on *cognition as a mediating factor* in the development and maintenance of psychological disorders; therefore CBT teaches clients to identify, evaluate and respond to their dysfunctional thoughts (or cognitions) and beliefs by utilising a variety of techniques to change the dysfunctional thinking, mood, and behaviour with the ultimate goal of teaching them to be their own therapist; and therefore lowering relapse rates (J. S. Beck, 1995).

The CBT Model.

The CBT model hypothesises that a client's emotional and behavioural responses are influenced by their *perception* of the current situation; the situation itself has only an indirect effect on how the client will feel. Simply put, it is the client's thinking, or cognitions, that will affect their mood and behaviour. The CBT model further differentiates between three (hierarchical) levels of cognition.

The deepest level is the "core belief" or "schema" level; this level can be viewed as absolutist or unconditional beliefs an individual holds about them self. They tend to originate in childhood; are deeply in-grained; and influence the way an individual experiences and interprets events (A.T. Beck, 1976). Most negative core beliefs fall into a category of either "helplessness" or "unlovability" (J. S. Beck, 168). Psychopathological symptoms in client cognition, behaviour and emotion are thought to result when pathological schemas (or core beliefs) are activated by specific stressful events (Persons, 2008).

The second level is termed "intermediate beliefs", or "underlying assumptions". These are the conditional beliefs that occur across situations and are generally comprised of rules, attitudes or assumptions (J. S. Beck, 1995). They tend to be revealed by "If...Then..." statements and often assist an individual to cope with their unconditional core beliefs (Haarhoff, 2008). For example, a client with the assumptions of "If I have to rely on myself, then I will fail" may have the unconditional belief of "I am incompetent".

The third and most accessible level is the "Automatic thought" level. Automatic thoughts are situation-specific, rapid, uncensored cognitive responses to a particular set of triggers that have an influence on the client's emotional, and subsequent behavioural and physiological reactions (J. S. Beck, 1995). These thoughts occur *prior* to experiencing the associated emotion, and can therefore assist in revealing client beliefs by identifying the originating cognition that has lead to the emotional,

behavioural, or physiological response within the specific situation, or event (A.T. Beck 1976; J. S. Beck, 1995). For example, a client with the core belief of "I am incompetent"; is likely to have a variety of negative automatics thoughts (such as "I can't cope with this", or "I'll never get this right") when they feel a task, trigger, or event will test their competency.

Use of the CBT model has shown therapeutic gains in clients of varying ages, genders, educational achievements or socio-economic status' (Knell, 1993; Persons, Burns, & Perloff, 1988). Studies testing the efficacy of CBT have shown treatment gains in clients with major depressive disorder; generalised anxiety disorder; panic disorder; Post Traumatic Stress Disorder (PTSD); substance abuse; Obsessive Compulsive Disorder (OCD); personality disorders; chronic pain disorders; eating disorders; sleep disorders and somatoform disorders (J. S. Beck, 1995; Martin & Pear, 2007; Sadock & Sadock, 2007).

The Role of Case Conceptualisation in CBT

Within CBT, case conceptualisation is one of the core components; and has been described as "the heart" or "cornerstone" of CBT; the "linchpin of clinical practice"; and is considered a "primary skill", or "first principle" of CBT; (A.T Beck et al., 1979; J. S. Beck, 1995; Betan & Binder, 2010; Persons, 1989; Persons, Davidson, & Tompkins, 2001; Sudak, J. S. Beck, & Wright, 2003). The role of case conceptualisation in CBT is to link theory, research and practice; thereby assisting the practitioner in organising client information and therapeutic notes into a structured and ordered "map" of the client. A map, which can be utilised as a marker for change (showing growth from earlier conceptualisation versions) as well as a guide for future treatment (Haarhoff, 2008; Persons, 1989). CBT case conceptualisation is a collaborative, dynamic and ongoing process that assists in understanding client problems, planning treatments, guiding decision making, monitoring progress and identifying problems. Ultimately, it should encourage client engagement by piquing curiosity and interest (Eells, 2007; Kuyken, Fothergill, Musa, & Chadwick, 2005; Persons, 2008).

According to Kuyken et al. (2009) an effective CBT case conceptualisation allows the practitioner to successfully integrate client experiences with relevant Cognitive-Behavioural theory, as well as current research. This assists the client to organise diverse and overwhelming problems into more manageable objectives; to normalise their issues and to validate their experiences. All of which can install hope and increase client "buy in". It also assists the practitioner to identify the client's strengths; determine the correct interventions to use at specific stages of therapy; and to determine the most efficient way of reaching desired therapeutic goals, thus providing a cost effective programme.

Levels of Conceptualisation within CBT

CBT case conceptualisations develop longitudinally (as more information about the client is discovered), over three integrated stages or levels: The Symptom or situational level; the disorder or problem level and the case level. According to Persons (2008, p. 7), the "case consists of one or more disorders, and a disorder consists of symptoms - the three levels are nested". The levels of conceptualisation merge with the three levels of cognition as identified in the CBT model.

The symptom, or situation level aims to identify and target the client's initial thoughts, moods, behaviours and physical reactions; ultimately aiming to reduce the client's immediate distress (Persons, 2008). Within the CBT model, this level links to the client's automatic thoughts; which are specific to certain events or stressors and influence the client's emotion, behaviour and physiology (J. S. Beck, 1995). The problem with utilising the symptom or situational level without progressing further into the other levels is that practitioner may incorrectly identify symptoms as important or distressing when other issues may be more pertinent. An example of a symptom- or, situation-level model is, the 5 Part Model:

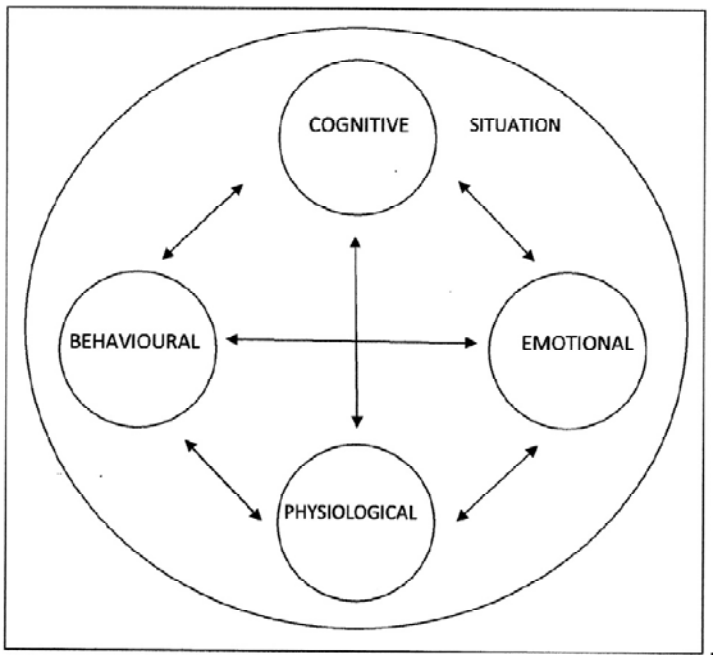

Figure 1. The Five-Part Model (Padesky & Mooney, 1990).

The smaller internal circles represent the clients' emotional, cognitive, behavioural and physiological symptoms. The larger encompassing circle represents the specific situation that has triggered the psychopathological response. The arrows between each circle indicates to the client the interactivity between the four symptoms types; (showing that change in one area can lead to change in another); as well as highlights any potential precipitating, protective, and perpetuating factors. The simple, graphical, ease-of-understanding, and collaborative nature of this model, make it the ideal type of model for clients and practitioners' alike. Other situational-specific models include "The Dysfunctional Thought Record" (A.T. Beck et al., 1979), Jacqueline Persons "Problem List" (Persons, 1989), and "The behavioural Chain Analysis" (Linehan, 1993).

The second level of CBT case conceptualisation is referred to as the "disorder-specific" case conceptualisation (Persons, 2008). Some common psychological disorders have many common elements and therefore have a specific cognitive presentation which can aid the practitioner in targeting the correct client beliefs. The linking of particular cognitions with specific emotions is termed the cognitive specificity hypothesis (A.T. Beck et al., 1979). For example major depressive disorder has been linked to Beck's,

negative triad of depression (A.T. Beck et al., 1979); this basic conceptualisation informs the practitioner that a depressed client is likely to be experiencing negative cognitions of their self, their world, and their future. These identifying characteristics assist the practitioner in predicting the likely emotion, behaviour, errors of thought, and thought process of the individual suffering from depression (Persons, 2008). By attending to these specific cognitions, the client's distress is likely to be minimised in the most effective and efficient manner.

Alternatively, for clients suffering from panic attacks; the "Panic Hook" model (Clark, 1988) is effective at educating clients about their panic attacks; and assists practitioners to identify points for intervention. This model proposes that a client suffering from a panic attack could misinterpret their physiological symptoms (such as racing heart and clammy hands) as a catastrophic physical problem (such as a heart attack). This catastrophic misinterpretation is likely to further increase the client's anxiety, and therefore increase their physical symptoms; leading to a repetitive cycle where the client becomes progressively more anxious.

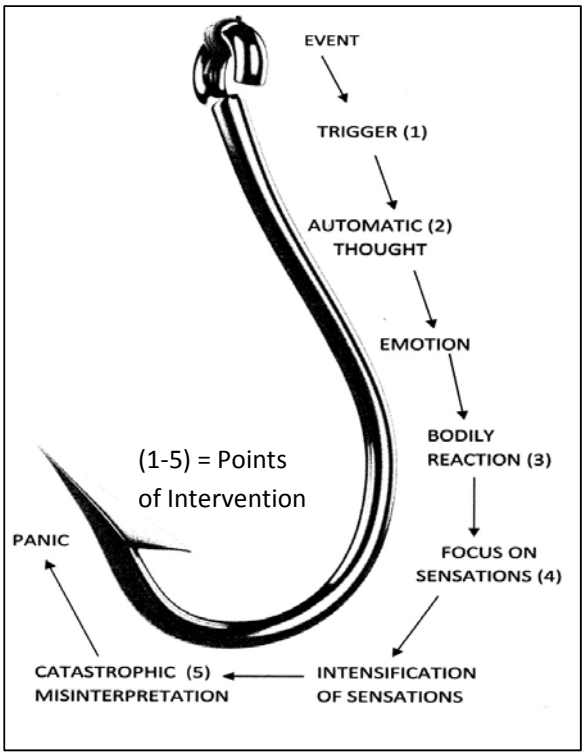

Figure 2. The Clark Model (Clark, 1988).

As illustrated above; intervention can occur at five points: 1) The trigger; where the initiating events, or triggers are identified and alternate options are introduced to prevent further anxiety. 2) The client's automatic thoughts; where the client is taught to seek out non-catastrophic interpretations for their physical symptoms. 3) The client's bodily sensations; where the client is taught relaxation techniques or breathing exercises aimed at reducing their physical symptoms. 4) The focus on bodily symptoms; here the client is taught not to focus on their physical symptoms, as focusing on the symptoms only intensifies them. Instead client's can be taught to utilise distractions, such as phoning a friend, which should divert their focus. 5) Finally, intervention can occur at the catastrophic misinterpretation stage; this is usually achieved through the use of behavioural experiments that aim to induce panic and then test alternate hypotheses through the use of Socratic questioning (Clark, 1988).

These 'off the shelf', or 'ready-to-use' conceptualisations mean the conceptualisation process doesn't always have to start from scratch (Wills & Sanders, 1997); disorder-specific models provide details of emotional and behavioural markers; presentation, precipitants and maintaining factors; as well as the cognitive patterns, information processing errors, and potential obstacles likely to occur within a specific disorder; thus assisting the practitioner with a predictive blueprint for treatment (J. S. Beck, 1995; Eells, 2007). The predictive quality of the disorder-specific conceptualisation makes it a valuable therapeutic tool; however, according to Beck and colleagues "There is no standard format that can be applied systematically to all patients to obtain the crucial data and change the idiosyncratic pattern." (A.T. Beck et al., 1979, p. 29). Therefore utilising only standardised approaches can cause the practitioner to overlook the individual nuances of the client; which can lead to treatment failure, non-compliance or relapse (Eifert, 1996; Persons, 2005).

Whilst disorder-specific conceptualisations have shown efficacy in treating a variety of mental health disorders; (such as the aforementioned major depressive disorder),

treatment at this level is dependent on the practitioner having a *correct* diagnosis; allowing for error and therefore possible treatment failure (Persons, 2008). Furthermore, disorder-specific conceptualisations are based on an *accurate* diagnosis; a construct in itself that has a number of reliability issues attached. Diagnoses are often limiting in their application to the individual; with many of the current diagnostic frameworks not providing complete descriptions of disorders; forcing practitioners to utilise the "not otherwise specified (NOS)" category (Bentall, 2009; Bentall et al., 1988; Persons, 1986; Zimmerman, McDermut, & Mattia, 2000; all in Dudley, Kuyken, & Padesky, 2011). In light of this; CBT case conceptualisation encourages the use of disorder-specific models as one of many components in the conceptualisation process; which is combined with a variety of other client-specific information to construct individualised, client-specific "case-level" conceptualisations.

Individualised CBT Case Conceptualisation Models

In the "case" level; all the known information (obtained from the situation and disorder specific conceptualisations) about the client (including their historical and developmental histories), the disorder, and the therapeutic approach, are integrated to form an individualised and comprehensive case conceptualisation (Persons, 2008). This level also aims to target the client's core beliefs; the absolutist statements about themselves, others, or the world (Greenberger & Padesky, 1995).

Examples of popular Individualised "Case level" CBT case conceptualisation models include: The Jacqueline Person's Case Formulation Approach (Persons, 1989), one of the first individualised CBT conceptualisations; The Judith Beck Cognitive Conceptualisation Diagram (J. S. Beck, 1995), which is the most frequently used model in research; and The Kuyken, Padesky & Dudley Case Conceptualisation "Crucible" (Kuyken et al., 2009); one of the most recent models. Each of these models will be described below.

The Jacqueline Persons Case Formulation Approach (Persons, 1989).

Persons utilises an extended version of the symptom-disorder-case level format to design a principle-driven comprehensive CBT conceptualisation format. It involves the following seven steps (Persons & Tompkins, 2007):

1) Develop and refine a comprehensive problem list which includes all the problems a client is having, including their psychological, physiological, social, occupational and interpersonal issues.

2) Utilising the problem list, complete a five Axial DSM diagnosis for the client.

3) Taking into account the treatment goals, the DSM diagnosis, and the problem list; select an "anchoring diagnosis"; which will be used as the primary diagnosis for treatment planning.

4) Based on the "anchoring diagnosis," select a suitable evidence-based, nomothetic formulation (or disorder-specific conceptualisation) to utilise as a model for intervention.

5) Tailor the conceptualisation to fit the individual client by including the client's relevant cognitive, behavioural, emotional, and somatic problems, with a focus on identifying potential relationships.

6) Focus on collecting information about how the client developed certain schemas or emotional regulation deficits; learned their dysfunctional behaviour(s); or developed a specific vulnerability; in order to develop hypotheses about the origins of these mechanisms.

7) Finally, collect descriptive information about the precipitating events or triggers of the current episode from the client and/or someone close to the client. Examine these activating situations, or precipitants, together with the hypothesised mechanisms in order to identify relationships or links that assist in explaining the client's current distress.

Although this model is based on the behaviourist tradition of the functional analysis; it does also incorporate theories of cognition and emotion. It is a principle-driven, rather than protocol-driven, approach; that prizes collaboration (the therapeutic relationship is viewed as essential to each therapeutic stage). The practitioner aims to construct a logical and coherent conceptualisation that describes all of the client's problems, disorders and symptoms (as well as the precipitating events or triggers); and that proposes explanatory hypotheses about the mechanisms that are causing the symptoms as well as the origins of these mechanisms. The conceptualisation is then utilised "like a map" to assist the practitioner to guide the client through the process of therapy, to their therapeutic "destination" (Persons, 2008).

The Judith Beck Cognitive Conceptualisation Diagram (J. S. Beck, 1995).

This flow-chart model depicts the relationships between the clients' automatic thoughts, intermediate assumptions and core beliefs; thereby mirroring the three levels of cognition within the CBT model. It is usually a bottom-up process for both practitioner and client; with the practitioner beginning by noting behaviours, emotions and automatic thoughts the client experiences within certain situations. This bottom section can then be utilised as a situational conceptualisation. By understanding the meanings of these automatic thoughts, the practitioner can begin to identify the underlying assumptions, compensatory behaviours and core beliefs a client holds. The inclusion of childhood data assists in understanding how the client came to develop these core beliefs and how they have been maintained; whilst the client's compensatory strategies often reveal the underlying assumptions a client holds (J. S. Beck, 1995).

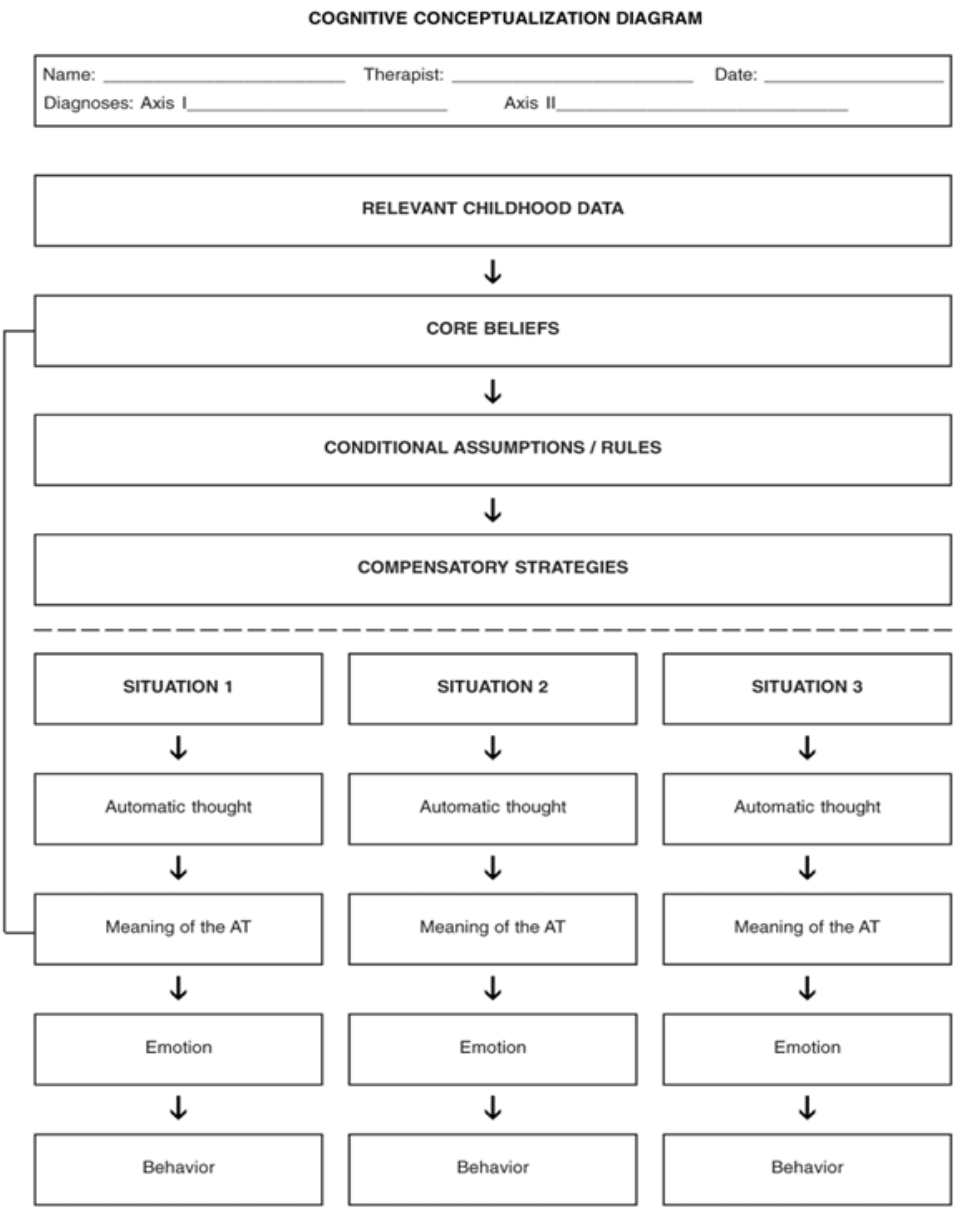

Figure 3. The Judith Beck Cognitive Conceptualization Diagram (J.S. Beck, 1995, p. 139).

Once the practitioner has completed the conceptualisation, they will often share it with the client in a bottom-up fashion; beginning by noting three typical situations in which the client became upset, together with the associated emotions, behaviours and automatic thoughts they experienced (situation-specific conceptualisations). The practitioner will encourage the client to consider the meaning of their automatic thoughts as a way of connecting the client with their underlying core beliefs. As the

client becomes more comfortable with the conceptualisation; items higher on the diagram can be explored (J.S. Beck, 1995).

This process is collaborative, with the practitioner taking note of both; the items that the client identifies as pertinent (as potential future targets for intervention); and the hypotheses that have been identified as minimally distressing (and are therefore not immediate treatment targets). It is also a dynamic process with new core beliefs emerging as the therapeutic relationship develops and the client begins to trust the practitioner more (Eells, 2007).

The Kuyken, Padesky and Dudley Case Conceptualisation "Crucible" (Kuyken et al., 2009).

This newer approach is metaphorically represented by the below figure of a crucible: A solid container designed to withstand temperatures high enough to melt or otherwise alter its contents. In this metaphor the agent of change is not high temperature, but "Collaborative Empiricism". CBT has been described as both collaborative and empirical in nature (A.T. Beck et al., 1979); with "collaborative empiricism" encapsulating the ideal of a team approach; where the client and practitioner are seen as two scientists working together to set up experiments and test hypotheses. The client collects the data, and then with the guidance of the practitioner (by use of guided discovery and Socratic questioning), investigates the best solutions to their problems (Greenberger & Padesky, 1995; Kuyken et al., 2009, Psychology I: Theory, Research and Practice: Course Materials, 2010).

The contents of the crucible include the "Client's Experiences and Strengths"; as well as "CBT theory and research" which ensures the therapeutic process remains grounded in relevant empirical CBT research. The inclusion of "Client Strengths" into the crucible at every stage of the therapeutic model increases the likelihood of

relieving client distress, increasing client resilience and adaptability, and provides more possibilities for intervention (Kuyken et al., 2009).

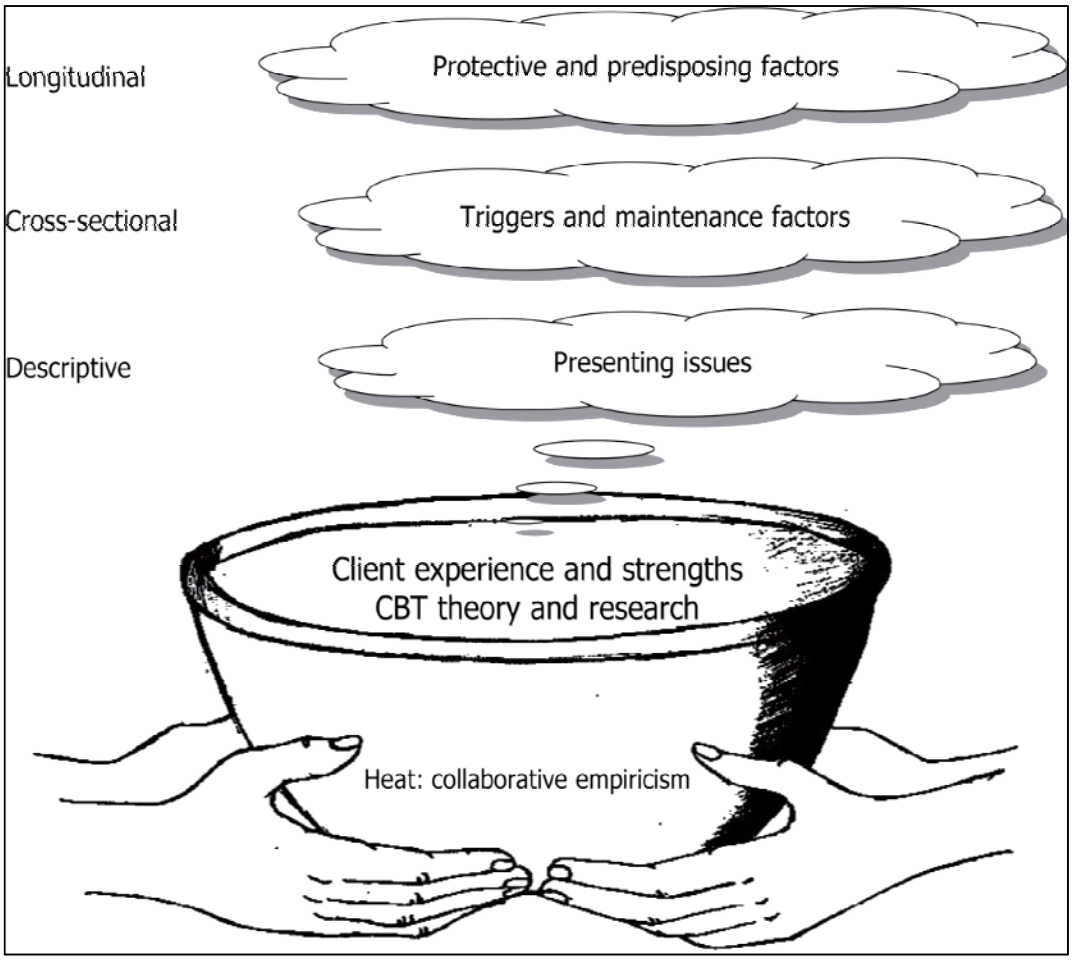

Figure 4. The Kuyken, Padesky and Dudley "Case Conceptualization Crucible" (Kuyken, Padesky, & Dudley, 2009, p. 3).

CBT conceptualisation is seen an ongoing and layered process; in the crucible metaphor this can be seen as the chemical reaction that occurs when heat is applied. The first level involves describing all of the client's problems in cognitive terms. The next (cross-sectional) level involves linking the clients' presenting issues to cognitive-behavioural mechanisms. Finally the third level utilises longitudinal conceptualisations

to draw on the clients' developmental history to better understand predisposing and protective factors (Kuyken et al., 2009).

The Content and Process of CBT Case Conceptualisation

As the three individualised models discussed above show; construction of a CBT case conceptualisation should follow a progression from a descriptive level to a more explanatory or inferential level; that in turn drives intervention. In general, most case conceptualisation models contain descriptive and prescriptive components. Descriptive data forms an information base, consisting of the central facts of the client's life and problems; whilst the prescriptive component of the conceptualisation flows from the descriptive data (and subsequent hypotheses); to propose a plan for treatment (Eells, 1997).

At the descriptive level the client's problems are observed and described in CBT terminology; there is no attempt to interpret or infer anything, merely to gather sufficient client information. This information is usually attained from either; the client, significant others, or collateral sources (such as doctors or case workers), but can also be identified by use of psychometric measures, as well as by observation of non-verbal information such as the client's presentation and response in therapy (Eells, 2007).

At the explanatory level, the practitioner attempts to organise the information in such a way as to provide understanding and clarity. Utilising their clinical knowledge and experience, the practitioner will often conduct some form of functional-analysis in order to interpret the descriptive information and infer any relationships between the variables (Eells, 2007). The analysis assists the practitioner to identify the "five Ps'": Namely the client's "predisposing", "presenting", "precipitating", "perpetuating", and "protective" factors. The 5Ps' model is based on Weerasekera's Four Ps' Approach (Weerasekera, 1996). Although other models may utilise different terminology and

place differing levels of importance on specific concept; most categorise information in a similar manner. For example: Persons model highlights the importance of the "problem list"; a list of all the clients *presenting* problems; Beck's model incorporates childhood data as a means to understand *predisposing* factors; whilst a primary focus of the Kuyken et al. crucible is "client strengths"; a *protective* factor.

These categories assist in the formation of a set of hypotheses that can then be tested in therapy; and dependent on the outcomes, revised. The case conceptualisation should assist the practitioner to not only select the best behavioural or cognitive experiments for the hypothesis testing; but should also guide the overall intervention strategy (Eells, 2007). Case conceptualisation is identified not as an outcome but as an ever-evolving process in all three previously discussed individualised models; with both new descriptive information being revealed throughout therapy as trust and rapport develop; and with new hypotheses being constructed, tested, evaluated, revised, and either accepted or rejected continuously (Persons, 1989). Therefore, CBT case conceptualisation should *always* be open to modification throughout the course of treatment. A practitioner can never be entirely sure that their hypotheses about the underlying mechanisms are correct; and must therefore always be prepared to revise or change the conceptualisation in the face of contrary evidence. Empirical disconfirmation and consequent modification, or even abandonment, of treatment hypotheses is central to the CBT approach (based on the hypothetico-deductive scientific epistemology of CBT), (A. T. Beck, 1976; A. T. Beck et al., 1979).

Finally as the three aforementioned models indicate; CBT case conceptualisation should strongly advocate collaboration; which has a positive effect on the therapeutic relationship (Kuyken et al., 2009). Persons & Tompkins (2007, p. 13); describe collaboration as "essential to every process at every stage". Judith Beck also emphasises collaboration and active participation, with the view that "therapy is teamwork" (J.S. Beck, 1995, p. 6). Whilst, Kuyken et al. (2009) argue that practitioner and client should develop every level of conceptualisation *collaboratively.* The

collaborative nature of CBT conceptualisation can be explained by Persons (1989, p. 48): “If (conceptualisation) is so helpful to the therapist, we might also expect it to be helpful to the patient in understanding and managing his behaviour.” According to J. S. Beck the CBT protocol for sharing a conceptualisation is for the practitioner to present their conceptualisation to the client as a set of hypotheses for discussion; which in turn helps the client to construct their own hypotheses through guided discovery. This means that the client has an as-full-as-possible understanding of what is happening in their own treatment (J. S. Beck, 1995). A focus on collaboration is in line with the epistemological groundings of CBT; with a positive therapeutic relationship correlated with positive outcomes in psychotherapy in general, and CBT in specific (Horvarth & Greenberg, 1994).

In summary; case conceptualisation is a central component of CBT; that aims to assist the practitioner in organising all the client information into a meaningful and coherent account. It is a unique process which advocates collaboration between client and practitioner to create a truly individualised treatment plan that is continuously referred to, and altered. In the following chapter the empirical evidence and current research regarding CBT case conceptualisation is explored; with special attention paid to the reliability and validity, practitioner use, and criticisms, of case-level conceptualisation.

Current Case Conceptualisation Research

In this chapter a review of the empirical evidence regarding conceptualisation, with a focus on the following, is presented: The reliability and validity of individualised CBT conceptualisations; what is currently known about practitioner use of conceptualisation, and the criticisms regarding CBT conceptualisation. Finally, the rationale for this study is presented.

Empirical Support for CBT Case Conceptualisation

In spite of the central role placed on conceptualisation within CBT, there has been relatively little research conducted on the topic (Chadwick, Williams, & Mackenzie, 2003); with the few comparative studies conducted, providing conflicting results regarding the effect of individualised case conceptualisation on clinical outcome: For example a study by Emmelkamp, Bouman, & Blaauw (1994) identified the individualised approach (or case-level conceptualisation) as equally effective as the standardised approach in the treatment of Obsessive Compulsive Disorder. Jacobson, Schmaling, Holzworth-Munroe, Katt, Wood, & Follette (1989) found equally effective results between an individualised, and the standardised, approach for the treatment of marital problems; however, the individualised approach achieved better results at a six month follow-up. Whilst a study by Shulte (1996) revealed that clients treated with the standardised protocol for specific phobia, responded better than those receiving individualised treatment.

Reliability of case-level conceptualisation.

Reliability in regards to case-level conceptualisation refers to either, how well independent practitioners can construct similar conceptualisations based on identical

information; or the extent to which consensus can be reached on an already conceived conceptualisations (Eells, 2007). By this definition, certain aspects of case conceptualisation have shown very good reliability:

At the situation level of conceptualisation; Mumma and Smith, reported excellent interrater reliability (α=.83) when utilising situation-level conceptualisations on video-taped "clients" with mood and anxiety disorders. These results were, however, averaged over the ten raters with the reliability of paired ratings not indicated (Mumma & Smith, 2001). A 1986 study based on the disorder-specific 'negative cognitive triad' conceptualisation of depression by A. T. Beck (1976), revealed excellent (α=.95) overall reliability (Beckham, Boyer, Cook, Leber, & Watkins, 1986). CBT disorder-specific conceptualisations have, perhaps, the most impressive evidence base of the conceptualisation levels; with positive outcomes achieved across a variety of disorders when utilising standardised treatment (J. S. Beck, 1995). These studies indicate that practitioners are able to formulate reliable conceptualisations at both the situational and disorder levels. But good, or even acceptable, levels of reliability in regard to individualised or "case-level" conceptualisations have been more difficult to achieve.

A 1998 study by Muran Samstag, Segal, & Winston; which utilised practitioner-constructed scenarios with clients; was able to achieve excellent (α=.91) interrater reliability on several parameters of conceptualisation; as well as test-retest reliability; and criterion and convergent validity.

The scenarios contained specific information regarding the following categories: 'Automatic thoughts and/or immediate feelings of the self', the 'Interpersonal action of the self', and the 'Interpersonal reaction of others', and were each anchored within an interpersonal context of either 'When I am at my best', or 'When I am at my worst'. The items were rated by the client, the interviewer, a third-party observer, and the

practitioner who constructed the scenario. The ratings were used to establish interrater reliability and criterion related validity; whilst repeated ratings (at the end of each session) on selected parameters were compared to establish test-retest reliability. Whilst this Muran et al. study utilises levels and concepts similar to those of the CBT approach, it is in fact, not based on the CBT model (Muran & Segal, 1992; Muran, Segal, & Samstag, 1994).

Persons, Mooney, & Padesky (1995) achieved an averaged 77% accuracy for their participants in identifying depressed or anxious clients' problems. The design of the study was based on Persons' (1989) case conceptualisation model but incorporated only limited parts of therapy for the raters to review; furthermore participants were provided with contrived multiple choice statements that limited their responses. As such this study is not representative of the real-world data gathering and interpreting process of conceptualisation. However, in 1999, Persons & Bertagnolli replicated the study in hopes of increasing the overall reliability. This time participants were provided with a specific set of problem categories or domains; as well as more formal schema assessment tools. The results showed good agreement regarding identification of presenting problems, but poor agreement for hypothesised underlying mechanisms. The study also revealed that increased practitioner training can lead to increases in reliability (Persons et al., 1995; Persons & Bertagnolli, 1999). Whilst these studies show potential for good reliability on the descriptive aspects of case conceptualisation; the results for the inferences drawn (from the descriptive information) are not at an acceptably reliable level.

A 2002 study by Fothergill and Kuyken, which aimed to present a real-world-therapy conceptualisation scenario, was able to achieve high reliability on certain inferences. The participants in this study consisted of a broad range of psychological practitioners, of varying lengths of experience. All participants were provided with the standardised assessment data; as well as extensive client information from an intake assessment. Participants also received training in the highly systemised case conceptualisation

model selected for the study (J. S. Beck's Cognitive Conceptualisation Diagram, 1995). The participants' conceptualisations were compared with one another, as well as against a 'benchmark' conceptualisation provided by J.S. Beck. The results suggested that practitioners can reliably conceptualise in terms of some inferential aspects, specifically; relevant childhood data, core beliefs and compensatory strategies. However, levels of agreement on dysfunctional assumptions were low.

Validity of case-level conceptualisation.

As with the reliability, there too, are issues with the validity of CBT case-level conceptualisation. The first of course being, that the validity of a construct is dependent on its reliability; which as identified above, is lacking in many areas. To date, there has been little empirical support for a correlation between case-level conceptualisation and client outcomes (Easden, 2010); and given the highly individualised, time consuming, and cyclical nature of case-level conceptualisation; measuring for validity, especially construct validity, is not truly possible. Instead Wilson and Hutchinson, (1991) encourage practitioners to focus on accurate representation; which can be achieved through practitioner disclosure of orientation (including descriptions of the practitioners own internal processes); strong supervision; collaboration (to ensure the client feels accurately represented); and by providing a conceptualisation that is coherent and comprehensive, including alternative ideas and theories (Wilson & Hutchinson, 1991; Crotty, 1998).

Discussion.

In general, randomised trials comparing outcomes of standardised CBT conceptualisation versus individualised CBT conceptualisation have found that individualised treatment is no different from (although it is sometimes a bit better than) standardized treatment (Persons & Tompkins 2007). The research available is minimal, and provides predominantly disappointing results, for both the reliability and validity of individualised CBT conceptualisations. The overall consensus (based on less

representative, but more controlled studies) is this: The rate of agreement between practitioners is generally low, the quality of the conceptualisations are often poor and that conceptualisation has only limited value in treatment planning (Dudley et al., 2011; Eells et al., 2005; Kendjelic & Eells, 2007; Kuyken et al., 2005; Kuyken et al., 2009; Persons & Bertagnolli, 1999; Persons et al., 1995; Persons & Tompkins, 2007).

Although reliability is an important aspect of any scientific measure; high levels of agreement by participants within conceptualisation (ie interrater reliability), does not equate to high levels of agreement on the *correct* concept. Somehow, it seems counter-intuitive to pursue reliability at the expense of coherence and utility; especially when taking into account that measuring reliability in this type of study will always be problematic; which can mostly be attributed to the disjunction that exists between research and practice. The underlying epistemology and subsequent methodology of this research is post-positivistic and phenomenological (a holistic, rather than elemental, approach); and therefore it is the authors view that thought, feeling, and action are structurally and functionally inseparable; that no human behaviour occurs within a vacuum and by treating phenomena as if they are object-like entities we remove the conditions for true understanding (Easden, 2010; Packer, 1985). Therefore it is important to acknowledge that it is impossible to separate out the individual components of case conceptualisation without invalidating the concept entirely.

Furthermore, CBT practitioners may be behavioural, cognitive, or cognitive-behavioural in their therapeutic inclinations; which is likely to lead to differences in conceptualisations. Yet, different conceptualisations of the same case could both be valid; by each being coherent and meaningful to both the practitioner and client. The strongest empirical support for the reliability of CBT case conceptualisation is then: The emphasis that CBT places on supervision and team work, which increases the likelihood of a reliable conceptualisation; the strong evidence base for the theoretical grounding of CBT; and the use of (and reliance on) empirically validated, disorder-

specific conceptualisations. Although, it is important to note that many of the most frequently used disorder-specific conceptualisations are principle-driven; meaning that the practitioner is still required to select the appropriate course of action within the particular presentation. It is therefore, important that practitioners measure the reliability of their conceptualisations against the relevant theory (Easden, 2010; Eells, 1997; Persons, 2008).

Practitioner Use of Case-level Conceptualisation

A number of authors have identified a paucity of research regarding real-world use of conceptualisation by practitioners; with only a limited number of studies addressing its in-therapy use (Beiling & Kuyken, 2006). As discussed above; the rates of agreement between practitioners is generally low, however, certain (more descriptive) areas seem easier for practitioners to master. Furthermore, as conceptualisation is a process and not an outcome; different practitioners could choose to emphasise different areas across the process, or choose different interventions, which could lead to slightly different conceptualisations that may (or may not) be equally effective (Eells et al., 2005).

Early research into practitioner use of case-level conceptualisation revealed five common, practitioner-held misconceptions about conceptualisation that may have led to non-use of conceptualisation within therapeutic practice (Perry, Cooper, & Michels, 1987): 1) That conceptualisations are indicated only for clients in long term care. 2) To construct a conceptualisation is an elaborate and arduous process. 3) That conceptualisation is a training-only exercise and has little utility for experienced practitioners. 4) That loosely constructed conceptualisations done from memory are sufficient. 5) And that a practitioner may become too invested in their conceptualisation; causing them to ignore any contradictory information the client may provide. These misconceptions were counter-argued by Perry et al. with the

ultimate conclusion that the need for further training (regarding the understanding and use of conceptualisation), of practitioners was required.

Since then, case conceptualisation has become “almost universally recognized (as) important” (Eells, 2007, p. xi), and as such, both the knowledge and training of practitioner’s; and the status of conceptualisation have increased. Kuyken (2006) also identified that the attitude to case conceptualisation had changed; specifically that workshops on the topic have increased; and that a great deal of time and money is now spent on training novice practitioners how to conceptualise. However, whilst training novice practitioners can improve their ability to create reliable conceptualisations (Persons et al., 1995; Persons & Bertagnolli, 1999); it does not guarantee the best-possible conceptualisation.

Eells et al. (2005) identify expertise is a critical factor in the successful development of case-level conceptualisations; specifically, that novice practitioners differed from their expert counter-parts in that their treatment plans; possible diagnoses; symptom or problem lists; and psychological mechanisms were less elaborate; and did not ‘fit’ the conceptualisation as well. The expert participants also utilised more structured and consistent processes and had a higher overall quality rating than that of the novices. An examination as to why the expert practitioners were able to construct “better” conceptualisations revealed the following: Experts excel in their own particular domain, and therefore may just have a unique ability, or talent, within their area of expertise; they are able to perceive large and meaningful patterns, within data specific to their identified domain; they see and interact with the data at a deeper level; and they have strong self-monitoring skills and are therefore more self-aware of their actions and processes. However, the study also identified overconfidence as a risk for expert practitioners; with novice practitioners achieving higher scores on “total conceptualisation quality”, which is most likely attributed to the recentness of their conceptualisation training.

A 2011 study by Haarhoff, Flett, and Gibson, evaluating the content and quality of twenty-six CBT case-level conceptualisations; which were completed by NZ practitioners and were based upon a series of clinical vignettes; revealed some relevant data regarding real-world conceptualisation use (Haarhoff et al., 2011).The Case Formulation Content Coding Method or CFCCM (Eells, Kendjelic, & Lucas, 1998, as cited in Haarhoff et al., 2011) was used to measure how comprehensive the conceptualisations were. Overall, the participants averaged 4.5 out of a possible 10 (SD = 1.5); indicating that less than half of the categories were considered with the most prominent exclusions being "Therapy interfering behaviours"; "positive indicators for treatment", and "underlying biological and socio-cultural mechanisms". The Fothergill and Kuyken (2002) Cognitive Therapy Case Formulation rating scale was also used to rate each participant. At least 50 % obtained 'good enough' conceptualisations, with five producing 'top category' conceptualisations; four producing 'poor' conceptualisations and an additional two producing 'very poor' conceptualisations. Utilising the CBT Case Conceptualisation Rating Scale; the "problem list" was identified as the weakest category; with participants failing to prioritize or provide a functional analysis of the problems. Furthermore, whilst most (70%) of participants were able to identify Axis I disorders, little attention was paid to enduring personality traits.

The study also revealed the following about the content of NZ practitioners CBT case conceptualisations: Clients' 'developmental history' and their 'symptom information' received the most attention within the descriptive category of conceptualisation. Whilst the inferential category showed practitioners devoting the most attention to 'Inferred psychological mechanisms' and 'predisposing factors'. With more than 50% of participants neglecting certain inferential area's including 'Protective factors', 'Biological factors', and 'Problems in global functioning'. Within the treatment category, participant's emphasised use of 'specific structured CBT interventions'; with the Thought Record identified as the most frequently used intervention. The least frequently mentioned treatment information included 'client strengths'; as well as 'biological and socio-cultural information'. In spite of this, most (64%) of participants

were able to develop an appropriate treatment plan based on CBT protocol (Haarhoff et al., 2011).

Given the limited research on real-world practitioner use of case conceptualisation it is difficult to truly examine the effect of influence that practitioners have on the conceptualisation process. Early practitioner misconceptions about case-level conceptualisation seem to have been replaced, with more time and money devoted to training practitioners in the art of conceptualisation. However, conceptualisation is an idiosyncratic process, with different practitioners identifying different components of conceptualisation. Furthermore, as revealed by Haarhoff et al. (2011) in their New Zealand based study; practitioners are only identifying approximately half the categories needed for a truly comprehensive conceptualisation; with only half the practitioners producing "good enough" conceptualisations. These results highlight the need for more systematic conceptualisation models, methods and training.

Criticisms of CBT Case Conceptualisation

CBT conceptualisations tend to be client-friendly; with content that is understandable, non-esoteric, and easy to share. Critics argue that this may lead to the oversimplification of complex psychological dynamics (Persons, Gross, Etkin, & Madan, 1996). In particular, critics question if CBT conceptualisation models (especially if it is only one page; or require practitioners only "insert data" into boxes) can really account for all of a client's problems?

While the chief criticism made by those in the psychodynamic tradition is CBT's focus on dealing only with symptom reduction, and therefore not attending to an underlying rationale. CBT theorists rebut this by arguing that conceptualisation does look for common themes within problems with the aim to identify underlying beliefs (Persons et al., 1996). Psychodynamic theorists also criticise CBT conceptualisation for accepting

the client's judgement as to the accuracy and 'fit' of the conceptualisation; thereby ignoring the role of the client's unconscious processes (Persons, 2008; Weishaar, 1993).

The behavioural tradition have criticised the CBT model for relying on entities such as 'beliefs', or 'schemas'. The ontological status of which remains controversial, and according to some behaviourists are no more than 'Folk Psychology' (Skinner, 1971; Weishaar, 1993). Whilst those favouring theories of emotions; have recently conceptualised schemas as cognitive-affective structures; arguing that emotions are central to the organisation of cognitive processing, and that 'emotional commitment' is one of three factors underlying deeply rooted attitudes and beliefs (Lang, Cuthbert, & Bradley, 1998; Leventhal, 1984; Oatley, & Johnson- Laird, 1987; Safran & Segal, 1990).

CBT case conceptualisation is admittedly open to the above criticisms, which only increases the need for more scientific research. In spite of this; CBT conceptualisation has shown itself to be a powerful tool in both theory and practice.

Discussion

In light of the poor levels of reliability and validity in regards to individualised CBT conceptualisation one must wonder why practitioners would chose not to utilise disorder-specific conceptualisations exclusively. Although it seems the disorder-specific approaches are not without their own problems: Not all clients respond to disorder-specific manualised treatments. The majority of psychotherapy outpatients meet the criteria for more than one disorder; which makes co-morbidity the norm, rather than the exception. And even though disorder-specific approaches focus on the differences between individual disorders, the treatment protocols are often similar. This raises the issues of where the practitioner should start and whether there may be common core processes across the co-morbid disorders. If this is the case, targeting

these processes first, may produce change in several presenting issues. It is in these complex cases that the individualised approach hase been viewed as especially important (Barlow, 2002; Barlow, Allen, & Choate, 2004; Brown et al., 2001; Brown et al., 1995; all in Dudley et al., 2011).

After all, conceptualisation is more than diagnosis - it should aim to understand and guide intervention at the individual or case level. Therefore the test of an effective case conceptualisation should be based on the quality of the conceptualisation, or the outcomes achieved rather than evidence of reliability and validity. Although higher rates of agreement regarding underlying cognitive mechanisms can still be achieved through the use of systematic, empirically-based, conceptualisation frameworks; and through practitioner training and experience (Beiling & Kuyken, 2006; Fothergill & Kuyken, 2002; Kuyken et al., 2005; Kuyken et al., 2009).

Whilst many of the claimed client benefits are yet to be substantiated, it is reasonable to assume that the practitioner benefits are valid (as much of the literature is written by practitioners). If so, conceptualisation helps the practitioner focus on the most relevant problems, and provides suggestions as to both the most appropriate intervention point for treatment, and the possible techniques and homework exercises to utilise. It can predict possible problems and suggest ways to handle them; and can lead to an increase in empathy for the client, potentially improving the therapeutic relationship (Eells, 1997; Persons, 1989; Wills & Sanders, 1997). These are not insignificant benefits; and therefore it is the opinion of this author that a well prepared, coherent and comprehensive conceptualisation, can at worst, increase practitioner confidence and preparedness; and therefore the utility of the case-level conceptualisation outweighs its empirical short fallings. After all,

> "Scientific theory is not about the real world as we experience it, but about abstract idealized models that do not and cannot account for the infinite

number of variables that exist in reality. The real world, unlike the model, is far too complex to be explained thoroughly by a theory." (Muran, 1990, p. 399).

Rationale for Current Study

Beiling and Kuyken identified the need for an understanding of current, real-world use of CBT conceptualisation in 2006 when they stated that much is assumed about case conceptualisation in practice; and that a basic understanding of how practicing CBT practitioners conceptualise in the real world, "would enable research-based advances in the profession's understanding" (Beiling & Kuyken, 2006, p. 6). More recently, Dudley and colleagues identified that "it is important to acknowledge that there is a paucity of research around the *real world use* of conceptualisation in treatment" (Dudley, et al., 2011, p. 214). While Kuyken, Padesky and Dudley identify "An obvious and initial question is 'How do cognitive therapists conduct case conceptualisation in real-world practice?'" (Kuyken et al., 2009, p. 319).

Therefore, it is the purpose of this research to bridge the identified gap between the recommended theory and actual therapeutic practice; which is to be achieved by evaluating the current practices of New Zealand based mental health practitioners, (who utilise CBT techniques) in regards to the use of case conceptualisation in their therapeutic practice.

Methods

This chapter provides an account of the method followed in this study. It begins by discussing the research design and theoretical approach of the study. The research process is then fully investigated by examining each of the following: The ethics approval process; the research participants, including the demographics of the sample; the survey development and data collection; and finally the process of data analysis.

Research Design

This study utilises qualitative methods to examine trends in case conceptualisation within a cross-section of mental health practitioners. It aims to examine (through the use of a survey), the current views, attitudes, and practices of New Zealand mental health practitioners in regards to their use of CBT case conceptualisation in therapeutic practice. The following questions will guide this research process:

> *What is the current understanding of "Case Conceptualisation" to the Mental Health practitioners?*
>
> *Are they actively utilising case conceptualisation in their psychotherapeutic practices? And if so, why?*
>
> *How do they go about forming case conceptualisations - what content, processes, and tools do they utilise?*
>
> *What impact does a case conceptualisation have on the therapeutic process and relationship?*

The underlying epistemology influencing this research is a post-positivistic paradigm. Epistemology is, the nature and theory of knowledge, embedded in both the theoretical perspective and the methodology of a paradigm of study; and given that the underlying epistemology informed the design, implementation and analysis of this research it must be acknowledged and considered prior to undertaking any analysis (Crotty, 1998).

The post-positivist paradigm aims to search for meaning within a particular (social or cultural) context, and not to identify general laws that can be applied to the general population. For this reason, the researcher cannot remain neutral or unbiased; therefore the post-positivist approach advocates subjective and value-laden or -driven research processes, where the researcher has a clear role or part in the research. As such this research was informed by both; a set of personal beliefs and pre-existing ideas about conceptualisation; as well as an extensive review of the theoretical and empirical components of conceptualisation (McGregor & Murnane, 2010).

The post-positivistic approach utilises methodologies that are interpretive or humanistic in nature; and are therefore concerned with subjective understanding. In light of this, the chosen methodology for this research is that of Hermeneutic phenomenology; which is concerned with the study of subjective experience, with the goal of creating meaning and achieving a sense of understanding (Wilson & Hutchinson, 1991).

Hermeneutic phenomenology as methodology views action as “perspectival”; namely that it has different meaning based upon which point of view it is being seen from and is therefore open to interpretation. Furthermore, human action is considered holistic in nature, as one cannot understand an act without also understanding the context it was performed in (after all no human action occurs within a vacuum), and treating phenomena as if they are object-like entities removes the conditions for true understanding (Martin & Sugarman, 2001).

The role of the researcher in the Hermeneutic Paradigm is that of active co-learner, interpreter and meaning-maker; but given the nature of this type of analysis it must be acknowledged that objectivity is not considered an aim, or goal; rather an acknowledgement of the researcher's own ideas and past experiences should be included (Martin & Sugarman, 2001). Within the hermeneutic approach a number of suitable methods exist. A thematic analysis (loosely based on Braun & Clarke's (2006) model) was selected as the primary method of data analysis. The analysis was conducted in a theoretical manner (with conceptualisation as the underlying analytic interest); and was informed by the post-positivist epistemology. Thematic analysis as a method is discussed in more detail within the data analysis section of this chapter.

Research Process

Ethics approval.

This research project was evaluated by peer review and judged to be low risk. Consequently, it was not reviewed by one of the University's Human Ethics Committees. (Ethics approval can be found in appendix A). This research was deemed to have low-risk ethical considerations due to the following factors:

The sample was aware of their ethical rights and obligations (as they have all completed psychological training). The research was cross sectional in nature, and therefore respondents were not involved in the research for any substantial length of time. The nature of the study was entirely voluntary and required answers to survey questions only; these questions involved no physical or emotionally distressing items and participants were advised that if they wished to change their answers or withdraw their information, they will be permitted to do so during a set time frame. Participants were also required to give consent prior to beginning the survey.

Research participants.

The research participants were a convenience sample; made up of those working in the fields of mental and/or primary health care who self-identified as utilising Cognitive Behaviour Therapy as their primary psychological treatment modality. Participants were recruited in a snowball fashion in the following manner; first the study was advertised in the Aotearoa New Zealand Association of Cognitive Behaviour Therapies (ANZACBT) newsletter and website; the online advertisements provided a link to both the online version of the information sheet, and survey for participants to complete. Other participant responses were obtained through personal connections with the School of Psychology, Massey University; and others were recruited through the direct mailing of 60 registered members of "The New Zealand Psychologists Board" (Members who had their postal addresses listed in the online directory were sent hard-copy surveys). In addition seventy-three past graduates of the Massey University Post Graduate Diploma in Cognitive Behaviour Therapy were directly emailed. In order to encourage participation (and survey completion) all participants who completed the survey (and provided their contact details), went into a random draw to win a prize to the approximate value of $400. Approximately two weeks after the survey return date a prize winner was selected through a randomised computer draw.

Participant sample demographics.

In total, 51 responses were received; with 48 of the respondents consenting to the research; 12 hard copy and 36 online responses were received; although 12 respondents had only partially completed the questions. The demographics of the sample were: 17 male and 28 female respondents (three respondents did not specify a gender); 28 of the respondents live in the Auckland region (62%); four in Waikato (9%); three in Canterbury & the Bay of Plenty (each 7%); two in Southland & Marlborough (each 4%); and finally one in Northland Wellington, and Hawke's Bay (each 2%). The average age was 43 years (SD =10.87); with a range from 24 to 64 years. The sample was predominantly NZ European (n=34; 68%); with the remaining participants

identified as Maori (n=4; 8%); European (n=5; 10%); Pacific Island Persons (n=3; 6%); Asian (n=1; 2%); and "other" (n=3; 6%).

The majority of the sample (n=28; 56%) identified their job title as "Clinical Psychologist", with the remainder identified as "Registered Psychologist" (n=4; 8%), "Counsellor" (n=4; 8%), "Psychotherapist" (n=3; 6%), "Psychiatrist" (n=3; 6%), "Nurse" (n=2; 4%), "Health Psychologist" (n=2; 4%), "General medical Practitioner" (n=1; 2%), and "other" (n=3; 6%). The most common work places were "Private Practice" (n=26; 43%), and "DHB" (n=23; 38%), followed by "University Clinic or Academic Department" (n=4; 7%), "Hospital" (n=3; 5%), "Corrections" (n=2; 3%), and "Other" (n=2; 3%) ; with 25% of practitioners (15 respondents) working at more than one work place. Thirty-seven practitioners sampled (74%) provide services to the "Adult" population. Nine (18%) of the practitioners work with "Children and Adolescents"; two practitioners (4%) work with "Families" and with another three (6%) with "Older Adults".

The sample had varying years of experience; with nine participants (19%) having 0-2 years experience; twelve (25%) having 2-5 years experience; fifteen (31%) having 5-10 years experience; seven (15%) having 10-15 years experience; and five (10%) having more than 15 years experience. Respondents spent an average of 11.3 hours a week practicing CBT (SD = 7.9 hours); with almost all (n=45; 94%) of respondents currently receiving supervision on either a weekly (n=12; 27%), fortnightly (n=18; 40%), 3-weekly (n=4; 8%), monthly (n=9; 20%), or 6-weekly (n=2; 4%) basis. The highest qualification(s) achieved ranged from a Bachelors degree to a variety of Doctorates and Post-Graduate diplomas; in total there were: Sixteen Post Graduate diplomas in Psychology (33%); ten Masters degrees' (21%); nine PHD's (19%); four Doctorates of Clinical Psychology (8%); three Honours degrees (6%); three Bachelor of Medicine degrees' (M.B.ch.B) (6%); two Bachelor's degrees' (4%); and one Registered Mental Nurse (RMN) (2%).

Table 1.

Participant Demographics and Occupational Information.

Item	Participant responses	N	%
Consent	Consented	48	94
N=51	Did not consent	3	6
Gender	Male	17	35
N=48	Female	28	58
	Did not specify	3	6
Location	Northland	1	2
(By Region)	Auckland	28	62
N=45	Waikato	4	9
	Wellington	1	2
	Canterbury	3	7
	Bay of Plenty	3	7
	Southland	2	4
	Marlborough	2	4
	Hawke's Bay	1	2
Age	Mean = 43 Years		
N=48	SD = 10.8 Years		
Ethnicity	NZ European	34	68
N=50	Maori	4	8
	European	5	10
	Pacific Islander	3	6
	Asian	1	2
	Other	3	6
Job Title	Clinical psychologist	28	56
N=50	Registered psychologist	4	8
	Counsellor	4	8
	Psychotherapist	3	6
	Psychiatrist	3	6
	Nurse	2	4
	Health psychologist	2	4
	General medical practitioner	1	2
	Other	3	6

Place of Work	Private practice	26	43
N=60	District Health Boards (DHB's)	23	38
	University	4	7
	Hospital	3	5
	Corrections	2	3
	Other	2	3
Primary Clients	Children & adolescents	9	18
N=50	Adults	37	74
	Older adults	3	6
	Other	1	2
Years Experience	0-2 Years	9	19
N=48	2-5 Years	12	25
	5-10 Years	15	31
	10-15 Years	7	15
	15+ Years	5	10
Hours of CBT/ Week	Mean = 11.3 Hours		
N=48	S/D = 7.9 Hours		
Receiving Supervision?	Yes	45	94
N=48	No	3	6
Frequency of Supervision	Weekly	12	27
N=45	Fortnightly	18	40
	Every three weeks	4	8
	Monthly	9	20
	Every six weeks	2	4
Highest Qualification	Bachelors Degree	2	4
N=48	Registered Mental Nurse (RMN)	1	2
	Honours Degree	3	6
	Masters Degree	10	21
	Post-Graduate Diploma	16	33
	Doctorate of Clinical Psychology	4	8
	Bachelor of Medicine Degree (MBCHB)	3	6
	PHD	9	19

Survey development.

Data was collected using a questionnaire, or survey, with both open- and closed-ended questions. The survey questions (created by the author and refined in supervision) were informed by a review of the relevant conceptualisation and CBT conceptualisation literature, the earlier discussed research questions, as well as a process of self-reflection (as advocated in the post-positivistic paradigm and hermeneutic approach). The questions were selected to cover a specific set of topics; these include: Demographic and occupational data (questions 1-11); Practitioner use and understanding of conceptualisation (questions 12 & 13); the process and content utilised in conceptualisation (questions 14-17 & 19); difficulties with conceptualisation (questions 22 & 23); CBT conceptualisation training and education (questions 20 &21); and the influence of conceptualisation on therapy (question 18). The question-types included multiple choice options; short answer question; as well as longer questions which provided descriptive data. The longer questions were interspersed with the shorter, and multiple choice questions to provide a "mental break" between the more detailed responses. All questions related to *personal or subjective* understanding, experience and use of case conceptualisation; and therefore would not in any way compromise client confidentiality. An information sheet that outlined the purpose, or aims of the research, as well as the participant's rights and the conditions of consent accompanied the survey. Both the researcher and supervisors' contact details were provided, should respondents have concerns or questions.

The first draft of the information sheet (See Appendix B) and the questionnaire (See Appendix C); together with a letter requesting assistance (See Appendix D), were sent to an expert panel of six clinical psychologists (academic and practicing professionals with extensive experience in Cognitive Behaviour Therapy). The expert panel reviewed the content, format and validity of the questionnaire and information sheet, and returned comprehensive feedback. (See Appendix E) The suggestions were discussed in supervision and changes were made as necessary. The final Information Sheet (See Appendix B) and Questionnaire (See Appendix C) were re-reviewed in supervision, approved, and finally, distributed to participants.

Data collection.

Participants were given two ways to respond the questionnaire. Some received hard copies of both the information sheet and questionnaire; others accessed the survey online. The Information sheet was available at http://cbtccstudy.webs.com/ and provided a link to the online survey, which was available at www.surveymonkey.com/s/NCH9XL3. Participants were given two months from the survey distribution date to return the questionnaire in order to qualify for the random draw; return of the questionnaire implied consent, but respondents were still required to give written consent in the form of a signature (in the case of hard-copy questionnaires) or an acknowledgement and the date (for the online version).

Hard copy surveys were either mailed to potential participants; or handed directly to them by faculty at the School of Psychology, Massey University. Surveys included a prepaid return envelope addressed to the author's supervisor at Massey University. The online version was run through, and securely stored with, SurveyMonkey.com. Both the researcher and the supervisor's details were made available to all survey recipients (should they wish to discuss any items relating to the study). The returned hard-copy questionnaires were securely stored in a locked cupboard with Dr. B.A. Haarhoff (Supervisor) until they could be passed on to the author, who stored the data in a locked personal safe. The identifying personal information was separated from the remainder of the survey until a winner was selected for the random draw prize - at which stage it was destroyed. The remaining data was combined in a computer file which was stored in a password encrypted flash drive. The hard copies have been securely stored for a period of one year, at which stage they too will be destroyed. The online responses were maintained on a secure server until the information was transferred to a secure flash drive (at which time it was deleted off the server).

Data analysis.

In keeping with the research paradigm the collected data was submitted to a qualitative and interpretive method of analysis: Thematic Analysis. According to Braun & Clarke (2006), thematic analysis aims to identify and analyse patterns or themes within the data; which helps to explain certain phenomena. In the context of thematic analysis a theme is cluster of linked categories, which convey similar meanings and tend to reveal a patterned response (which in turn provides meaning) within the data. This thematic analysis was carried out in a theoretical manner; meaning that the analysis was informed and driven by an underlying analytical interest – namely conceptualisation. Furthermore, the themes were identified at a semantic or explicit level; which is a predominantly descriptive process aimed at organising data in a meaningful way.

Data analysis began with a preparation of the raw data for analysis. This was achieved by reading each individual response in its entirety. Following this the hard-copy responses were transcribed and all the responses were tabulated according to the question number. The data was then checked against the original response to ensure no errors were made. At this stage the identifying information from the respondents was destroyed and the actual survey responses stored in a locked safe. The data was then read a number of times to promote familiarisation. Following familiarisation, the data for each question was colour-coded according to its content. The coded items were utilised to provide basic quantitative data (such as number or percentage of respondents who answered in a specific way within a question) which in turn assisted in developing a detailed description of the entire body of data (the *Data Corpus*).

The descriptive component of the results is discussed (and summarised in table form) under the following categories: Demographic and occupational data; practitioner use and understanding of conceptualisation; process and content utilised in conceptualisation; difficulties with conceptualisation; CBT conceptualisation training

and education; and influence of conceptualisation on therapy (all of which were already established as survey categories). The descriptive component of the analysis provides the thematic analysis with an appropriate context.

Whilst organising the information into the descriptive categories the author began to note any initial ideas, or patterns, in order to assist in getting a "sense of" the various topics. The entire body of data was then read more closely to locate any overlooked or hidden items embedded in the data. At this stage similar topics and ideas were organised into basic categories (the categories remained simple so to promote flexibility) which helped to create and re-define the initial themes (As many initial themes as possible were considered in the event that less obvious patterns may emerge at a later stage).

All themes were then refined; as such a single overarching theme was identified: Some of the originally identified themes had little to no relevance to the study while others had insufficient data for a full analysis and were therefore discarded; whilst the similar themes were combined together to form the one overarching theme, with a set of sub-themes. Once the content of the individual theme was deemed coherent, it was judged on its validity and relevance to the data as a whole. This process helped to clarify the theme within a more holistic paradigm; making each sub-theme explicit, whilst linking it to the other sub-themes to provide a clear picture of the whole. The indentified main theme was then named; the sub-themes described, and supporting respondent quotes provided.

Whilst the above procedure is based on Braun & Clarke's (2006) approach for conducting a Thematic Analysis; the author has chosen to maintain flexibility within the analytic procedure in such a way as to mirror the conceptualisation process identified in the literature. Namely, analysis began with a detailed and descriptive account of the provided information. This account was then integrated with the

Author's theoretical knowledge and experience, in order to progress to a more inferential or explanatory level; which is aimed at identifying over-arching themes in order to provide meaning. Finally, the themes and results are incorporated into our general understanding of conceptualisation; leaving them to be re-examined by future studies; and ensuring a cyclical process of continual discovery and rediscovery.

Results I: Descriptive Information

This chapter provides a descriptive review of the data, which assists in establishing a context for future analysis. The data gathered from the survey is examined and discussed by the following set of predetermined question categories:

Demographic and Occupational Data

The first questions of the survey (Q2 – 11) focused on collecting demographic and occupational data in order to be able to understand and fully describe the sample. These demographics are described in detail in chapter four (See table 1, p. 39); but to re-cap; the respondents were primarily made up of women; were Auckland based, European New Zealanders; and had an average age of 43 years. The majority of the sample classified themselves as “clinical psychologists”, and worked in either “private practice” or “District Health Board’s (DHB’s)” with adult populations. Most practitioners had been practicing between five and ten years; received supervision on a fortnightly basis and spent an average 11.3 hours per week (SD=7.9 hours) practicing CBT.

It is of interest to note that all participants in their 20s are currently employed at District health boards (DHB’s); with only one working at an alternate place, such as private practice, as well. As the age of the respondents increases, the number working in “the public sector” begins to decrease; whilst those working in private practice, or in consulting or educational roles, begin to increase. As would be expected, as age increases, years of experience increases, with the exception of female respondents between 39 and 55 years; most likely attributed to time off for child rearing. In regards to training, less experienced respondents have completed either Post Graduate

Diploma's (PGDip) or Doctorates of Clinical Psychology (DClin); whilst the more experienced respondents tend to have completed PHD's; most likely due to the new programmes of study that have been developed and refined in recent years.

Respondents who had the least years of experience, often received supervision more frequently; with those in their 20s, and the aforementioned female population receiving supervision no less than fortnightly; whilst respondents in their 50s to 60s were more likely to receive supervision monthly or even at six-week intervals. Supervision was also more frequent in public work environments; with those in corrections, universities and DHB's often receiving supervision on a weekly basis. Three participants received no supervision at all; one nurse, a full-time student, and one registered psychologist.

The Survey

Practitioner use and understanding of conceptualisation.

The next set of survey questions (Q12 & 13) focused on practitioner use and understanding of conceptualisation.

Practitioner Use of Conceptualisation.

Based on the responses, 98% (45 of the 46 respondents) of practitioners are actively utilising CBT case conceptualisation in their everyday practice; with the single respondent who replied no; not yet practicing. A further 58% of respondents (n=22) stated they utilise conceptualisation in *every case*; with an additional 13% (n=5) utilising it in *most cases*. Furthermore, 37% of respondents (n=14) acknowledged the utility of case conceptualisation in especially complex cases.

Table 2.

Results for Question 12: Respondent Use of CBT Case Conceptualisation in Practice.

Utilise CBT case conceptualisation in practice?	N=46	%
Do not use CBT case conceptualisation	1	2
Do use CBT case conceptualisation	45	98
Details of CBT case conceptualisation use	**N=38**	**%**
Use in every case	22	58
Use in most cases	5	13
Use in complex cases	14	37

Practitioner understanding of conceptualisation.

The sample identified the following components of CBT case-level conceptualisation: Twenty-six respondents (74%) identified the descriptive functions of conceptualisation; with 30 (86%) respondents making mention of the individualised nature of conceptualisation; and a further eight (23%) incorporating that a conceptualisation should cover *all* of the client's problems. Twenty-four participants (69%) stipulated that conceptualisation assists them to understand the client and make sense of all the presenting issues; with an additional 22 respondents (63%) identifying the utility of conceptualisation in the planning of treatment; and to the therapeutic process. Fifteen participants (43%) identified the importance of linking client information with relevant CBT theory; while seven respondents (20%) identified the central role of collaboration, and an additional seven (20%) made reference to conceptualisation evolving or changing as therapy progresses (or the need arises).

Table 3.

Results for Question 13: Respondent Understanding of CBT Case Conceptualisation.

Understanding of CBT case conceptualisation	N=35	%
Descriptive functions of case conceptualisation	26	74
Individualised in nature	30	86
Covers all a client's symptoms	8	23

Provides understanding/clarity	24	69
Role in treatment planning	22	63
Links theory & practice	15	43
Collaborative in nature	7	20
Dynamic / cyclical in nature	7	20

In summary when considering all responses made by the sample, across all the questions; the number of respondents who correctly identified the above components of CBT case-level conceptualisation increased as follows:

Overall, all 36 respondents (100%) identified the descriptive functions of conceptualisation, 32 respondents (89%) made mention of the individualised nature of conceptualisation; and 22 respondents (61%) incorporated that conceptualisations should cover *all* of the client's problems. Thirty-five participants (97%) stipulated that conceptualisation assists them to understand the client and make sense of the presenting issues; while all 36 respondents (100%) identified the utility of conceptualisation in the planning of treatment. Furthermore, 23 participants (64%) identified the importance of linking client information with relevant CBT theory; while 33 respondents (92%) identified the central role of collaboration, and 28 (78%) made reference to conceptualisation evolving or changing as therapy progresses.

Table 4.

Respondent Understanding of CBT Case Conceptualisation Over all Survey items.

Understanding of CBT case conceptualisation	N=36	%
Descriptive functions of case conceptualisation	36	100
Individualised in nature	32	89
Covers all a client's symptoms	22	61
Provides understanding/clarity	35	97
Role in treatment planning	36	100

Links theory & Practice	23	64
Collaborative in nature	33	92
Dynamic / cyclical in nature	28	78

Process and content utilised in conceptualisation.

The next section of the survey (Q14-17, & 19) contains questions aimed at understanding the process practitioners follow in order to complete a conceptualisation; as well as the content most frequently included. These question aim to explore not only the information required and the predesigned templates utilised to create a conceptualisation, but also the method practitioners use to attain that data; the models, tools or templates they utilise to make sense of the data; the steps they follow in designing a conceptualisation; the difficulties they experience; and the level of client involvement.

Content included in conceptualisation.

Most respondents stated that they began the conceptualisation process by gathering client-specific information (see p. 53). Thirty-four respondents (97%) identified the majority of this information as being attained directly from the client; this includes: Current symptoms; family and medical history; drug and alcohol use; past and present relationships; education; occupation; demographic information; the precipitating factors or event that has led them the seek therapy; and their targets for therapy. With 11% of respondents (n=4) identifying additional information as being attained from collateral sources such as: Referring doctors, *whānau* or family members, co-workers, friends, and social case workers; or from case histories, criminal records, or any previous psychological reports. The client's physical presentation; and manner in session were also identified as revealing important non-verbal information to the practitioner. Finally, 37% of respondents (n=13) stipulated that they utilised psychometric measures to gather additional information; with 20% (n=7) stipulating

they would only do so if the client's presenting problems and history, as well as what was revealed in the clinical interview, deemed it as necessary.

Table 5.

Results for Survey Question 15: Content Included in CBT Case Conceptualisation.

Content in case conceptualisation	N=35	%
Information provided by client	34	97
Collateral information/sources	4	11
Client presentation in therapy	3	9
Results of Psychometrics	13	37
- Only utilised if deemed necessary	7	20
Info revealed by therapy	5	14

Psychometric measures, tools, and models utilised.

Respondents stipulated they utilised measures to assist them to clarify the range of symptoms (n=3; 13%) and to ensure that the correct interventions were utilised (n=4; 17%). The most frequently identified measures include those for mood disorders as well as those that assist the practitioner in accessing the client cognitions (ie DAS, ATQ). These measures were reported as more frequently utilised when; forming a 5-Axis diagnosis, for Accident Compensation Corporation (ACC) reports, or for referral reports.

Table 6.

Results for Question 16: Respondent Use of Tools or Measures in CBT Case Conceptualisation.

Utilise tools or measures to create conceptualisation	N=37	%
Yes	24	65
No	13	35
Details of tools and measures used	N=23	%

Psychometrics	12	52
Tools	3	13
CBT case conceptualisation models	11	48
Benefits of utilising tools or measures	N=23	%
Assist to clarify symptoms	3	13
Assist in intervention selection	4	17
Extra utility for reticent clients	5	22

Some respondents also utilise tools to assist them in gathering data and revealing clients' deeper cognitions; for example the thought record assists practitioners in identifying dysfunctional cognitions and attitudes to target for treatment; with 22% of respondents (n=5) identifying tools as having additional utility for clients who are reluctant to open up or share. In total 65% of respondents (n=24) are utilising some form of tool (n=3; 13%), psychometric measure (n=13; 52%), individualised conceptualisation template or model (n=11; 48%) to assist them in forming coherent conceptualisations that cover all relevant information. Of the individualised models, the J.S. Beck Cognitive conceptualisation diagram (1995) is the most popular; in particular with less experienced respondents (who also made more reference to using measures); whilst the more experienced participants made more frequent mention of utilising the 5Ps' (Weerasekera, 1996) to conceptualise. For a full list of measures, tools and models mentioned by the sample please see table seven below.

Table 7.

Psychometric Measures, Tools and Models Utilised Respondents to Construct Case-Level Conceptualisations.

Psychometric measures utilised	N = 23	%
Beck's Mood Inventories	8	35
(BDI; A. T. Beck, Steer, & Brown, 1996 & BAI; A.T. Beck, Steer, 1993).		
Hamilton Depression Scale	5	22
(HAM-D; Hamilton, 1966).		

Automatic Thought Questionnaire (ATQ; Hollon & Kendall, 1980).	3	13
Dysfunctional Attitudes Scale (DAS; Weissman & Beck, 1978).	2	9
Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983).	2	9
Millon Clinical Multi-axial Inventory (T. Millon, C. Millon, Davis, & Grossman, 2009).	2	9
Obsessive Compulsive Inventory (OCI; Foa, Kozak, Salkovskis, Coles, & Amir, 1998).	2	9
Structured Clinical Interview (SCID; First, Spitzer, Gibbon, & Williams, 2002).	2	9
Children's Depression Inventory (CDI; Kovacs, 1992).	1	5
Illness perception Questionnaire (IPQ; Weinman, Petrie, Moss-Morris, & Horne, 1996).	1	5
Multi-dimensional Anxiety Scale for Children (MASC; March, 1998).	1	5
Patient Health Questionnaire (PHQ; *Kroenke*, Spitzer, & Williams, *2002*).	1	5
Social Phobia Inventory (SPIN; Connor, Davidson, Churchill, Sherwood, Foa, & Wesler, 2000).	1	5
State-Trait Anxiety Inventory for Children (STAIC; Spielberger, 1973).	1	5

Tools or conceptualisation models utilised	N=23	%
5 Ps' (Weerasekera, 1996).	11	48
Cognitive Conceptualisation Diagram (J.S. Beck, 1995).	11	48
Dysfunctional Thought Record (A. T. Beck et al., 1979).	6	26
J. Young's Schema Questionnaire (YSQ; Young, & Lindemann, 1992)	3	13
Old system / New System model (Mooney & Padesky, 2000)	3	13
Monitoring Forms i.e. Visual Analogue Scale	2	9

Symptoms Checklist Scales	2	9
5 part model (Padesky & Mooney, 1990).	2	9
ABRA case format (Lane, Montgomery, & Schmid, 1995)	1	5
Downward arrow technique (Burns, 1980).	1	5
J. Persons Formulation Method (Persons, 1989).	1	5
Maudsley Format (LeGrange, 2005).	1	5
Panic Hook Cycle (Clark, 1988).	1	5
Social anxiety model (Rapee & Heimberg, 1997).	1	5
Socratic questioning	1	5
Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997).	1	5

Process followed in conceptualisation.

Many of the respondents (n=29; 83%) identified that as soon as any relevant information was identified they would begin to organise it into preconceived categories, with most respondents (n=11; 48%) utilising categories similar to the 5Ps' (Based on Weerasekera's 4 Ps' (1996) - see p. 22 for details on the 5P's). Whilst organising and processing the data, some practitioners (n=5; 14%) identified that they began to hypothesise about the links or connections within the data (such as linking childhood trauma to current dysfunctional thinking); whilst others (n=9; 26%) focused on identifying disorders based on recognizing certain clusters of symptoms (for example The Negative Cognitive Triad of Depression, A.T. Beck, 1976).

Approximately 37% of respondents (n=13) identified that as therapy progresses, and more complex information is revealed they will begin to make inferences about client temperament, interpersonal factors, belief systems, conflict resolution models, coping strategies, underlying assumptions, and core beliefs. All new information (both descriptive and inferred) is then fed back into the conceptualisation to provide a complete, and current, understanding of the client.

Padesky & Mooney's 5-part model was the most frequently mentioned model for use in the initial stages of therapy (n=2; 9%). Initial, situation-level intervention models appear to be utilised by the respondents as a way of introducing the cognitive model; sharing their hypotheses; and providing perspective to the client about the cyclical nature of their symptoms. A further 23% of respondents (n=8) stipulated that they would add to the conceptualisation after each session and then present it back to the client at the beginning of the next session as a way of promoting both continuity and collaboration.

Table 8.

Results for Question 14: Process Followed by Respondents to Create a CBT Case Conceptualisation.

Process followed in case conceptualisation	N=35	%
Gather client-specific Information	27	77
Organise information into categories	29	83
Hypothesise about inferential links	5	14
Identify disorder-specific symptom clusters	9	26
Share hypotheses with client	7	20
Repeat cycle	13	37

Collaboration and conceptualisation.

In total, 92% of respondents (n=33) stated that conceptualisation was a collaborative process. Furthermore; 44% of respondents (n=16) indicated that they co-create the conceptualisation with the client from the very start, an entirely collaborative process; whilst an additional 31% indicated that they would first developed a basic, or first-draft, conceptualisation of their own; that they would then share with the client as a starting position to develop a more collaborative conceptualisation. Finally only one respondent (who worked with children) claimed that the process was not collaborative at all.

Almost all respondents (n=32; 89%) indicated that they shared the entire conceptualisation with the client. Although it must be noted that there was insufficient data to provide an analysis of how respondents went about doing this (i.e. all at once, or as therapy progresses); with only four respondents stipulating that the levels of sharing would be dependent on the client; their reasons for this being: some beliefs may be too difficult and therefore may do more damage if introduced at the wrong time; the client may not be ready to face certain truths; the client is very unwell/unbalanced and therefore will not be able to understand or follow the conceptualisation; or, if the client is a child. A further 53% of respondents (n=19) stated that they relied on the client to determine the accuracy or fit of the conceptualisation.

Table 9.

Results for Question 17: Respondents View on Client Involvement in CBT Case Conceptualisation.

Client involvement in conceptualisation	n=36	%
Case conceptualisation as a collaborative process	33	92
Practitioner creates case conceptualisation; then shares with client.	11	31
Practitioner& client co-create entire case conceptualisation	16	44
Entire case conceptualisation shared with client	32	89
Share case conceptualisation prior to each session	8	22
Client determines accuracy of case conceptualisation	19	53

Conceptualisation as a cyclical process.

In total, 75% of respondents (n=27) change their conceptualisations as therapy progresses; with an additional 22% (n=8) changing theirs “sometimes”; only one participant (3%) stipulated that their conceptualisations did not change. The predominant reason (n=25; 76%) respondents gave for altering a conceptualisation is

to incorporate new information; which may make previous information invalid or superfluous. An additional 21% of respondents (n=7) stipulated that they would change their conceptualisation if the client was not responding to the interventions (or treatment plan) formulated as part of the conceptualisation.

Table 10.

Results for Question 19: Respondents View of CBT Case Conceptualisation as an Ever-Evolving Process.

Does case conceptualisation change as therapy progresses?	N=36	%
Yes	27	75
No	1	3
Sometimes	8	22
Reasons to Change Case Conceptualisation	**N=33**	**%**
To incorporate new information	25	76
Client not responding to plan	7	21

Difficulties with conceptualisation.

Questions 22 & 23 on the survey dealt with the conceptualisation-specific difficulties that practitioners experience; as well as how they deal with those difficulties. Approximately half of the respondents (n=18) stipulated that they experienced some form of difficulty with conceptualisation. Six respondents (32%) mentioned client factors such as: no motivation for change; not buying into therapy or not responding to the model; confusion or difficulty in remembering their childhood experiences; inability to articulate or express their emotions; unable or unwilling to open up, which is especially pertinent if client has trust issues.

Fourteen respondents (74%) identified the following practitioner difficulties: Core belief and underlying assumptions are more difficult to decipher than automatic thoughts; simple cases can bring the temptation to not conceptualise fully; and either,

too much information (which makes it difficult to identify what is really important), too little information (which makes drawing conclusions difficult), or contradictory or conflicting information, can all lead to difficulties in clarifying the conceptualisation.

Finally, three respondents (16%) identified problems that they had with the CBT model: Namely, a lack of consideration for the impacts of social conditions; an absence of systems and family factors; and an ignorance of feminist factors.

Table 11.

Results for Question 22: Difficulties Experienced by Respondents in Creating CBT Case Conceptualisations.

Difficulties with CBT Case Conceptualisation?	N=36	%
Yes	18	50
No	17	47
N/A	1	3
Nature of CBT Case Conceptualisation Difficulties	**N=19**	**%**
Client Factors	6	32
Practitioner Factors	14	74
CBT Model Factors	3	16

As a way to combat these difficulties, 53% of respondents (n=9) identified supervision as critical. An additional 41% of respondents (n=7) stipulated that they would involve the client in trying to combat the difficulties; namely be honest about the difficulties and attempt to work through them collaboratively. Twenty-nine percent of respondents (n=5) said they would utilise additional alternative structured conceptualisation formats (both CBT based and Multi-Systemic therapy based) to clarify the data; whilst 24% of respondents (n=4) stipulated that they would engage in some form of self-education about the particular area there were struggling with. Finally an additional 24% of respondents identified practice, or experience as essential to overcoming any professional issue.

Table 12.

Results for Question 23: Respondent Techniques for Overcoming Difficulties Experienced in Creating CBT Case Conceptualisations.

Ways to Overcome CBT Case Conceptualisation Difficulties	N=17	%
Increase supervision	9	53
Involve Client	7	41
Use additional conceptualisation models	5	29
Engage in self-education	4	24
Practice & experience	4	24

CBT conceptualisation training and education.

Continued education was addressed by questions 20 & 21 in the survey. Approximately seventy percent of (n=25; 69%) of survey respondents have attended some form of course or conference on CBT case conceptualisation; with 89% (n=32) having completed some form of self-study (ie: reading books) in the area. Nine respondents (41%) received CBT case conceptualisation training as part of their University training; with additional nine having completed a specialised CBT training course.

The specialised training included: The Massey University Post Graduate Diploma in CBT; The Otago University Post Graduate Diploma in Health Science with Advance Topics in CBT; as well as Schema, REBT & ACT training. In addition, 13 of the respondents (59%) had also attended conferences or workshops on CBT CC and related topics. These conferences included the NZCBT conference; as well as workshops hosted by Christine Padesky (n=4); Jacqueline Persons (n=1); Judith Beck (n=1); Frank Dattillio (n=1) & Keith Dobson (n=1); covering topics including Anxiety (n=1), Disorder-specific cases (n=1); and PTSD (n=2).

Table 13.

Results for Question 20: Respondents and CBT Case Conceptualisation Training Courses or Workshops.

Ever Attended Course on CBT Conceptualisation?	N=36	%
Yes	25	69
No	11	31
Course Details	**N=22**	**%**
Part of university training	9	41
Specialised university course	9	41
Independent conference / course	13	59

Of the respondents who had indicated that they had previously completed some form of self-study; 97% (n=31) had read either books or articles on conceptualisation, including those by Persons, Beck, Padesky, Maruish, Clark, Weerasekera, Stallard, Wells, Leahy, Kuyken, Dudley, and Brewin; as well as a variety of CBT Manuals and internet guides. Many of the practitioners (n=21; 66%) highlighted the importance of continuous reading of up-to-date literature as a means to develop skill and understanding, and to acquire new knowledge on topics they have limited experience in, topics mentioned include: Conceptualisation and Anxiety, Conceptualisation for children, as well as Multi-perspective and Family-systems perspective case conceptualisations.

Table 14.

Results for Question 21: Further Education and Self-Study of CBT Case Conceptualisation by Respondents.

Any Self Study of CBT Case Conceptualisation Completed?	N=36	%
Yes	32	89
No	4	11
Details of Self Study	**N=32**	**%**

Keep up to date with current research	21	66
Read case conceptualisation-specific literature	31	97

Influence of conceptualisation on therapy.

Question 18 dealt with the effect that conceptualisation has on both the client, and the therapeutic process. Many of the respondents (n=23; 64%) stated that conceptualisation is beneficial to the client. Specifically; that conceptualisation provides perspective to the client, who may be feeling overwhelmed (n=5; 22%); that identifying repetitive patterns or cycles can assist the client to understand the continual setbacks in certain aspects of their lives (n=4; 17%); that understanding the inter-connectedness of their symptoms can assist in providing the client with objectivity, which helps them to "own the process" (n=8; 35%); and finally, conceptualisation increases client motivation or buy-in (n=5; 22%) and decreases anxiety about therapy (n=3; 13%).

Furthermore, 22% of respondents (n=8) stipulated that sharing the conceptualisation with the client improves the therapeutic relationship and provides a stronger foundation for working with more difficult issues. With the exception of one respondent who replied "Sometimes"; all survey respondents (n=35; 97%) stated that conceptualisation has an influence of the therapeutic treatment process. Eighty-one percent of respondents made reference to conceptualisation directly influencing treatment in the planning, implementation and assessment stages. Specifically, conceptualisation guides practitioners through treatment process by revealing: The types of interventions to utilise (n=19; 53%); when or how to implement the interventions (n=9; 25%); the potential obstacles that may be encountered (n=7; 19%); and the most effective and efficient manner in which to get results (n=7; 19%).

Table 15.

Results for Question 18: Respondent-Perceived Influence of CBT Case Conceptualisation on the Therapeutic Process.

Does Case Conceptualisation Influence Therapy?	N=36	%
Yes	35	97
No	0	0
Sometimes	1	3
Ways Case Conceptualisation Influences Therapy	**N=36**	**%**
Beneficial to client	23	64
- Provides client with perspective	5	14
- Increases client "buy-in"	5	14
- Helps client to identify patterns	4	11
- Allows client to "own the process"	8	22
- Decreases client anxiety about therapy	3	8
Determines treatment plan	29	81
Reveals intervention to use	19	53
Reveal when to use particular interventions	9	25
Reveals potential roadblocks	7	19
Sharing of conceptualisation improves therapeutic relationship	8	22
Conceptualisation ensures efficiency, and effectiveness	7	19

Results II: Thematic Analysis

Chapter six continues the process of data analysis in the form of a thematic based review. A basic introduction to the analysis is followed by an analysis and discussion of the predominant theme. The sub-themes, and originating statements of respondent support, are incorporated to ensure that a rich account of the parent theme is provided. Finally, the main theme and sub-themes are summarised.

Thematic Analysis

A thematic analysis was used to identify the main and sub-themes embedded in the responses. The analysis was loosely based on Braun & Clarke's (2006) model and was conducted in a theoretical manner; with conceptualisation as the underlying analytic interest. The data set consisted of written responses to survey questions that sought to understand *subjective* use and understanding of conceptualisation; and therefore all items discussed below refer to the practitioner's *subjective perception* of CBT case conceptualisation. Responses were obtained from 48 respondents (although 12 respondents provided only partially completed surveys); who had a total of two months to complete the survey.

The quotations and examples provided below have been selected in order to best illustrate the identified themes. However, given that case-level conceptualisation is an individualised process for both client and practitioner some of the responses contain idiosyncratic, single-practitioner perspectives; these items have been included as they add to overall tone of the theme. Throughout the data set, respondents made predominantly positive references to case-level conceptualisation; with indicators that practitioners value case conceptualisation and that they view conceptualisation as

beneficial, noted throughout the responses. As such a single overarching theme of "value or benefit" was noted; this is explored below.

Conceptualisation as a Highly Valued Therapeutic Process

This theme is divided into two distinct categories: The indicators that respondents value conceptualisation; and the practitioner perceived benefits of conceptualisation to the therapeutic process. The earlier can be viewed as informing the overall theme of value, while the latter explores *why* respondents value conceptualisation.

The indicators that respondents value conceptualisation

As previously mentioned, participant responses were predominantly positive regarding conceptualisation, with higher ratios of "benefit- or, value-coded" responses noted within four specific clusters or subthemes, namely: The level of conceptualisation use; the pursuit of further education of case conceptualisation; the selection and use of conceptualisation compatible therapeutic tools; and the qualities accredited to conceptualisation by practitioners.

1. **Level of case conceptualisation use.**

Almost all respondents (n=45; 98%) stipulated that they are using case conceptualisation in their everyday practice; in fact, most are using it in every case, and session as indicated by the following examples:

"All the time" (Respondent's three, five, & 18).

"All the time for every case. Use a generic formulation for the disorder and an individual conceptualisation for each person I see." (Respondent 33)

"All the time, after an initial assessment will check with client in 2nd session then periodically as we go through therapy." (Respondent 37)

"Formualte [sic] during and following assessment; CBT concwptualisation [sic] is ongoing work," (Respondent 38)

With the following respondents making reference to the view that case conceptualisation has further added utility, or value, in complex cases:

"I generally try and conceptualise all my cases but do tend to apply it a lot more to complex cases," (Respondent 16)

"Every client, more cognitive detail with more complex cases." (Respondent 17)

"Use in most instances - but particularly in complex cases." (Respondent 25)

Case-level conceptualisation is a complex and time-consuming process; and yet, as indicated by the above respondents; practitioners are utilising it "all the time". Therefore, this is the first indicator that respondents value conceptualisation.

2. Pursuit of continued learning about case conceptualisation.

An additional indicator of value was noted in the fact that many practitioners (n=32; 89%) had pursued further study in the area in order to increase their understanding of the concept. Some (n=25; 69%) by completing workshops and/or attending conferences; including those by renowned CBT case conceptualisation experts; as indicated by the below responses:

> *"Schema training, anxiety disorders, RET training, Padesky Conference" (Respondent one)*

> *"Variety of disorder-specific training workshops with case examples and conceptualisations." (Respondent three)*

> *"Several (conferences), can't remember them all but have included Keith Dobson, Judith Beck, Christine Padesky." (Respondent 13)*

Furthermore, almost all respondents (n=31; 97%) had read some form of literature about case conceptualisation; as indicated by the following:

> *"Keep up to date on articles and books within the field." (Respondent five)*

> *"I have academic books on various types of case formulation that I read as I need to." (Respondent 36)*

Reading is an important way for practitioners to stay aware of new research (a component that should be incorporated into any conceptualisation); but reading can also provide guidance; or develop skill as described by the following respondents:

"Read to develop skill and understanding," (Respondent six)

"Read books and articles for guidance." (Respondent 14)

The above statement indicate that practitioners are actively engaging in further education in order to increase their skill and understanding of conceptualisation; something they would not be likely to do if they did not value it.

3. **The selection and use of conceptualisation compatible therapeutic tools.**

An additional indicator of value was the already high level of use of CBT conceptualisation specific tools and measures, with the majority (n=24, 65%) of respondents utilising these tools. In particular, respondents identified and stated that they utilised a variety of conceptualisation models; for example:

"(I) use 5part model as part of assement [sic] session" (Respondent eight)

"I elicit automatic thoughts through thought records and five part models" and "I might use Jeffrey youngs [sic] Schema questionnaire for certain clients" (Respondent 19)

"I use models such as Clark's panic cycle, Beck's cognitive conceptualisation forms, 5 part model, Rapee and Helmberg's (1997) social anxiety model. I use thought records and monitoring forms mostly from Greenberger and Padesky (1995)." (Respondent 31)

"I use ABRA case formulation tool," (Respondent 35)

As well as the following respondents who made reference to utilising normed measures in order to assist in the conceptualisation process:

"I might also do some additional screening questionnaires that are disorder-specific." (Respondent five)

"It depends on the client, but I might use... the ATQ or DAS to get at thoughts and attitudes" (Respondent 19)

The aforementioned models and measures are designed specifically for use in the development of conceptualisation; or to assist the practitioner to elicit information required for effective conceptualisation; furthermore utilising normed measures is time-consuming and in some cases, complicated. The fact that respondents are aware of these models; that they are actively utilising them; and that practitioners are willing to spend the time and effort required to form a case-level conceptualisation; further indicates that they attach value to the process.

4. **The qualities accredited to conceptualisation by practitioners.**

Finally, the below references about the qualities that practitioners accredit to conceptualisation confirmed that practitioners value conceptualisation as a therapeutic process; for example:

> *"It is the thepretical [sic] framework we use to help us make sense" (Respondent two)*

> *"The conceptualisation drives the entire treatment." (Respondent 19)*

> *"Very often the conceptualistaion [sic] is at the core of therapeutic change." (Respondent 20)*

> *"It's the basis of ongoing therapy," (Respondent 25)*

Specifically, practitioners identified numerous qualities of conceptualisation as beneficial to their self, their client, or the therapeutic process. These are fully-explored as separate sub-themes under the second category of "practitioner perceived benefits of conceptualisation".

The practitioner-perceived benefits of conceptualisation

As discussed above, practitioners appear to value conceptualisation, we now attempt to explore *why* they value it. The positive attitude is most likely due to the following respondent-identified benefits to the practitioner; the client; and the therapeutic relationship. These are now explored in detail.

1. The benefits of case conceptualisation to the practitioner

The respondents identified a number of practitioner-specific benefits of using conceptualisation. These include the utility of case conceptualisation as a clinical tool; and for its use as a map for therapeutic intervention. These are now discussed in detail.

1.1. Utility of conceptualisation as a clinical tool.

Respondents identified two purposes of conceptualisation within therapeutic practice: Descriptive and prescriptive. As previously discussed in the literature (See page 21) the descriptive component of conceptualisation assists the practitioner to organise large amounts of (sometimes complex and confusing) client data; link the individual symptoms to underlying mechanisms; incorporate theoretical knowledge and provide hypotheses to account for the client's current predicament. This ensures a coherent account of all client factors. This attitude is mirrored by the following respondents, for example:

> *"A case conceptualisation gives a workingdezcription [sic] that, were possible, provides an understamding [sic] of the factors, interactions etc that have contributed to the development [sic] of a clinical problem and of the current factors that are maintaining the problem." (Respondent five)*

> *"Case formulation is a way of working out the significant beliefs and behaviours the client holds / uses that are the psychological contribution to their problems." (Respondent 19)*

Respondent 28 additionally highlighted some specific ways that conceptualisation assists them to link things together, for example:

> *"The case conceptualisation provides a framework for helping to understand the connection between NATS (Negative Automatic Thoughts) and deeper level beliefs. It also provides an understanding of how thinking structures maintain dysfunctional behaviour or compensatory strategies." (Respondent 28)*

According to the literature the prescriptive component of conceptualisation flows from the descriptive; with practitioners utilising the organised information to inform intervention. The following quotations indicate that respondents are adhering to this process:

> *"It is the thepretical [sic] framework we use to help us make sense of the information gathered in assessment... a framework for understanding what can be done about it." (Respondent two)*

> *"...organising information known about a client (gained from an assessment process) to construct a hypothesis about the current difficulties. This hypothesis then informs our treatment plan." (Respondent 13)*

> *"CC is about constructing a meaningful explanation of the client [sic] current presentation withon [sic] the context of his/her external and internal world in order to determine treatment." (Respondent 34)*

"understanding of the clients presenting issues and assists in intervention of their problems." (Respondent 28)

In this sample it would appear that for the practitioner, the primary purpose of the descriptive component is to inform its prescriptive counterpart; which in turn is valued for its ability to inform treatment. This is indicated by the following:

"The conceptualisation directly influences the therapy. It is on the basis of the formulation that the prioritised list for intervention arrives." (Respondent five)

"(although) CBT conceptualization underpins the gathering of data for all reports, it is more formally used with treatment." (Respondent 28)

"It is a working hypothesis which helps to guide treamtn [sic]." (Respondent 33)

As the below quotation reveals, practitioners feel that utilising conceptualisation, will assist them to achieve the best possible treatment.

"The conceptualisation drives the entire treatment... You have to have (a) conceptualisation to understand and plan for the best possible treatment for the particular individual." (Respondent 19)

1.2. Conceptualisation as a map for therapeutic intervention.

As identified above, practitioners place emphasis on case conceptualisation for informing their treatment plan. In fact, to this particular set of practitioners, the

overarching purpose of case conceptualisation seems to be its ability to act as a map, guide, or blueprint for the therapeutic process; as indicated by the following respondents:

> *"A framework that provides a map for therapy." (Respondent 35)*

> *"A road map for change." (Respondent 24)*

> *"The conceptualisation guides therapy and enables you to plan the treatment accordingly." (Respondent 13)*

Practitioners appear to continually refer to the conceptualisation at each stage of intervention;

> *"Case conceptualisation always informs the next step as a clinician." (Respondent four)*

> *"It's the basis of ongoing therapy; frequent references back to conceptualisation for 'roadmap'" (Respondent 24)*

Specifically, as a guide to which interventions to use, and what homework to incorporate:

"...conceptualisation determines nature of exercises and homework." (Respondent nine)

"I base my therapy plan on my formulation and the client goals. It also guides the timing of which technique or goal we will work on, and when." (Respondent 31)

As well as to the potential obstacles to therapy, including client factors such as motivation:

"I consider potential roadblocks in therapy... this assists with planning intervention." (Respondent 13)

"I also go back to my formulation to understand my client's response to therapy, and the therapy relationship." (Respondent 31)

As indicated by the above quotations, respondents appear to believe that conceptualisation assists them in each stage of the therapeutic process. First, by organising information into a meaningful framework that accounts for all aspects of the client (both descriptive and inferential); second, by providing a treatment plan that includes; the best interventions and homework exercises to use, and any obstacles that may be encountered along the way.

2. The benefits of case conceptualisation to the client.

The client plays the central role in CBT conceptualisation; the very nature of a case-level conceptualisation being that it revolves around an individual client. The client

provides much to the conceptualisation process; including the raw data, and their feedback to determine relevance. According to the participants, the return for the client is two-fold: First, many respondents (n=23, 64%) feel that the clarity the descriptive component of conceptualisation provides, is especially valuable to the client; as indicated by the following:

> *"The client gets to see on paper what beliefs they operate out of and this tends to objectfy [sic] their beliefs and behaviours." (Respondent 20)*

> *"It is really helpful having hte [sic] thinking laid out so one can see the thinking across different situations. It is like turning the lights on for clients, provides a platform for change." (Respondent 23)*

> *"It has a positive effect as the client feels they own the process and gain a lot more understanding of themselves." (Respondent 35)*

> *"It provides... psychoeducation for the client. Improved understanding is a good start to treatment." (Respondent 36)*

As indicated by the following responses, practitioners seem to view this clarity as empowering to the client; namely by increasing their insight and sense of self-efficacy; for example:

> *"The conceptualisation has to have meaning to them (the client) and be accessible - hopefully also help to provide insight or access to new strategies." (Respondent 17)*

"conceptualisation typically increases the clients [sic] sense of self efficacy and own understanding of what has lead to current predicament." (Respondent 29)

Second; participant responses indicated a belief that clients would benefit from the prescriptive components of conceptualisation. Specifically, in that it accounts for all their individual nuances; meaning they are more likely to receive an individualised and comprehensive treatment, as indicated by the following respondents:

"understanding how the clients background & experiences have influenced their beliefs & way of interacting with the world, tying this to their presenting problems and treatment plan." (Respondent six)

"The conceptualisation is idiosyncratic understanding of the clients presenting issues and assists in intervention of their problems." (Respondent 28)

"2 patients who present with similar problems could still have different treatment approaches be more effective - it is based on their individual conceptualisation." (Respondent 34)

Furthermore, respondents indicated that they believe treatment information (from the prescriptive components) ensures the client is treated in the most effective way; lowering the chances of non-compliance and treatment failure; and improving the therapeutic relationship. For example:

"It also serves as a vehicle for introducing the client to how the model relates to their difficulties." (Respondent 16)

"People who have the core belief that they are useless will require slower work with early behavioural experiments geared more towards things that are likely to be successful. People with significant trauma histories will need to feel safe in the therapeutic environment," (Respondent 33)

These benefits can have an effect on the therapeutic relationship; which is especially important as CBT requires a sound therapeutic alliance or relationship.

3. The benefits of conceptualisation to the therapeutic relationship.

Ideally, both practitioner and client should be involved in the development of a case conceptualisation; the practitioner provides the theoretical knowledge and clinical experience; whilst the client provides the raw data and motivation for change; this is mirrored by the following respondents:

"they co-create with me." (Respondent three)

"Most of the information is shared from the client – client actively involved in process." (Respondent 22)

"Client very involved in process - collaboratively develop conceptualisation together." (Respondent 28)

Collaboration; or therapy as teamwork, is one of the core theoretical components of CBT case conceptualisation. This attitude is mirrored in practice, as indicated by almost all of the respondents (n=33; 92%); for example:

"The conceptualisation arises from collaboration." (Respondent five)

"Collaborative process...Totally client driven really." (Respondent 25)

"Fully involved, collaborative, a partner" (Respondent 27)

With some respondents involving the client to such a large degree that the client may begin to assume some of the roles of the practitioner; which is in line with the CBT goal, of teaching the client to become their own therapist. This is indicated by the following statements:

"It is collaborative. Ffull [sic] schema review is given and "answer" sheet for client to add to, change, give examples if doesn't fit." (Respondent one)

"Client is involved in offering their own understanding and construction of their problems," (Respondent four)

"... go through with the client – adding / deleting/ getting new info." (Respondent seven)

"We will discuss it (the conceptualisation) and add ideas and meaningful items the client identifies." (Respondent 17)

With some respondents identifying that the client determines the accuracy of the conceptualisation:

"... discuss my hypotheses with the client to get confirmation / disconfirmation as to its accuracy." (Respondent 19)

(Client involvement): "Actively, as often as possible through shared understanding, constantly referred to and modified" (Respondent 18)

"If the patient fundamentally disagrees with the conceptualisation ...the conceptualisation should change" (Respondent 34)

"I always involve the client and make changes according to their views" (Respondent 32)

Whilst other respondents maintained a more teacher-student type relationship:

"I do the conceptualisation first then feed it back to the patient," (Respondent ten)

The level of sharing "Varies from very little to a lot depending on the client. Some clients... are severely unwell and it is not appropriate." (Respondent 15)

"...difficult to discuss the conceptualisation with an individual if their beliefs are particularly painful (and) the client is not ready to articulate them themselves yet." (Respondent 22)

Overall the responses indicate that the conceptualisation can both guide; and have a dramatic impact on, the therapeutic relationship. Some of the respondents have linked a better therapeutic relationship with increased client trust; while the majority of respondents (n=25; 76%) made mention of new information being revealed as the client begins to open-up or trust the practitioner, and process. This new information often alters or effects the original conceptualisation. For example:

"Frequently, as trust develops, additional information may require the conceptualisation to be revised." (Respondent five)

"Initially it can be difficult for the client to express their issues and history – it takes time to build up rapport and for clients to trust you to work collaboratively," (Respondent 22).

"Further information will emerge about schemas and traumas as the clients trust and disclosure grows" (Respondent 31)

"Sometimes there are gaps in my understanding of a clients issues after assessment. Often those gaps get filled later in therapy...Information gained during therapy can change your formualtion [sic] dramatically...the client develops trust and gives you more information. Alternatively, during therapy a behavioural experiment may be devised to get a deeper understanding of what is happening..." (Respondent 32)

As participant 32 stipulates above, new information can also be revealed in therapy by hypothesis testing. This new information is then incorporated into the existing conceptualisation; repeating the process over and therefore ensuring that conceptualisation is a cyclical process; as indicated by the below items:

"Assesment [sic] is ongoing. Formulating / conceptualising is a fluid process that encorporates [sic] new information and a clients changes to remain an accurate guide for treatment." (Respondent three)

"New conceptualisations can occur as the therapeutic process progresses [sic] and new issues are uncovered as others are resolved" (Respondent 25)

"I use and modify my conceptualisation each time a [sic] see the client, helping me to understand the client presenting difficulties and the process of each session." (Respondent 33)

With the following respondents making specific mention of case conceptualisation as a hypothesis; therefore (as recommended by the literature), conceptualisation should remain open to modification through hypothesis testing; for example:

"New information is gained - we learn more about the client and the factors affecting their behaviours and current situation. Treatments that are planned may not be affective, so the formulation may need to be re-assessed. Conceptualisation is more of a working hypothesis." (Respondent 14)

"Sometimes additional beliefs or behaviours become apparent that need to be added to the conceptualisation, or you might have to change a belief or behaviour in some way as it more accurately reflects the presentation. As your conceptualisation is a hypothesis, it really does change throughout therapy." (Respondent 19)

In summary, the respondents appear to value conceptualisation. Indicators of value were noted within specific clusters, including: The high level of conceptualisation use among respondents; the pursuit of further education about case conceptualisation; the use of conceptualisation compatible therapeutic tools; and the qualities that respondents attribute to conceptualisation. Respondents appear to value conceptualisation because of the number of benefits they believe it provides to themselves, their clients, and the therapeutic process.

Discussion and Conclusions

This chapter provides a summary of the findings reported in chapters five and six; as well as a discussion aimed at interpreting the results within the context of both the original research questions; as well as the literature discussed in chapters two and three. The broader implications for clinical practice; limitations of the present study; and directions for future study are then presented, before the author's subjective experiences and understanding are integrated as required by the Hermeneutic methodology. Finally the conclusions reached are presented.

Discussion

The focus of this thesis has been to explore CBT case-level conceptualisation from the practitioner's perspective; with the specific aim of investigating the following four research questions:

> *What is the current understanding of "Case Conceptualisation" to the Mental Health practitioners?*
>
> *Are they actively utilising case conceptualisation in their psychotherapeutic practices? And if so, why?*
>
> *How do they go about forming case conceptualisations – what content, processes, and tools do they utilise?*
>
> *What impact does a case conceptualisation have on the therapeutic process and relationship?*

In order to achieve the above aim; a survey, designed to elicit subjective experience from practitioners about their use, practices, and understanding of case conceptualisation; was created and distributed to a variety of mental health practitioners. The returned surveys were analysed at a descriptive level; which in turn, informed a thematic based review of the themes or patterns within the data. The process of data analysis was designed to imitate the real-life information gathering and meaning-making process of case conceptualisation.

Descriptive results.

Almost all respondents were using case conceptualisation in their practices; this overwhelming support for the use of conceptualisation is in line with recent trends; with research in the area having increased dramatically in recent years (Eells, 2007). Furthermore many respondents acknowledged the utility of case conceptualisation in especially complex case.

Respondents also appear to have a good understanding of the central components of CBT case-level conceptualisation; as each respondent made reference to at least half of the following author-identified components of conceptualisation: CBT case conceptualisation is a summary, account, or description, of all an individual client's problems. It assists the practitioner to organise diverse and sometimes conflicting information, with the aim to connect, link, or incorporate, the individual client's symptoms with the relevant CBT theory; in order to explain, gain understanding into, or make sense of, the client's problems. It acts as a blueprint (or map) to effectively guide both treatment and the therapeutic process; and should be a collaborative and dynamic process that follows the hypothetico-deductive model of both the client and practitioner testing and altering hypotheses together.

Furthermore, the process that respondents follow mirrors that which was identified in the literature (see p. 21): Case conceptualisation begins with data collection; in particular descriptive information is collected from: The client; collateral sources; previous relevant reports; or psychometric measures (the use of standardised measures has previously been identified as a way for practitioners to construct more accurate conceptualisations). The descriptive information covers as many aspects of the client's life as possible; including: Current symptoms; family and medical history; drug and alcohol use; past and present relationships; education; occupation; demographic information; the precipitating factors or event that has led them the seek therapy; and their targets for therapy.

The client information is then organised into categories; with the 5Ps' (Weerasekera, 1996) being the most popular categories; this provides the practitioner with an as-full-as-possible understanding of all the client factors; and essentially equates to the descriptive component of conceptualisation. The descriptive conceptualisation then assists the practitioner to hypothesise about the more inferential aspects of the case presentation; which is in turn applied to the therapeutic process (by being constantly referred to in order to inform the treatment plan at every stage of therapy) to ensure a prescriptive conceptualisation.

The respondents also identified the cyclical nature of conceptualisation; with new information provided by the client, or revealed by the therapeutic process, incorporated into existing conceptualisations to provide the best possible understanding of the case. Conceptualisation has been identified as an ongoing process that should be open to modification (openness to empirical disconfirmation is a core principle of CBT; see p. 18). The respondents further identified collaboration as at the heart of the conceptualisation process within CBT; with clients described as therapeutic partners, and consulted with regarding the accuracy of the conceptualisation. Collaboration too, is a highly valued principle in CBT, in general, and CBT case conceptualisation specifically. (See p. 18)

Finally; almost all respondents feel that conceptualisation has a beneficial effect on the therapeutic process; specifically: The descriptive component of conceptualisation can provide the client with clarity and perspective regarding their problems; this can further increase buy-in and improve the therapeutic relationship. Whilst the prescriptive component informs treatment; including what interventions to use; the obstacle likely to occur; and the most effective treatment strategy. This too, is in line with the literature.

In summary, respondents in this study appear to mirror the recommended theory in both their theoretical understanding, and practical use, of CBT case conceptualisation. This descriptive component of the analysis assisted to provide an appropriate context for the thematic analysis, which is discussed below.

Thematic analysis results.

A number of themes were initially identified, however, each theme contained a common underlying component of "value" or "benefit", and as such a single overarching theme (that incorporated the numerous sub-themes), was created. The overarching theme was entitled "Conceptualisation as a highly valued therapeutic process"; and incorporates both; the indicators that respondents value case conceptualisation; as well as, the value or benefits that respondents believe case conceptualisation provides to the practitioner, client and therapeutic relationship. This positive attitude to case conceptualisation is in line with the literature; with Eells (2007, p. xi) stating that conceptualisation has become "almost universally recognized (as) important".

The indicators that respondents valued case-level conceptualisation included: The high level of use of case conceptualisation (in spite of the time-consuming and sometimes

complicated nature of the process); the pursuit of further learning, or continued education about case conceptualisation; the selection and use of conceptualisation compatible therapeutic tools; and the qualities accredited to case conceptualisation by the respondents.

Case conceptualisation, in turn, is believed to benefit the practitioner by assisting to organise complex information; develop a comprehensive treatment plan (including the interventions and homework exercises to incorporate); overcome potential obstacles; and inform the therapeutic process (all of the above listed practitioner benefits have previously been identified; see p. 17). According to respondents; the client benefits from the comprehensive and individualised nature of case-level conceptualisation; but also from the psycho-education and perspective that shared (or collaborative) conceptualisation can provide (this attitude has been mirrored by a number of authors; see p. 18). Finally; respondents indicated that the therapeutic relationship and process are benefited by: Encouraging client and practitioner to work together (collaboratively), as a team; which teaches the client to be their own therapist; and leads to an increase in rapport or trust, ultimately leading to a more comprehensive conceptualisation. Collaboration has previously been identified as a core component within CBT case conceptualisation; while teaching the client to be their own therapist is a key goal of CBT (see p. 5). The thematic analysis is presented in a graphical mind-map below.

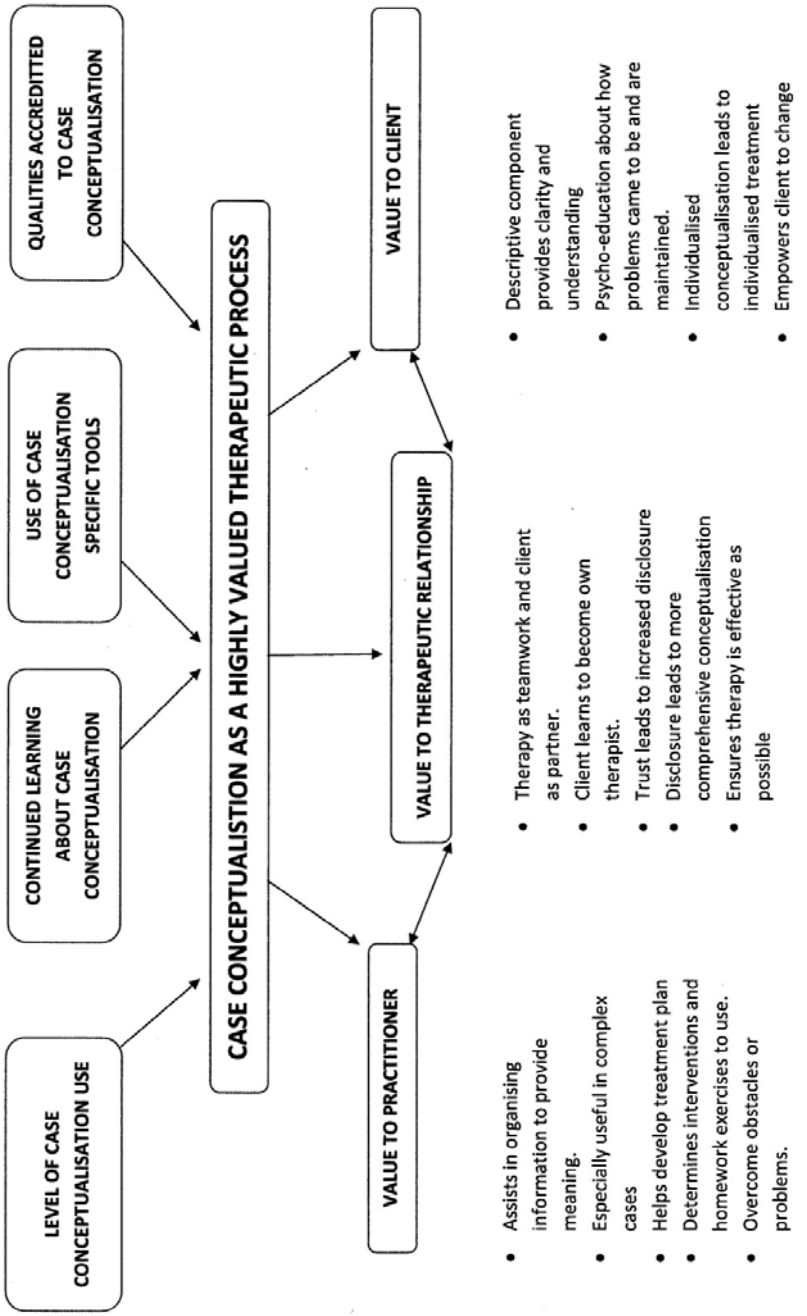

Figure: 4. Thematic Analysis Mind-Map.

As is indicated by this diagram; conceptualisation appears to be considered a highly valued therapeutic process; as such it is identified as the single overarching theme. That respondents do value conceptualisation, is indicated by the high level of conceptualisation use among respondents; their pursuit of further education about case conceptualisation; their use of conceptualisation compatible therapeutic tools; and the qualities that they attribute to conceptualisation. These sub-themes can be viewed as informing the overall theme of value; specifically that respondents value conceptualisation. While the lower portion of the mind-map explores *why* respondents value conceptualisation; which it would seem, is due to the number of benefits they believe it provides to themselves, their clients, and the therapeutic process.

Limitations

The first identified limitations of the present study relate to the sample. Although attempts were made to include as many participants as possible; the fact that participants were required to utilise CBT as their predominant therapeutic approach and be in current therapeutic practice made recruitment difficult; and therefore the sample size was limited. Therefore, themes that had insufficient data for a full analysis were perhaps overlooked in favour of the dominant theme; which limits the ability of the study to adequately represent the views and attitudes obtained. Additionally, the fact that the respondents chose to participate in this particular survey could indicate that they were already favourably primed to view conceptualisation as a valued process, further limiting the generalisability of the results.

Second, the limited number questions on the survey narrowed the range of items that could be explored. In order to encourage participants to complete all questions; the survey was kept as brief as possible; therefore limiting the range of topics that could be addressed. In particular, the questions regarding the process followed by respondents did not request specific detail regarding the way that conceptualisations are shared with the client; as such there was insufficient data to examine the process

of conceptualisation as a whole. Furthermore, in spite of a number of multiple-choice, and yes/no items included in the survey, that provided a "mental break" between more the open-ended questions (that required longer descriptive answers); some respondents still skipped the open-ended questions and provided answers to only the shorter-type questions.

Finally; the underlying research design and subsequent use of qualitative methods for analysis present additional limitations: Post-positivism as an epistemology; and hermeneutic phenomenology as a research methodology; are concerned with the study of subjective experience; and therefore objectivity is not considered an aim in the analysis; this limits the generalisability of the results. Data analysis could be improved by the inclusion of additional raters, who would contribute an additional (unique) set of interpretations regarding the data. Furthermore, inter-rater agreement could strengthen the reliability of the analysis.

Implications

The present study provides insight into the real-world use of case conceptualisation; making a contribution to the ongoing debates of psychological theory versus practice. The need for an understanding of current, real-world use of CBT conceptualisation has been identified by a number a prominent authors; who hypothesise that a basic understanding of how practicing CBT practitioners conceptualise in the real world, "would enable research-based advances in the profession's understanding" (Beiling & Kuyken, 2006, p.6). The present study; based on a New Zealand sample; narrows the gap between recommended theory, and actual in-practice use of case-level conceptualisation; by revealing that practitioners represented in this study are mirroring the recommended theory within their practices. And whilst this does expand on a small amount of previous research; it is a new avenue of research within a New Zealand context.

First and foremost; this thesis highlights the fact that the New Zealand practitioners who participated in this research are continuously, and consistently, utilising case conceptualisation in their practices; and that these practitioner's value conceptualisation as a critical and integral part of successful treatment. This implies that practitioners are going to continue to utilise conceptualisation; further highlighting the importance of more empirically validated research into conceptualisation. Furthermore, the present study fishtails with current literature and research in the view that case-level conceptualisation is not an outcome, but a continual process; therefore measuring for reliability and validity of conceptualisation following only an intake assessment; is not truly representative of real-world practice.

Overall, respondents seem to mirror the literature in both their theoretical understanding, and practical use, of conceptualisation. Furthermore; the hypothesised practitioner and therapeutic benefits identified in chapter three, were confirmed by the sample. This implies that, at the very least, practitioners *perceive* case conceptualisation to be effective and valuable in therapeutic practice; with "perceived benefit" having a potentially positive impact on other areas of therapy.

Recommendations for Future Study

As identified above; an exploration of the actual influence of "practitioner perceived benefit," on the conceptualisation process; could reveal hidden benefits for other therapeutic processes. Alternatively; future researchers should focus on measuring conceptualisation as a cyclical and ongoing process, and not an outcome. Specifically, research identifying the changes that occur, within a single conceptualisation, across the therapeutic process should be incorporated to identify the differences between initial post-assessment conceptualisations; and conceptualisations at therapy termination.

Furthermore; utilising the present study as a base; more in-depth research could be conducted on any of the predetermined question categories discussed in chapter five. For example, regarding process; the present study has revealed that practitioners utilise conceptualisation to inform treatment; but it does not incorporate information on *how* practitioners go about this. More specific research on this topic could be valuable in understanding treatment selection choices; which in turn, impacts on client outcomes. Alternatively; the present study highlights that practitioners value collaboration within conceptualisation; often sharing all components of conceptualisation with the client in order to provide psycho-education. However, the *manner in which* practitioners share the conceptualisation; including when and how they share the progressively more difficult items; has not been explored. Finally; comparison of the content and process; that is followed by experienced vs. novice practitioners; could help to identify procedural errors most commonly made by novices.

Self-Reflection

The role of the researcher within a Hermeneutic Paradigm is that of active co-learner, interpreter and meaning-maker; and the relationship between the researcher and the object of study is one of blending and fusion; aimed at achieving not just an empathetic understanding of the data but an altering of the researchers' perspective (Martin & Sugarman, 2001). This means that objectivity within the research is not truly possible; instead an acknowledgement of the researcher's own ideas and past experiences are included:

My initial response to the concept of case conceptualisation was one of support. The idea of a comprehensive and detailed account of an individual client seemed logical; and that conceptualisation could inform an individualised treatment plan and

anticipate procedural issues in therapy, was (and is) highly appealing. However, the research revealed disappointing results when investigating the reliability; validity; and claimed benefits of case-level conceptualisation. And yet, in spite of this, after completing a review of the literature, my support was as strong as possible, for one simple reason: As my theoretical knowledge increased I found myself using the exact conceptualisation techniques I had read about, to give myself some perspective; and it was effective.

However it was the participant responses that had the greatest effect on both my professional and personal growth. The examples and explanations that the respondents provided highlighted the way that core beliefs affect all aspects of a client's life; including their coping strategies and patterns of thought/behaviour. And once again as I began to understand the theory; I found myself "connecting the dots" on my own underlying issues. Whilst this process brought about a large amount of personal insight into my own coping strategies and thinking patterns; which in turn enlightened me to some deeper core beliefs; it was an emotionally painful and difficult experience. Therefore it is my view that conceptualisation should be conducted by an experienced professional that can guide the client through the process to ensure that therapy is beneficial, rather than harmful; however, as a psychological tool it *is effective* at revealing deeper issues and providing understanding about seemingly random actions; especially to the practitioner.

Conclusions

This study explored the current views, practices and attitudes of New Zealand mental health practitioners; with the aim to connect the recommended theory with actual therapeutic practice. The need for research in this area has been identified by a number of author's; and whilst some research has begun to emerge of recent, none has been explored within a New Zealand context. This study is exploratory in nature;

and is therefore limited to providing insight rather than direct generalisations; further, is based on an analysis of subjective views rather than empirical observation.

A purpose-created survey was utilised to obtain the subjective insight of practitioners regarding the use of case conceptualisation. The responses were subjected to descriptive and thematic based reviews; revealing the following: Practitioners are consistently and frequently utilising case conceptualisation in their practices, they are doing so in the belief that case conceptualisation offers an array of benefits to the client, the therapeutic relationship and to themselves. They are following a process similar to that identified by Eells (2007); with the ultimate aim of conceptualisation informing treatment.

The overarching theme identified in this research is "Case conceptualisation as a highly valued therapeutic process". It contains both; indicators that practitioner's value case conceptualisation; as well as, the value or benefit that case conceptualisation provides to the practitioner, client and therapeutic relationship. Case-level conceptualisation as a concept, is seen as the process that gets client and practitioner from disorganised content to descriptive clarity; which in turn, informs therapeutic treatment. In conclusion, the findings of this study indicate the high level of importance placed on case conceptualisation within New Zealand CBT *practices;* indicating that practitioners are going to continue their use of case conceptualisation. This highlights the need for further research of case-level conceptualisation; such as differences in conceptualisation at assessment and conceptualisation at termination.

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APPENDIX A

Ethics Approval

MASSEY UNIVERSITY

14 April 2011

Kim Kusel
[redacted]

Dear Kim

Re: Cognitive Behaviour Therapy Case Conceptualisation and Psychotherapeutic Practice – The Practitioner's Perspective

Thank you for your Low Risk Notification which was received on 6 April 2011.

Your project has been recorded on the Low Risk Database which is reported in the Annual Report of the Massey University Human Ethics Committees.

The low risk notification for this project is valid for a maximum of three years.

Please notify me if situations subsequently occur which cause you to reconsider your initial ethical analysis that it is safe to proceed without approval by one of the University's Human Ethics Committees.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:

> *"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.*
>
> *If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor John O'Neill, Director (Research Ethics), telephone 06 350 5249, e-mail humanethics@massey.ac.nz".*

Please note that if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to provide a full application to one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely

J. O'Neill

John G O'Neill (Professor)
Chair, Human Ethics Chairs' Committee and
Director (Research Ethics)

cc Dr Bev Haarhoff
School of Psychology
Albany

Assoc Prof Mandy Morgan, HoS
School of Psychology
PN320

APPENDIX B

Information Sheet

First Draft

Final Draft

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Cognitive Behaviour Therapy Case Conceptualisation and Psychotherapeutic Practice – The Practitioners Perspective.

INFORMATION SHEET

Researcher(s) Introduction

Survey Authors are: Kim Küsel; under the Supervision of Dr Beverly Haarhoff. This survey forms part of a thesis, which is a partial fulfilment for the degree of Master of Arts (Psychology), at Massey University; Albany.

Project Description and Invitation

This research aims to examine the relationship between practicing cognitive behaviour therapists and the use of case conceptualisation in their everyday practice. Much research is currently underway into the validity of case conceptualisation with promising results to date. However, there is no current research into the way that clinicians are using Cognitive Behaviour Therapy case conceptualisation in their clinical practices. This information sheet serves as an invitation to participate in this research. We realise your time is important so participation will be limited to a quick online survey.

School of Psychology – Te Kura Hinengaro Tangata
Private Bag 102904, North Shore Mail Centre, Auckland 0745, New Zealand T +64 9 414 0800 extn 41244 F +64 9 414 0831
www.massey.ac.nz

Participant Identification and Recruitment

Participants are required to be ANZACBT registered members who are in current psychotherapeutic practice and are utilising Cognitive Behaviour Therapy as their primary treatment modality. Participants are to be recruited by advertising in the ANZACBT newsletter and requesting assistance. All participants who complete the survey will go into a random draw to win a prize; the winner will have three choices of prize as well as the option to donate the prize value to the Canterbury Earthquake Fund. The three prize choices are: an 8GB IPod Touch; a spa package to the value of $400, or a romantic night away for two in the area of your choice.

Project Procedures

This study will require you to complete an online survey about your personal use of case conceptualisation in your psychotherapeutic practice.

Data Management

The data obtained from this survey will be subjected to both statistical analysis and qualitative review. All responses will be coded and demographic information separated from the remainder of the survey. All data will be stored securely in password encrypted flash drives, with hard copies stored in a safe until disposal. Upon completion of data analysis the demographic information will be destroyed and the survey information will be stored in the research archives unless otherwise requested. All respondents are entitled to view the completed research; this will be made available on www.cbtccstudy.webs.com at the completion of the academic year.

Participant Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

· Decline to answer any particular question;

· Withdraw from the study;

· Ask any questions about the study at any time during participation;

· Provide information on the understanding that your name will not be used unless you give permission to the researcher;

· Be given access to a summary of the project findings when it is concluded.

Completion and return of this questionnaire implies consent. You have the right to decline to answer any particular question.

Project Contacts

Researcher:

Kim Küsel

Ph: [redacted]

Email: [redacted]

Supervisor:

Dr Beverly Haarhoff, Senior Lecturer, Massey University.

Ph: [redacted]

Email: [redacted]

Compulsory Statements

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor John O'Neil, Director, Research Ethics, telephone 063505249, email: humanethics@massey.ac.nz.

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Cognitive Behaviour Therapy Case Conceptualisation and Psychotherapeutic Practice – The Practitioners Perspective.

INFORMATION SHEET

Researcher(s) Introduction

This information sheet serves as an invitation for you to participate in my study entitled "Cognitive Behaviour Therapy Case Conceptualisation and Psychotherapeutic Practice – The Practitioners Perspective". My name is Kim Küsel; and I am under the Supervision of Dr Beverly Haarhoff. This survey forms part of a thesis, which is a partial fulfilment for the degree of Master of Arts (Psychology), at Massey University; Albany.

Project Description and Invitation

This research aims to examine the relationship between practicing Cognitive Behaviour Therapists and the use of case conceptualisation in their everyday practice. Much research is currently underway into the validity of case conceptualisation with promising results to date. However, there is no current research (in the New Zealand context), regarding the way that clinicians are using Cognitive Behaviour Therapy Case Conceptualisation in their clinical practice. This information sheet serves as an invitation to participate in this research. We realise your time is important so participation will be limited to a quick 15 minute survey.

Participant Identification and Recruitment

Participants are those working in the fields of mental and/or primary health care that utilise Cognitive Behaviour Therapy as their primary psychological treatment modality. Participants will be recruited through the Aotearoa New Zealand Association of Cognitive Behaviour Therapies (ANZACBT) newsletter and website, and through placement of hard copy information and surveys in places with high percentage of the sample population (i.e. DHB's). All participants who complete the survey will go into a random draw to win a prize; the winner will have three choices of prize as well as the option to donate the prize value to the Canterbury Earthquake Fund. The three prize choices are: an 8GB IPod Touch; a spa package to the value of $400, or a romantic night away for two in the area of your choice.

Project Procedures

This study will require you to complete an online, or hard copy survey about your personal use of Case Conceptualisation in your psychotherapeutic practice.

Data Management

The data obtained from this survey will be subjected to both statistical analysis and qualitative review. All responses will be coded and demographic information separated from the remainder of the survey. All data will be stored securely in password encrypted flash drives, with hard copies stored in a locked cupboard with Dr. Beverly Haarhoff (Supervisor) until disposal. Upon completion of data analysis the demographic information will be destroyed and the survey information will be stored in the research archives for an additional year (unless otherwise requested). All respondents are entitled to view the completed research; this will be made available on www.cbtccstudy.webs.com at the completion of the academic year.

Participant Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

· Decline to answer any particular question;

· Withdraw from the study at any time;

· Ask any questions via email about the study at any time during participation;

· Provide information on the understanding that your name will not be used unless you give permission to the researcher;

· Be given access to a summary of the project findings when it is concluded.

· Completion and return of this questionnaire implies consent. You have the right to decline to answer any particular question.

Project Contacts

Researcher:

Kim Küsel

Ph: [redacted]

Email: [redacted]

Supervisor:

Dr Beverly Haarhoff, Senior Lecturer, Massey University.

Ph: [redacted]

Email: [redacted]

Compulsory Statements

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor John O'Neil, Director, Research Ethics, telephone 063505249, email: humanethics@massey.ac.nz.

APPENDIX C

Survey

First Draft

Final Draft

Electronic Survey Print Out

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Cognitive Behaviour Therapy Case Conceptualisation and Psychotherapeutic Practice – The Practitioners Perspective.

1. *If* you agree that:

You have read the information sheet and you understand that you may ask further questions at any time. And you wish to participate in this study under the conditions set out in the information sheet.

Then: Please tick "I agree," and the sign and date below.

If you do not agree, please feel free to contact the researcher to discuss your concerns.

Please note that by submitting your agreement, you are legally consenting to participate in this research.

*If you wish to reread the Information Sheet at this time please visit: http://cbtccstudy.webs.com/

- ☐ I Agree
- ☐ I Do Not Agree

Signature:_____ Date:_____

2. Please enter your demographic information (optional - required if prize is won.)

Name:_____

Address: _____

City/Town:_____

Post Code: _____

Email Address:_____

Phone Number:_____

3. What year were you born? _____

4. What is your ethnic group? Please tick all that apply.

- ☐ European New Zealander
- ☐ Maori
- ☐ Pacific Islander
- ☐ European
- ☐ Asian
- ☐ Other (please specify):_____

5. Nationality. Please list all: _____

6. What is/are your professional title(s) / affiliation?

- ☐ Clinical Psychologist
- ☐ Registered Psychologist
- ☐ Nurse
- ☐ Occupational therapist
- ☐ Social worker / case worker
- ☐ Psychotherapist
- ☐ General Practitioner
- ☐ Psychiatrist
- ☐ Other

7. What is your current place of work?

- ☐ Private practice with others
- ☐ Private Practice on own
- ☐ DHB
- ☐ Hospital

- ☐ Prison
- ☐ Treatment centre
- ☐ Drug and Alcohol centre
- ☐ Other (please specify):_____

8. How would you describe your primary client group? (For example: children and adolescents; geriatrics, adults). _____

9. Approximately how long have you been practicing as a CBT therapist?

- ☐ 0-2 Years
- ☐ 2-5 Years
- ☐ 5-10 Years
- ☐ 10-15 Years
- ☐ 15+ Years

10. Approximate number of hours spent doing CBT per week? _____

11. Are you currently receiving supervision?

- ☐ Yes
- ☐ No
- ☐ Other
- ☐ If Yes, How often? _____

12. What is your highest academic qualification? _____

13. Do you utilise CBT case conceptualisation / formulation in your psychotherapeutic practice?

- ☐ Yes
- ☐ No
- ☐ Chose not to answer / don't know

If yes, please describe how and when you might use a CBT conceptualisation (I.e All the time or only in specific instances). Please elaborate: _____

14. What is your understanding of case conceptualisation / formulation? _____

15. How do you go about formulating a case conceptualisation? I.e. do you follow a particular format? Do you make notes or just work from memory? How in depth do you go? _____

16. What kind of client information do you use to formulate your CBT case conceptualisation? _____

17. What tools or measures do you use to formulate your CBT case conceptualisation? _____

18. How involved is the client in the conceptualisation process? _____

19. Does the conceptualisation influence the therapy and/or treatment of the client? Could you explain how this might occur, include examples if you wish:

_____

20. Does your case conceptualisation change as therapy progresses?

- ☐ Yes
- ☐ No
- ☐ Sometimes
- ☐ N/A

21. If your conceptualisation does change, could you explain how and why this might happen. _____

22. Have you ever attended a workshop on CBT case conceptualisation?

- Yes
- No
- N/A

If yes, please elaborate: _____

23. Have you completed any self study in the area of case conceptualisation?

I.E. Read books or articles.

- Yes
- No
- N/A

If yes, please elaborate: _____

24. Do you experience any difficulties regarding the construction of a CBT case conceptualisation? Could you describe what these might be? _____

25. If you do experience difficulties how do you think these could be overcome?

- Reading
- Attending workshops
- Supervision
- Personal therapy
- other

Thank you for taking the time to answer these questions. The prize winner will be contacted by the end of September.

26. If you wish to have the results of this study sent to you please provide your email or postal address below:

_____

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

Cognitive Behaviour Therapy Case Conceptualisation and Psychotherapeutic Practice – The Practitioners Perspective.

1. *If* you agree that:

You have read the information sheet and you understand that you may email the researcher to ask further questions at any time, and you wish to participate in this study under the conditions set out in the information sheet.

Then: Please tick "I agree," and the sign and date below.

If you do not agree, please feel free to contact the researcher to discuss your concerns.

Please note that by submitting your agreement, you are consenting to participate in this research.

*If you wish to reread the Information Sheet at this time please visit: http://cbtccstudy.webs.com/

- ☐ I Agree
- ☐ I Do Not Agree

Signature:_____

Date:_____

2. Please enter your demographic information (optional - required if prize is won.)

Name:_____

City/Town:_____

Email Address:_____

Phone Number:_____

3. What year were you born? _____

4. What is your ethnic group? Please tick all that apply.

- ☐ European New Zealander
- ☐ Maori
- ☐ Pacific Islander
- ☐ European
- ☐ Asian
- ☐ Other (please specify):_____

5. What is/are your professional title(s) / affiliation?

- ☐ Clinical Psychologist
- ☐ Registered Psychologist
- ☐ Nurse
- ☐ Occupational therapist
- ☐ Social worker / case worker
- ☐ Counsellor
- ☐ Psychotherapist
- ☐ General Practitioner
- ☐ Psychiatrist
- ☐ Other (please specify):_____

6. What is your current place of work?

- ☐ Private practice
- ☐ DHB
- ☐ Hospital
- ☐ Corrections
- ☐ Specialised Treatment centre
- ☐ Drug and Alcohol centre
- ☐ University Clinic

- ☐ Child, youth and family services
- ☐ Defence Force
- ☐ Community organisation
- ☐ Iwi Health Provider
- ☐ Other (please specify):_____

7. Who would you describe as your primary client group?

- ☐ Children and Adolescents
- ☐ Adults
- ☐ Older adults
- ☐ Other (please specify):_____

8. Approximately how long have you been practicing CBT?

- ☐ 0-2 Years
- ☐ 2-5 Years
- ☐ 5-10 Years
- ☐ 10-15 Years
- ☐ 15+ Years

9. Approximately how many hours do you spend doing CBT per week? _____

10. Are you currently receiving supervision?

- ☐ Yes
- ☐ No
- ☐ If Yes, How often? _____

11. What is your highest academic qualification? _____

12. Do you utilise CBT case conceptualisation / formulation in your psychotherapeutic practice?

- Yes
- No

If yes, please describe how and when you might use a CBT conceptualisation (I.e All the time or only in specific instances / complex cases). Please elaborate: _____

13. What is your understanding (or working definition) of case conceptualisation / formulation? _____

14. How do you go about formulating a case conceptualisation? I.e. do you follow a particular format? Do you make notes or just work from memory? How in depth do you go? _____

15. What kind of client information do you use to formulate your CBT case conceptualisation? _____

16. Do you utilise any tools or measures to formulate your CBT case conceptualisation?

- Yes
- No

If yes, please provide details: _____

17. How involved is the client in the conceptualisation process? _____

18. Does the conceptualisation influence the therapy and/or treatment of the client?

- Yes
- No
- Sometimes

If yes, could you explain how this might occur, include examples if you wish:

_____

19. Does your case conceptualisation change as therapy progresses?

- Yes
- No
- Sometimes

If yes, could you explain what would cause you to change your original conceptualisation? _____

20. Have you ever attended a workshop / conference / course on CBT case conceptualisation?

- Yes
- No
- N/A

If yes, please elaborate: _____

21. Have you completed any self study in the area of case conceptualisation?

I.E. Read books or articles.

- Yes
- No
- N/A

If yes, please elaborate: _____

22. Do you experience any particular difficulties regarding the construction of a CBT case conceptualisation?

- Yes
- No
- N/A

If yes, could you describe what these might be? _____

23. If you answered yes above, can you think of any ways in which these difficulties could be overcome? _____

Thank you for taking the time to answer these questions. The prize winner will be contacted by the end of September. If you wish to have the results of this study sent to you please provide your email or postal address below: _____

_____

CBT Case Conceptualisation and Psychotherapeutic Practice.

1. Study Consent

***1. If you agree that:**
You have read the information sheet and you understand that you may email the researcher to ask further questions at any time,
and you wish to participate in this study under the conditions set out in the information sheet.

Then: Please type "I agree," and the date in the text box below. i.e. "I agree, 28 June 2011".
If you do not agree, please feel free to contact the researcher to discuss your concerns.

Please note that by submitting your agreement to participate you are consenting to participate in this research.

***If you wish to re-read the Information Sheet at this time please visit:**
http://cbtccstudy.webs.com/

CBT Case Conceptualisation and Psychotherapeutic Practice.

2. Demographic Information

2. Please enter your demographic information (optional - required if prize is won.)

Name:

City/Town:

Email Address:

Phone Number:

***3. What year were you born?**

4. What is your ethnic group? Please select all that apply.

- [ ] European New Zealander
- [ ] Maori
- [ ] Pacific Islander
- [ ] European
- [ ] Asian
- [ ] Other (please specify)

***5. What is/are your professional title(s) / affiliation?**

- [ ] Clinical Psychologist
- [ ] Registered Psychologist
- [ ] Nurse
- [ ] Occupational therapist
- [ ] Social worker
- [ ] Counsellor
- [ ] Psychotherapist
- [ ] General Practitioner
- [ ] Psychiatrist
- [ ] Other (please specify)

CBT Case Conceptualisation and Psychotherapeutic Practice.

***6. What is/are your current place(s) of work?**

- [ ] Private practice
- [ ] DHB
- [ ] Hospital
- [ ] Corrections
- [ ] Specialised Treatment center
- [ ] Drug and Alcohol center
- [ ] University Clinic
- [ ] Child, youth and family services
- [ ] Defence Force
- [ ] Community Organisation
- [ ] Iwi Health Provider
- [ ] Other (please specify)

***7. Who would you describe as your primary client group?**

- [ ] Children and Adolescents
- [ ] Adults
- [ ] Older adults
- [ ] Other (please specify)

***8. Approximately how long have you been practicing CBT?**

- ◯ 0-2 Years
- ◯ 2-5 Years
- ◯ 5-10 Years
- ◯ 10-15 Years
- ◯ 15+ Years

***9. Approximately how many hours do you spend doing CBT per week.**

***10. Are you currently receiving supervision?**

- ◯ Yes
- ◯ No

If Yes, How often?

CBT Case Conceptualisation and Psychotherapeutic Practice.

***11. What is your highest academic qualification?**

CBT Case Conceptualisation and Psychotherapeutic Practice.

3. Case Conceptualisation use.

***12. Do you utilise CBT case conceptualisation / formulation in your psychotherapeutic practice?**

- ◯ Yes
- ◯ No
- ◯ Don't know.

If yes, please describe how and when you might use a CBT conceptualisation (I.e. All the time or only in specific instances / Complex cases).Please elaborate:

CBT Case Conceptualisation and Psychotherapeutic Practice.

4. Case Conceptualisation Details.

***13. What is your understanding (or working definition) of case conceptualisation / formulation?**

***14. How do you go about fomulating a case conceptualisation? i.e. do you follow a particular format? Do you make notes or just work from memory? How in depth do you go?**

***15. What kind of client information do you use to formulate your CBT case conceptualisation?**

***16. Do you utilise any tools or measures to formulate your CBT case conceptualisation?**

◯ Yes

◯ No

If yes, please provide details.

***17. How involved is the client in the conceptualisation process?**

CBT Case Conceptualisation and Psychotherapeutic Practice.

***18. Does the conceptualisation influence the therapy and/or treatment of the client?**

- ◯ Yes
- ◯ No
- ◯ Sometimes

If yes, could you explain how this might occur in the box below, include examples if you wish.

***19. Does your case conceptualisation change as therapy progresses?**

- ◯ Yes
- ◯ No
- ◯ Sometimes

If yes, could you explain what would cause you to change your original conceptualisation?

CBT Case Conceptualisation and Psychotherapeutic Practice.

5. Further Learning

***20. Have you ever attended a workshop / conference / course on CBT case conceptualisation?**

- ◯ Yes
- ◯ No

If yes, please provide details.

***21. Have you completed any self study in the area of case conceptualisation? i.e. Read books or articles.**

- ◯ Yes
- ◯ No

If yes, please provide details.

22. Do you experience any particular difficulties regarding the construction of a CBT case conceptualisation?

- ◯ Yes
- ◯ No
- ◯ N/A

If yes, could you describe what these might be?

23. If you answered yes above, can you think of any ways in which these difficulties could be overcome?

CBT Case Conceptualisation and Psychotherapeutic Practice.

6. Thank You

Thank you for taking the time to answer these questions. The prize winner will be contacted by the end of September.

24. If you wish to have the results of this study sent to you please enter your email, or postal address, below.

APPENDIX D

Letter to Expert Panel Requesting Assistance

Dear Expert Panel Member,

I am writing to you with a request for assistance. I am a master's student, collecting data for my thesis, entitled Cognitive Behaviour Therapy Case Conceptualisation and Psychotherapeutic Practice: The Practitioner Perspective. As you will be aware, my supervisor Dr Beverly Haarhoff has approached you with a request for your assistance in the task outlined below.

I have designed an online survey for the purpose of data collection and would be grateful if you would review the content of the survey and provide feedback regarding any issues / problems you identify; as well as your personal reaction to an online survey of this nature.

It would be greatly appreciated if you could pay special attention to the following:

- Clarity of the question.
- Length of the survey.
- Ease of navigation through the web pages.
- Any item(s) you believe may have been omitted and could add further value to the study
- Any other comments you feel may be relevant.

I Realise your time is valuable but I would be extremely grateful for any feedback you can provide. At this stage we are hoping to publish the survey early to mid June which will provide you with four weeks to complete the above task. Upon completion please return your feedback to Dr Beverly Haarhoff by placing it in her mail box.

Again, many thanks for your time.

Kind Regards,

Kim Küsel

Kim_cbtcc@vodafone.co.nz

APPENDIX E

Expert Panel Suggestions

EXPERT PANEL SUGGESTIONS

Expert Details

Expert 1: Senior Lecturer & Clinical Psychologist

Expert 2: Senior Clinical Psychologist

Expert 3: Senior Clinician and CBT Practitioner

Expert 4: Senior Clinical Psychologist

Expert 5: Associate Professor in Psych and CBT

Expert 6: Senior Psych and CBT lecturer

Expert Suggestions

Information Sheet

Expert 1: Increase sample pool by removing prerequisite of ANZACBT registration.

Expert 2: Clear and concise.

Expert 3: Clear and easy to understand.

Expert 6: Identified grammatical error and suggested adding more detail on certain issues; re storage.

Survey

Question 1.

Expert 1: Remove “legally” from consent statement.

Expert 6: Grammatical errors

Question 2.

Expert 2: Good to keep required info to minimum.

Expert 6: Suggested removing address section to encourage more participation.

Question 3.

Expert 3: Suggest providing multiple choice options instead of open ended response.

Question 4.

Expert 1: Combine with Q5

Question 5.

Expert 1: Combine with Q4

Expert 5: Same as Q4.

Question 6.

Expert 3: Provided additional multiple choice option.

Question 7.

Expert 1: Provided additional options

Expert 3: Provided additional multiple choice options.

Expert 4: Make it possible to select multiple options.

Expert 6: Allow selection of multiple options

Question 8.

Expert 1: Change to multiple choice options

Expert 4: Grammatical error.

Expert 5: Suggested alternate wording – Older adults instead of geriatrics.

Expert 6: Change to multiple choice option rather than open-ended.

Question 9.

Expert 4: Suggested different wording.

Question 10.

None

Question 11.

None

Question 12.

None

Question 13.

Expert 4: Suggested clarifying the question

Expert 6: Remove "chose not to answer" as an option.

Question 14.

Expert 1: Check wording as question very broad.

Question 15.

Expert 5: Suggested clarifying question or wording in a different way.

Question 16.

None

Question 17.

Expert 1: Change to 2-part question. 1- do you and 2 - then what.

Question 18.

Expert 1: Change to 2-part question. 1- do you and 2 - then what.

Question 19.

Expert 5: Change question from yes/no type answer to more open-ended.

Expert 6: Suggested splitting question into 2 parts.

Question 20.

None

Question 21.

None

Question 22.

Expert 6: Remove N/A as an option.

Question 23.

None

Question 24.

Expert 1: Wording clumsy

Expert 6: Split into 2 part question.

Question 25.

Expert 1: Change to personal use rather than general recommendation.

Question 26.

None

General Comments

Expert 2: Questions seem clear, concise and well ordered.

Expert 3: Time survey to assess how long it will take to complete and add into Info sheet.

Expert 4: Easy to navigate, not too long.