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“The map, the navigator, and the explorer”

Evaluating the content and quality of CBT case conceptualizations and the role of self-practice/self-reflection as a training intervention.

A thesis presented in partial fulfillment of the requirements of the Doctor of Philosophy in Psychology at Massey University Albany New Zealand

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Abstract

Cognitive Behaviour Therapy (CBT) leads the way as an evidenced based psychotherapy, and the evaluation of CBT training programs is increasingly seen as important if this position is to be maintained. In this dissertation, CBT case conceptualization, as a core psychotherapeutic competency, acquired in training, is evaluated. Case conceptualization, integrates precipitating, predisposing, maintaining, and protective factors, functioning as an explanatory and prescriptive roadmap for therapy.

Gaining self-knowledge through exposure to some form of personal therapy is cited as important in gaining psychotherapeutic competency. Self-practice/ self-reflection, show promise as a form of personal therapy compatible with the principles of CBT.

This study evaluates the content and quality of CBT case conceptualizations produced by a sample of 26 participants who have completed the Massey University Post Graduate Diploma, using three case conceptualization rating scales. In addition, the impact of a self-practice/self-reflection manualised training intervention designed to improve the quality of case conceptualization in trainee cognitive behaviour therapists, is explored using thematic analysis.

The evaluation of the CBT conceptualizations showed predisposing factors and psychological mechanisms as receiving the most attention from participants. However, the majority of participants failed to pay attention to socio-cultural, biological, protective factors and factors pertaining to the therapeutic relationship. The majority of the participants were able to produce a "good enough" CBT case conceptualization, however the 'problem list' was not well developed, and the conceptually relevant aspects of the therapeutic relationship and protective factors were given less attention.

The effect of a self-practice/self-reflection training intervention on the quality of CBT case conceptualizations produced by the intervention group (n = 16) drawn from the main participant sample, was qualitatively evaluated using thematic analysis. Theoretical understanding of the model, self awareness, empathy, conceptualization of the therapeutic relationship, adaptation of clinical interventions, and clinical practice were all subjectively perceived by participants to have increased as a result of the intervention.

An inferential analysis compared the performance of the intervention group (n=16) that of a comparison group (n=10), made up of the remainder of the larger sample described in the context of the first question. The comparison group had not been exposed to the manualised intervention. The comparison was both within, and between the two groups. The quality of the intervention group showed an improvement on one of the rating scales, indicating a possible link between the training intervention and case conceptualization competency, however, the improvement was not replicated by the other two rating scales.

The findings are discussed in the context of improving CBT training with regard to case conceptualization.

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"Where, and how is the poor wretch to acquire the ideal qualifications which he will need for his profession? The answer is in the analysis of himself with which the preparation for his future activity begins."

(Freud, 1937/1943 p.246)

Chapter one

Introduction

"Research on the process of training is as important as the study of various therapeutic modalities themselves" (Henry, Schacht, Butler & Binder, 1993, p. 447).

"Expertise in counselling and therapy is both desirable and elusive" (Jennings et al., 2003, p. 59)

Overview

Training cognitive behaviour therapists

Due to an impressive evidence base, and wide range of applicability across diverse mental health problems and disorders, Cognitive Behaviour Therapy (CBT) has become one of the most widely sought after psychotherapies in the developed world (Hollon & Beck, 2004), and the demand for effective evidenced based psychotherapy, is growing (Holland, 2006). In the United Kingdom, the National Institute for Health and Clinical Excellence (NICE), estimated that between 5,000 and 10,000 cognitive therapists need to be trained over the next ten years to meet the increasing demand (Holland, 2006). The need for well trained therapists capable of delivering evidenced based psychotherapy is mirrored in the New Zealand context as demonstrated by the New Zealand Mental Health Survey' statistics which show that 47% of the New Zealand population will meet the criteria for a mental disorder at some time in their lives and, that in comparison with both developed and underdeveloped countries, New Zealand has a high prevalence of anxiety, mood, and substance use disorders (Oakley Browne, Wells & Scott, 2006). In view of this, the development of effective evidenced based

clinical training programmes to ensure good use of the limited resources allocated for mental health training is an important priority (National Mental Health Workforce Development Coordinating Committee, 1999). Training cognitive behaviour therapists is therefore important and we need to do it more effectively by identifying and streamlining mastery of core competencies. Systematic evaluation of teaching methods is an important part of this process.

For the past eight years I have been involved with the development, teaching, and supervision of the Massey University Post Graduate Diploma in Cognitive Behaviour Therapy (PGDipCBT). The PGDipCBT is based on the Vail "practitioner/scholar" model of clinical training (Stoltenberg, Pace, Kashubeck-West, Biever, Patterson, & Welsh, 2000). As a consequence of this involvement I have become increasingly aware of the importance of evaluating training to the methods, particularly regarding the transfer of knowledge gained in training to actual clinical practice. The post graduate diploma is the first of its kind in the Southern hemisphere which makes the development and evaluation of training methods to improve core psychotherapeutic competencies in CBT extremely important in establishing the credibility of the training.

Evaluating therapist training

Despite recognition of the importance of high quality clinical training, and the fact that some authors have expressed concern regarding the need for a more focussed approach to the evaluation of the training of psychotherapists (Binder, 1993, Shaw & Dobson, 1988, Dobson & Shaw, 1993), there continue to be comparatively few studies which evaluate psychotherapy training (Binder, 1993, Binder, 1999). Difficulties accounting for this state of affairs are methodological complications, complexity and variability of the subject, problems in obtaining funding for an

area of research which falls between psychotherapy and education, organisational constraints common in the workplace such as competing models, entrenched medical hierarchies and practices, and most importantly, the lack of a theoretical framework or model of therapist skill acquisition (Bennett-Levy, 2006). The result of the above factors is that an emphasis on building a firm evidence base supporting training methods in psychotherapy, or researching transfer of training to the workplace, has not been a mainstream focus in psychotherapy research.

Recently, however, the effectiveness of CBT training has been identified as an important issue as the effectiveness of new treatment interventions can be negatively affected by poor generalisation of skills to the workplace (Freiheit and Overholzer, 1997; Milne, Dudley, Pepper & Milne, 2001; Bennett-Levy, 2006). Several studies in CBT have shown that training has improved overall competency (Milne, Baker, Blackburn, James & Reichfelt , 1999; Williams, Moorey & Cobb, 1991). However the processes involved in the improvement of specific competencies such as case conceptualisation, have not received similar attention (Bennett-Levy, 2006).

Case Conceptualisation as a core CBT competency

The identification of core competencies which should be included in training programs is a critical starting point in planning CBT training. Knowledge of case conceptualisation, the capacity to build an effective therapeutic relationship, and the ability to apply conceptually congruent tailored interventions, are identified as key CBT competencies (Dobson & Shaw, 1993). The importance of case conceptualisation as a key competency is supported by general consensus from all established psychotherapeutic orientations (Eells, 1997, Eells, 2007; Eifert, 1996, Persons, 1989; Persons, 2005). This consensus is amplified by the division of

clinical psychology of the British Psychological Society (2001) which has selected case conceptualisation as one of the core skills involved in the defining role of "scientist practitioner". In cognitive behaviour therapy it is regarded as "a cornerstone of evidenced-based cognitive behaviour therapy practice" (Kuyken, 2006 p. 309) and is listed as one of its guiding principles (Beck, 1995; Blackburn & Twaddle, 1996). Furthermore, Jerome Frank, the leading advocate for the "common factor" approach in psychotherapy, selects what he calls "a conceptual scheme, rationale, or myth which provides a plausible explanation for the patient's problems", as one of four factors common to all psychotherapies (Frank & Frank, 1993, p. 40-43).

Aims and objectives

In this research, case conceptualisation takes centre stage as a key competency to be acquired in CBT training. Two broad questions are asked; first, what is the content and quality of CBT case conceptualisations produced by clinicians who have completed the specialist training delivered by the Massey University Post Graduate Diploma in CBT? Secondly, what is the impact or effect, of a manualised training intervention on the content and quality of CBT case conceptualisation? Each of these questions is discussed below.

Evaluating the content and quality of CBT case conceptualisations

Although case conceptualisation is widely regarded as a key competency there are few examples of clear criteria for systematic evaluation. In addition, routine evaluation of case conceptualisation skills in psychiatric and psychotherapy training is relatively uncommon (Eells, 1997, Eells, 2007).

Taking the above statements into account, the following questions have guided this research:

"What kind of information do novice CBT clinicians generally include in their case conceptualisations?" "What kind of information do they omit?" "What components of information should be included in a CBT case conceptualisation of quality?" and, "What is the quality of CBT case conceptualisations produced by novice CBT clinicians?"

To answer these questions, three case conceptualisation rating scales are utilized to evaluate the content and quality of case conceptualisations produced by the research participants. One of the rating scales is a comprehensive CBT Case Conceptualisation rating scale developed specifically for this research.

The impact of a self-practice/self-reflection training intervention on the quality of CBT conceptualisations

A generally held assumption, by those involved in the training of clinicians, is that effective instruction in complex clinical skills such as case conceptualisation cannot be provided by "book knowledge" alone. In addition to "hands on" clinical practice, greater self-knowledge is often cited as one of the most important ways a trainee therapist can develop psychotherapeutic competency (Henry, Strupp, Butler, Schacht and Binder, 1993). In this research, the impact of a manualised self-practice/self-reflection intervention designed to enhance conceptual self-awareness in the context of the CBT model, is qualitatively evaluated. The next question asks, "If conceptual self-understanding is enhanced through the experience of self-practice/self-reflection within the framework of the CBT model, will the improved conceptual self-understanding generalise, and influence the quality of the CBT case conceptualisations, produced by the participants?"

To facilitate this, a self-practice/self-reflection workbook "Understanding Myself" has been designed as an addition to standard CBT training methods. Influenced by psychotherapies' (other than the Cognitive Behavioural therapies) traditional reliance on "personal therapy", as an important training mechanism, the workbook utilises self-practice/self-reflection (practicing psychotherapy techniques on self as therapist and reflecting on the process), as potentially helpful mechanisms which could be used in the training of cognitive behaviour therapists to facilitate the development of case conceptualisation competency. It is proposed that this could occur firstly, through an increased understanding of "self" in the context of the of the CBT model, and secondly by the ability to generalise this learning to the use of the CBT case conceptualisation in clinical practice.

Organisation of the thesis

The chapters will be organised in the following manner. Chapter two outlines case conceptualisation as a key psychotherapeutic competency, with particular emphasis on the way in which it is conceived in CBT. In this chapter, the importance, together with the functions of case conceptualisation is discussed. In addition, the three levels of conceptualisation are described, and the "disorder specific" and "individualised" case conceptualisation distinguished, along with the identification of the components of superior case CBT conceptualisation. In chapter three, the research on the evaluation of content and quality of case conceptualisation is reviewed. Self-practice/self-reflection, as forms of personal therapy compatible with the principles and practices of CBT are introduced in chapter four. The utility of these processes, as training mechanisms which may impact on the quality of case conceptualisation, is discussed in the context of

literature describing methods for training clinicians in case conceptualisation skills. Bennett-Levy's (2006) Declarative-Procedural-Reflective model for psychotherapy skill acquisition is outlined to provide theoretical support for the inclusion of self-practice/ self-reflection as potentially useful training components. Chapter four concludes with a review of the main themes outlined in the literature thus far, and revisits the research objectives. Chapter five presents the research methodology in two parts. Part one outlines the main study, and part two, describes two preliminary studies. The preliminary studies trace the development of the case vignettes used to elicit the case conceptualisations evaluated in the main study. The results of the research are presented in three chapters. Chapter six documents the results of the evaluation of *content* and *quality* of CBT case conceptualistions produced by all the participants, chapter seven presents the qualitative analysis of the self-reflections contained in the manualised self-practice/self-reflection workbook , and chapter eight, the within, and between group comparisons. The *within* group comparison, compares the results of three content and quality of case conceptualisation rating scales, before and after an intervention group had completed a manualised self-practice/self-reflection workbook. The *between* group comparison, compares the content and quality of CBT case conceptualisations of the *intervention group* and a *comparison* group, which did not complete the manualised intervention. Chapter nine, is a discussion leading to a number of conclusions and recommendations for training in CBT case conceptualisation.

Terminology

"Formulation" and "conceptualisation" often appear as interchangeable in the psychotherapy literature, the term "conceptualisation" being more frequently used in CBT. This author distinguishes these concepts in the following manner: A *case formulation* in psychotherapy refers to the generic task of linking relevant

information relating to the patient's presenting problems in terms of predisposing, precipitating, protective, and perpetuating or maintaining factors. This includes the notion of assessment, and the collection of relevant data. The *conceptualisation* is the *theoretical model* which orders and makes sense of (explains) this information. In this thesis the focus is on case formulation informed by the CBT theoretical model. In the following chapters, the term *case conceptualisation* will be used in line with the usage common in CBT. The term *conceptualisation* also emphasises the explanatory and inferential functions of the process which are highlighted in this dissertation. From time to time however *case formulation* will continue to be used interchangeably with conceptualisation. This will occur because some of the studies reported use "formulation" to describe the process. It is anticipated that the reader will recognise that the terms both refer to the same process and tolerate this occasional inconsistency.

"Patient" and "client" are also used interchangeably to refer to the individual receiving psychotherapy. Similarly "clinician" and "therapist" refer to the individual delivering the psychotherapy. The two groups compared in the main study will be referred to as the intervention and comparison groups.

Chapter two

Case conceptualisation in cognitive behaviour therapy

"….case formulation is a core psychotherapy skill that lies at the intersection of diagnosis and treatment, theory and practice, science and art, and etiology and description" (Eells, 2007 p. 4).

In this chapter, case conceptualisation is defined and the main functions of the process outlined, highlighting the importance and utility, of the process, in psychotherapy generally. This is followed by a description of the way in which the case conceptualisation is conceived and utilised in CBT, making the distinction between individualised and disorder specific CBT case conceptualisation. The importance of the individualised case conceptualisation is theoretically justified and the empirical support for individualised case conceptualisation in CBT is discussed. This distinction is emphasised as, in this research, the focus is on individualised CBT case conceptualisation. The chapter concludes with a description of the components of clinical information considered important in a comprehensive individualised CBT case conceptualisation.

Case conceptualisation defined

Case conceptualisation has been variously defined as; "an hypothesis about the causes, precipitants, and maintaining influences of a person's psychological, interpersonal and behavioural problems" (Eells, 1997, p. 1); "a parsimonious

understanding of clients and their problems that guides effective and efficient treatment" (Sacco & Beck, 1995 cited in Needleman, 1999 p. 3); "an individualised model of a patient's problems and their hypothesised causes" (Mumma, 1998, p. 251), and "Individually-tailored treatments based on idiographic functional analysis, guided by psychological theory" (Eifert, 1996, p. 75). All of these definitions emphasise the notion that the case conceptualisation provides a "map" or "blueprint" for therapy by systematically drawing together the precipitating, predisposing, perpetuating, and protective factors thought to be idiosyncratically related to a particular patient's presenting psychological problems.

The functions of the case conceptualisation

The individualised case conceptualisation links theory, research and practice, helping the therapist organise large amounts of complex information. A hypothesised, explanatory account of the patient's problems, together with the identification of a mechanism for change which has implications for treatment planning is the result (Eells, 1997; Persons, 1989). In CBT a competent case conceptualisation will provide clear guidelines for specific treatment interventions. Predictions concerning obstacles to therapy, positive or negative outcomes, client suitability for psychotherapy, and the nature of the therapeutic relationship can be made on the basis of a competent case conceptualisation. Furthermore if a case conceptualisation is systematically constructed and written down, treatment stages can be evaluated and points of treatment failure or success better understood (Persons, 2005). This facilitates high quality supervision. When, as recommended in CBT, the case conceptualisation is collaboratively shared with the patient, problems can be normalised and contextualised which facilitates empathy (Kuyken, 2006).

A primary task of the psychotherapist is to make informed decisions concerning the selection of appropriate and efficacious interventions which will enable the patient to overcome or manage psychological problems. The case conceptualisation, as a conceptual bridge between assessment and intervention, is central to this decision making task (Meier, 2003), translating theory to therapy (Tarrier, 2006). In most busy clinical settings, many patients have several problems with multiple causal variables of differing significance and, in addition, the same problem can be precipitated and maintained by different variables, making the clinical decisions complex. This is compounded by the fact that in psychotherapy there are different treatments for the same problem. For example, a behaviour therapist would encourage the patient to increase pleasurable activities to combat depression, a psychodynamic approach would emphasise the contribution of historical and developmental factors in maintaining the depression and focus on interpretation to promote insight, and a biological approach would emphasise the importance of a pharmacological solution. The use of a structured case conceptualisation can assist the clinician's constructive engagement with the factors listed above (multiple problems and possible interventions), by providing a hypothetical framework which integrates and summarises the most important aspects of the case.

A well structured, explicitly documented case conceptualisation provides the clinician with a flexible feedback loop, whereby decisions are made explicit, points of success or failure can be identified, and accountability fostered (Persons, 1989). A conceptualisation generates hypotheses, which are tested through the

application of treatment (Tarrier, 2006 p. 4). The classic single case research design (Kazdin, 1982), is thus created in the "real-life" clinical milieu fostering an "on the spot evidence-based" practice (see Figure 1 for an illustration of the "feedback loop").

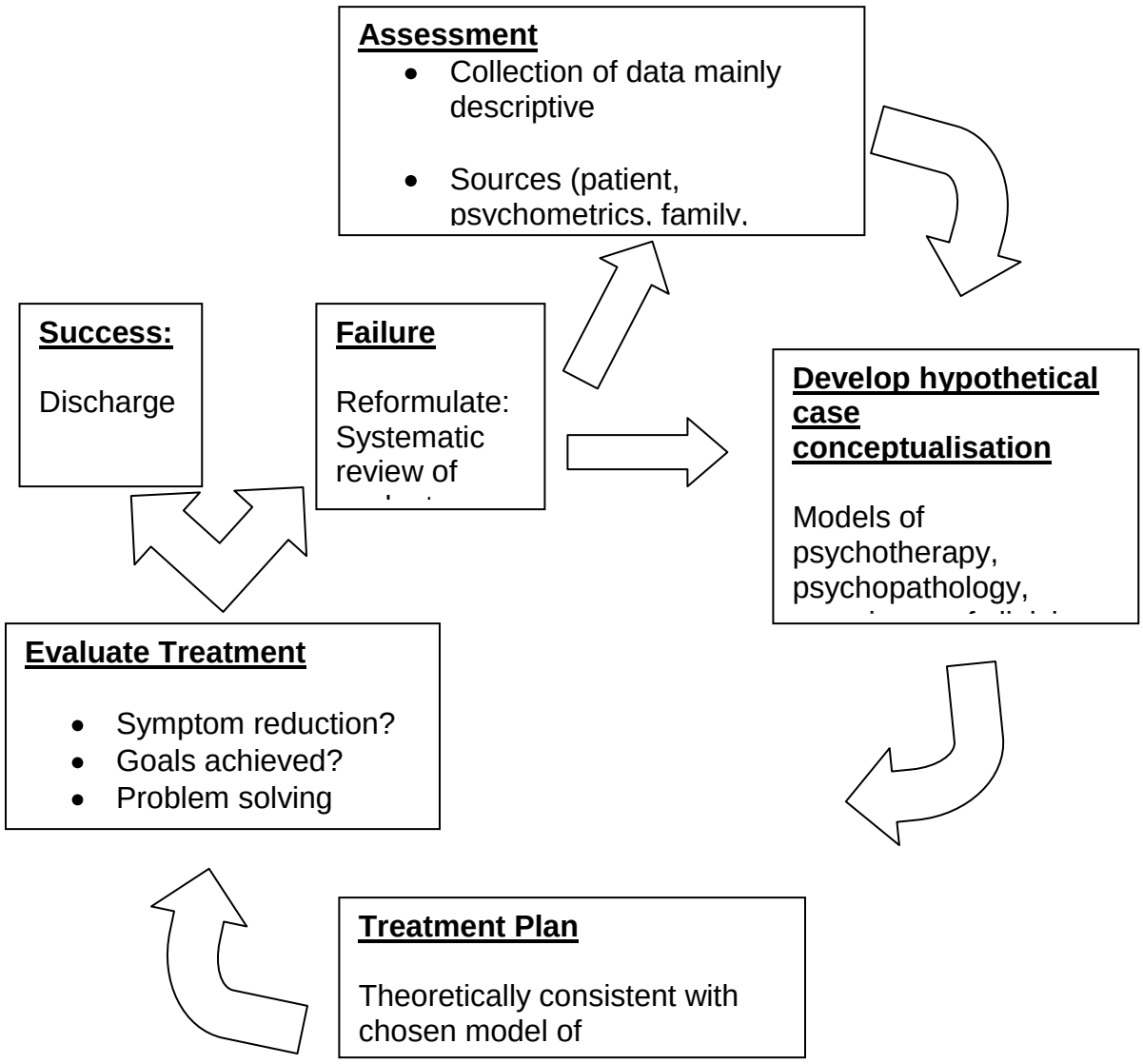


Figure 1. **Case conceptualisation feedback loop**

Having a case conceptualisation enables the clinician to make predictions about therapy interfering, or therapy enhancing behaviour. This can improve the therapeutic relationship by promoting empathy when the clinician is faced with difficulties such as homework non-compliance (Haarhoff & Kazantzis, 2007;

Kazantzis, Macewan, & Dattillio, 2005). In addition challenging behaviours can be conceptualised and strategically managed in a manner consistent with the psychotherapy model being used. When constructed collaboratively, and shared with the patient, patient motivation, and confidence in therapy is often increased (Meier, 2003). This aspect resonates with Jerome Frank's identification of the "conceptual scheme which provides a plausible explanation for the patient's problems" as a fundamental common factor associated with positive treatment outcome (Frank & Frank, 1993). Increased motivation is the result of a greater understanding of problems which often seem overwhelming at the beginning of psychotherapy.

To summarise, a well constructed individualised case conceptualsation, which is theoretically grounded in a sound evidenced- based model, open to scrutiny and evaluation, functions as a useful clinical, therapeutic, integrative tool for the clinician (Needleman 1999; Persons, 1989; Sim, Gwee & Bateman, 2005).

The CBT model as guiding template

Case conceptualisations are based on theories of psychological change. A theory enables the clinician to propose a hypothetical explanation for the patient's psychological difficulties. Meier (2003) describes this "explanation" or conceptualisation as the link between process elements (the etiology), and outcome elements (the multiple problems presented by the patient in therapy).

The conceptual template guiding the CBT case conceptualisation can be summarised as follows: perception, informed by idiosyncratic cognitive processes (beliefs), influences the way in which circumstances and events are interpreted or

perceived. The idiosyncratic perception of situations affects emotional experience, and influences behaviour (Beck, 1976). CBT therefore places an emphasis on cognition as an important mediating factor in the genesis and maintenance of psychological problems which are often evidenced by a negative emotional experience and unhelpful behaviour patterns.

The CBT model proposes three different levels of cognition, expressed hierarchically, namely core beliefs or schema, intermediate beliefs, and automatic thoughts. (Beck, et al., 1990) At the deepest level are the schema or core beliefs. A schema is a stable structure originating from early childhood experiences, in which the individual's beliefs about self, others, the world and the future reside (Blackburn & Davidson, 1995). It is proposed that schemas or core beliefs, are unconditional, and have a profound impact upon which aspects of experience the individual attends to and how these experiences are interpreted. Cognitions deriving from these core structures are called intermediate beliefs. Intermediate beliefs occur across situations, are conditional, and often expressed as "if….then…." statements. They assist the individual cope with the perceived consequences of the unconditional core beliefs. For example, the assumption; "If I put the needs of others before my own, then I will be accepted", might derive from a core belief "I am unlovable". Intermediate beliefs are expressed as assumptions, attitudes, and rules, which guide behaviour (for example pleasing others), and influence emotion, in this example, anxiety. The most accessible cognitive level of is that of the automatic thoughts, which are specific to particular situations or triggers. Automatic thoughts are uncensored, reflex commentaries on specific situations (Blackburn & Davidson, 1995).

Some schema or underlying beliefs are typical of certain psychological problems or disorders. For example, those diagnosed as depressed have a negative view of themselves, the world, and the future, this is known as the "negative cognitive triad" in depression (Beck, Rush, Shaw & Emery, 1979). On the other hand, anxious individuals have a tendency to overestimate future threat and underestimate of own ability to cope (Beck , Emery, & Greenberg, 1985). The link between certain kinds of emotions and specific cognitions is referred to as the "cognitive specificity hypothesis" (Beck et al., 1979), which is at the heart of the CBT model. These specific cognitive models specify schema or beliefs characteristic of particular diagnostic presentations. On this basis emotions, behaviour patterns, and thought processes can be predicted, for example, an anxious patient would have a tendency to magnify and catastrophize about the possibility of danger and disaster with resultant avoidant or dependant behaviour patterns.

Individualised and disorder specific CBT case conceptualisations

The proposed specificity of cognitive processes assists with treatment planning, for example, identifying and modifying dysfunctional negative thinking patterns in depression. These specific cognitive models are known as *disorder specific conceptualisations*. Disorder specific conceptualisations are dependent on an accurate diagnosis. A classic example of a disorder specific conceptualisation is the "Panic Hook" model (Clark, 1988). In this model it is proposed that the patient has an enduring tendency to catastrophic misinterpretation of bodily symptoms (usually anxiety symptoms). The model suggests, an individual suffering from panic attacks might interpret rapid heart beat, a common anxiety symptom, as an indication of a heart attack. This catastrophic belief increases the physical manifestation of anxiety, (the rapid heart beat), and the patient becomes more

convinced that he is about to die. The intervention involves inducing symptoms of anxiety, exposing the patient to these sensations, and simultaneously modifying the dysfunctional beliefs associated with the misinterpretation. In this way the patient comes to view his physical symptoms as simply the result of anxiety and thus is able to challenge the catastrophic belief.

CBT has a strong reputation as an evidenced- based psychotherapy. The evidence base in CBT is derived from numerous randomised controlled trials which have compared treatment protocols. The NIMH Treatment for Depression Collaborative Research Program (Elkin et al., 1989) is an example of the use of randomised controlled trials in psychotherapy. Participants are selected on the basis of a clear diagnosis and randomly assigned to different treatment conditions. Adherence to manualised treatment protocols based on disorder specific case conceptualisations is enforced through careful supervision of the therapists delivering the treatments, and every effort is made to eliminate individual differences which may occur between therapists, so that the contribution of the specific treatments, can be compared. This emphasis on treatment uniformity appears to undercut the importance placed on the individualized conceptualisation by many prominent CBT proponents (Beck, 1995; Padesky, 1996; Persons; 1989)

The contradiction between the importance of individualizing treatment plans according to the idiosyncratic symptomatology presented by individual patients and the use of manualised treatment protocols , resembles the debate between ideographic (individualised) and nomothetic (general) orientations (Evans, 1996). In CBT the debate is concretised in divided opinion regarding the application of standardised manualised treatment protocols which have been developed for randomised controlled trials, or individualised treatment plans derived from

individualised conceptualisations based on theory driven principles (Eifert, 1996; Wilson, 1996).

There are strong arguments which favour the standardised approach, for example a clear evidence base, easy duplication, straightforward training of therapists. In addition, the increased emphasis on managed, cost effective treatment in the public mental health sector in most developed countries, legally requires that practitioners use evidenced based treatment protocols when the diagnosis is clear (Persons & Silberschatz, 1998).

However, in real-life clinical practice, using a standardised approach is not as simple as the outcomes of some randomised controlled trials would suggest, namely making a diagnosis and matching the appropriate evidenced based protocol. Whilst diagnostically specific treatment protocols, are useful they are often not wholly satisfactory due to comorbidity (multiple problems or disorders), multiple therapies (medication and psychotherapy, or different forms of psychotherapy), implementation difficulties, such a failure to complete homework tasks, treatment failure, or when, in unusual presentations, there is no protocol available (Eifert, 1996; Evans, 1996; Persons, 1989; Persons 1991; Persons, 2005). As previously stated, **w**hen an individualised case conceptualisation is formulated the selection and implementation of appropriately targeted treatment interventions is streamlined. The explanatory power of the individualised case conceptualisation is amplified as it resonates with the patient's idiosyncratic phenomenology. This increases the motivation of both therapist and patient as the direction and process of the therapy is clarified. Obstacles to therapy can be identified and the clinician can strategise to overcome these early in therapy optimizing the chances of a good therapeutic relationship and alliance (Needleman, 1999).

Empirical support for the individualised case conceptualisation

Given the growth of manualised step by step disorder specific CBT treatment protocols which have been shown to be effective, is there a place in CBT for the individualised case conceptualisation? Furthermore, is treatment derived from an indivdualised case conceptualisation superior to manualised disorder specific treatment protocols? Underlying these questions is a concern that the use of individualised case conceptualisation may undermine the empiricism that CBT prides itself on, in that, clinicians may ignore reliable well validated treatment protocols preferring to construct their own highly individualised conceptualisations (Wilson, 1996).

Addressing these questions, a small number of studies have compared manualised treatment protocols with individualised case formulations. Standardised and individualised CBT treatment of Obsessive Compulsive Disorder (OCD) was compared (Emmelkamp, Bouman, & Blaauw, 1994), and found to be equally effective. The following three therapies were compared in the treatment of specific phobia; an individualised treatment where the therapist was given a free rein in terms of intervention, a standardised package which consisted of in-vivo exposure, and a yoked control group, where each patient received the same treatment as those in the individualised group. The results showed the standardised treatment as the most effective (Schulte, Kunzel, Pepping, & Schulte-Bahrenberg, 1992; Schulte, D. 1996). In a study tracking outcome in marital therapy, a standardised treatment package, consisting of six modules applied in sequence, was compared to the same six modules applied in whatever order the therapist deemed fit on the basis of an individualised conceptualisation. The two treatments were equally

effective post treatment, but the clients receiving the individually tailored treatment did better after a six-month follow up thus giving the individualised package a slight edge (Jacobson, Schmaling, Holzworth-Munroe, Katt, Wood, & Folette, 1989). Forty-five patients, most of whom presented with comorbid problems, treated by Persons using individualised CBT case conceptualisations, (Persons, et al., 1995) had outcomes similar to those treated with standardised Cognitive Therapy in the NIMH Treatment for depression Collaborative Research Program (Elkin et al. 1989). This study indicates that treating more complex cases using an individualised conceptualisation yields similar outcomes to less complex disorders, in this instance uncomplicated depression, showing that an individualised case conceptualisation is very useful under these circumstances.

These few comparative studies are somewhat inconclusive (unfortunately a conclusion all too often reached when attempting to evaluate particular components of psychotherapy) however, do offer some support for the use of standardised protocols in cases where the diagnosis is clear and the treatment protocol empirically established. The first two studies used patients diagnosed with OCD and Specific Phobia. These are diagnostic presentations particularly responsive to the well-researched treatment interventions of "response prevention" and "in-vivo exposure".

There is also some tentative support for the utility of the individualised case conceptualisation in cases of greater complexity. Persons (2005), points to the fact that some of the most widely used treatment protocols such as CBT for Depression (Beck, et al.,1979) and Cognitive Therapy; Basics and Beyond (Beck, 1995) which have demonstrated efficacy, are written in a "principles driven" manner, rather than in a highly structured cookbook type format. This approach relies on

clinicians' selecting appropriate interventions based on idiosyncratic assessment and conceptualisation, rather than sticking to a strict order of intervention. Other examples of principle driven treatment manuals are; Dialectical Behaviour Therapy (Linehan, 1993), and Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 2003).

In addition, some recent studies show that feedback to therapists regarding the progress of patients (whether positive or negative) affects the outcome of treatment, demonstrating that individualised adjustments have a beneficial effect (Lambert, Hansen, & Finch, 2001). Individualised case conceptualisation approaches have been used in clinical trials, in the treatment of schizophrenia (Tarrier, et al., 1998), Post Traumatic Stress Disorder (Tarrier, Sommerfield, & Pilgrim, 1999), and juvenile offending (Henggeler, Melton, & Smith 1992).

To sum up, there are advantages and disadvantages in the use of standardised treatment protocols in clinical practice. The advantages are; most importantly, the treatments have been shown to be effective in randomised controlled trials. The use of manuals structures and focuses treatment and encourages the use of core psychotherapy principles such as, specifying the goals of therapy, providing a clear rationale for treatment and giving feedback. Treatment manuals also clarify the use of particular strategies and interventions making training easier both in the learning and the monitoring of the skills acquired (Wilson, 1996). The disadvantages relate to a critique of the randomised controlled trial which supports the use of standardised protocols. This critique is the following; sample selection is perceived as biased and unrepresentative, with many of the complex cases typical of clinical practice ruled out. A relatively inflexible treatment protocol can be problematic in a treatment programme which is being evaluated in a

naturalistic setting. The advantages in using a more individualised approach in research would be to approximate a more "real life" situation and to focus more on the psychological processes rather than the diagnosis.

A more comprehensive and pragmatic approach is to use the disorder specific and individualised case conceptualisations in an integrated way (Persons and Davidson, 2001). As previously mentioned it would be foolhardy and irresponsible to ignore well established effective treatment protocols in favour of an idiosyncratic hypothesis. Similarly, disregarding idiosyncratic information provided by the patient which can be used to enrich the standardised protocol, would be equally dysfunctional. The integrated approach is well described in the following manner; "Nomothetic and ideographic perspectives are typically contrasted as opposites, yet they can be used as complementary approaches with different purposes" (Meier, 2003, p. 6)

It would seem therefore that in Person's words, the jury remains out regarding the relative superiority of either approach. In a recent paper, Persons (2005) debates the utility of these questions. She points to the fact that case conceptualisation is not a specific "treatment", but a "*principles driven approach"* which systematically adapts evidenced based treatment protocols to accommodate the idiosyncratic requirements of patients.

The structural CBT model

Persons (1989) proposed a structural model for parsimonious case conceptualisation. Her model has been influential, and is widely quoted and referred to by authors interested in case conceptualisation (Mumma, 1998,

Needleman, 1999). The result has been the production of a variety of visual conceptual formats or diagrams based on her original model (Needleman, 1999).

Person's model conceptualised patients' psychological problems as occurring on two interacting levels namely, "overt difficulties" and "covert difficulties" (underlying psychological mechanisms). Overt difficulties are the real life problems that the patient brings to therapy, for example, depressed mood, panic attacks, relationship difficulties, angry outbursts etc. The underlying psychological mechanisms are "the psychological deficits that underlie and cause the overt difficulties" (Persons, 1989 p. 6). These are often expressed in terms of a number of "core" or central beliefs or schema, about the self, world, and other people. These core beliefs are unconditional, generally originate from early experience and exert a strong influence on perception. For example an anxious mood and avoidant behaviour patterns fuelled by catastrophic thinking about impending danger (overt level), may be maintained by an underlying belief "I am a vulnerable weak person" (covert or underlying mechanism).

Person's model is an interactive one, proposing a logical connection between significant factors, and, that change in one area impacts on the other areas. This is known as the "interdependence hypothesis" which shows that interventions directed at one system, for example thinking, appear to produce changes in all systems (Zeiss, Lewinsohn, & Muňoz, 1979; Rehm, Kaslow & Rabin, 1987; Simons, Garfield & Murphy,1984), for example, less catastrophic thinking could reduce anxiety and foster more adventurous behaviour. In a functional analysis consistent with the CBT model, the patient's problems manifest in cognition, emotion, physiology and behaviour. The underlying psychological mechanism (schema or core belief) is believed to be a significant factor in the maintenance of some of the

overt problems. The structural model underlies the construction of an individualised case conceptualisation specifying which idiosyncratic presenting problems are maintained by which prominent and problematic core beliefs.

The three levels of conceptualisation in CBT

Persons and Davidson (2001) describe three levels of case conceptualisation which should be integrated when formulating a comprehensive CBT case conceptualisation, namely, *situational, disorder specific*, and *individualised levels of case conceptualisation*.

The situational conceptualisation

The situational conceptualisation is a formulation of a specific situation related to a problem. In CBT this takes the form of a functional analysis, for example the specific thoughts, emotions, physiological, and behavioural reactions which occur in response to a trigger. The situational conceptualisations provide the basis for the hypothesised patterns identified and used in the individualised case formulation (Beck 1995). For example, the underlying meaning of the patient's many negative automatic thoughts in a variety of situations, may relate to a small number of cross-situational underlying beliefs. Examples of situational, conceptualisations are the Dysfunctional Thought Record (Beck, 1979); the Five-Part Model (Padesky & Mooney, 1990; Greenberger & Padesky, 1995), and the Behavioural Chain Analysis (Linehan, 1993). The Five-Part model is particularly useful as it clearly indicates the cyclical nature of response patterns, which maintain or exacerbate problems. The triggering situation is recorded in the large surrounding circle, which represents the idea that there is a wider context to the immediate problem. The smaller circles show the patient's responses to the situation in the cognitive, affective,

physiological, and behavioural domains. The arrows between the smaller circles indicate a cycle where one thing leads to another. It is easy, in this context, to introduce the possibility of change to the patient who can clearly see that a small change in one of the circles will impact on all. The dysfunctional thought record enables the patient to record the triggering situation, the emotional response, and the resulting negative automatic thoughts, and the way in which an alternative more helpful thought can positively influence a negative emotion.

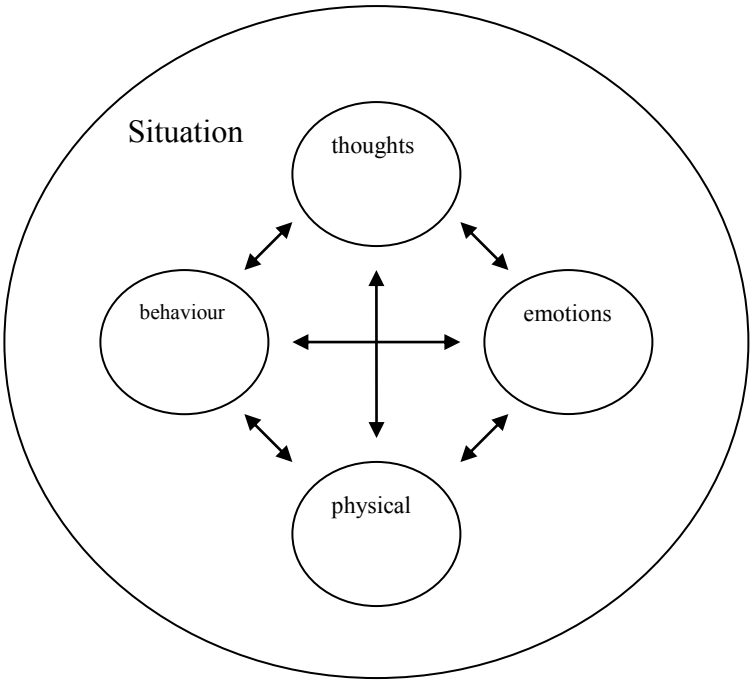


Figure 2 **. The Five-Part model (Padesky & Mooney, 1990)**

The Disorder Specific conceptualisation

Secondly, the CBT therapist can formulate at the level of the diagnosis. This is referred to as the disorder specific conceptualisation. A well known example is that of panic disorder. Here the disorder specific conceptualisation proposes that individuals given this diagnosis misinterpret bodily sensations (usually

physiological manifestations of anxiety such as breathlessness and racing heart in a catastrophic manner ("I'm having a heart attack") thus exacerbating the symptoms. Disorder specific conceptualisations specify which thought processes and maintaining behaviour patterns are characteristic of particular diagnostic presentations. Sharing the disorder specific conceptualisation with the patient provides a compelling rationale for the treatment plan. In the case of panic disorder this would involve exposing the patient to the feared symptoms through a panic induction (Wells, 1997).

The Individualized case conceptualisation

The individualised case conceptualisation is an integration of information obtained from the situational and disorder specific conceptual frameworks, together with more idiosyncratic information provided by the client (Padesky, 1996). The situational conceptualisation provides a functional analysis of the overt problems, which have brought the patient to therapy, out of which idiosyncratic maintaining patterns and cycles can be detected. The disorder specific conceptualisation will indicate cognitive processes typical of the diagnosis, or diagnostic cluster. An individualised conceptualisation is tailored to the specific phenomenology of the patient. Building on the Person's model, Needleman (1999), suggests that in addition to the patient's integrated cognitive, affective, and behavioural response to triggering circumstances, the following elements need to be incorporated and meaningfully related, when developing an individualised conceptualisation: The particular circumstances that activate the responses, the reaction of the environment to the patient's behaviour, and the negative events that precipitated the patient's vulnerability to the specific problems. Hypothetical predictions about

possible therapy interfering and therapy enhancing factors can be included together with the implications these may have for the therapeutic relationship.

As previously discussed, the individualised case conceptualisation is important for the following reasons, first, it assists the therapist in planning treatment for those patients suffering from multiple disorders or diagnoses, such as personality disordered patients, or those presenting with an unusual diagnosis for which there is no evidence supported treatment available. Second, it enables the clinician to manage difficulties arising in therapy, particularly therapy interfering behaviours or issues which may cause ruptures in the therapeutic relationship. Third it helps with treatment failure, and can assist when patients are having more than one treatment (Beck, 1995, Mumma, 1998, Needleman. 1999, Persons, 1989). Fourth, an individualised case conceptualisation helps the clinician understand and manage his or her own reactions to the patient which is important in managing the therapeutic relationship (Haarhoff & Kazantzis, 2007; Persons, 2005).

Information required for an individualised CBT case conceptualisation

Persons and Tompkins (2007), propose seven steps necessary in obtaining and structuring the clinical information necessary for a comprehensive individualised case conceptualisation. These are: the problem list, a five Axial diagnosis, an anchoring diagnosis, the selection of a disorder specific conceptualisation of the anchoring diagnosis, an individualised template obtained by collecting information concerning cognitive, behavioural, emotional, and physiological factors relevant to the presenting problems, a hypotheses about the origins of the mechanisms (predisposing factors), and finally a description of the precipitants. Protective factors, such as strengths, relationship factors, or other supports, should

be included, along with any indication of therapy interfering, or therapy enhancing factors. Needleman (1999), and Beck (1995) provide headings under which to summarise the patient's relevant childhood data, core beliefs, conditional assumptions, beliefs, rules and compensatory behaviours. These would make up the "individualised template' proposed by Persons and Tompkins (2007). The maintenance of the problems in terms of vulnerability and epidemiological factors, and the role of interpersonal systems should also be considered (Tarrier & Calam, 2002). The components of information which are integrated in an individualised CBT case conceptualisation will be described in detail in the following chapter.

In summary, case conceptualisation is considered a core competency in the delivery of CBT. There is strong theoretical support for the clinical utility of a well constructed individualised case conceptualisation. Empirical support is less clear with no unambiguous superiority established for the individualised CBT case conceptualisation. Persons (2005), however, raises the pertinent point that comparing standardised treatment protocols with an individualised treatment based on an individualised case conceptualisation is misguided as individually conceptualising a patient is an *approach* to treatment not a treatment per se.

Randomised controlled trials have provided information about the general efficacy for the "average" patient. The disorder specific standardised protocols are therefore an important starting point for the development of a case conceptualisation. However, clinicians should become skilled at integrating this general empirically supported information with that which is specific, unique and meaningful to the patient in the form of an individualised case conceptualisation.

The following chapter will examine the small amount of research on the content and quality of individualised case conceptualisation.

Chapter three

What are the components of information required for a case conceptualisation of quality?

"There is a universe of potentially available information about patients. One must decide what information is most relevant, how to obtain it, and how to integrate what has been obtained, and how to relate it to what are often nebulous and ill-defined categories…"
Faust (1986, p. 423)

In the previous chapter the importance of case conceptualisation in psychotherapy generally, and CBT in particular was explained with reference to the descriptive, explanatory, and predictive functions inherent in the process. "Disorder specific" and "individualised" CBT case conceptualisations were distinguished, and the debate concerning the clinical utility of each discussed with reference to the small number of studies comparing individualised case conceptualisation with manualised disorder specific protocols. A conclusion regarding the practical utility of integrating both forms of conceptualisation was reached. The CBT theory guiding case conceptualisation was presented and the suggested components of a high quality CBT case conceptualisation were listed.

In this chapter, the literature regarding what constitutes clinically useful "content" of a case conceptualisation/ formulation is reviewed. The nature of the information selected for inclusion in a case conceptualisation underpins the "quality" of the

case formulation. The first question in this study concerns the "content' of case formulations produced by novice CBT clinicians and asks what categories of information are given attention, or ignored, and what implications this has for the quality of the case conceptualisation? Two methods used for the assessment of case conceptualisation are described, and the studies examining the content and quality of case conceptualisation/formulation using these measures are discussed. The measures are the Case Formulation Content Coding method (Eells, Kendjelic, & Lucas, 1998) and the Quality of Cognitive Therapy Case Formulation rating scale (Fothergill & Kuyken, 2002). Both these measures are used in the current research for the evaluation of the content and quality of the case conceptualisations produced by the participants in this study.

The few studies addressing the reliability (the degree to which clinicians agree on the salient features of the case conceptualisation when given the same clinical information), and the validity, or clinical utility of the case conceptualisation are discussed. The validity of the individualised case has been discussed in the previous chapter where Persons (2005) concluded that these questions are somewhat misdirected as case conceptualisation is not a specific treatment but a "principles driven" approach to treatment. I would agree with this position and would argue that whilst reliability and validity may be relevant questions, they may be premature in the examination of the case conceptualisation process. Changing the focus to the consideration of what constitutes a high quality case conceptualisation is, in my opinion, a more practical first step when considering the implications for training clinicians in this complex skill. In this research the emphasis is placed on the quality of the content of case conceptualisations produced by novice cognitive behaviour therapists and the broader considerations of reliability and validity are only discussed in this context.

Evaluation of case conceptualisation content

Given the consensus regarding the importance of case conceptualisation in clinical practice, it makes intuitive sense to develop mechanisms for evaluating the content and quality of case conceptualisations. Unfortunately reviews of psychiatric and clinical training programs have found little, if any evidence to suggest that either clear criteria for evaluation, or routine assessment of case conceptualisations takes place (Eells, Kendjelic, & Lucas. 1998). The lack of clear assessment and criteria for evaluation reflects the difficulties inherent in making judgements about what exactly constitutes a quality clinical case conceptualisation. Given the plethora of psychotherapy models, an important question is "What type of information should a clinically useful case conceptualisation contain?"

A Chicago psychoanalyst (Seitz, 1966 cited in Eells, 1997), was the first to articulate the lack of clarity around the sort of information which should be included in a case conceptualisation. He labelled the apparent confusion or disharmony the "consensus issue in psychoanalysis" (Eells, 1997 p. 13). For three years, Seitz documented the work of a group of Chicago psychoanalysts who reviewed each others' case notes and independently constructed case formulations based on that information. Seitz observed that there was little consensus concerning conceptually relevant information. He was particularly critical of the interpretive methods used by the group which often strayed from what the patient had actually presented in the session (Eells, 1997). Seitz's paper was influential, and his concerns relating to the lack of consensus regarding content resulted in systematic efforts, initially from within psychoanalysis and later by other theoretical orientations in psychotherapy, aimed at improving consensus about relevant information for a useful case

conceptualisation. As a consequence, in the last thirty years, there has been considerable progress towards achieving agreement about the kind of data which should be collected for a case conceptualisation (Eells, 1997).

To date, most systematic models of case conceptualisation would include a description of the presenting problems, the patient's developmental history, precipitating and predisposing factors, maintaining factors, strengths or protective factors, weaknesses, and some suggestions for treatment based on the collected information (Bieling & Kuyken, 2003). The systematic collection of this information has been facilitated by the development of structured methods for data collection, which are either diagrammed, or systematically summarised in a particular format. The Judith Beck (1995) case conceptual diagram is an example of one of the formats commonly used in CBT.

Structured methods of case conceptualisation have generally been developed for outcome research purposes, and methods now exist for most well established psychotherapy orientations. Fifteen of these model specific, structured methods are collected in an edited book (Eells, 1997, Eells, 2007). The following seven common features characterise these structured methods and assist with developing reliability or consensus (Luborsky et al. 1993); 1) the focus is on relationship interactions expressed in psychotherapy sessions; 2) core relationship patterns are identified based on the frequency with which patterns are conveyed in therapy; 3) clinical judgement, and the patient's self-report are taken account of; 4) provisions to assess inter-clinician agreement as to the inferred underlying mechanisms are included; 5) inference is based on the observable statements and behaviours (avoiding interpretation); 6) the case conceptualisation is broken down into components each of which can be evaluated individually for reliability; and 7)

psychotherapy integration is encouraged, for example, the notion that enduring maladaptive cognitive representations or schemas, are implicated in many psychological disorders. The aim of the case conceptualisation is to integrate various pieces of information to form an explanatory picture of the presenting problems so as to guide treatment planning.

The common features outlined above were influential in the development of the first content coding manual (the Case Formulation Content Coding method), used to assess the content and quality of case formulation across different models of psychotherapy (Eells et al. 1998). This is, to date, the only published manual which reliably codes categories of information in the content of case conceptualisation across models of psychotherapy. To develop the manual, a variety of case conceptualisation methods were analysed so that broad categories of relevant information could be established.

On this basis, categories of information were distinguished as being contained in the content of most case conceptualisation methods across theoretical orientations (Eells et al. 1998). The categories are: symptoms and problems, precipitating stressors or events, predisposing life events or stressors, and a mechanism linking the preceding categories together in an explanatory manner. From a psychotherapeutic point of view, the most important mechanism would be the psychological one, however biological and socio-cultural mechanisms are also included in the method. The problem/symptom list, predisposing and precipitating events categories would contain predominantly descriptive information, although perception and attention would be influenced by psychotherapeutic orientation and model. The final category, which suggests the mechanism maintaining the problem, is inferential and most influenced by

psychotherapeutic theory, and thus lies at the core of the case conceptualisation. Other categories were various types of descriptive information, therapy interfering and therapy enhancing factors, and overall levels of adjustment. The categories themselves are theoretically neutral and therefore can be usefully applied across different models.

Evaluation of case conceptualisation quality

A high quality case conceptualisation is defined as "a parsimonious, coherent, justifiable, and meaningful account of a client's presenting problems" (Fothergill & Kuyken, 2002, p. 13). A first step towards improving the quality of case conceptualisation is to categorise the clinical information used to construct the case conceptualisation (Eells et al. 1998). Once the information has been categorised it can be compared and evaluated across a number of different dimensions or criteria such as quality and elaboration. The Case Formulation Content Coding Method has four *content* categories, namely, descriptive, diagnostic, inferential, and treatment planning categories of information. These categories are considered representative of the type of information contained in most case conceptualisation methods.

An exploratory study tested the reliability of data on the Case Formulation Content Coding Method, sought to establish the categories as broad and inclusive, and assessed the comprehensiveness and quality of a set of written case formulations (Eells, et al., 1998). From a pool of approximately 300 intake reports at an inner-city outpatient psychiatric unit, 56 reports were randomly selected. The interviewers were nine psychiatric residents, four social workers and a psychiatric nurse. Their psychotherapeutic orientations were CBT, psychodynamic, and

humanistic. The sample of patients was broad and represented a typical inner city psychiatric population. Two advanced clinical psychology students coded the content of the reports using the Case Formulation Content Coding Method. Results showed high reliability for both content and quality categories (mean kappa = 0.86) and that the method tapped an adequate range of information (as described above).

The Case Formulation Content Coding method used the following descriptive categories to assess the quality of case conceptualisation; complexity (the degree to which the case conceptualisation takes into account several factors relating to the presenting problem and integrates these facets into a meaningful account), degree of inference (the extent to which the case conceptualisation moves beyond simple descriptive information in the consideration of theory driven hypothesis), precision of language (the tailoring of language to the specific individual, as opposed to generic language). A five-point scale was developed to measure the degree to which these categories were present (1 = not present, 2 = rudimentary presentation, 3 = adequate presentation, 4 = good presentation, and 5 = excellent presentation). The means obtained for the categories of quality were; complexity, 2.05 (*SD*=.94), degree of inference, 1.80 (*SD*=.77) and precision of language, 2.57 (*SD*=.93). The authors found that overall the clinicians in this study tended to use the case conceptualisation to summarise descriptive data and placed less emphasis on the inferential aspects of the case conceptualisation, and there was little evidence that the different elements of the case conceptualisations were meaningfully integrated to provide an explanatory account of the patients' problems.

This trend (a focus on descriptive data), is also present in the only study evaluating reliability and quality in Cognitive Therapy case conceptualisation (Kuyken, Fothergill, Musa, & Chadwick, 2004) (this study is reported later in this chapter). These authors speculate that the tendency to summarise descriptive data at the expense of presenting an explanatory inferential hypothesis accounting for the patients' problems, supports the view that case conceptualisation is a "poorly taught skill" (a factor highlighted by Sperry et al., 1992 cited in Eells, 1997). The inferential part of the case conceptualisation proposes the theory or hypothesis that links the descriptive and diagnostic categories in a theoretically consistent and meaningful way. The inferential information is the crux of the case conceptualisation and determines how the treatment will be designed and the patient managed in an optimal manner. It is in this area that the quality of the case conceptualisation is revealed.

An expanded and revised Case formulation Content Coding Method was used to evaluate the quality of the case formulations produced by expert, experienced, and novice psychotherapists from psychodynamic and CBT backgrounds (Eells & Lombart, 2003; Eells, et al., 2005). Additional quality categories included were comprehensiveness (the range of inferential categories discussed), formulation elaboration (the degree to which the clinician developed the inferred information category), coherence (the degree to which the formulation provided an internally consistent account of the patient's problems), and "goodness of fit" of treatment plan (extent to which the treatment plan was consistent with the formulation).

Sixty-five participants completed all the requirements for the study, of these participants, 24 were novices (less than 1500 hours of supervised experience), 19 were defined as experienced clinicians (more than 10 years of practice), and a

further 22 defined as "expert". To be an "expert" at least one of the following criteria had to apply: the development of a system of case formulation, publications regarding case formulation, be leaders of workshops in the field of case formulation, or have obtained national recognition as an expert in the area. The formulations of the expert therapists were predicted to be of higher quality than both the experienced and novice clinicians in terms of the criteria of quality listed above. The participants were required to construct case formulations based on six case vignettes describing patients with one of three common psychiatric disorders (Generalised Anxiety Disorder, Major Depressive Disorder, and Borderline Personality Disorder). The vignettes were presented to the participant via audiotape over the telephone (they were also given a written copy of the vignette and allowed to make notes while the audiotape was played). After this the participant was invited to "think aloud" about the content of the vignette for five minutes, addressing what they thought was important. A further two minutes was allocated to reflecting upon an appropriate treatment plan. After the participants had completed the "think aloud" exercise for each vignette, six post interview questionnaires (one for each vignette) were mailed to participants.

The recorded case formulations based on the case vignettes were transcribed and segmented into idea units (an idea unit is a fragment of language, sentence, phrase of word which is judged to contain a complete idea, (Stinson, Milbrath, Reidbord, & Bucci, 1994), and then content coded and rated on the different dimensions of quality listed above. Results showed that, as predicted, the case formulations of the experts were of higher quality across multiple dimensions than those of the experienced and novice participants. The following cognitive characteristics are proposed as factors which may account for the superiority of the experts; 1) practice; 2) the perception of meaningful patterns; 3) an emphasis on general

principles and using a consistent, systematic formulation process across all case vignettes; and 4) an ability to skilfully self- monitor or *self-reflect*, making them more vigilant to the errors they might make. Differences between the groups regarding the balance of the content of information across the descriptive, diagnostic, inferential, and treatment categories included in the formulations were noted, together with the relative importance the different groups attached to the components. As far as the relative importance of the components was concerned most of the clinicians placed more emphasis on symptoms and problems, precipitating stressors, coping or defensive styles, and childhood history. One surprising finding was that the case formulations of the novice group were of higher quality than those of the experienced group, suggesting either "overconfidence" in the experienced group or a "training drift" as clinicians become more experienced.

The proposed differences in the approaches of the expert therapists when compared to the other groups have implications for improving training. It is suggested that training in case conceptualisation could be improved by training novices in the use of the processes thought to be characteristic of expert performance namely practice in case formulation, general principles , systematic methods, and self monitoring or self-reflection. Self-monitoring in this instance refers to self-awareness of one's own psychological process and the possible effect that this may have on the type of clinical information given attention. For example an awareness of one's emotional reactions to certain clients may give an indication of the client's belief system or some of the potential relationship problems which may occur as a consequence. The reference to self-monitoring is of interest to this research which investigates the impact of self-reflection on case conceptualisation

competency, which includes the ability to reflect on the therapeutic relationship in a conceptually congruent manner.

The quality and reliability of cognitive therapy case formulations, using the Quality of Cognitive Therapy Case Formulation Rating Scale, was evaluated (Fothergill & Kuyken, 2002; Kuyken, et al. 2004). In this scale, the selection of items to evaluate quality was influenced by the quality categories in the Case Formulation Content Coding method, but adapted to fit more closely with the specific cognitive therapy orientation (the authors were only evaluating cognitive therapists whereas the Case Formulation Content Coding method is designed to evaluate different models of psychotherapy including psychodynamic, humanistic and CBT models). The quality of Cognitive Therapy case formulation was rated as a whole, on a four- point scale (4 = good, 3 = good enough, 2 = poor and 1 = very poor). According to this rating scale the cognitive therapy case conceptualisation should integrate relevant cognitive therapy information to provide a meaningful account of the patient's psychological problems in cognitive therapy terms. This would mean identification of core beliefs, underlying assumptions and compensatory behaviours. "Relevant" childhood data should be based on descriptive information obtained from the patient (factual data). The core beliefs, conditional assumptions, and compensatory strategies should be appropriate and meaningful inferences derived from this data. In addition the information should be accurate, relevant, and parsimonious, with the information recorded in the correct section of the conceptualisation diagram (Fothergill & Kuyken, 2002).

The reliability of the conceptualisations was established by comparing the case conceptualisations with one another and with the benchmark case conceptualisation provided by Judith Beck (an acknowledged expert in case

conceptualisation and a prominent author and practitioner of cognitive therapy). The index of quality used was the degree to which the case conceptualisations produced by the participants corresponded with the benchmark case conceptualisation provided by Judith Beck. The quality and reliability of the participants' case conceptualisations was assessed in three continuing education workshops on cognitive case formulation conducted by first author of the study (Fothergill). In these workshops participants were given an opportunity to practice case conceptualisation using the Judith Beck case conceptualisation diagram.

A sample of 115 mental health practitioners, with at least a basic knowledge of cognitive therapy participated in the study. Half of the participants had completed a professional training and 20.9% of the sample were accredited cognitive therapy practitioners. The "case of Anna", a client presenting with major depression and personality difficulties was used in all workshops for the case conceptualisation. The information provided was based on an intake interview and included presenting problems, a psycho-social history, the results of standard psychological assessments, and a multi axial diagnosis. In addition participants were provided with written copies a three typical thought records and watched a video tape where they observed the therapist discussing the thought record with the client. Judith Beck provided the benchmark case conceptualisation based on the information outlined above. Participants were given the intake assessment information concerning "Anna" before the workshops. During the workshops they were supplied with theoretical information about case formulation and taught how to use the Case Conceptualisation Diagram. They were then asked to complete the blank case conceptualisation diagram using the source materials described above.

As far as quality was concerned, when participants' case conceptualisations were compared with the benchmark, there was high agreement in the categories relating to childhood data, core beliefs, and compensatory strategies. When coded for quality using the Quality Rating Scale, 43.4% of the formulations were at least "good enough" ("very poor" 21.7%, "poor" 33%, "good enough" 33.9%, and good 7.3%). The content (descriptive data) of the case conceptualisations was of high quality, but the way in which the information was integrated so as to be meaningful and coherent (inferential and explanatory information) was less well performed. Improved overall quality was associated with a higher level of professional qualification and British Association of Behaviour and Cognitive Therapy accreditation, showing that in this case, the quality of training made a difference. It is however surprising that less than half of the participants (43%) managed to be "good enough" even after what appears to be quite substantial prior training relating specifically the case of Anna. This raises the question concerning whether any additional training methods, such as a degree self-practice/ self-reflection, may have made a difference.

Case conceptualisation and reliability

The reliability of some the structured conceptual formats within the psychoanalytic orientation have been tested with encouraging results (Barber & Crits-Christophe, 1993). For example the Core Conflictual Relationship Theme case formulation method examined in eight studies (Luborsky & Diguer, 1998) has been shown as a reliable method of case formulation, demonstrating agreement in the moderate to good range (Kappa .6-.8). These case formulations were also related to improved patient outcomes. Although these limited studies have shown a degree of reliability there are limitations such as; very small samples, the bias and

investment of the researcher who developed the method, the influence of theoretical orientation, and the fact that positive outcomes in the psychodynamic studies appear to be limited to those patients who have good interpersonal relationship skills (Eells et al. 1998).

There is also some limited evidence to suggest that a degree of reliability in individualised case conceptualisation in CBT can be achieved. In one study, 46 clinicians listened to audiotapes of initial interviews with two patients, after which they were asked to construct case conceptualisations using Person's, 1989 model for CBT case conceptualisation (Persons, Mooney, & Padesky, 1995). In this model the overt level (presenting problems) is connected to the covert or level of underlying psychological difficulties. This study found that clinicians' ability to reliably identify presenting problems was 'good' but not 'outstanding'. The identification of the underlying psychological mechanisms, precipitating, and maintaining problems, was 'poor'.

In a later study Persons and Bertagnolli (1999), attempted to improve reliability by supplying the participants with specific problem domains, and a definition of the variety of schema which could be identified. Results showed agreement in identifying schema to be adequate across multiple judges, averaging K =.75 for randomly selected judges, however it remained poor for single judges K=.37. It would appear that good agreement on descriptive data was achieved but not maintained for the inferential data.

Mumma and Smith (2001) examined the reliability of case conceptualisation using narrative descriptions presented on videotape, of four patients, which were independently formulated by two pairs of clinicians. The reliability of mean ratings

was good for all 15 dimensions (K=.83) when aggregated across 10 clinical raters. As with the two previous studies the reliability for single clinician ratings was acceptable for the descriptive elements, but low for inferential elements (K = .33-.63).

As mentioned above in the assessment of quality, Kuyken, et al.(2004), also assessed the reliability of cognitive therapy case formulations. This study assessed the ability of 115 clinicians of different levels of experience and professional background, in producing a reliable cognitive therapy case conceptualisation. The cognitive therapy case formulations produced by the participants were compared with the "benchmark" formulation was provided by Judith Beck. The reliability was calculated on the percentage of agreement found between the "benchmark" conceptualisation and those of the participants. Results showed very good reliability between participants and the benchmark on the descriptive elements of the case formulation. As far as reliability was concerned, the levels of agreement were high for categories which related to early developmental experiences, and for the compensatory behaviours related to avoidance and self-harm and moderate for the more easily inferred categories such as core beliefs and compensatory behaviours. The agreement on dysfunctional assumptions was low. It was assumed by the authors that this occurred because these categories are more abstract and difficult to infer (relevant childhood data K=.91, core beliefs K=.83, dysfunctional assumptions K=.63, compensatory strategies K=.84). Reliability, therefore, decreased for aspects of the case conceptualisation requiring greater levels of theory driven inference. The use of the structured format, in this instance the Judith Beck conceptualisation diagram, did however facilitate reliability. Some authors suggest that the reliability between clinicians is less important than the *quality* of the case conceptualisation and that a highly focussed parsimonious case

conceptualisation may be more valuable for treatment planning, than a reliable one, of poor quality (Kuyken, et al. 2004).

In summary, there is a strong agreement regarding the type of information which should be included as content in a high quality case conceptualisation. The Case Formulation Content Coding Method and the Cognitive Therapy Quality Rating Scales have demonstrated that the evaluation of content and quality of case conceptualisation is possible to achieve. The few studies using these scales also show a consistency in the type of clinical information most clinicians (novice or experienced) attend to and that generally, the descriptive elements, of the case conceptualisation receive more emphasis than the inferential or theory driven aspects. The development of methods to evaluate the content and quality of case conceptualisations is in its infancy and it is hoped that this thesis will be a meaningful contribution to this area.

In the following chapter, *training* novice CBT clinicians in case conceptualisation skills will be discussed and self-practice and self-reflection are introduced as mechanisms which could potentially interact with, and improve case conceptualisation skills.

Chapter four

Training and CBT case conceptualisation: Does self-practice/self-reflection have a role?

"Although constructing a case formulation is quite difficult, little is known about how to train clinicians to do this" (Persons & Tompkins, 2007 p. 309)

The consensus regarding the status of case conceptualisation as a key psychotherapeutic competency has been extensively documented. There is also general agreement regarding the key functions of the process and the assumed positive effects on CBT practice (Kuyken, 2006). The agreement extends to the type of information which should be included in the content, of what would generally be considered, a high quality case conceptualisation (Eells et al, 1998; Eells, 1997, 2007; Persons & Tompkins, 2007).

Turning to the question of the content and quality of case conceptualisations produced by clinicians, several studies have shown that when case conceptualisations are systematically evaluated, the quality ratings, as far as the inferential theory driven aspects are concerned, are disappointing, and that most clinicians focus on descriptive information (Eells et al., 1998; Kuyken et al., 2004; Persons et al., 1995; Persons & Bertagnolli, 1999; Mumma & Smith, 2001). One study differentiated novice, experienced and expert clinicians and found (not surprisingly) that the experts produced superior case conceptualisations.

Commenting on factors accounting for this the authors noted practicing case conceptualisation of clients' presenting problems, the perception of meaningful patterns, an emphasis on general principles, the use of a consistent format (such as the Judith Beck form), and the ability to *skilfully self-monitor and self-reflect* (Eells et al., 2005). All of these factors, particularly the final one, are relevant to this thesis which investigates the impact of encouraging novice cognitive behavioural therapists to systematically reflect on their practice of CBT interventions, and measures the possible impact of this self-reflection on the quality of their case conceptualisations.

In this chapter, the changes which have taken place in CBT regarding the status of personal therapy as a training method and vehicle for professional development are enumerated. Self-practice/ self-reflection as forms of personal therapy compatible with the principles and practice of CBT, are introduced. Self-Practice is a process which involves practicing CBT interventions and strategies on oneself as therapist, for example using the dysfunctional thought record to identify unhelpful cognitions (Beck, 1995). Self-Reflection is the reflective consideration of both the process (for example, "what was it like to do a thought record?"; "Was it difficult?"), and the results of the self-practice (for example "How does this experience effect me, and my understanding of CBT?"). A review of the qualitative studies tracking the effects of personal therapy with particular emphasis on self-practice/self-reflection on the professional development of psychotherapists, with the emphasis on CBT, will be provided. The focus of the studies discussed in this chapter is on the improvement of a number of general psychotherapeutic competencies identified as integral to development of the novice CBT psychotherapist.

Moving beyond the studies documenting the improvement of general competency (Myles & Milne, 2004), the chapter reviews some of the strategies for training clinicians in case conceptualisation found in the literature, and concludes with some speculation concerning the way in which structured self-practice/self-reflection exercises could interact with the case conceptualisation competency of novice cognitive behaviour therapists. Finally the Declarative-Procedural - Reflective model for skill acquisition in psychotherapy (Bennett-Levy, 2006), is presented. This model emphasises the important role self-reflection has in the development of psychotherapeutic expertise and competence. The chapter concludes with an argument for the inclusion of self-practice/self-reflection in CBT training as a means towards the development of specific competencies such as case conceptualisation. Finally the main research objectives are outlined.

Psychotherapist development and the role of personal therapy

Personal therapy refers to psychological treatment of mental health practitioners, which can be a voluntary, or a required part of training (Geller, Norcross, & Orlinsky, 2005). Personal therapy can also be psychotherapy sought by psychotherapists for the purpose of examining personal psychological problems and processes with the goal of personal and professional development (Norcross, 2005). Traditionally, personal therapy involves the selection of a therapist and attending therapy sessions in the same way as a client or patient would. Personal therapy has, since the development of psychoanalysis, been seen as a cornerstone in most established models of psychotherapy (Laireiter & Willutski, 2003; Norcross, Strausser, & Faltus, 1988; Norcross, 2005). The following quote

highlights the degree of this importance, "Personal therapy or analysis is, in many respects, at the centre of the mental health universe" (Geller et al., 2005, p. 3).

Subjective reports collected from numerous therapists who have undergone personal therapy support the view that personal therapy was professionally and personally helpful in the following areas; self-esteem, work functioning, social-life, emotional expression, characterological conflict, and symptom severity (Norcross, 2005). The psychoanalytic and humanistic / experiential models of psychotherapy give pride of place to the therapeutic relationship as the primary conduit through which psychological change is achieved, and strongly advocate personal therapy as the most effective way of learning about working with the interpersonal aspects of the therapeutic relationship (Laireiter & Willutski, 2003).

In some European countries such as; Finland, Sweden, Denmark, Germany, The Netherlands, Italy, Portugal, and Israel, personal therapy in psychotherapy training is legally mandated and the number of training hours specified (this includes psychotherapists training in CBT). Interestingly, the English speaking countries such as Great Britain, Canada, America, Australia, and New Zealand, have no such legal mandate (Laireiter and Willutski, 2003). These national differences possibly reflect the greater influence of psychoanalytic theory and principles in Europe (Laireiter, 1998).

However, even where there is no legal mandate, surveys in the United States, indicate that the majority of mental health professionals, regardless of their professional or theoretical orientation, have undergone personal therapy at some stage during their professional life. The estimated percentages based on a review

of 17 studies involving over 8,000 participants are between 72% and 75% (Norcross and Guy, 2005). Prevalence rate varies with theoretical orientation. In the United States a recent survey of 694 therapists showed the following prevalence rates, 100% of psychoanalytic clinicians, 86% of systems therapists, 83% of eclectic or integrative therapists, 76% of humanistic therapists, 65% of cognitive therapists, and 64% of behaviour therapists had sought personal therapy (Norcross, Karplak, and Santoro, in press, cited by Norcross, 2005). This distribution is reflected in another multi disciplinary study which found that worldwide, 92% of psychodynamic and humanistic therapists and 60% of cognitive behavioural therapists reported having undergone personal therapy (Orlinsky, Norcross, Rønnestad, and Wiseman 2005). Norcross (2005) points out that this rate far eclipses the rate of therapy seeking in the general adult population which, in the United States, is estimated at 25% to 27%. Furthermore, he notes, most clinicians seek out personal therapy more than once and many remain in personal therapy for many years. Personal therapy is not only sought as part of training but many clinicians return to personal therapy at different stages along their path of professional development.

The impact of personal therapy on therapeutic outcomes has not been objectively investigated, and support for the beneficial effects of personal therapy is based on the subjective accounts of therapists who have received personal therapy. For example, in a very large multinational survey of 4000 therapists from differing orientations, 88% rated their experience of personal therapy as beneficial (Orlinsky and Rønnestad, 2005 in press cited by Orlinsky et al., 2005). In this study 194 of the psychologists surveyed were from New Zealand, and of this group, 87% rated the experience positive and 72% very positive (Orlinsky et al., 2005). Clinicians rated

direct patient contact, formal case supervision, and personal therapy as the most important sources of positive professional development, over didactic experiences such as taking courses and reading professional journals and textbooks. Personal therapy is consistently reported to enhance the interpersonal therapeutic skills of the clinician, specifically in fostering empathy, standing in the shoes of the patient and knowing what it is to experience therapy, recognising the importance of transference and counter transference, the need for patience and tolerance, and an increased respect for the power and effectiveness of psychotherapy (Norcross, Strausser-Kirtland, & Missar, 1988; Norcross, Dryden, & De Michele, 1992).

From the clinicians' point of view, the reasons for entering personal therapy are most often personal, with the clinician seeking help with personal problems in much the same way as the general population would (Laireiter, 1998). However, the resultant improvements in awareness, functioning and life satisfaction, resulting from the personal therapy are reported by clinicians as enhancing to professional development. The following factors relevant to professional development are identified as consequences of the personal therapy; improved emotional and mental functioning, sharper understanding of the interpersonal dynamics of the therapeutic relationship, better emotional regulation of stress factors inherent in the demands of the mental health arena, effective socialisation as to the benefits of psychotherapy, an improved understanding of what it means to be a client or patient, and an opportunity to observe clinical methods and interventions in action (Norcross, 2005). In a synthesis of 25 years of research in the field, Norcross, summarises his findings in the following statement, "The cumulative results indicate that personal therapy is an emotionally vital, interpersonally dense, and professionally formative experience, one that should

rightfully assume its centrality in the formation of health care psychologists." (Norcross, 2005 p.2).

Personal therapy and CBT

In contrast to the strength of the quotation above, the consensus that personal therapy is an important training component has not traditionally been shared by the CBT and Behavioural Therapies (BT), and personal therapy, apart from the European exceptions outlined above, is not as a rule recommended as an integral part of CBT and BT training programs (Rudd & Joiner, 1997). The lack of objective evidence supporting the positive effect on therapist development, or clinical outcome, has been one of the factors underlying the reluctance of the cognitive behavioural therapies to embrace personal therapy as an important and necessary component of professional development.

Additionally, failure to acknowledge the reported benefits of personal therapy is due to the historic differentiation of the CBT and BT models from the older psychoanalytic and humanistic/experiential models of psychotherapy. CBT and BT are committed to empirically establishing the effectiveness of specific interventions unique to CBT or BT (Laireiter & Willutski, 2005). The resultant use of randomised controlled clinical trials minimises the idiosyncratic contribution of the therapist in favour of therapeutic protocols which detail specific interventions (Wampold, 2001). The focus on the exact replication of therapy interventions has resulted in "common factor" variables such as the impact of the case conceptualisation and therapeutic relationship on outcome being sidelined or minimised in CBT research trials (Wampold, 2001). The net result of this perspective is that the individual

interpersonal and psychological development of the psychotherapist is not generally a focus of training in CBT and BT, and CBT research has, to date, identified no quantifiable link between personal therapy in the traditional form, as outlined above, and the development of professional skills. It is quite simply, not a focus of mainstream CBT research. The British Association of Behaviour and Cognitive Therapy News (May, 2003), articulates the current professional position regarding the status of personal therapy and cognitive therapy training, printing the following draft statement: "The BABCP does not require personal therapy as part of training and neither encourages nor discourages the use of personal therapy" (Williams, 2003).

This does not mean that CBT and BT therapists do not seek personal therapy. The surveys reported in the introduction show that between 44% and 66% do seek personal therapy, most often from psychotherapy models outside of CBT models, for example, 50% to 60% choose a psychodynamic therapist, and 20% to 30% someone representing the humanistic psychotherapies (Laireiter & Willutski, 2005). Therapists trained in the other modalities are more loyal, with up to 90% of psychodynamic therapists, and 70% of humanist existential therapists choosing their own models (Laireiter & Willutski, 2005). This is not surprising since it is a training requirement in these orientations. There has been no research regarding the effect that receiving therapy from therapists representing models outside of the cognitive behavioural therapies has had on the therapy skills of CBT therapists. One could speculate that this anomaly (selecting a therapist outside of one's chosen modality) has arisen from a belief held by cognitive behavioural therapists, that the "problem focus" of CBT precludes the "personal growth" agenda that many therapists seeking their own personal therapy require. If true, this would be

unfortunate as it would indicate a degree of scepticism among CBT therapists regarding the power of their chosen model for enhancing personal and professional development. This scepticism is not surprising given earlier attitudes held in mainstream CBT which would have discouraged supervisors and trainers recommending personal therapy to novice CBT therapists. The present research addresses this anomaly by investigating the utility of self-practice/self-reflection as forms of personal therapy compatible with the principles of CBT.

Recent developments in CBT regarding the role of personal therapy and training

The acceptance, by funded mental health providers, of CBT as one of the few evidenced based, cost effective psychotherapies, has fuelled its rapid expansion and development (Roth & Fonagy, 2004). Since its inception in the early 1970's with Beck's cognitive model for understanding depression (Beck et al., 1979), CBT has continued to evolve to a point where most of the diagnoses defined in the Diagnostic and Statistical Manual of Mental disorders (fourth edition) have disorder specific CBT conceptualizations. Whilst each disorder specific conceptualisation has subtle differences, the fundamental principles of CBT such as the focus on cognition as an important mediating factor, collaborative empiricism, guided discovery, clear structure and outward focus have remained constant.

Over the past two decades an increasing number of complex and chronic diagnostic presentations such as the various personality disorders are now being treated with CBT. The disorder specific CBT conceptual models do not fit so easily with these complex presentations which often show a mixture of symptomatolgy

and comorbidity, along with significant interpersonal difficulties. This has meant a shift to individualising the conceptualisation, longer-term therapy, and an increased focus on interpersonal and emotional factors, as the domains in which clients with entrenched personality problems experience the most distress (Beck et al., 1990; Layden, Newman, Freeman & Byers Morse, 1993).

The above factors have meant that CBT has evolved to include the following components of psychotherapy, previously sidelined; working with the individualised case conceptualisation, imagery as a cognitive process, an increased emphasis on emotions, the therapeutic relationship, and early developmental history. The competent contemporary cognitive behaviour therapist is expected to be familiar with individualised case conceptualisation of the patient's presenting problems and interpersonal processes (the therapeutic relationship as an agent of change) (Padesky, 1996).

The result of these developments has been a repositioning of the "established" opinion regarding the role of the therapeutic relationship and interpersonal factors in CBT (Beck et al., 1990; Beck, Freeman, & Davies, 2004; Safran & Segal, 1996). The therapeutic relationship, understood conceptually, is increasingly seen as a powerful tool for therapeutic change when working with challenging patients (Beck, 2005), and in some types of CBT, for example Schema Therapy (Young 1990, Young, Klosco, & Weishaar, 2003). In this regard, a greater emphasis is placed on the individualised case conceptualisation which includes an understanding of the therapeutic relationship. The traditional case conceptualisation diagram developed by Judith Beck has been expanded to include additional "boxes" for recording therapy and therapist related beliefs and behaviours (Beck, 2005). With the

growing emphasis on understanding and working with the therapeutic relationship, psychoanalytic concepts such as transference, counter transference and resistance, formally rejected by the CBT therapies, have been resurrected, revised and re-conceptualised so as to fit more comfortably within the CBT model (Leahy, 2001; Rudd & Joiner, 1997; Young et al., 2003).

In thinking about the how best to apply these concepts in CBT, a fresh look at the way in which emotions and strong affective reactions are conceptualised in the CBT model has been necessary. Standard, short-term CBT has always ascribed an important role to emotional response (Beck, 1995). The emphasis however, has been on managing troublesome emotional responses *rationally* by identifying, tracking and linking emotional reactions to cognitive processes, which, once identified, can be modified using interventions such as the "dysfunctional thought record" (Beck, 1995). Increasingly, however, emotional expression is seen as having an *adaptive* role in human functioning (Safran, 1998). Interventions which facilitate emotional expression are therefore, an important variable in effecting the patient's ability to change (Safran, 1998). How best to work therapeutically with strong emotional reactions, is therefore receiving and increasing amount of attention in CBT (Laydon, et al., 1993; Safran & Segal, 1996; Safran & Greenberg, 1998; Young et al., 2003).

This has implications for training. The growing emphasis on the interpersonal aspects of the therapeutic relationship, highlights the significance of the therapist's awareness of his or her belief system as played out in the interpersonal process as an integral part of the therapeutic relationship as illustrated in the following quote, "To be optimally helpful to her clients, a psychotherapist must be at least

minimally aware of her inner life. Knowledge of self facilitates knowledge of others and this relationship is a reciprocal one" (Mahoney, 2000, p. 727-728). To foster self-understanding in the context of the complexities of the therapeutic relationship some *form* of personal therapy is probably necessary as a means to fostering this awareness. Prominent CBT proponents place considerable emphasis on the importance of experiential learning. Christine Padesky states, "To fully understand the process of therapy there is no substitute for using cognitive therapy methods on oneself" (Padesky, 1996, p. 288).

The growing emphasis on understanding the interpersonal aspects of therapy in CBT terms, points the way towards developing more conceptually congruent ways of understanding the interpersonal process in CBT. The Therapeutic Belief System (Rudd & Joiner, 1997) and Therapist Schema Questionnaire (Leahy, 2001; Haarhoff, 2006; Haarhoff & Kazantzis, 2007) are examples of innovative, conceptually consistent methods which, as methods that facilitate a deeper self understanding in CBT terms, can be conceived as a form of personal therapy which can be usefully applied in CBT. These methods facilitate psychotherapist awareness of the cognitive aspects of the interpersonal process which have implications for expanding the individualised case conceptualisation to understand and use the therapeutic relationship constructively. This understanding enriches the individualised case conceptualisation providing the basis for hypothetical predictions concerning therapy enhancing or inhibiting interpersonal factors.

Self-practice/self-reflection: a form of personal therapy compatible with CBT?

The recent change of attitude within the CBT establishment regarding the importance of the individualised case conceptualisations which include a focus on therapy enhancing or inhibiting factors, the impact of the therapeutic relationship, and therapist belief system, raises questions as to how traditional training methods should be supplemented to take cognisance of these factors. In line with some of the developments outlined above, some notable authors have begun to recommend that therapists practice CBT techniques on themselves in order to increase knowledge of protocols and practices, along with other relevant psychotherapeutic skills, such as case conceptualisation, which depends to some extent on interpersonal and relationship skills (Beck, 1995; Bennett-Levy et. al.,2001; Dobson & Shaw, 1993; Padesky & Greenberger, 1995; Padesky, 1996; Safran & Segal, 1996).

The introduction of self-practice/self-reflection training components offers promise as a method which could be usefully incorporated in CBT training as a form of personal therapy compatible with the CBT model. Self-practice/self-reflection differs from traditional personal therapy in that there is no *external* therapist. In self-practice/self-reflection only the *self* is therapist.

Some important advantages of using self-practice/self-reflection in training are; 1) economic (personal therapy can be very expensive particularly for trainees), 2) the self-practice/self-reflection can be targeted at the development of specific competencies such as case conceptualisation, 3) standardisation can be achieved in that variability of model and therapist in personal therapy can be eliminated, and 4) the impact of these processes on understanding and practical application can be monitored and evaluated in an objective manner more compatible with the

evidenced based empirical approach typical of CBT. For example, rating scales such as those used in this research can be used to measure changes in specific competencies targeted by structured self-practice/ self-reflection. It should be noted that advocating the replacement of personal therapy, which may under certain circumstances be indicated during training, is not the goal of this research, but rather that self-practice/self-reflection offer exciting possibilities for introducing a structured form of personal therapy which is very compatible with the specific goals of CBT training.

Sadly there are very few examples of CBT training programs where self directed personal therapy such as self-practice/self-reflection are systematically used or evaluated (Bennett-Levy, 2002). The exception to this is some work in German speaking countries still influenced by the psychoanalytic tradition, where personal therapy for all trainee psychotherapists, regardless of theoretical model, is legally mandated. In these countries it is also required that the personal experience of psychotherapy should occur within the psychotherapist's chosen model of practice. This meant that cognitive behavioural therapists were compelled to experience personal therapy within their own model (as previously mentioned there is a tendency for CBT therapists to seek therapy outside of their model of practice).

The first discussions concerning terminology to describe the training elements concerned with the personal development of the trainee took place in Germany and Austria, and the German word "Selbsterfahrung" was coined. This is translated as self-directed or self-related experience (Laireiter, 1998). A further elaboration describes the two parts of self-directed experience in CBT, that is, the

actual practice of the different interventions on oneself as therapist, *Self-Practice,* and the thinking about, or self-reflection on the consequences of such application. This metacognitive process has become known as *Self-Reflection* (Laireiter & Willutski, 2003). The two processes can occur in tandem, however, self-practice could occur without self-reflection and vice versa. Once the terminology had been established the conceptualisation of the way in which self-practice/self-reflection as forms of personal therapy useful in CBT was elaborated, and efforts were made to state specifically what the goals of self-directed experiential work might be in CBT. This aimed to differentiate CBT from the psychoanalytic and humanistic experiential models.

The following list of goals was developed; 1) educational goals, such as the identification and management of the personal involvement of the therapist and the improvement of insight and self-knowledge; 2) preventative goals resulting in the reduction of the negative effects of the therapist. For example , the development of interpersonal skills such as self-monitoring, self-esteem, interpersonal sensitivity, and social assertiveness, 3)the acquisition of specific therapeutic skills such as empathy, models of practice, learning to conduct therapy, and experiencing therapy as a client to increase awareness of process; and 4) didactic goals, such as the acquisition of therapeutic techniques and models and identifying with CBT and seeing how it works in "real-life" (Laireiter & Willutski, 2003).

In this context, a number of models for self-practice/self-reflection have been developed in Austria and Germany (Laireiter, 1998). These models are; person

centred, practice-related, models of self practice/self-reflection, and combined models.

"Person centred" self-practice/self-reflection concentrates on the individual and aims to develop self-knowledge. Sessions are in group format and are thematically structured around such topics as personal learning history, interpersonal schema and family background. Trainees exposed to this model reported a greater understanding of and sensitivity to their style of interaction, and could link this to their cognitive processes such as schema. Empathy was increased and the trainees believed that they were better able to deal with patient emotions and manage the therapeutic relationship. They found "person centred" self-practice/self-reflection less useful in developing specific technical competencies (in these instances no self-practice of CBT interventions was required as the work centred on general themes for discussion). Trainees expressed the preference for working in dyads and reported that this dyadic work facilitated the development of insight regarding their own cognitive-emotional schema (Zimmer & Zimmer, 1998, cited in Laireiter & Willutski, 2003).

"Practice-related" models examine the therapist's personal involvement in the process of therapy by looking at themes of professional life and difficulties in the therapeutic relationship. These self-management programs have not been sufficiently evaluated to draw firm conclusions (Laireiter & Willutski, 2003).

"Self-practice" models are "methods" focussed, and examine the self-application of interventions such as the dysfunctional thought record. These programs have been shown to foster the development of specific technical competencies through

mastering the use of CBT techniques, and by experiencing the role of the patient and have also been effective in managing target behaviours (McNamara, 1986; Pfingsten, 2000; Roder, Dubuis, Lächler & Hecht, 2001; Teegen, 1977, all cited in Laireiter & Willutski, 2003). Most of these studies have used pre and post measurement and control groups (quasi-experimental designs) with participants selected as convenience samples. The Bennett-Levy et al. (2001) study is an example of one of these and will be reported in detail below.

The "combined" training programs integrate personal and practice elements and have used subjective post hoc evaluations. In these instances trainees report that they prefer the 'person' focussed elements, but see the relevance and usefulness of the 'practice' focus. Laireiter concludes that in an optimal training situation both these aspects (person and practice focus) should be included.

The empirical status of self-practice/self-reflection

To date, as in the earlier surveys of the effects of personal therapy, none of the studies on the effects of self-practice/self-reflection in CBT have investigated the effects of these processes on actual clinical outcomes, in addition, and all of the studies summarised below have relied on the subjective reports of the participants.

With the exception of the Bennett-Levy et al., (2001) and the Haarhoff & Stenhouse (2004) studies, all of the following results are reported in German journals. Due to translation difficulties I have relied on Laireiter, (1998) and Laireiter & Willutski (2003) for the following summary of results from the most important German studies. Trainees accepted self-directed experience as a valuable and important

training component in CBT and reported that they had learned a lot about CBT by practicing the techniques on themselves (Döring-Seipel, Schüler, & Seipel, 1995; Lieb, 1998). Heightened self-awareness (Görlitz & Hippler, 1992), and perceived improvement in interpersonal skill and empathy were also noted by trainees (Döring-Seipel, Schüler & Seipel, 1995). One study used data obtained from patients' subjective reports and found an improved therapeutic relationship and interpersonal sensitivity when trainees had had self-directed experiences of CBT (Hoyer and Stangier, 1998) (all cited in Laireter, 1998 and Laireiter & Willitski, 2003).

Beyond the German studies, only four qualitative studies (three conducted by Bennett-Levy as first author) have examined the impact of CBT self-practice/self-reflection on trainee CBT therapists. In the first two consecutive studies, Bennett-Levy et al. (2001) investigated the experience of CBT trainee therapists who had self-practice/self-reflection included as a training component. A total of 19 participants in two groups, all of whom were enrolled in a post graduate clinical psychology training program, took part in the study over a two year period. The first group had seven participants (year one) and group two had 12 participants (year two). The CBT course work consisted of 39 hours of teaching over 13 weeks, 75 hours reading, homework assignments, essay, videotape, reflective diary keeping, and reflective assessment. Self-practice/self-reflection was made a course requirement for each group, although no grades were given for this aspect of the course work. Group one was required to submit a 1000 word paper called "reflective assessment" which recounted what they had learned in CBT from the self-practice/self-reflection. The form of the self-reflection was left up to the trainees. In group two, the requirements were more structured and the participants

were provided with a self-practice/self-reflection workbook developed by the first author who was also the course coordinator (James Bennett-Levy). The participants worked their way through a series of CBT interventions, systematically arranged in the workbook. The interventions followed a standard CBT protocol, which included the identification of personal problems and goals, followed by standard techniques such as the activity schedule, Five-Part models, the dysfunctional thought record, and behavioural experiments. After each self-practice exercise the participants were required to reflect on their personal experience of CBT, guided by a series of self-reflective questions. This reflective process resulted in the identification (by the participants) of a number of domains, where, they had subjectively experienced an effect on their practice of CBT and on their development as CBT therapists.

The qualitative data was analysed using grounded theory and practitioner-researcher self-study, and a model showing the impact of self-practice/self-reflection in CBT was developed. The model identified self-practice / self-reflection as process mechanisms, and a "deeper sense of knowing" as a core process. A "deeper sense of knowing" was a difficult concept to describe and analogy and metaphor were resorted to, for example, "experiencing cognitive therapy from the inside" or the difference between seeing something in three-dimensions as opposed to two-dimensions. The "deeper sense of knowing" involves reflection on experience and is a meta-cognitive process and appears to describe the emotional and rational mind defined by Epstein (1998).

In addition, three types of outcome, namely, therapeutic understandings, therapist skill, and changes in therapist self concept were identified. Ninety percent of the

data collected referred to "therapeutic understandings" which related to professional and personal usefulness of self-practice and self-reflection. The data was weighted in this area because most of the participants were not at this stage practicing as CBT therapists so participants were unable to comment on therapist skill or therapist self-concept.

Specifically, such aspects as an increased understanding of the therapist's role in CBT, the CBT model, the processes of change in therapy, together with a greater understanding of self, and experiencing CBT as an effective tool for personal change, were all identified by the participants as positive effects. As far as therapist skill was concerned, participants identified improvements in the following key areas: refining specific cognitive therapy skills, communicating the conceptual framework of CBT, creating a therapeutic foundation for change, being where "the client is at", increased empathy and improved therapist self reflection (Bennett-Levy et al., 2001). The positive results of the Bennett-Levy study provide an argument for the inclusion of structured self-practice/self-reflection as a part of CBT training.

In a follow-up study, Bennett-Levy et al. (2003) extended the findings from the previous study. The purpose of the study was to map the impact of self-practice/self-reflection on the CBT skills of practitioners (the previous study obtained data predominantly from trainees). Fourteen practitioners participated in the study, six practiced CBT techniques with a partner and eight worked through the experiential exercises on their own. Both groups used the Self-Practice/ Self-Reflection Workbook used in the earlier study and reflected in writing on their experience. Four of the participants (authors of the paper) assessed the impact of

the self-practice/self-reflection on their therapist skills in the following manner; first by writing a general reflection outlining ways in which they thought their skills had changed and secondly by "closely observing" eight to ten of their therapy sessions with clients, and immediately after sessions, and noting ways in which they thought their skills had changed. The sessions were not audio or video taped. Their subjective reportage listed improvement in the following areas; refinement of specific CBT skills, enriched communication of the conceptual framework of CBT, increased attention to the therapeutic relationship, improved empathetic atunement, enhanced self-reflection, and increased therapeutic flexibility.

The improvement in communicating the conceptual framework of CBT was of particular relevance to this research. Specifically participants found that they were better at explaining the CBT model, they presented stronger rationales, conveyed a greater belief in the model. They also reported taking more time to "sell" the model and provided an increased number of examples.

Overall, the participants once again supported self-practice/self-reflection as a valuable learning experience having tangible benefits for their clinical work. A weakness of these studies mirrors that of other studies attempting to measure the impact of personal therapy, namely all the information collected is based on the subjective view of the participants. It is also unfortunate that video or audio taped sessions were not used as this would have been a way of providing actual examples of the improvements described by the participants.

Bennett-Levy's qualitative findings were supported by a qualitative study by myself, which evaluated the impact of self-practice as teaching components in a first level CBT training program (Haarhoff & Stenhouse, 2004). In this study, the first theoretical paper in the Massey University PGDipCBT, The Theory and Practice of CBT, was selected and 26 trainees took part in the study. The fundamental theoretical and practical principles of CBT were introduced through the following topics; the generic CBT model, the importance of structure, principles of CBT assessment, and the use of targeted behavioural interventions in the treatment of depression and anxiety. Teaching methods utilised were: didactic teaching, role-plays, observational learning, watching the "experts", class presentations, self-practice (practicing cognitive behavioural interventions on oneself), and self-reflection (reflecting on the process of self-practice). Discussion and active participation were encouraged. Students worked alone, in pairs and in larger groups. Tutors modelled the principles of CBT by being collaborative, guiding discovery, encouraging feedback, and using the "Socratic" questioning approach.

The following sequence of topics were covered; problem identification, functional analysis of problems, goal setting, and behavioural interventions. After each component had been introduced through didactic teaching, participants, working in pairs, were required to practice the intervention or principle taught, using their personal experience (self-practice). Participants were asked to choose a "problem" evoking a moderate emotional response. They were cautioned not to discuss major life decisions or problems such as significant losses or abuse. The importance of confidentiality was emphasised.

After the self-practice exercise had been completed participants reflected in writing (self-reflection) on the experience of self-practice. Questions aimed to elicit information concerning the perceived impact of the self-practice exercises on learning CBT were provided. The following themes were captured by the questions, the application of the principles and practice of CBT, the implications of taking on the role of therapist, experiencing CBT from the client's perspective, the therapeutic relationship' confidence in the CBT model, and their general development as CBT therapists.

As far as the application of general principles was concerned; participants reported an increased respect for the importance of having a structured framework, "taking time", and "being specific". They could see how a comprehensive assessment of problems was essential if underlying themes were to be identified. Practical aspects, such as the importance of writing things down, were noted and participants were able to understand the relevance of an initial explanatory conceptualisation. More specific learning involved understanding the cyclical nature of the model and the usefulness of the Five-Part model as a conceptual tool. Connections between negative automatic thoughts and underlying assumptions were noticed and participants could begin to understand in real-life terms the role of avoidant and compensatory behaviours in maintaining problems. When considering the role of therapist, most of the participants commented on the importance of self-awareness and how the self-practice and self-reflection facilitated this. They noticed the effects of their own schema on the "therapeutic process" and could see good reasons for identifying personal schema. Feeling helpless in the face of a client's difficulties was noted. Some participants were surprised at how difficult some of the exercises were and acknowledged the importance of further training. The importance of asking questions in a manner

which moved from simpler to more complex issues was noted. Thinking about the role of the client proved to be an eye opener for most participants, who reported being surprised at how difficult self-disclosure was. A reluctance to change or commit to change was also observed. Some participants felt that they minimised problems and found themselves avoiding or denying the more serious aspects of the problem they had chosen to discuss. The importance of the "therapist" asking clarifying question was seen as helpful. Many found the careful analysis of problems using the Five-Part model very helpful. The majority of participants reported an increased confidence in the utility of the CBT model as a conceptual tool to understand problems. Using the model with real-life as opposed to fictitious scenarios gave credibility to the model. Of the twenty-six participants, only two reported difficulties or discomfit with the experience.

This qualitative study supports Bennett-Levy's conclusions concerning the utility of including self-practice/self-reflection as an integral part of CBT training. The analysis of the responses to the questions guiding self-reflection clearly demonstrated how the self-practice exercises, in the participants' opinions, cemented the acquisition of specific CBT skills important in the development of overall competency. The use of structure and the conceptual components of the model gained credibility in the eyes of the participants when they were able to "test drive" them. Participants were also able to grasp the significance of "common factors" (Hubble, Duncan, & Miller, 1999), such as the therapeutic relationship and the role of the client, in influencing therapeutic outcome. Beyond this qualitative work, no empirical studies in CBT in the English-speaking world, evaluate the effects of personal therapy on the training of CBT therapists.

Studies, based on the self-report of trainees, reviewed thus far, show a positive effect of self-practice/self-reflection on a number of general CBT competencies, and that self-practice/self-reflection are perceived as professionally and personally helpful. Specifically, therapeutic understandings (professional and personal), therapist skill, and therapists' self-concept are reported to have been favourably impacted upon.

Turning to individualised case conceptualisation as a specific competency, there is no published work linking self-practice/self-reflection to the development of this complex competency. In the following section some of the methods used to train clinicians in this competency are described.

Training clinicians to construct case conceptualisations of quality: does self-practice/self-reflection have a role?

Little is documented concerning specific methods for training clinicians in case conceptualisation construction (Persons & Tompkins, 2007). However a number of common difficulties in training case conceptual skills have been identified (Persons & Tompkins, 1997). Firstly, clinicians frequently do not construct comprehensive problem lists, often omitting important information such as medical and other non psychological problems. Furthermore there is a tendency to over generalise and use jargon such as "co dependency" to describe problems rather than a specific functional analysis of the actual situation. These authors recommend that detailed discussions of the problem should be encouraged. Secondly it is reported that clinicians are often too cautious in generating a number of alternative hypothetical explanations for presenting problems, which can then be discussed and either

applied or discarded as deemed appropriate. It is suggested that clinicians should be encouraged to generate multiple hypothesises and treatment interventions in the first instance and not be too concerned with the idea that there is only one "right answer". These writers also emphasise the need for the trainer to distinguish between two recurring questions asked by trainees namely, "How do I ?" and "What do I do if?" The second question is a question relating to the individualised case conceptualisation. Their final point is to stress the importance of the trainee clinicians being aware of the importance of applying disorder specific conceptualisations when appropriate (individualised using the client's idiosyncratic information). In their view, teaching case conceptualisation requires, that in the first instance, the clinician is familiar with the model of psychotherapy used in conceptualising the problem, and that secondly they be given practice in generating and applying hypothesises in a situation where debate and discussion can occur. Familiarity with the model is dependent on traditional didactic teaching methods and the clinician's own reading, research, and practice. These authors make no reference to the "therapist's personal therapy" as a training mechanism.

Indeed, most methods of case conceptualisation see conceptualisation as a rational intellectual process, stipulating that trainees should familiarise themselves with the theoretical model and method of case formulation, practice on clients, read widely, and seek supervision. Familiarity with behavioural assessment, adult and child psychopathology, psychometrics, problem solving principles, developmental psychology, and interviewing skill are all emphasised as important in case conceptualisation (Nezu, Nezu, Friedman, & Hayes, 1997).

Exceptions are, in Cognitive Analytic Therapy, where personal "non-time limited' Cognitive Analytic Therapy is required for advanced trainees and first level trainees would generally have had some form of dynamic therapy (Ryle & Bennett, 1997), which is assumed to be a necessary part of coming to grips with the case conceptualisation process. Similarly, as would be predicted, in most psychoanalytic approaches therapists in training are expected to undergo their own dynamic therapy to develop the necessary clinical judgement to create a "complex dynamic formulation" (Messer & Wolitsky, 2007 p. 96). These psychodynamic approaches are in line with the more generally recognised view of personal therapy which helps therapists identify blind spots and thus work more effectively with transference and counter transference issues.

Conceptualisation in Dialectical Behaviour Therapy (DBT) requires the therapist to "think like a behaviour therapist and experience like a Zen student" (Koerner, 2007 p. 365), with little clear direction as to how this could be achieved. However self-practice/self-reflection could be assumed to have a part to play in this instance, for example the DBT training program requires that trainees understand mindfulness and practice meditation (Linehan, 1993). In DBT the therapist's awareness and sensitivity to his or her own emotional reaction to the client is emphasised as important in DBT case conceptualisation (Koerner & Linehan, 1997), once again this skill would seem amenable to the impact of structured self-practice/self-reflection.

Producing a CBT case conceptualisation of high quality requires that the clinician integrates a number of different strands of information about the patient such as the diagnosis, idiosyncratic patterns or cycles, triggering situations, thoughts,

emotions, and behaviours. Relevant information is obtained through sensitive interviewing, interpersonal sensitivity, and the skilful application and understanding of CBT interventions such as the dysfunctional thought record. Interpersonal understanding is essential in the conceptual use of the therapeutic relationship and requires a thorough understanding by the therapist, of his or her own beliefs and behaviours and their impact on the therapeutic relationship.

Information relevant to case conceptualisation, gained through more acute understanding of the therapeutic relationship includes identifying problematic systems of beliefs and behaviours (in both therapist and client), information about the ability of the patient to engage in therapy, motivation, possible obstacles which may be encountered, and the most appropriate interpersonal style needed to promote constructive engagement. Studies reporting on the effects of exposure to self-practice/self-reflection indicate that the clinician's sensitivity to this kind of information may be facilitated by what Bennett-Levy and his research participants have called a "deeper sense of knowing". This facility, reported to be heightened by the interaction between self-practice/self-reflection is important in coming to grips with the complexity and richness of information conveyed in the interpersonal transactions in psychotherapy.

The Declarative-Procedural-Reflective model for skill acquisition in psychotherapy

The Declarative-Procedural-Reflective (DPR) model proposed by Bennett-Levy (2006) is a model for therapist skill development aimed at refining cognitive

therapists' interpersonal skills. The model integrates three systems of information processing (declarative, procedural, and reflective) proposed as helpful in the "identification of key learning processes and training strategies to enhance and refine psychotherapeutic competency" (Bennett-Levy & Thwaites, 2007 p. 255). The model considers the way in which relevant therapeutic information is processed and refers back to the two systems information processing model proposed by Binder, which distinguished the *declarative* and *procedural* systems of knowledge (Binder, 1993; Binder,1999). The declarative system refers to learning factual information ("knowing that"), for example learning about the different CBT models or what elements constitute a good therapeutic relationship. This type of learning generally takes place through observation, didactic teaching, or reading relevant texts, and can exist in a purely abstract form. It does not necessarily transfer to practical situations and thus can remain "inert" or unused. It is therefore possible to have a great deal of declarative knowledge which does not necessarily transfer into clinical practice because the therapist lacks procedural knowledge.

The procedural system is concerned with knowing *"how"* and "*when"* to apply the factual knowledge, translating the declarative knowledge into practice (such as "when" and "how" to use certain CBT interventions). Procedural knowledge is difficult to teach directly and efficient use of procedural knowledge is what differentiates an experienced or expert clinician from a novice (Dobson & Shaw, 1993). According to the DPR model the development of procedural knowledge, or therapeutic expertise, requires the use of the reflective system. The DPR model proposes a distinction between self-schema and self-as- therapist schema. Both of these cognitive systems form part of the procedural information processing system

and influence the way in which therapeutic decision making proceeds. Self-schema, contain the clinician's beliefs about self, others, and the world derived from significant developmental experiences which predate the individual's role as therapist, and exert a powerful influence upon the way the individual operates within the interpersonal arena . Although self-as- therapist schema will differ from self-schema, there will be an interaction between these two systems, and the more awareness the clinician has regarding the way in which these two information processing parts of the procedural system interact, the more skilfully the interpersonal aspects of therapy are likely to be managed. A lack of awareness either regarding the schema about self or "therapist schema" can result in what has been termed "schematic mismatch" within the therapeutic relationship (Leahy, 2007). A result of this could be a rupture or disruption in the relationship which could interfere with the progress of therapy. For example a therapist who had "unrelenting standards" (Young & Klosko, 1994) as self schema, and "demanding standards" as therapist schema could experience problems relating to a dependent client with schema concerning personal vulnerability (Leahy, 2001). In this instance the client would seek reassurance whereas the therapist would insist on "getting on with the job". It is proposed that the ability to be self-aware and objective in interpersonal relationships can be as difficult for therapists as it is for clients. Evaluative, or cognitive constraints such as viewing one's own behaviour as a legitimate response to an external stimuli, whereas the response of the 'other' is most often attributed to internal or personality factors, can severely impede a therapists' effective management of the interpersonal factors within the therapeutic relationship (Leahy, 2007). Many schools of psychotherapy are well aware of this factor, hence the emphasis on personal therapy in the traditional sense as a means to identify blind-spots. Encouraging the therapist to develop and use the reflective

system is therefore very important in increasing awareness of the potential effects of the therapist's belief system.

Self-reflection is not an observable phenomena and, and has been overlooked by experimental psychology as an important factor in skill acquisition (although recognised as central in psychoanalysis and derivations of that model). Bennett-Levy highlights the fact that self-reflection is given centre stage in adult learning theories where it is considered to play a key role in the development of professional expertise. "Once basic skills have been learned, reflection enables practitioners to discern in what context, under what conditions, and with what people, particular strategies may be useful" (Bennett-Levy, 2006 p. 60).

Unlike the other information processing systems, the reflective system holds no permanent knowledge, and only comes into play under certain "attention getting" conditions such as noticing a problem, often precipitated by a "mismatch of expectations" or a rupture in the therapeutic relationship. When this happens, a well developed reflective system enables the clinician to recall, and mentally represent the problem in such a way that related past, present, and future experiences of the clinician, including the operation of self-schema, are integrated. Finally, cognitive operations such as "self questioning", "following a train of thought", and logical analysis can come into play. These processes enable the clinician to reflect upon problems occurring in a previous psychotherapy session (mentally represented) which can then be examined from a number of different perspectives (Bennett-Levy, 2006). The reflective system then "returns" the conclusions reached through this process, to the declarative and procedural systems, and the clinician's expertise or skill is enhanced (Bennett-Levy &

Thwaites, 2007). The reflective component appears to draw on both the rational and the experiential ways of knowing identified by theorists such as Epstein (1994), to produce what Bennett-Levy calls a "deeper sense of knowing".

CBT training has traditionally emphasised the *declarative ("the what?")* component of the model. *Procedural knowledge (how?/when?),* relating to the clinician's interpersonal perceptual skills such as empathy, being where the patient is at, mindfulness, and the ability to reflect upon and incorporate the interpersonal process as expressed in the therapeutic relationship, in a therapy enhancing manner, is given less attention. The development of procedural knowledge, requires high levels of self awareness, which, it is argued, can only be achieved through self-reflection. It follows therefore that structured self-practice/ self-reflection as part of psychotherapy training, could potentially improve all the information processing systems described above (declarative, procedural, and reflective), facilitating the integration of both the experiential and rational mind.

Case conceptualisation skill development is often considered a purely rational process (Persons & Tompkins, 2007). In the present study, however, understanding the interpersonal transactions which occur within the therapeutic relationship are considered crucial in the development of a sophisticated CBT case conceptualisation. Differentiating between self-schema and self-as-therapist schema is important. Self-schema can be a very powerful, often negatively influencing the interpersonal therapeutic domain if they are not clearly understood. Managed self-reflection offers trainees the opportunity to conceptually integrate the professional and the personal, enabling them to come to

grips with their self-schema and reflect upon how these strongly held beliefs might impact on the CBT practice with clients.

In attempting to understand therapeutic expertise, the clinical practice of those identified as "master therapists" is often considered, and it has been reported that these individuals have exceptional relational skills, are non-defensive, tolerate ambiguity, and continuously self-reflect (Jennings, Goh, Skovholt, Hanson, & Benerjee-Stevens, 2003), providing support for further investigating the impact of a type of self-reflection which integrates the personal and the professional.

To date, objective evidence supporting personal therapy as having a beneficial and significant effect on the delivery of psychotherapy remains inconclusive (Orlinsky et al., 2005). However, there is considerable evidence showing that subjectively, psychotherapists from diverse therapeutic orientations, rate the experience of personal therapy profoundly important in their professional and personal development (Norcross, Strausser, & Faltus, 1988; Orlinsky et al., 2005). As previously noted, some of the effects identified as being beneficial include, practical experience of the techniques leading to improved delivery of therapy, increased self-awareness, greater empathy, interpersonal skill and a better general understanding of the client. As a general rule psychotherapists are intelligent sensitive individuals who often have prior tertiary educational experience and qualifications and are therefore in a good position to comment insightfully and thoughtfully on their experience (Bennett-Levy & Beedie, 2006). It seems therefore, that although objective empirical data is not available, the reflections of this group should be taken seriously when considering the benefits of forms of personal therapy for the improvement of psychotherapeutic competency.

Laireiter (1998), in his review of the CBT models of personal therapy in German speaking countries, identified five goals of personal therapy or self-directed experience, in CBT, namely: didactic (learning to practice CBT), educational (learning therapeutically relevant behaviours), preventative (reduction of negative therapist factors), therapeutic (help with the personal problems of the therapist), and resource improving (developing personal and interpersonal resources). He reaches the conclusion that, from the psychotherapists' subjective point of view, personal or self-directed experience such as self-practice/self-reflection, are perceived to be beneficial for positive professional development, achieving the didactic, educational, interpersonal, and preventative goals, outlined above (Greenberg & Staller, 1981; Macaskill, 1988; Norcross, 1990; Sherman, 1996).

Studies undertaken within the CBT field, dovetail with earlier findings (Bennett-Levy et al., 2001; Bennett-Levy et al., 2003.; Haarhoff & Stenhouse, 2004). There would therefore appear to be agreement among therapists both practicing and in training, that personal therapy, and self-practice/self-reflection as a form of personal therapy, is professionally and personally, extremely useful.

A major longitudinal and cross- sectional study tracking the professional development of one hundred psychotherapists and counsellors over a fifteen year period, reaches some significant conclusions concerning the importance of ongoing self-reflection in maintaining professional development and competency (Rønnestad & Skovholt, 2003). These researchers conclude that regular and continuous self-reflection is a necessary for learning and professional development at all levels of experience. In addition, if the practitioner is unable to engage in

self-reflection, "stagnation" and "deterioration" are likely to occur. A further finding is that the personal life experiences of the practitioner exert a profound influence on professional functioning, and that problematic early developmental experiences can affect professional development in a negative manner (this references the earlier discussion concerning the importance of differentiating self and therapist schema). These effects however appear to be mediated by the practitioner's openness to personal therapy and self-reflection (Rønnestad & Skovholt, 2003). This has a direct bearing on the clinician's degree of self-understanding which may be facilitated by their ability to conceptualise their own psychological process. Reflecting on the future of personal therapy in CBT it is argued that a greater emphasis on some form of personal therapy needs to be more forcefully included in CBT training, stating, "Self-reflection is no luxury but a necessary component of therapeutic practice Accordingly it should be regarded as a criterion of quality therapeutic practice in CBT" (Laireiter & Willutski 2005, p. 48).

The role of therapist competency, which includes case conceptualisation as one of three core competencies, is increasingly seen as a key to successful treatment outcome (Orlinsky, Rønnestad & Willutzki, 2003). The convergent evidence regarding the reported positive effects of self-practice/self-reflection outlined above suggests that re conceptualising and reconstructing personal therapy in a manner more consistent with the principles of CBT needs to be seriously considered as an important addition to traditional training CBT programmes. Case conceptualisation is generally thought of as declarative knowledge. In the present research, it is proposed, that case conceptualisation competency would be enhanced by procedural knowledge, and that structured self-practice/self-

reflection has a role to play in this endeavour. Accordingly, the impact of a manualised self-practice/self-reflection training intervention on the case conceptualisation competency of novice CBT clinicians is investigated in the present study.

The introductory chapters have focussed on the importance of evaluating CBT training if its solid reputation as an evidenced based psychotherapy is to be maintained. The small number of studies measuring transfer of training in CBT have focussed general competency as measured by versions of the Cognitive Therapy Scale(CTS) (Young & Beck , 1980) and the Revised Cognitive Therapy Scale(CTS-R) (Blackburn et al., 2001). In the present research the focus is more specific and asks "what specific training mechanisms might be appropriate for the development of key competencies such as case conceptualisation?" Despite the consensus regarding its importance, case conceptualisation competency it is not well researched and, furthermore it is often poorly taught (Eells, 2007; Sperry, Gudeman, Blackwell, & Faulkner, 1992). In addition, little is known about ideal teaching methods (Persons & Tompkins, 2007), and the systematic evaluation of case conceptualisations produced by clinical trainees is relatively rare (Eells et al., 1998). It is only in the very recent past that assessment measures in the form of rating scales measuring content and quality of case conceptualisation have been developed and few, if any, are utilized routinely outside of research projects.

In this research the case conceptualisation competency of novice CBT clinicians who have completed a specialist post graduate training program is systematically evaluated. This will provide valuable information concerning the transfer and maintenance of the training delivered by the Massey University PGDip CBT. In

addition the utility of a manualised training intervention in the form of a self-practice/self-reflection workbook designed to consolidate and enhance case conceptualisation skill will be investigated using both qualitative and quantitative data. To date studies reporting the impact of self-practice/self-reflection have all been qualitative and relied on the participants' subjective perception. Previous studies have also looked at more generalised effects of these processes, whereas the current research extends previous work by objectively evaluating the effects of self-practice/self-reflection on one important competency, namely case conceptualisation. Four objectives guiding the current research are described in the next section.

Guiding research objectives

Objective one aims to systematically evaluate the content and quality of CBT individualised case conceptualisations produced by a sample of novice CBT clinicians. The participant sample in this instance is a combined group made up of an "intervention group" and a "comparison group". These groups will be separated when the other research questions are addressed. Three case conceptualisation rating scales will be utilized to evaluate the content and quality of case conceptualisations produced by the research participants after reading four clinical case vignettes. One of the rating scales is a comprehensive CBT case conceptualisation rating scale has been developed specifically for this research. In addition the trainees' case conceptualisations will be compared with four "benchmark" case conceptualisations produced by an acknowledged CBT expert.

In achieving objective two, the impact of the self-practice/self-reflection workbook "Understanding Myself", as a manualised training intervention, will be qualitatively analysed. The analysis aims to uncover clinically relevant themes consistent with, or different to, the existing literature on the effects of self-practice/self-reflection. The present study will extend previous research which concentrated on general effects, by focussing specifically on the way in the participants in the intervention group subjectively perceive the effects of the manualised self-practice/self-reflection training intervention on their understanding, and use of the' CBT individualised case conceptualisation. The workbook was designed specifically for this research.

Objective three seeks to determine if there is an interaction between the self-practice / self-reflection manualised training intervention, and the content and quality of the CBT case conceptualisations produced by the "intervention group". To achieve this, the *content* and *quality* of case conceptualisations before and after the completion of the self-practice/self-reflection workbook "Understanding myself" will be evaluated. The evaluation will rely on the three rating scales listed in objective one. Previous studies have investigated the impact of self-practice /self-reflection on *general* CBT competencies by reporting the *subjective* experience of cognitive behavioural trainees and therapists. This study is more specific in focus and evaluates the impact of targeted CBT self-practice /self-reflection exercises on case conceptualisation as a specific and key competency. It extends previous studies in two important ways, firstly by specifying the competency to be measured namely individualised case conceptualisation, and secondly by evaluating the content and quality of the participants CBT case conceptualisations, using objective criteria of content and quality as contained in the three rating scales.

The aim of the final objective is to compare the ratings obtained by the "intervention" and "comparison" groups on three case conceptualisation rating scales. The *intervention* group will complete the self-practice/self-reflection workbook between the two conceptualisation tasks, and thus be exposed to systematic self-practice/self-reflection. The *comparison* group, will complete the case conceptualisation task before and after a designated period of time (this group will not be exposed to any self-practice/self-reflection exercises).

The groups will be compared to determine, first, whether or not there are differences between the groups, and second if these differences could be attributed to the self-practice/self-reflection experience of the intervention group. The two groups have similar backgrounds and learning experiences. In the following chapter the research methodology is presented in two parts. Part one presents the methodology informing the main study and includes a detailed description of the four assessment measures utilized and the creation of the manualised self-practice/self-reflection training intervention. In part two, two preliminary studies explaining the construction of the clinical case vignettes are described. The case vignettes are used to elicit the written case conceptualisations which are rated qualitatively and quantitatively. The case vignettes are also described in part one.

Chapter five

Methodology

Overview of the research design

The study is a mixed methods research design which uses quantitative and qualitative data in a complementary manner. The following rationale informs this approach: the sample of participants is relatively small, recruited as a convenience sample, and the individual participants were well known to me and vice versa. The possibility that "demand characteristics" contained in the responses from the participants could be at play, along with the risk of "researcher bias" is acknowledged. In addition all of the data collected (case conceptualisations and self-reflective responses to the workbook) was in the form of written narratives which required qualitative analysis. "Pragmatism" as a paradigm which places value on objective and subjective knowledge was an important influencing factor (Hanson, Creswell, Piano Clark, Petska, & Creswell, 2005). One of the fundamental steps in designing a mixed methods study is making the "theoretical lens", informing the study, explicit (Hanson et al., 2005; Ponterotto, 2005). The present study is rooted in the post positivist tradition as described by Ponterotto (2005) in that it is literature driven with some of the themes and categories of analysis already identified. The participant sample was selected prior to the study, and the data collection informed on the one hand, by a clearly specified task, and on the other, by specific questions decided prior to the study.

Research questions

1. What is the content and quality of four written CBT case conceptualisations produced by 26 novice CBT clinicians using three case conceptualisation rating scales, and four "bench mark" case conceptualisations?

2. What is the effect of a newly developed manualised self-practice/self-reflection training intervention on the case conceptualisation skills of an intervention group (*n* =16) drawn from the sample of 26 novice CBT clinicians? The effect was measured qualitatively and quantitatively.

The research methodology is presented in two parts. In part one, the methodology informing the main study is outlined. This section includes detailed descriptions of the four assessment measures used in this research, the self-practice/self-reflection training intervention, and the research procedure. The following assessment measures were used; 1) the Case Formulation Content Coding Method (Eells et al., 1998), 2) the Fothergill and Kuyken Quality of Cognitive Therapy Case Formulation rating scale (Fothergill & Kuyken, 2002), 3) the CBT Case Conceptualisation rating scale (developed specifically for this research), and 4) four "benchmark" expert case conceptualisations. Part two introduces the four clinical case vignettes, created for this research. The case conceptualisations were derived from written clinical case vignettes containing data which would typically be collected in an initial clinical assessment interview. The case vignettes were used to elicit the case conceptualisations evaluated in the primary study. Two preliminary studies describe the construction and validation of the clinical case vignettes

Part One: Research process

Data collection took place between July and December of 2004. Approval for the study was granted by the Human Ethics committee, application number 04/58.

Research participants

Participants in the "intervention" and "comparison" groups were recruited as a convenience samples. Participants in the intervention group had graduated from the Massey University Post Graduate Diploma in Cognitive Behaviour Therapy (PGDipCBT) . The participants in the "comparison" group were 10 trainees who had completed the final practicum component of the PGDipCBT, including the final oral examination. They were yet to officially graduate but had completed all the requirements specified in the diploma.

ThePGDipCBT has been in existence since 2000. It is completed on average, over a two-year period. Trainees enrol in four theoretical papers; Theory and Practice of CBT, CBT for Depression, CBT for the Anxiety Disorders, and CBT for Chronic and Complex Problems. The second year is a clinical practicum which requires that the trainee delivers CBT to at least two patients over a period of 35 clinically supervised, psychotherapy sessions. Over this period, eight videotaped psychotherapy sessions are assessed for competency using the Cognitive Therapy Scale (Beck and Young, 1980). In addition, trainees present and document two case studies. The PGDipCBT is described in more detail at http://psychology.massey.ac.nz The participants had all experienced the same amount of training in CBT and had completed all the requirements of the training program thus pressure to participate for fear of compromising grades was eliminated.

Twenty-eight graduates were available for recruitment to the intervention group at the start of the study. Participants were approached directly by the researcher. An initial telephone contact was followed by an information sheet detailing the aims of the study and the degree of active participation required (see Appendix A). Sixteen graduates agreed to take part (representing a participation rate of 57%). This became the intervention group. Reasons for non- participation were; work commitments (n = 6), overseas travel (n = 1), and professional involvement with the teaching of the postgraduate diploma (n = 2), personal reasons (n = 1) and unable to contact (n = 2). Ten participants graduating at the end of 2004, approached in the same manner, volunteered to become the comparison group. In this instance 100% of the potential participants agreed to take part.

It should be noted that the intervention group and the comparison group were united as a combination group of N = 26 when the first research question regarding the content and quality of CBT case conceptualisations was addressed and the demographics of the whole group is described below.

The demographics of the participants in the combined group varied in terms of age, sex, professional qualifications, academic qualifications, clinical experience, employment setting, and hours spent per week doing CBT. There were seven males and 19 females in the group. The average age was 45 years (SD = 10 years) with an average of 9 (SD = 6) years experience, and an average of 7 (SD = 8) hours spent doing CBT per week. All had professional experience associated with mental health. The following professions were represented; registered psychologists (n = 6), nurses (n = 5), psychotherapists (n = 3), general practitioners (n = 2), psychiatric registrars (n = 2), Counsellors (including school and drug and alcohol) (n = 4), occupational therapists (n = 2), and social workers (n = 2). Participants were

employed in the following settings, community mental health (*n* =10), private clinical practice (*n* = 5), hospital (*n* = 4), and child and adolescent mental health facilities (*n* = 2). The remaining participants were employed in a high school, correction services, sundry non governmental organisations and a university. Nine participants had tertiary qualification to Masters' level, five had a Bachelors degree and the remainder had medical qualifications. Individual differences such as those outlined above are the common in many CBT training programs. As Table 1 indicates, the two groups were essentially alike in the type of CBT training experienced and in the professional affiliations and employment settings. A greater range in years of experience is recorded in the intervention group where one participant had 28 years experience which was far greater than the majority of the other participants. The comparison group received all the same information as the intervention group, with the exception that information about the completion of the Self-Practice/Self-Reflection workbook was omitted as they would be completing the two sets of case conceptualisations without the intervening exposure to the self-practice/self-reflection exercises contained in the workbook. Participants in the comparison group were however offered the option of receiving a workbook after the study had been completed. Due to the practicalities of the recruitment process random allocation to groups was not possible.

Table 1. Average age, years of experience, and hours spent doing CBT per week in Combined, Intervention, and Comparison groups

	Combined group N=26	Intervention group N=16	Comparison group N=10
Age	*M* = 45 (*SD* = 11)	*M* = 44(*SD* =11)	*M* = 46 (*SD* =9)
Years of experience	*M* = 8.63 (*SD* = 5.69	*M* = 9 (*SD* =7)	*M* = 7(*S D*=4)
Hours spent per week doing CBT	*M* =7.18 (*SD* =8)	*M* = 8(*SD* =8)	*M* = 6 (*SD* =8)

M = Mean
SD = Standard deviation

Assessment measures

The following four assessment measures were used; 1) the Case Formulation Content Coding method (Eells et al., 1998), 2) the Fothergill and Kuyken Quality of Cognitive Therapy Case Formulation Quality rating scale (Fothergill & Kuyken, 2002) and, 3) the Cognitive Behaviour Therapy Case Conceptualisation rating scale (developed specifically for this research), and 4) four "benchmark" case conceptualisations produced by an "expert" CBT practitioner. The three rating scales assessed *content, comprehensiveness, and quality*, of the case conceptualisations produced by participants and the "benchmark" case conceptualisations were as an additional measure of quality.

The case conceptualisations were evaluated using three rating scales for the following reasons: The Case Formulation Content Coding Method provided a framework, and method, which facilitated the coding and categorisation of the content of the case conceptualisations. Furthermore, the method clearly specified

the categories of clinical information, important in case conceptualisation and treatment, and could be applied across different psychotherapy models, enabling the present study to be compared to studies addressing conceptualisation in psychotherapy models other than CBT. The other two rating scales were specifically designed to assess the quality of CBT case conceptualisations. The Fothergill and Kuyken scale assessed only the quality of the actual cognitive therapy case conceptualisation (the hypothetical inferential aspects) according to a specific format, whereas the CBT Case Conceptualisation rating scale was broader in its capture of information, measuring both content and quality across a number of dimensions namely the problem list, diagnosis, and treatment plan, in addition to the core CBT case conceptualisation. As discussed in chapter two, the development and use of case conceptualisation rating scales is at the time of writing is limited to a few studies (Eells et al 1998; Kuyken et al., 2004).

The three case conceptualisation rating scales will be described in detail below. This will be followed by an account of the development of the "benchmark" case conceptualisations.

The Case Formulation Content Coding Method

The Case Formulation Content Coding Method (Eells et al.,1998) is contained in the Manual for Case Formulation and Treatment Coding (Appendix B). It is, at the time of writing, the only published method available for reliable and comprehensive categorization of the content and quality of information used in case conceptualisation. In addition the method can be applied across different psychotherapy models, for example CBT, psychoanalytic, and humanist existential models.

The Case Formulation Content Coding Method assesses case conceptualisation by systematically coding the different content categories of information considered necessary in a high quality, comprehensive case conceptualisation. Four broad categories of information are distinguished, namely *descriptive, diagnostic, inferential*, and *treatment information.* Under each category heading is a list of subcategories representing the type of information deemed relevant for inclusion under the main category heading. Each subcategory is assigned a numerical code.

The degree to which the case conceptualisation comprehensively captures the breadth of information necessary for a high quality case conceptualisation can be easily assessed by observing which subcategories have been attended to by participants and which have been omitted. Descriptive and inferential information are distinguished, and this facilitates the evaluation of quality (the inferential information is considered more relevant to the intrinsic quality of the case conceptualisation). The assessment of the "content" is described below. With the exception of the "comprehensiveness" scale, the quality rating scales in this scale were omitted in favour of the CBT quality ratings as the participants had been asked specifically to conceptualise within the CBT model.

Evaluation of content

The written case conceptualisations produced by the participants, based on the four clinical case vignettes, were segmented into "idea units" by the author. An idea unit is a segment of narrative, usually a sentence or phrase, judged to contain a complete idea (Stinson, Milbrath, Reidbord, & Bucci, 1994). The idea units were then coded under the subcategories listed under each of the four broad categories (descriptive, inferential, diagnostic, and treatment categories).

In the original manual some subcategories appear as a single entity designated by a single number, such as "identifying information" (1). In other instances a subcategory might have several sub-subcategories listed under it. For example, the subcategory "inferred social or cultural factors" (21) had "absence of /or poor psychosocial support" (21.1), "demographic/cultural factors" (21.2), and "role conflict" (21.3) listed. In this research, the original numerical codes in the descriptive and inferential categories were abbreviated and subcategories were combined under a single coded heading. For example, the single code (21) is used to indicate the presence of any of the sub-subcategories listed above under "inferred social or cultural factors". As a result nine subcategories are distinguished under "descriptive" and "inferential" information respectively. The original manual was altered to make the comparison of the two groups, required in the second research question, more manageable. The modified scale can be found in Appendix C. To evaluate the case conceptualisation, the idea units representing the various subcategories were coded with the appropriate number and a frequency count made. For example if a participant had five idea units indicating "identifying information" (5) would be coded under the category designated (1).

Category one: Descriptive information

"Descriptive information" is factual information collected in the initial clinical assessment. The nine sub-categories listed under this heading are; 1) identifying information, 2) symptom identification, 3) history of previous episode, 4) medical history, 5) developmental history, 6) adult life history, 7) mental status, 8) other descriptive information, and 9) need for more descriptive information. Idea units coded in this section were not explanatory or inferential, and indicated attention to the factual information contained in the vignette.

Category two: Inferential Information

The category containing "Inferential information" is the crux of the case conceptualisation. Here, the hypothetical explanation for the presenting psychological problem(s) is outlined and significant precipitating, predisposing, maintaining, and protective factors are integrated to provide this explanation.

As in the descriptive category , the inferential category contains information coded under nine headings, namely 1) problems in global psychological, social or occupational functioning, 2) symptoms and problems inferred from the vignette, 3) precipitating stressors or events, 4) predisposing life events or stressors, 5) psychological, 6) biological and 7) socio-cultural mechanisms, 8) factors suggesting positive motivation for treatment and strengths, and 9) indications of therapy interfering behaviour. Information coded under this section must be judged "explanatory" in so far that it is (*hypothetically*) linked to the precipitation, perpetuation, and predisposition of the presenting problems.

In other words, the case conceptualisation is "spelled out" under the "inferential" category. The first three sub-categories coded under inferential information are largely self- explanatory. Problems and symptoms are the presenting issues bringing the patient to therapy. These are generally described by the patient at the intake interview, but can also be based on clinical observation, or reported from other sources such as clinical reports and family members. Precipitating events are those events activating or exacerbating the patient's problems and symptoms such as accidents, illnesses, relationship difficulties, and losses. Predisposing events are developmental traumas or other past stressors assumed to have increased the patient's susceptibility to developing the presenting problems or symptoms.

The next three sub-categories of inferential information specifically describe explanatory mechanisms which relate to the presenting problem, these are; psychological, biological, and socio cultural mechanisms. From the perspective of the psychotherapist the "psychological mechanism" is the most important sub-category, providing the explanatory or "sense making" aspect of the case conceptualisation. This may not be the whole explanation, and biological and socio/cultural mechanisms can be equally important explanatory mechanisms.

The content of the *psychological mechanism* is theory specific, for example the influence of cognition (beliefs and assumptions) on the psychological problems would be important in CBT. Although the mechanisms identified offer an explanation for the presenting problems these can only be proposed as an hypothesis. The psychological mechanism is an *interpretation* of the descriptive data through the lens of the theoretical model of choice. Psychological mechanisms in CBT are usually expressed as a "vicious cycle" which links the dysfunctional cognitive schema and underlying assumptions with compensatory behaviours which maintain or exacerbate the problems and symptoms. Other subcategories coded under the inferential category are biological mechanisms, socio-cultural mechanisms, and the positive and negative indicators for treatment. Biological mechanisms would include genetic and physiological factors. Socio-cultural mechanisms refer to important influences such as race, gender, marital status, cultural perspective, religion and so forth. Positive and negative indicators involve such aspects as patient motivation and compliance and the quality of the therapeutic relationship.

Category three: Diagnostic information

The diagnostic category contains four codes namely; Axis I diagnosis, Axis II diagnosis, a mixed presentation (both Axis' referred to), and the presence of a drug and/or alcohol issue. Whilst the diagnostic category contains the smallest amount of information, it is important from a CBT perspective as it indicates both an appropriate treatment plan and a point of departure for developing hypotheses about thought processes and predictable behaviour patterns. In CBT the diagnosis often indicates a disorder specific conceptualisation which has important implications for treatment planning and the selection of evidenced based interventions. The diagnostic sub-categories were collapsed into one category, "diagnosis" under which all idea units referring to diagnosis were recorded. The "Diagnosis" category of information is included in the *comprehensiveness* and *quality* ratings discussed later in this chapter.

Category four: Treatment- planning information

The treatment- planning category is a list of 38 treatment strategies which could be included in a treatment plan. There are nine headings in this category under which the various sub-categories involved in treatment planning have been listed as follows:

1. *Type of treatment/therapy considered* (individual, CBT, individual psychodynamic or interpersonal therapy, group, couples, marital or family, inpatient psychiatric, refer elsewhere for psychotherapy, and no psychotherapy recommended).
2. *Evaluation and assessment* (physical or medical, psychometric testing, further develop case conceptualisation, ongoing use of scales to monitor progress).

3. *Specific structured techniques* (relaxation exercises, exposure, assign homework, role playing, and psycho-education). CBT is a system of psychotherapy with a large array of structured specific techniques. Some examples of these would be the "Five-Part model" Padesky & Mooney, 1990, the "dysfunctional thought record" (Beck, 1995), "core belief worksheet" (Beck, 1995), and the "activity schedule" (Greenberger & Padesky, 1995). To accommodate this, an additional subcategory "specific CBT techniques", was included to capture the participants' reference to these treatment interventions.
4. *"Broad aspects" of the patient, such as,* "red flag issues", treatment contract, therapist-patient relationship, problems/symptoms, and goals.
5. *Predisposing experiences, events, and traumas* such as childhood and adulthood events, precipitating or current stressors, past therapeutic relationships, and family psychiatric history.
6. *Psychological mechanisms* (problematic aspects of the self and relationship to others, dysfunctional thoughts, affect regulation, coping mechanisms, skills or social learning deficits).
7. *Social and cultural factors (ethnicity, religious influences, sexual orientation, age cohorts)*
8. *Biological factors (the influence of genetics, medical problems, age relate changes such as menopause or pregnancy)*
9. *Strengths in global psychological and social or occupational functioning*.

All the categories and sub-subcategories were included in the coding of "treatment-planning" so as to reflect, in the broadest terms, the conceptually congruent treatment planning and decision making process of the participants. The "treatment planning" category of the Case Formulation Content Coding Method

was rated in the same way as the other content categories (segmentation into idea units which were then appropriately coded).

Evaluation of quality

The evaluation of the overall quality of the case conceptualisation using the Case Formulation Content Coding Method takes three sources of information into account, first, the comprehensiveness, second, the relative emphasis placed either on descriptive or inferential information, and third, the ratings obtained on the specific dimensions of quality. As mentioned above in this research only "comprehensiveness scale" as a measure of quality will be utilised in this research.

The assessment of the comprehensiveness

The comprehensiveness of the case conceptualisation refers to the total number of subcategories of information coded under the *inferential* category, with the addition of information coded under the diagnostic category. The more sub-categories of information attended to by the participant, the more comprehensive the case conceptualisation is assumed to be. Comprehensiveness is related to *quality* in the sense that the breadth of information attended to by the clinician will add to the richness of the case conceptualisation and offer increased options for effective treatment planning.

The Case Formulation Content Coding Method identifies nine subcategories of *inferential* information. These subcategories, together with diagnosis (10 subcategories in total), are considered when evaluating the comprehensiveness of a case conceptualisation (Eells et al., 1998). Participants received a score of "one" for recording idea units in each of the subcategories. For example if a participant had recorded idea units coded under "precipitating factors", psychological

mechanisms" and "therapy interfering factors" they would receive a score of three out of ten.

The Fothergill and Kuyken Quality of Cognitive Therapy Case Formulation rating scale

Quality, in this instance, is defined as "a parsimonious, coherent and meaningful account of a client's presenting problems in cognitive therapy terms" (Fothergill and Kuyken, 2002 p.13). The development of the Quality of Cognitive Therapy Case Formulation rating scale was influenced by the Case Formulation Content Coding Method. This scale differs from the older scale in that it was designed as a specific measure of the quality of Cognitive Therapy case conceptualisations. In format, it focuses solely on the inferential aspects of the case conceptualisation as expressed in cognitive therapy terms, and does not have the four separate categories of information included in the Case Formulation Content Coding Method namely; descriptive data, diagnostic and treatment planning information. In contrast, the case conceptualisation/formulation is based on what is generally accepted as "best-practice" in CBT (Beck, 1995; Persons, 1989), and is rated as a single entity. (See Appendix D for a copy of the manual).

The rating scale has the following four points rating quality; 1 = "very poor", 2 = "poor", 3 = "good enough" and 4 = "good". The manual describes the criteria necessary for each score.

According to this rating scale the cognitive therapy case conceptualisation should integrate relevant cognitive therapy information to provide a meaningful account of the patient's psychological problems in cognitive behavioural terms. This would mean identification of core beliefs, underlying assumptions and compensatory

behaviours. "Relevant" childhood data and compensatory behaviours should be based on descriptive information obtained from the patient (factual data). The core beliefs and conditional assumptions should be appropriate and meaningful inferences derived from this data. In addition the information should be accurate, relevant, and parsimonious, with the information recorded in the correct section of the Judith Beck conceptualisation diagram (Fothergill & Kuyken, 2002).

The case conceptualisation is scored as a whole achieving a single rating. All the elements of the case conceptualisation are rated in terms the integration of *relevant* information upon which a useful cognitive therapy treatment plan can be based.

The CBT Case Conceptualisation rating scale

Why develop an additional case conceptualisation rating scale?

Developed specifically for this study, the Cognitive Behaviour Therapy Case Conceptualisation rating scale is specifically targeted at CBT case conceptualisation. It is included as a more wide ranging measure targeting aspects of the case conceptualisation beyond those elements related specifically to the psychological aspects of the cognitive model. The differences between the two scales are outlined as follows:

Firstly the CBT Case Conceptualisation rating scale is an inclusive measure including the following categories; the development of a useful *problem list, accurate diagnosis, hypothesis (case conceptualisation),* and *treatment plan.* The Fothergill and Kuyken Quality of Cognitive Therapy rating scale rates only the inferential aspects of the CBT case conceptualisation, namely the relationship between core beliefs, underlying assumptions and compensatory behaviours and the possible link with significant historical experience. The new scale includes the

problem list, diagnosis, and the treatment plan giving the scale a very practical focus highlighting the important link between assessment, conceptualisation and treatment planning. In this way the individualised and disorder specific aspects of the case conceptualisation are captured. Including a rating for treatment is a very important addition for training purposes, as this is the whole point of a case conceptualisation. Obtaining a high rating in the treatment section also requires the participant to reflect on implications for the therapeutic relationship, obstacles which may interfere with therapy, and therapy enhancing factors.

Secondly the new scale rates each category, (problem list, diagnosis, hypothesis, and treatment plan) separately. In this way the strengths and weaknesses of the case conceptualisation can be clearly specified, for example it is possible to see at a glance which areas may be weak, such as an incomplete, or absent 'problem list'. The Fothergill and Kuyken Quality of Cognitive Therapy rating scale relies on one overall score, which rates the overall quality of the inferential aspects of the conceptualisation in isolation from problem identification, diagnosis, and treatment planning. The primary function of the case conceptualisation is to direct treatment planning. The scale designed for this research takes this important factor into account.

Thirdly the categories utilised in the new scale are derived from Persons, (1989), and Persons and Tompkins, (2007) case formulation model, and the Case Formulation Content coding method. The Fothergill and Kuyken scale relies solely on the Judith Beck (1995) case conceptualisation diagram.
The new scale is therefore more comprehensive, CBT specific, and has particular relevance for CBT training.

Since its development for this study in 2004, the CBT Case Conceptualisation rating scale has been used on an annual basis as an assessment measure in the final oral examination of trainees completing the Massey University PGDipCBT. Used in this manner, it has proved to be a very helpful measure identifying both strengths and weaknesses in trainees. To date, there has been consensus between the examiners regarding the utility of the rating scale, and agreement, concerning allocation of ratings, within the practical dimensions of its application, has been good.

Developing the categories in the CBT Case Conceptualisation rating scale

The selection of the broad categories; problem list, diagnosis, hypothesis, and treatment plan were derived from the Case Formulation Content Coding Method (Eells, et al., 1998) described above. The content contained in each category is influenced by Persons (1989) and Persons and Tompkins (2007). The content and quality of each category was rated on a five-point rating scale as follows, absent = 0, barely adequate = 2, mediocre = 4, satisfactory = 6, good = 8, and excellent = 10. The anchor points are based on those used in The Cognitive Therapy Scale (Young and Beck 1980), which is widely used in the assessment of general competency in CBT therapists. (see Appendix E for a copy of the CBT Case Conceptualisation rating scale). To obtain an optimal rating, the criteria listed below would have to be achieved.

The Problem List category

All problems identified by the patient listed and prioritized. There should be an indication of ability to: functionally analyze problems using the CBT Five-Part model (Padesky & Mooney, 1990), integrating interpersonal, cultural or environmental/ situational problems if relevant. The ability to speculate about

problems outside of the patient's immediate awareness, and to note problems that the patient may wish to avoid, for example, suicidal, self-harm, or addictive behaviours. Genetic or medical factors should be included if relevant.

The Diagnosis category

An accurate Axis I diagnosis is recorded, which shows "goodness of fit" with presenting symptoms. An Axis II two diagnosis noted if relevant as the primary diagnosis. The clinician demonstrates an awareness of personality clusters or traits which may be related, and specifies how these personality traits may affect the delivery of treatment, therapeutic relationship, and length of treatment.

The Working Hypothesis category

The working hypothesis can be compared to the explanatory mechanisms described by Eells et al (1998) in the inferential category in the Case Formulation Content Coding method. In this instance the clinician should present a *coherent, meaningful, parsimonious* case formulation which includes: the identification of core beliefs about self (beliefs about "others" and "the world' are of secondary importance but still relevant); underlying assumptions, compensatory behaviours, precipitating factors, activating circumstances, relevant historical or developmental origins to the presenting psychological problems, maintaining factors, and protective factors. Reflections on the implications of all of the above factors on the therapeutic relationship, and the predicted progress in therapy should also be included. A key element is the ability to link the above in a relevant and meaningful manner (for example, 'x' behaviour or 'x' emotion stems from 'y' underlying belief).

The Treatment Plan category

Treatment planning should be guided by the following factors; adherence to an appropriate disorder specific CBT case conceptualisation ("goodness of fit of interventions"), attention to structure (e.g. appropriate order of interventions), and use of appropriate behavioural and cognitive interventions. The treatment plan should be individualised according to the case conceptualisation (for example reflection on the therapeutic relationship, obstacles, length of therapy, need to refer out, seek supervision, and address safety issues).

Expert "benchmark" case conceptualisations as a measure of quality

The four "benchmark" case conceptualisations were obtained during "preliminary study one" which is reported in part two of this chapter (Copies of the benchmark case conceptualisations can be found in Appendix F, 1-4). The use of a "benchmark" quality case conceptualisation is derived from the study measuring the quality and reliability of case formulations produced by Cognitive Therapists (Kuyken et al., 2004) reported in chapter three. A benchmark case conceptualisation provided by Judith Beck was used in the evaluation of the quality of cognitive therapy case formulations using the Quality of Cognitive Therapy Case Formulation rating scale" (Fothergill & Kuyken, 2002), already described.

Preliminary study one, assessed the viability of using case vignettes to elicit case conceptualisations which could be systematically evaluated. Briefly, five "expert" clinicians were approached to act as a panel. Expertise was defined as more than five years clinical experience and expertise in CBT. Using the following criteria defining "expert" listed by Eells et al (2005); having published regarding case formulation, leading workshops on case formulation, and to have obtained

national recognition as a leader in the field, one member of the panel, Lynley Stenhouse, stood out as an acknowledged "expert" in the field of CBT case conceptualisation, and her CBT case conceptualisations, based on the clinical vignettes, were selected as the quality "benchmarks".

In the previous study, which used benchmark conceptualisations produced by Judith Beck, as the expert, the benchmark conceptualisations were prepared in advance. (Kuyken et al., 2004). In this research the "expert" was not informed prior to completing the conceptualisations that her conceptualisations would be used in this way. She therefore approached the task in exactly the same way as the participants, and did not have the advantage of giving extra thought or time to the task.

The four "benchmark" case conceptualisations were transcribed and segmented into idea units and coded in the same manner as the participants' case conceptualisations. The "expert" had used an identical format for each conceptualisation, structuring the information under the following nine headings. The headings in this instance were: relevant childhood data, core beliefs, underlying assumptions, compensatory behaviours, presenting problems, diagnosis, therapy interfering behaviours, treatment plan, and implications for the therapeutic relationship.

Quality was assessed by the percentage of agreement obtained for the information recorded under the categories selected by the "expert". For example if the expert identified the core belief "I am vulnerable" and 50% of participants had also made that choice, an assumption could be made that 50% of the group were on "the right track" towards producing a coherent and high quality case conceptualisation.

The development of the self-practice/self-reflection workbook "Understanding Myself"

This section documents the construction of the workbook designed specifically for this research in the following manner. A brief introduction to the use of workbooks in psychotherapy contextualises the current workbook. The primary purpose of the workbook is to lead the participant through the steps involved in constructing a CBT case conceptualisation and a brief summary of the structural and functional components of the model is provided as a reminder of the steps. This is followed by a description of the layout and details of the self-practice and self-reflection exercises. The section concludes with an account of the qualitative method employed in the analysis of the participants' self-reflective responses.

Workbooks in psychotherapy

Over the past 20 years self-help workbooks have become increasingly common in the mental health field and are used independently by individuals with mental health problems, or as a complementary or supplementary component of traditional psychotherapy. This trend has been described as a "quiet revolution in clinical practice" (Corcoran, 2005 p. 229). Clinically focussed self-help workbooks generally require active participation in the completion of tasks and assignments which are in a written format. The aim of workbooks is usually to facilitate personal change by consolidating skills learnt in therapy. An obvious assumption is that these skills will transfer and generalise to the wider interpersonal, occupational, or social context of the individual seeking help and prevent relapse (L'Abate, 2005).

Self-practice/self-reflection workbooks and psychotherapy training

Given the wide range of self-help workbooks available in the psychotherapy field, there are few self-help workbooks designed specifically to facilitate the training of mental health professionals. An unpublished exception is a self-practice/self-reflection workbook produced by James Bennett-Levy and Michelle Smith (1999) as part of a PhD thesis (Bennett-Levy, 2002). This workbook leads the trainee cognitive therapist through a series of alternating self-practice/self-reflection exercises. A wide variety of cognitive therapy techniques commonly employed in the treatment of depression (reflecting the generic cognitive behaviour therapy model) are included as self-practice exercises. The self-reflective exercises take the form of questions to which the trainees had to respond in writing. The point of departure was identifying a problem the trainee wished to resolve along with specific goals relating to the identified problem. Widely used CBT interventions such as the Five-Part model, personal visual analogue scales measuring identified mood, activity scheduling, thought records, behavioural experiments, and identification of underlying assumptions and core beliefs were included as self-practice exercises. The progression of interventions mirrored what would typically constitute an introductory training course, or workshop, teaching the generic CBT model. The aim of the workbook was to discover what sort of effect the self practice/self reflection might have on the trainee cognitive therapists in a general sense.

The self-practice/self-reflection workbook "Understanding Myself"

The format of the workbook created for this research was influenced by the Bennett-Levy and Smith workbook. The purpose however, was more specific, aiming to lead the participants systematically through the steps involved in

gathering and piecing together the information required for a CBT case conceptualisation.

The case conceptualisation is dependent on a clear understanding of the CBT model. The CBT model is both structural and functional. The structural model proposes three levels of thought namely, core beliefs, from which underlying assumptions, rules, and attitudes are derived, giving rise to negative automatic thoughts. The model is likened to the layers of skin on an onion with negative automatic thoughts forming the outside skin. It is recommended that the therapist proceed from the outermost layer, first gathering information about negative automatic thoughts which, when probed may link to the deeper structures of thought.

Following this template, the construction of a CBT case conceptualisation requires, as a first step, identifying the principal presenting problems (overt difficulties) which are presumed to be logically connected to underlying or predisposing mechanisms (psychological, social or biological) (Persons, 1989). A functional analysis of the problems using techniques such as the Five-Part model (Padesky & Mooney, 1990; Greenberger & Padesky, 1995) shows how the problems are triggered and manifested in thinking patterns, emotional expression, resulting behaviours, and physiological reactions. The use of the dysfunctional thought record amplifies the situational, thought, emotional connection. Situational triggers, typical reactive thoughts, emotions, physiological reactions and resulting behaviours all indicate characteristic negative maintaining cycles which assist the clinician in the extraction of unifying cognitive themes such as cross situational conditional underlying assumptions, unconditional core beliefs, and unhelpful compensatory behavioural cycles. In the CBT model the unconditional core beliefs

and conditional underlying assumptions are considered to be the underlying psychological mechanism which perpetuates the problems (Beck, 1995, 2005; Needleman, 1999; Persons & Tompkins, 2007). A final step requires linking the underlying psychological mechanism to key formative developmental experiences. The aim of the workbook was to deepen the trainees' understanding of this process through direct personal experience of the steps summarised above (through self-practice/self-reflection).

The design of the workbook

The workbook follows a similar layout as the Bennett-Levy and Smith workbook (self-practice exercises alternating with self-reflective questions) and contains frequently used CBT exercises, arranged sequentially, designed to elicit the information required to construct a personal case conceptualisation. Unlike the Bennett-Levy and Smith Workbook, this workbook was *not* designed to give the participant the experience of being helped with an identified problem, but to facilitate the participants' *conceptual understanding* of the genesis and maintenance of the identified problem. It was anticipated that if the exercises were completed in the correct order participants would be guided to think about his or her situation, problems, and emotional experiences in a conceptual manner consistent with the CBT model described above. It was expected that the CBT interventions would facilitate the emergence of personal patterns and themes, enabling the clinician to construct his or her personal case conceptualisation.

After an introduction outlining the purpose of the workbook, defining case conceptualisation, and explaining the layout, a summary of the order of the self-practice/self-reflection exercises, together with the estimated timeframe for each exercise was provided. It was estimated that the total time commitment in the

completion of the workbook would be approximately ten hours spread over about three weeks.

The workbook was divided into three sections following the "onion" analogy often used to describe the three levels of thought. The analogy indicates that in CBT one moves from the outside layer (negative automatic thoughts), to the deeper layers (underlying assumptions) and finally to the centre (core beliefs and schema). The three sections were: (1) "The outside of the onion: getting started", (2) "Moving on to the middle of the onion: Underlying assumptions", and finally (3) "Moving to the centre of the onion".

Section one: "The outside of the onion: getting started".

Three self-practice exercises namely, "understanding my problems", "the Five-Part model", and the "dysfunctional thought record" were included in section one. Each of these self-practice exercises was followed by self-reflection questions. Participants were asked to think of a recurrent personal problem eliciting a moderate emotional arousal, rated approximately 70% intensity on a visual analogue scale (as they would be working independently, participants were advised to steer clear of highly emotive experiences such as early developmental trauma, serious relationship problems or losses). The problem was made understandable in CBT terms through a functional analysis, using the Five-Part model (Greenberger & Padesky, 1995), and the dysfunctional thought record (Greenberger & Padesky, 1995).

Section two: "Moving on to the middle of the onion: Underlying assumptions"

In this section the "three levels of thought" (Greenberger & Padesky, 1995) was briefly revised and the concept of an underlying assumption explained. The three

self-practice exercises in this section were; firstly an exercise identifying cognitive themes from the thought records completed in section one, concerning self, others and the world, this was followed by a worksheet identifying underlying assumptions and behavioural themes. The participant's underlying assumptions were elicited through a number of exercises identifying repetitive behaviours and then linking the behaviour with an assumption for example *If* (behaviour: I keep very organised) *then* (?) (*nothing bad will happen*). Finally the participant was asked to use a summary worksheet to match the identified underlying assumptions with repetitive compensatory behaviours and avoidance strategies. One self-reflection exercise concluded this section.

Section three: "Moving to the centre of the onion"

This section contained seven self-practice exercises, three of which involved completing questionnaires. To identify core beliefs or schema participants were required to return to the dysfunctional thought records and choose a situation evoking high emotional intensity and then use the repeated question, "If this were true about me what would it mean?" to elicit the deepest underlying beliefs. Any insight was supplemented by a self-practice exercise which involved completing and scoring the Personal Beliefs Questionnaire (PBQ) (Beck & Beck, 1995), and the Young Schema Questionnaire (Young & Brown, 2003). These questionnaires identified the participants' schema or core beliefs. Two more questionnaires, the Young Compensatory Inventory (Young, 2003) and the Young Avoidance Inventory (Young & Rygh, 2003) enabled participants identify possible compensatory behaviours or avoidance patterns. At the time of writing the questionnaires used were available from the www.schematherapy.com website. These exercises are designed to help the participant identify the relevant cognitive mechanisms important in their idiosyncratic case conceptualisation. This is the

hypothetical or inferential part of the conceptualisation, which provides information about what maintains the current problem. The questionnaires were followed by a self-practice imagery exercise, asking the participant to link the identified core beliefs or schema with historical and developmental origins providing the predisposing component of the case conceptualisation. The final self-practice exercise required that participants complete a self- CBT conceptualisation, using the Judith Beck conceptualization form (Beck, 1995), thus comprehensively conceptualising themselves using the CBT model. Five self-reflection exercises were integrated into this section.

The final self-reflection exercise allowed for concluding reflections summing up the entire process. Participants were asked to summarise their progress in the following manner: "Self-practice? Comments?"; "Self-reflection? Comments?"; "What has it meant for you personally?"; "What has it meant for you professionally?"; "Have there been any changes in the way you think about clients conceptually?", "Has there been any change in your understanding of CBT?"; and finally, "include any positive or negative effects if relevant."

The Self-practice exercises

The self-practice exercises were adapted from the following widely utilised and available sources (Beck, 1995; Greenberger & Padesky, 1995; Leahy, 2003; and Young, 2002, Young et al., 2003). Participants would be familiar with these interventions through their training and would have used them with clients in their professional practice. In addition to the self-practice/self-reflection exercises, capsule summaries reminding the participants of core concepts such as the three levels of thought were provided at the beginning of each section.

The instructions for the completion of the self-practice exercises were very similar to the instructions a patient would routinely receive in a standard CBT session aimed at eliciting information to develop a case conceptualisation. For example the self-practice exercise relating to the dysfunctional thought record was presented thus: *"Use the three situations described in the Five-Part models to complete the following three thought records. If you have other related situations that you would prefer to use that would be fine. Something immediate with high emotional content is best. Write down what is going through your mind and then identify the hot thought (the thought with the highest emotional voltage). Use the following questions to help you find the meaning behind the hot thought."*

The Self-Reflection exercises

Ten self-reflection worksheets were included in the workbook headed; understanding my problems, the Five-Part model, the thought record, identifying underlying assumptions, core beliefs, completing questionnaires, summary of schema, compensatory behaviour , and avoidance, historical origins, conceptualisation, and concluding remarks on self-practice /self-reflection.
For the most part the self-reflection worksheets alternated with the self-practice exercises. Some examples of the type of questions used to elicit self-reflections are *"Comment on how it felt to process your thoughts in this way?"; "Did you experience any difficulties?"; "Did this exercise give you any insights about yourself?", "Did you notice any themes which might relate to some of your underlying beliefs?" and "Any additional comments?"*

To assess the face validity and "user-friendly" qualities of the workbook two newly qualified psychologists with training in CBT, worked through the self-practice/self-reflection exercises in a draft edition of the workbook. Their feedback

was utilized in improving and altering the original daft copy. One of the reviewers was wholly satisfied with the format and content. More detailed feedback came from the second reviewer and concentrated on the need to alter some of the self-reflection questions to a more open ended form. She also provided hints for the provision of organisational cues such as a summary of exercises at the beginning of the workbook and the estimated time required for each exercise. Both reviewers had a positive response to the task. (Enquiries concerning the workbook can be directed to B.A.Haarhoff@massey.ac.nz).

Distribution of the workbook

After the participants in the intervention group had completed and returned the two pre-intervention case vignettes, they were posted a copy of the self-practice/self-reflection workbook and asked to complete the exercises and return the pages recording their self-reflective written comments to the author.

Thematic analysis of the self-reflective responses

The data set consisted of the written responses to the self-reflection questions contained in the workbook. Thematic analysis, as a systematic technique for coding text into themes was used to identify themes perceived to be related to the research questions being asked regarding the impact of the intervention on the case conceptualisation quality of the participants. Thematic analysis can be applied across a range of theoretical and epistemological approaches (Braun & Clarke, 2006 p 78), making it compatible with the post-positivist approach and the mixed-methods research design used in the present study. The following six phases of analysis suggested by Braun and Clarke (2006) were followed: familiarizing self with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report.

When all the written self-reflections had been returned and transcribed, the responses were thematically analysed following the sequence of steps proposed by Braun & Clarke (2006), listed above. First I familiarised myself with the data set by repeated reading. The second step was to generate codes referring to aspects of the material relevant to the study. The self-reflection exercises in the workbook required the participants to respond to particular questions decided on prior to the study, some of which were open ended and others more specific, making the analysis 'theory' rather than 'data' driven. Most of the questions enquired about the meaning, or significance of the self-practice exercises, in the personal and professional (psychotherapy with clients) experience of the participants, with particular emphasis on how the experience may have effected case conceptualisation. The themes extracted were influenced by the questions in the workbook and themes identified by previous studies, such as "increased theoretical understanding of the model" and "developing empathy". Other themes were generated from the focus on CBT case conceptualisation.

The clinical case vignettes

Development of the narrative

Clinical cases, presented as written vignettes were developed specifically for the study. (see Appendix G, 1-4 for copies of the case vignettes). Each vignette was approximately 500 words in length. The vignettes were derived from clinical interviews with real patients referred for psychotherapy. Significant identifying information was altered to preserve confidentiality. The information included was elicited at the initial clinical interview/assessment of the patient. The following headings are adapted from by Eells et al. (2003), identifying information, presenting condition, history of the presenting condition, a history of mental health

and development, social history, and current mental status. These headings reflect the consensus regarding the kind of information required to construct a valid and reliable case conceptualisation, and mirror the categories of information coded in the assessment measures described at the beginning of the chapter. In addition, information consistent with the CBT model was embedded in the narrative. For example information from which underlying beliefs, assumptions, and compensatory behaviours could be deduced was included.

The use of case vignettes could be seen as method somewhat distant from a "real-life" encounter with a client (Eells et al, 2005). However, there are benefits to using this method. First, the researcher is able to control the information included in the narrative, making sure that similar categories of information were provided for each case vignette. This was important in the current research design which depends on a pre/post comparison of data. Secondly, the client's diagnostic presentation could be predetermined, again making comparison easier (Eells, 2005). For these reasons the written case vignette was selected as the method for eliciting the CBT case conceptualisation in this study. It is acknowledged that selecting the vignette as a vehicle to elicit the case conceptualisation was to some degree a compromise. Clearly the richness of information, relevant to a case conceptualisation of quality, which is obtained through a sensitive and astute clinical interview, was lost, and the quality of the participants' case conceptualisations was judged in this study, solely on their response to the written narrative. The vignettes were therefore selected as a "pragmatic solution" for the reasons outlined above. Vignettes were constructed to describe two common disorders namely major depressive disorder and generalized anxiety disorder. Each disorder was represented by two vignette examples.

Procedure

Potential participants (graduates of the Massey University PGDipCBT were mailed an information sheet and consent form (Appendices A and I) Subsequent to their recruitment, the 16 participants (intervention group) were mailed an instruction pack detailing how the following tasks were to be completed (Appendix J). After reading a short description of the case conceptualisation process, and the clinical benefits of such a process, the participants were asked to read case vignettes one and two and write down a CBT case conceptualisation for each, within a specified time-frame. The time allocated for the task was 20 minutes for the case conceptualisation, with an additional 10 minutes to construct a treatment plan. The time keeping had to be managed independently by the participant and a form detailing the time segments was provided as a reminder.

Participants were reminded that there is no right or wrong answer and it was suggested that the speculative generation of hypotheses (Persons & Tompkins, 2007) should be part of the exercise. Participants were identified by their real names. The fact that participants were known to myself, thus easily identified by their handwriting,, and some of the information contained in the content, meant that the maintenance of anonymity was unrealistic. On completion of this task the written case conceptualisations were placed in the stamped addressed envelope included in their information pack and returned to me.

After the completed case conceptualisations based on the pre test vignettes had been received, each participant was sent the workbook "Understanding Myself: Self-Practice and Self-Reflection" and asked to complete the alternating self-practice and self-reflection worksheets.

The self-practice/self-reflection workbook was introduced to the participants as follows:

> *"Finding ways to improve the quality of clinicians' case conceptualisations is the goal of this thesis. It has been noted by some important authors that practicing CBT techniques on oneself is very helpful way of learning about therapeutic processes in general (Padesky and Greenberger, 1995; Beck, 1995). It is hoped that using some of the methods and techniques in CBT on yourself will improve your case conceptualisation skill.*
>
> *"Competency as a cognitive therapist requires knowledge of cognitive therapy theory and the ability to apply this theory in a structured fashion. To do so, therapists must be able to formulate a useful case conceptualisation and skilfully apply empirically based clinical methods within a collaborative therapeutic relationship"* (Padesky, 1996)
>
> *Efficient case formulation is widely regarded as a cornerstone skill in the development of expertise as a Cognitive Behaviour Therapist.*
>
> *A case formulation is defined as*:
>
> *"….an hypothesis about causes, precipitants and maintaining influences of a person's psychological, interpersonal and behavioural problems. A case formulation helps organise often complex and contradictory information about a person. It should serve as a blueprint guiding treatment, as a marker for change, and as a structure enabling the therapist to understand the patient better. A case formulation should also help the therapist anticipate therapy interfering events and experience greater empathy for the patient" (Eells, 1997).*
>
> *It is important that the Cognitive Behaviour Therapist plans psychotherapy on the basis of an evolving formulation which includes integrating information from the following domains:*

What is happening in the present (current thinking and problems often expressed as behaviours)

Precipitating and activating factors (triggers).

Predisposing factors (significant development experiences and events).

Maintaining factors (the behaviours, patterns of avoidance, thoughts and other factors which may be keeping the problem going).

This workbook has exercises arranged in sequence to help you think about your own situation, problems, and emotional experiences in a conceptual manner consistent with the CBT model. The exercises in this workbook aim to help you identify personal patterns and themes which will help you construct a conceptual formulation which will make sense of the problem you have chosen to work with. These are the same kind of strategies that you would use with a client to collaboratively formulate a case conceptualisation.

The workbook is <u>not</u> designed to help you make personal changes. It is about putting the puzzle together, not changing the picture.

After each self-practice exercise (SP), there will be some questions guiding you in self-reflection (SR). This means thinking about the implications of what you have done in terms of your development as a CBT psychotherapist, particularly in relation to your conceptual case formulation skills. Working through the exercises contained in the workbook will take about 8-1O hours in total. These hours could be spread over a number of weeks. Three weeks would be the maximum period you would allow for the completion of the exercises in the workbook.

After the completion of the SR exercises you will be invited to post the completed response to me. The SR are all on coloured paper. Simply tear the page out of the workbook, place in the addressed envelope provided and return.

Please note that the self-reflection exercises contain information concerning the process rather than the content so your privacy is assured."

The self-reflections of the participants were recorded as responses to specific questions in the workbook designed to stimulate self-reflection. The self-reflection exercises were returned for qualitative analysis. The self-practice exercises remained in possession of the participant as these would contain sensitive personal information regarding their perceived psychological process. After returning the self-reflection worksheets, the participants were mailed case vignettes three and four (post test) and asked to repeat the exercise described for vignettes one and two (pre test).

The Comparison Group

The comparison group were sent an identical information sheet without information about the workbook. Three weeks was proposed as the intervening time between completing the conceptualisations based the pre and post vignettes. This time was predicted as the time it would take the intervention group to complete the worksheets in the workbook. The comparison group were offered an opportunity to complete the self-practice/self-reflection worksheets for their own interest. A copy of the workbook would be made available on completion of the four case conceptualisations based on the four case vignettes used by the intervention group.

Intervention group (n =16)	Vignette 1 'Elizabeth' *(GAD) Pre test	Vignette 2 'Joan' (Depression) Pre test	**MANUALISED INTERVENTION** ****SP/SR Workbook**	Vignette 3 'Mary' *(GAD) Post test	Vignette 4 'Belinda' (Depression Post test
Comparison group (n =10)	Vignette 1 'Elizabeth' *(GAD) Pre test	Vignette 2 'Joan' (Depression) Pre test	**NO INTERVENTION**	Vignette 3 'Mary' *(GAD) Post test	Vignette 4 'Belinda' (Depression) Post test

*GAD Generalised Anxiety Disorder

**SP/SR Self-practice/self-reflection

Figure 3. **Research design summarised: the order in which the case vignettes were presented to participants in both intervention and comparison groups.**

Data Analysis

Two sources of data were analysed; the CBT case conceptualisations derived from the four case vignettes, and the self-reflective responses from the self-practice/self-reflective workbook: Understanding Myself.

Case Conceptualisations

The written narratives produced by the participants were transcribed and segmented into idea units (Stinson et al., 1994) as preparation for coding the information under the content categories described in the Measures section. The process of segmenting the case conceptualisations into idea units was collaborative. One of the research assistants employed during the preliminary study (see following chapter), already familiar with the manual and coding process, was engaged. Sixteen of the case conceptualisations were segmented and coded independently by the research assistant and the author. The coders met when this task had been completed, and collaboratively discussed points of agreement and difference regarding the segmentation into idea units and the application of the codes of content. After two meetings the writer was sufficiently confident of consensus to proceed with the content coding independently.

The idea units were then coded for content and quality using the three rating scales described above under "measures". A total of 104 written case conceptualisations were returned for analysis and 10% (n = 11) were randomly selected for an independent quality rating by one of the original research assistants familiar with the rating scales. A recognised method of establishing reliability is to examine the percentage of agreement between raters (Kuyken et al. 2004). A 100% agreement within .5 was achieved for the Fothergill and Kuyken Quality of Cognitive Therapy Case Formulation rating scale, and 65% agreement averaged over the four

subscales of the CBT Case Conceptualisation rating scale. After the vignettes had been coded the data was entered into to SPSS 15.

The Workbook: Written self-reflective responses

The thematic analysis of the written responses to the self-reflection questions contained in the workbook has been previously discussed in the previous section of this chapter outlining the development and utilisation of the self-practice/self-reflection workbook "Understanding myself".

Part two: Case vignette development studies

To develop the clinical case vignettes, two preliminary studies were undertaken; first to compare the content of the case vignettes in terms of a number of criteria, and second to establish the clinical case vignette as a stable instrument for measuring case conceptualisation competency over a period of time. The first study also provided the "benchmark" case conceptualisations used to assess quality.

Preliminary study one

Are the four case vignettes equivalent?

The aims guiding this study were, firstly to determine whether the narratives of the four clinical case vignettes were equivalent in terms of amount, type and complexity of information provided, secondly, whether the time allocated for completing the written case conceptualisations was sufficient, and finally to obtain four "benchmark" case conceptualisations from an expert clinician working under the same conditions as the participants. The "benchmark" conceptualisations were

used as an additional measure of quality in the assessment of the case conceptualisations.

Participants

Five "expert" clinicians were approached to act as a panel. Expertise was defined as more than five years clinical experience and expertise in CBT. Two experts were Massey University staff members from the School of Psychology and the remaining three, employees at the Waitemata District Health Board CBT community mental health specialist service. As previously discussed under the measures heading, one member of the panel was selected as an "expert" in the field of CBT case conceptualisation, fitting the criteria used by Eells et al., (2005). Her case conceptualisations based on the clinical vignettes, became the quality "benchmarks" used in the main study.

Procedure

The panel was asked to read four case vignettes and produce a written case conceptualisation within a time-frame of 20 minutes, with a further 10 minutes to devise a treatment plan. They were advised that speculation and hypothesis generation is part of the process and that there was no right or wrong answer (in other words they were given the same instructions as the participants in the primary study).

After completing the exercise they were asked the following questions:
Did the case vignettes seem equivalent in terms of the following criteria:

1. Amount of information provided? Was there enough information in the case vignettes to construct a case conceptualisation of quality?

2. Type of information provided? Did the type of information contained in the vignettes conform to those subcategories of information rated as showing quality in the rating scales?
3. The Length of time taken to complete a case conceptualisation? Was the amount of time stipulated adequate for the construction of the case conceptualisation?
4. Degree of complexity? Were the case vignettes of equal complexity? In other words were some simpler in terms of the way in which the clinical information was presented.

Results

Visual inspection of Table 2, shows a majority of affirmative responses to the questions. Consensus was obtained, indicating that the vignettes were equivalent over the four dimensions listed above. Participant three pointed out that one of the vignettes was longer in terms of word count and complexity. This was corrected.

Table 2. Preliminary study one: Summary of results

Participants	**1**	**2**	**3**	**4**	**5**
Age	48	38	47	50	47
Years of experience	20	13	10	13	5
Profession	Nurse	*cl/psych	*cl/psych	*cl/psych	**psy/ther
Amount of information	Yes	yes	no	yes	yes
Type of information	Yes	yes	no	yes	yes
Time	Yes	yes	yes	yes	yes

Complexity	Yes	yes	no	yes	yes

* clinical psychologist
** psychotherapist

It was concluded on the basis of this study that the clinical case vignettes were sufficiently similar in terms of the above criteria. The next logical step was to test the stability of the case vignette as a useful measure of ability. In other words did the quality of case conceptualisations based on the clinical vignettes improve simply through repeated practice? A second preliminary study was devised to investigate this question.

Preliminary study two

Can the clinical case vignette be used as a reliable means to elicit the case conceptualisations?

The first aim of the second preliminary study was to assess the case vignettes as a stable method to elicit the four case conceptualisations. In the main study the quality of the participants' case conceptualisations were compared over time in pre and post conditions, and a question needed to be asked concerning the "practice effect" of this. In other words, did the quality of the case conceptualisations based on the clinical case vignettes improve over time simply because the participants had completed the exercise several times? The second aim was to enable the author and research assistant to gain familiarity with the three measures which would be used to assess the content and quality of the case conceptualisations produced in the primary study.

Participants

Four novice clinical psychologists were approached directly by the author agreed to participate in the study. "Novice" describes clinical psychologists with less than one year of experience. Two participants were commencing their clinical internship as the final stage of the Post Graduate Diploma in Clinical Psychology, and remaining two were newly graduated from the same program. All four were working full-time in the public mental health service. All participants had audited or completed all the theoretical papers in the PGDipCBT. In terms of background and training this sample was homogenous.

Measures

The following assessment measures were utilised to assess the content and quality of the case conceptualisations produced by the participants; The Case Formulation Content Coding Method (CFCCM), the Fothergill and Kuyken Quality of Cognitive Therapy Case Formulation Rating Scale, and the CBT Case Conceptualisation rating scale. These measures were used in the main study and a full description has already been provided in Part One of this chapter. At this stage, the sub-category coding adjustments had not been completed. However these adjustments would not have substantially altered the results obtained in this preliminary study.

Procedure

The participants were asked to complete three written case conceptualisations based on three case vignettes within a specified timeframe. The vignettes used were a selection of the same vignettes used in the final study. The first vignette

described a patient diagnosed with generalised anxiety, and the second and third described patients diagnosed as depressed. The time allotted to the task was 20 minutes, with a further 10 minutes given to the construction of a treatment plan. The exercise was repeated over three consecutive weeks with a different case vignette provided each time. Participants were encouraged to speculate and generate hypotheses as part of the process. The fact that there was no right or wrong answer was emphasized. In all respects the instructions replicated those given to participants in the main study already described. The instructions and the case vignettes were mailed to the participants who were asked to return the completed case conceptualisations either personally or by post.

Data analysis

After the handwritten case conceptualisations had been returned to the author they were transcribed and then segmented into *idea units* to facilitate coding. Two research assistants were engaged. Both were clinical psychologists with some clinical experience and appropriate theoretical knowledge of CBT. The segmentation the material into idea units was done independently by the research assistants and the author. When this was completed the three coders met and compared decisions regarding the segmented idea units and the content coding categories. Where differences occurred a discussion clarifying the decisions was initiated. Consensus between two out of the three coders was deemed sufficient for a final decision to be made.

After familiarising themselves with the measures the case conceptualisations were coded and the same process of reaching collaborative consensus, described above

followed. The Quality codes were completed independently by the writer. In line with the aims of this preliminary study, obtaining simple descriptive data for comparison across time was the goal.

Results

Table 3 summarises and compares the results. On the basis of visual inspection, a conclusion reached was that no particular pattern emerged either between, or within, participant performance over the three week time period

Table 3. Preliminary study two: Summary of results

Quality categories	participant 1			participant 2			participant 3			participant 4		
Vignettes	**V1**	**V2**	**V3**	**V1**	**V2**	**V3**	**V1**	**V2**	**V3**	**V1**	**V2**	**V3**
***Comprehensiveness**	3	1.5	2.5	2	4.5	2.5	3	3.5	3	3.5	3	2
****Total CBT RS**	10	11	11	5.5	7.5	4.5	7	9	8.5	5.5	6	7
*****FK CT quality RS**	4	4	3.5	3	3	2	3	3	2.5	3	2.3	2.5

* Comprehensiveness scale: top rating = 5
**CBT case conceptualisation rating scale: top rating = 20
***Fothergill & Kuyken quality of cognitive therapy case formulation rating scale:

top rating = 4

Discussion and conclusions

A visual inspection of the data presented in Table three, shows that there was no consistent pattern of improvement over time, in quality ratings. It was therefore assumed that a "practice effect" was not, in this instance, a contributing factor. On the basis of this data, it was concluded that the case vignette would provide a relatively stable method through which the case conceptualisations produced in the main study could be elicited and compared for content and quality over a time period. This small preliminary study also provided research assistants and the author an opportunity to become familiar with the categories of content coding.

The next three chapters, guided by the four research objectives outlined at the conclusion of chapter four, present the results of the main study. The research objectives structure the order of the results chapters in the following manner: Chapter six, reports the results of the assessment of the content and quality of four indiviudalised CBT case conceptualisations produced by the combined participant group, this is the first objective. Chapter seven, guided by objective two, presents the thematic analysis of the subjectively perceived impact of the self-practice/self-reflection manualised intervention on the intervention group, and chapter eight addresses objectives three and four. Objective three and four quantitatively assess the impact of the self-practice/self-refection intervention, first by comparing the quality of CBT case conceptualisation before and after the manualised intervention within the intervention group, and secondly by comparing the quality of the CBT case conceptualisations produced by the intervention and comparison groups (between group comparison).

Chapter six

Evaluating the content and quality of CBT case conceptualisations

As discussed in chapter three, despite the consensus regarding case conceptualisation as a key clinical competency, routine, systematic evaluation of this competency is rare in clinical training programs. Evaluation of case conceptualisations should play a key role in clinical training, helping to identify strengths and weaknesses in both individual trainees, and the program. To address this anomaly, the first research objective was the systematic assessment of the content and quality of CBT individualised case conceptualisations produced by a combined sample of 26 novice CBT clinicians. As stated in the methodology chapter, the case conceptualisations were based on four clinical vignettes, copies of which can be found in Appendix H, 1-4. However, to provide a context for the data presented below, the content of each vignette is summarized below.

Vignette one

"Elizabeth was in her mid thirties, happily married, with a ten year old daughter. She presented with high anxiety relating to a fear of dental procedures, precipitated by an upcoming visit to the dentist. She also reported worrying about many different situations and often feeling overcome by "anxiety waves". She was in full-time employment as an "image consultant". Her developmental history included some family history of mental health problems. She had a supported, somewhat overprotected childhood. She was teased at

school, and suffered from a number chronic health conditions such as hay-fever. She had underlying beliefs concerning her 'vulnerability' and a sense that others were often unpredictable, and that the world could be dangerous. Underlying assumptions were, a need to present herself in a favorable light, and at the same time, keep others at a distance. Compensatory behaviours involved the regular use of alcohol, and a tendency to keep others at a distance. Diagnostically she met criteria for generalized anxiety disorder, with avoidant dependent personality traits."

Vignette two

"Joan, aged forty was a divorced woman, living alone, in full time employment in marketing. She presented with symptoms of depression, and reported feeling overwhelmed at work, low motivation, and a sense that her life was out of balance. She had recently sustained a running injury. Her childhood had been a fairly isolated one, and she was brought up by her paternal grandmother. There were several events in her early childhood which disrupted her primary attachments. Core beliefs were that she was "not good enough" and that others could not be trusted. Underlying assumptions involved the need to please others, and to always control her emotions so as not to get hurt. Compensatory behaviours were a tendency to over-function at work and downplay her emotions. Diagnostically she met the criteria for a major depressive episode, with some avoidant personality traits."

Vignette three

"Mary was a single woman in her late fifties, employed an administrative capacity. She had three adult sons. Her presenting problems were chronic feelings of anxiety which resulted in her worrying continuously about many things, including her health, and always expecting the worst. She hated being alone and believed she did not fit in. Her developmental history was indicative of a very invalidating environment with little

consistent parental nurturing. Her core beliefs were that she was vulnerable, and others, on the whole unreliable. Her underlying assumption was related to a view that if anything went wrong it was her fault and she was responsible. Compensatory behaviours included reassurance seeking and a variety of "over- responsible" behaviours. She met the diagnostic criteria for generalized anxiety disorder with dependent personality traits.

Vignette four

"Belinda was in her twenties, had recently been married, and was employed as a nurse. She presented with symptoms of depression and was plagued with negative thoughts about "not measuring up to others". Her family had a history of depression. She reported a supported childhood in a high achieving, large family. Her core beliefs were that she was "not good enough" and "inferior" to other people, whom she regarded as "critical" and "superior". She assumed that if she made a mistake others would be disapproving or angry, and conversely, that if she excelled she was "special". Compensatory behaviours involved the maintenance of high standards, and pushing herself to accomplish challenges. Her diagnosis was that of a major depression, with some narcissistic personality traits.

In this chapter, the assessment of the content and quality of the case conceptualizations is presented. The assessment of content is reported first.

CBT Case conceptualization content evaluation

The content of four case conceptualizations based on the four case vignettes summarized above, were evaluated using the Case Formulation Content Coding method. The subcategories subsumed under each category heading represent the consensus concerning the type of information deemed relevant and necessary for the production of a comprehensive, clinically useful case conceptualization (Eells,

et al 1998). The number of idea units recorded under each subcategory shows the amount of attention given to each, and does *not* always, equate to quality. For example, it is possible to generate a large number of redundant or incorrect idea units in a particular subcategory. Content is however, an important starting point for the consideration of the quality of a case conceptualization, giving a clear picture of the type of clinical information emphasized or ignored. This has implications for training as gaps in knowledge, or attention, can be pinpointed and addressed. The number of subcategories of information attended to in the case conceptualization, therefore, can influence quality, in the sense that the greater breadth of information considered, the more likely a comprehensive picture of the presenting problems can be drawn, which should, in most cases, benefit treatment planning. The distribution of idea units over the various subcategories of coded information is therefore emphasized.

Participants from the intervention and comparison groups were combined to make a sample of 26. As can be seen from Table 1 in chapter five, the demographics of the two groups making up the combined group, were similar in terms of age, years of experience, hours per week practicing CBT, the distribution of professional affiliation, and their exposure to CBT training.

The Case Formulation content coding method yielded results showing the distribution of idea units under four main categories of information namely:

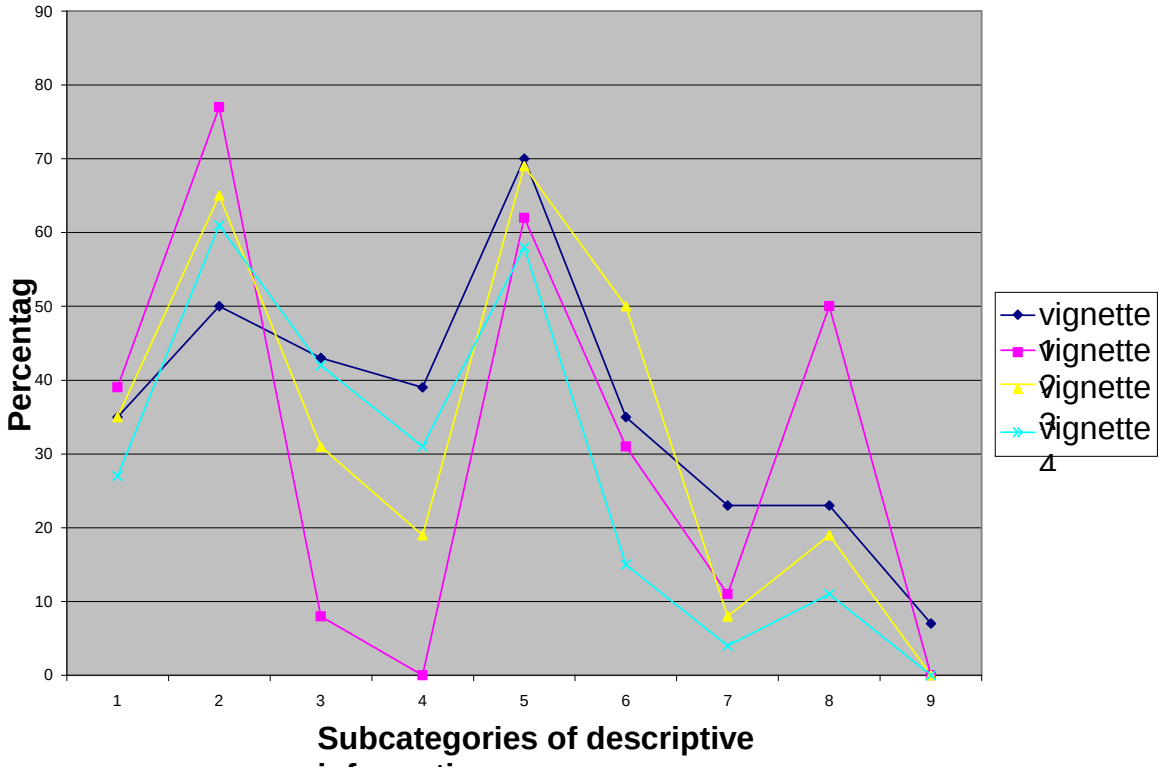
1. Descriptive information (factual information mainly concerned with identifying data).
2. Inferential information (information regarding the hypothesized conceptualization, particularly regarding the psychological mechanism involved in precipitating, predisposing and perpetuating the problem)
3. Diagnostic information
4. Treatment information (a treatment plan based on the case conceptualization)

The results pertaining to the *content* of each of the categories are discussed below.

Descriptive category of information

The descriptive category contains information which could be obtained directly from the case vignette. The purpose of this category is to introduce the client in terms of, basic demographics, history, presenting symptoms, and other relevant factual information. This information provides a context for the case conceptualization and is not considered explanatory. Idea units were coded under the following nine subcategories: identifying information, symptom information, history of previous episode, medical history (adulthood), developmental history, adult life history, mental status, other descriptive information, and need for more descriptive information. A consistent pattern of

emphasis across all four case vignettes emerged. The "developmental history" and "symptom information" subcategories proved to be the ones most often attended to. The subcategories "need for more information", and "other/different information from that provided in the case vignettes", and "mental status" were the three subcategories receiving least attention. Figure 4 illustrates the distribution of idea units across subcategories in the descriptive category.

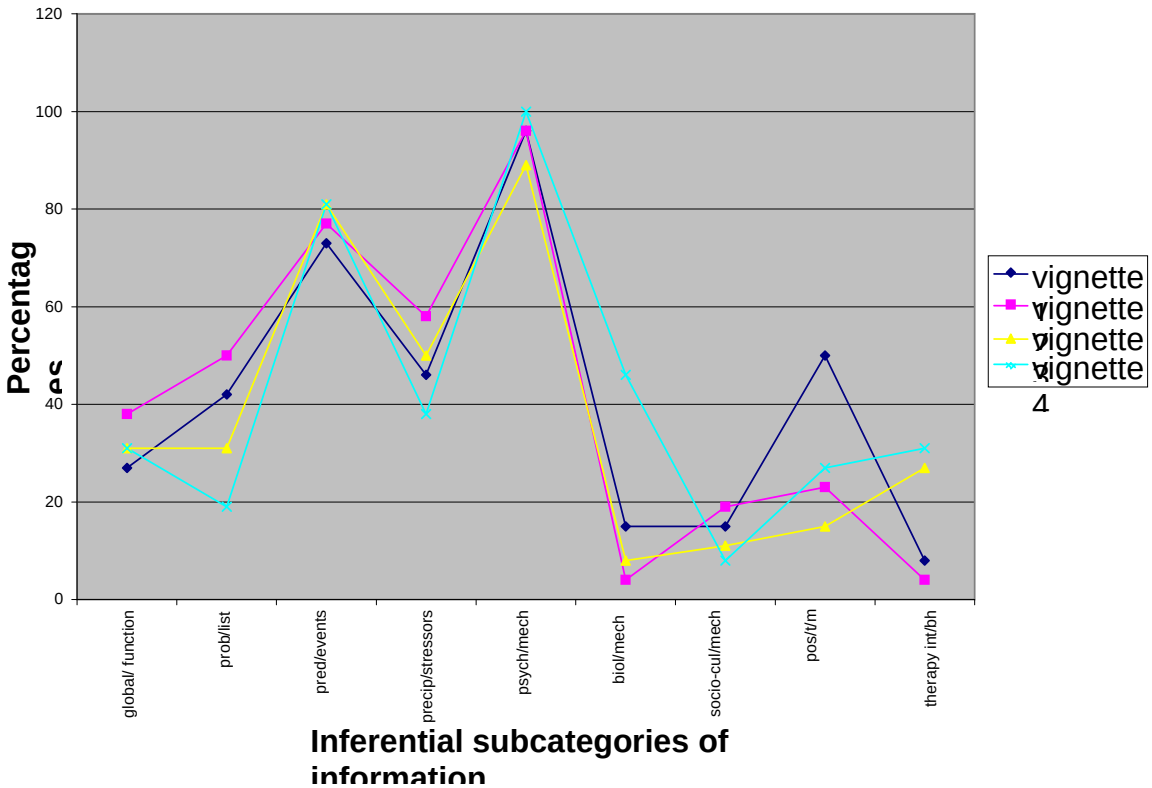


1 = identifying information
2 = symptom identification
3 = History of previous episode
4 = Medical history
5 = Developmental history
6 = Adult life history
7 = Mental status
8 = need for more information
9 = Need for other information

Figure 4. **Descriptive category of information: Percentage of participants recording at least one idea unit in each sub-category**

Inferential category of information

The inferential category of information is the most important part of the case conceptualization as it is here that the underlying mechanisms explaining the presenting problems are hypothetically proposed. In the instructions, participants were encouraged to speculate about how the information contained in the narrative could be pieced together in an explanatory manner. Nine subcategories of information are included under this heading namely; problems in global functioning, symptoms and problems inferred from the vignette, predisposing events or traumas inferred as explanatory, precipitating or current stressor, inferred psychological mechanisms, inferred biological and socio-cultural mechanisms, positive treatment factors, and the identification of therapy interfering factors. Figure 5, illustrates the distribution of idea units across the nine inferential subcategories in the same manner as the previous table.



Global/function = Problems in global functioning
Prob/list = Problem list
Pred/events = Predisposing events
Precip/stressors = Precipitating stressor
Psych/mech = Psychological mechanisms
Boil/mech = Biological mechanisms
Socio/cul/mech = Socio-cultural mechanisms
Pos/t/m = Positive treatment factors
Therapy/int/bh = Therapy interfering behaviours

Figure 5. Inferential category of information: Percentage of participants recording at least one idea unit in each sub-category

As can be seen in Figure 5, consistent distribution of idea units under the different subcategories occurred across all four case conceptualizations. By far the most attention was given to just two of the nine subcategories, namely, "inferred psychological mechanisms" and "predisposing events and traumas inferred as explanatory", with between 89% and 100% of participants recording at least one idea unit under the "psychological mechanism", and between 73% and 81% recording idea units under the "predisposing factors" sub-categories, respectively.

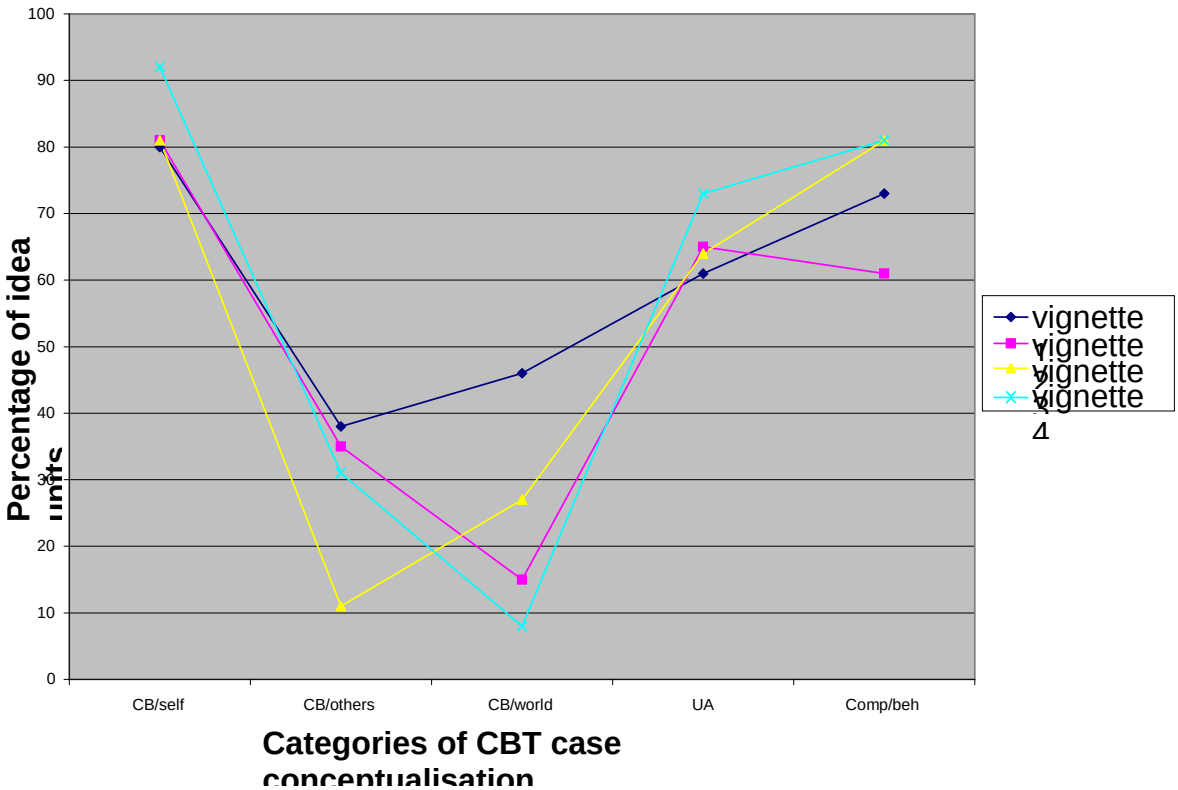
Predisposing factors relates to developmental history considered relevant to the formation of the cognitive behavioural profile.

"Precipitating factors" were noted by between 58% (*n* =14) and 38% (*n* =10) participants, making it the third most focused upon subcategory. The remaining four subcategories of information "problems in global functioning", "problems inferred from the vignette", "underlying biological mechanisms", and "protective factors", were attended to on average, by less than 50% of the participants. The clear identification of problems is a crucial starting point for the development of a case conceptualization particularly in CBT, often defined as "problem focused therapy" (Beck, 1995, p 1). Between 26% (*n* =5) and 38% (*n* =10) of the participants identified some presenting problems. Protective factors, such as a supportive family, full-time employment, personal insight and motivation, also have a clear role to play in any psychological case conceptualization. In case vignette one, 50% of participants did identify protective factors, however this degree of attention dropped in the remaining three vignettes with between 15% (*n*=4) and 27% (*n*=7) of participants noting this aspect. Biological factors were identified by between 4% (*n* = 1) and 15% (*n* = 4) of the participants for the first three case vignettes. This increased to 46% (*n* = 12) for vignette four where nearly half the participants referred to the presence of a strong genetic predisposition to depression. Biological factors embedded in the vignettes were indications of mental illness in the family, childhood health difficulties and the age of the clients.

The two sub-categories given least attention across the four case vignettes were; "inferred socio-cultural mechanisms" and "identification of therapy interfering behaviours". Between 8% (*n* = 2) and 19% (*n* = 5), and 4% (*n* = 1) and 31% (*n* = 8) of the participants, recorded ideas under the "socio-cultural" and "therapy

interfering behaviour" subcategories, respectively. Examples of socio-cultural elements embedded in the vignettes were immigration, marriage, divorce, being single, and religious influences. Examples of therapy interfering behaviours in the vignettes were; emotional avoidance, reassurance seeking, scepticism about the CBT model, and dependency.

Participants were specifically asked to produce a CBT conceptualization. The fact that the subcategory, "inferred psychological mechanism", was consistently emphasized, and that the chosen psychological mechanism was informed by the CBT model, was therefore not surprising. The CBT model links hypothesized core beliefs about the self, other people, and the world with underlying assumptions, and resultant compensatory behaviours. Within the "psychological mechanisms" subcategory a frequency count, identifying the number of idea units referring to core beliefs about self, others, and the world, underlying assumptions and compensatory behaviours, was undertaken. Core beliefs about the "self", underlying assumptions, and compensatory behaviours were identified by the majority of the participants. Figure 6, shows the percentage of participants identifying at least one idea unit representing these components of the CBT case conceptualization. Between 80% and 92% of the participants included core beliefs about the self in their case conceptualisations. As far as underlying assumptions and compensatory behaviours were concerned, between 61% and 73%, and 61% and 81% of the participants identified these, respectively, across the four case vignettes. The Core beliefs about the "others" and the "world" were less well attended to, with less than half the participants recording any ideas in these sub-categories across the four vignettes.



CB/Self = core beliefs about self
CB/Others = core beliefs about others
CB/World = core beliefs about the world
UA = underlying assumptions
Comp/beh = compensatory behaviours

Figure 6. **Psychological mechanism subcategory: Percentage of participants recording at least one idea unit in each component of the CBT conceptualisation**

Diagnostic category of information

The original diagnostic category of information contained four subcategories, namely Axis I diagnosis, Axis II diagnosis, a combination of Axis', and the influence of drugs and alcohol). In this analysis the subcategories were collapsed, and idea units referring to diagnosis were recorded under one category *diagnosis.* Few participants included idea units referencing Axis II diagnosis in their conceptualizations. When evaluating the 'comprehensiveness' of the conceptualizations as a measure of quality a rating of ten (nine inferential sub-

categories plus one diagnostic category) was more practical. The CBT quality rating scale reported under the measures of quality, accounts for the attention paid to Axis II diagnostic presentations.

Across the four case vignettes at least 81% of participants had idea units indicating an Axis 1 diagnosis of some sort. Diagnosis is important in CBT case conceptualization as an accurate diagnosis has implications for identifying specific thought processes which indicates the "disorder specific" treatment protocol most appropriate (for example if a client has a diagnosis of Generalised Anxiety Disorder, a focus on the different manifestations of "worry" would be appropriate") . As previously mentioned, the diagnostic category of information will be revisited when the results regarding the quality of the case conceptualistations are reported.

Treatment category of information

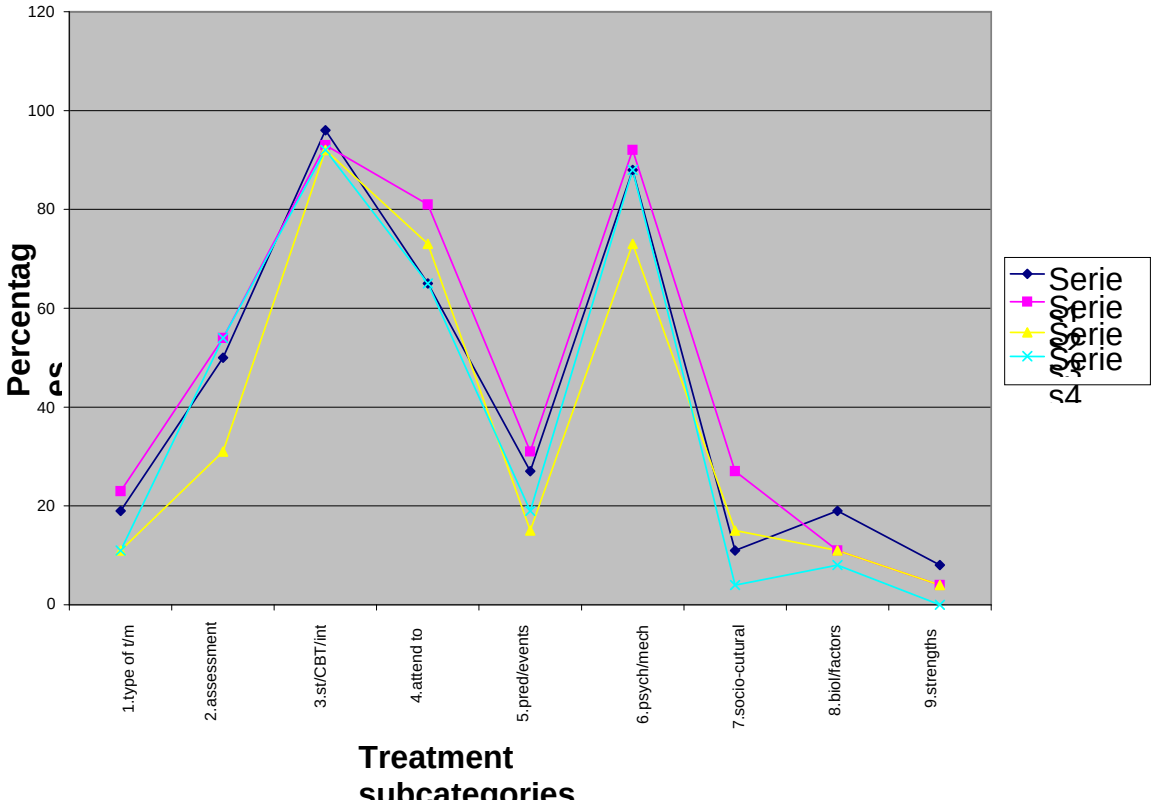
The treatment category of information shows how the clinician has structured and planned treatment. Treatment choices should derive from the inferential category, taking the diagnosis into account.

Thirty-eight sub-categories of information are included under the *treatment category,* grouped together under the following nine headings:

1. Type of treatment/therapy considered (individual, CBT, individual psychodynamic or interpersonal therapy, group, couples, marital or family, inpatient psychiatric, refer elsewhere for psychotherapy, and no psychotherapy recommended).

2. Evaluation and assessment (physical or medical, psychometric testing, further develop case conceptualisation, ongoing use of scales to monitor progress).
3. Specific structured techniques (relaxation exercises, exposure, assign homework, role playing, and psycho-education). CBT is a system of psychotherapy with a large array of structured specific techniques examples of which are the "five-part model", the "dysfunctional thought record", "core belief worksheet", and the "activity schedule". To accommodate this, an additional subcategory ""specific CBT techniques", was included to capture reference to these treatment interventions.
4. Structural element to focus on or attend to, *such as,* "red flag issues", treatment contract, therapist-patient relationship, and signs and symptoms.
5. Predisposing experiences, events, and traumas such as childhood and adulthood events, precipitating or current stressors, past therapeutic relationships, and family psychiatric history.
6. Psychological mechanisms (problematic aspects of the self and relationship to others, dysfunctional thoughts, affect regulation, coping mechanisms, skills or social learning deficits).
7. Social and cultural factors
8. Biological factors
9. Strengths in global psychological and social or occupational functioning.

Figure 7 shows the distribution of the percentage of participants having at least one idea unit recorded under the general components of treatment listed above.



1-9(see list of treatment headings above)

Figure7. **Treatment category: Percentage of participants recording at least one idea unit in each sub-category**

Type of treatment/therapy considered

Less than six participants recorded idea units under "type of treatment", with five recommending individual CBT, and only one participant (sixteen) differentiating between alternative options such as medical management, interpersonal therapy or individual CBT, across all four case vignettes. Participant fifteen suggested the possible utility of group treatment for depression in vignette two, and couple therapy for vignette four.

Evaluation and assessment

As far as "evaluation and assessment" were concerned at least 50% (*n* = 13) of participants in vignettes one, two and four considered the use of scales to assess and monitor symptoms, and in vignette three 31% (*n* = 8), considered this aspect of treatment). The scales selected were in all instances, the scales used in the standard baseline assessment for CBT, such as the Beck Depression Inventory II (Beck, Steer, Brown, 1998), the Hopelessness Scale (Beck & Weissman, 1974), and the Dysfunctional Attitude scale (Weissman & Beck, 1978).

Structural elements of therapy to focus on, or attend to

Four subcategories were listed under the heading "attend to". These were, "possible red flag" issues (safety), "treatment contract", which would include a problem and goal list, the "client therapist relationship", and "signs and symptoms". Between 65% (*n* =17) and 81% (*n* = 21) participants recorded ideas under this heading. Most attention was given to the "treatment contract" specifying the need to develop a problem and goal list. Almost no attention was given to "red flag" issues or safety. In vignette one three participants indicated that alcohol usage be assessed. No safety issues were raised for vignettes two and three, and in vignette four, three participants mentioned the fact that safety was not an issue. There were no indications in any of the clients described in the vignettes that there were any specific safety issues.

Attending to aspects of the therapeutic relationship as an aspect of therapy, was noted by a minority of participants (less than 23%, *n* = 6, across all vignettes). The same participants tended to refer to the therapeutic relationship across the four vignettes. As the examples below indicate, the few participants who did refer to working within the therapeutic relationship made good links to their CBT

conceptualisation. In case vignette one, participant six linked the fact that the client had reported that she made friends easily to the ease with which a therapeutic relationship could be established. She however was also mindful of the client's dependency traits and recognized that dependency could potentially develop in the relationship. For example:

> *"The therapeutic relationship should be easy given her ability to function socially, but clear planning of the length of therapy as this lady could develop dependency". (participant six)*

The next quote illustrates, participant fourteen's ability to connect the client's underlying assumption, "If others get to know the real me I will be rejected", to a style of behaviour which could potentially distort the therapist's perception of the client's progress.

> *"She is likely to be keen to please and may hide her true feelings because of fear of rejection" (participant 14)*

In vignette two, a potential for the client to feel abandoned was identified by two participants in the following manner;

> *"termination will be an issue" (participant 12) and "Abandonment schema loom large and this may impede emotional expression" (participant 14)*

This client had significant disruption of early attachments reported in the developmental history, making these predictions pertinent to consider. Participant four recognized that emotional disclosure would be difficult due to the client's

experience with close relationships and reflected that the pace of therapy should accommodate this.

> *"Therapy must be slow and gentle to help work through her issues. Allow time for disclosure and emotional response and coming to terms with."(participant four)*

The fact that the client had had a number of previous unsuccessful exposures to therapy was noted as follows by two participants:

> *"Since Mary has tried various forms of therapy some time would need to be spent having her buy the idea of CBT" (participant 12)*

> *"Taking into account that Mary has not benefited from anxiety management and supportive counseling and the formulation (the participant's) above, the treatment plan would focus on establishing the therapeutic relationship with particular accent on getting Mary to express emotional needs" (participant six)*

The client's assumption that if thing went wrong it was always her responsibility led participant fourteen to reflect on the relationship as follows;

> *"Watch for her being invested in pleasing you and being over responsible if things don't work out" (participant 14)*

Participant 22 noted the client's difficulty with focus, along with her previous experiences in therapy, and stated;

> *"Therapy interfering behaviours would need to be addressed, difficulty in sticking to the current issue, may continually introduce new problems or just want to talk about the past, have to ask 'is this helpful?'. The patient may decide CBT is not for her if she can't talk about the past in her terms" (participant 22)*

Finally in case vignette four, one participant identified the clients belief that she was "not good enough" as having the potential to interfere with the therapeutic and suggested the following adjustment to the therapeutic relationship;

> *"Establish client therapist relationship as firmly as possible, therapist needs to be careful as coming across as the expert because this would be threatening to the client. The idea of the client as expert needs to be strongly emphasized" (participant 12)*

Participant 16 referred to the therapeutic relationship in three of the vignettes but in such broad terms as to be conceptually meaningless, for example:

> *"establish therapeutic alliance"; "Build therapeutic alliance, education re her illness, engagement with significant others, and discuss options for psychotherapy", and "Important to develop the therapeutic alliance"*

Specific structured techniques

Between 92% and 96% of participants included ideas under the "specific structured techniques" heading, making this the sub-category under which the vast majority of idea units were recorded. In comparison to other models of psychotherapy, a large number of structured interventions are available to the cognitive behaviour therapist. The choice of intervention also indicated the degree to which the

participant had correctly conceptualized the information provided in the case vignette from both, a disorder specific and an individualized perspective, and on this basis, developed an appropriate treatment plan. Examples of this would be, using an "activity schedule" to monitor mood and levels of mastery and pleasure with a client who is depressed, or using a "responsibility pie" to work with a client struggling with an underlying belief concerning guilt, shame, or responsibility.

Analysis of the content of the idea units recorded under this heading, across all four case vignettes produced a list of forty-seven structured CBT interventions. The interventions have been grouped together in the following manner: Generic CBT interventions which are also those interventions most often used in the treatment of depression; CBT interventions most often used with the anxiety disorders; and CBT interventions used when working with the deepest levels of belief (core belief, and or schema). This last group will be discussed under the "psychological mechanisms heading". Vignettes two and four had a predominately depressed diagnostic focus, whereas vignettes one and three were anxiety disorders. Tables 4, 5, and 6 show the percentage of participants selecting specific structured CBT interventions, in each of the case vignettes.

Overall the most commonly chosen intervention across all vignettes was the "thought record", with at least 50% and 73% of participants recommending its use. It was more often chosen in vignettes two and four both of which described clients diagnosed as depressed, with between 65% and 73% of participants opting to use it. Similarly the "activity schedule" was most often selected in these vignettes with 69% and 63% of participants choosing to use it. Whilst both these interventions can be used in a variety of different contexts, they are particularly suitable in the treatment of depression, making them an appropriate choice for these vignettes.

Other frequently chosen generic interventions across all vignettes were the "Five-Part model", and "behavioural experiments". Behavioural experiments were more often selected for vignettes one and three (generalized anxiety disorder), with over 50% of participants making this choice. Behavioural experiments are often used in the treatment of anxiety disorders which generally involves exposure of some sort.

In addition to generalized anxiety disorder, in vignette one, there was also a specific dental phobia reported, and symptoms which could be construed as indicating panic disorder. Vignette three also had indications of panic disorder and some elements of health anxiety. In vignette one "graded exposure" as a treatment for the specific dental phobia was recommended by 58% of the participants. The other most often chosen intervention in these vignettes was "relaxation" with 54% and 42% of participants recommending its use in vignettes one and three respectively. As can be seen in Table five, these were appropriate treatment interventions for anxiety disorders. The following generic interventions were chosen by less than two participants; guided discovery, mindfulness, focus on emotions, biblio-therapy, flashcards, cognitive rehearsal, assertiveness training, booster sessions, positive coping statements, role plays, and social skills training. As far as interventions chosen to target anxiety, the "assertive defense of the self", health anxiety thought records, exposure and response prevention, and the "coping grid", were chosen by less than two participants.

Table 4. Percentage of participants selecting specific structured generic CBT interventions

Generic CBT interventions	v1	*v2*	v3	V4
thought record	50%	65%	54%	73%
five-part model	27%	46%	42%	54%
behavioural experiments	35%	50%	38%	54%
activity schedule	10%	69%	27%	63%
Visual Analogue Scale	23%	27%	15%	23%
Psycho-education about the disorder	23%	27%	34%	23%
"downward arrow"	10%	8%	8%	10%
relapse prevention	15%	10%	15%	15%
Homework	8%	15%	8%	4%
thinking errors	19%	11%	8%	19%
Imagery	11%	11%	8%	8%
focus on underlying assumptions	0%	11%	27%	19%

Table 5. Percentage of participants selecting specific structured CBT interventions for the treatment of the anxiety disorders.

CBT interventions for the anxiety disorders	*v1*	*V2*	*V3*	*V4*
controlled breathing	23%	0%	31%	8%
Relaxation	54%	11%	42%	19%
graded exposure	58%	8%	4%	4%1
panic induction	15%	0%	19%	0%
panic hook/cycle	0%	0%	15%	0%
focus on meta-worry/types 1 & 2	15%	0%	19%	0%
PR-Plan (predict, prepare, & practice)	0%	0%	11%	0%

Underlying psychological mechanisms

Under this heading, treatment foci are, problematic aspects of the self, and relationship to others, dysfunctional thoughts, affect regulation, coping mechanisms, skills or social learning deficits. The majority of participants, between 73% and 92%, paid some attention to the cognitive component of this aspect of treatment planning. From a CBT perspective, underlying psychological mechanisms refer to idiosyncratic core beliefs and schema, which underpin, the underlying assumptions, negative automatic thoughts, and compensatory behaviours maintaining the client's presenting problems. A number of structured techniques have been developed specifically to help clients adapt or alter these unconditional cognitive processes. Table 6 lists the structured interventions

chosen by the participants to work with this level of thought. It should be noted that the four case vignettes all described clients with an Axis I diagnosis. There was also evidence to suggest the presence of personality traits in each example. The CBT model is a "present centered, problem focused" therapy (Beck, 1995), which advises that that the presenting problems are addressed first, and that the deeper levels of negative thinking are often resolved or recede when the upsetting symptoms remit. Core belief of schema work is only advised if the problems continue or recur after the standard disorder specific protocol has been followed. It is to be expected therefore that these interventions would be given less emphasis than those used to treat the presenting problems of depression or anxiety.

The most prominent intervention chosen under this heading was "focus on core belief work" and the "core belief worksheet" Beck, 1995) with between 23% and 69% recommending its use across the four vignettes. The "responsibility pie" and the "cognitive continuum" (Greenberger and Padesky, 1995) were more often selected for specific presentations. In vignette three, 38% of participants chose the "responsibility pie". This intervention is commonly employed to target the emotions guilt and shame. The underlying assumption identified by the "expert" providing the benchmark case conceptualization for vignette three, and 54% of the participants was, "If something goes wrong then I am responsible". Choosing the "responsibility pie" was therefore a logical choice. The "cognitive continuum" was chosen by 35% of the participants in vignette four. One of the problems identified by the client described in this vignette, was the negative, "black and white" nature of her thoughts. The "cognitive continuum" targets extreme dichotomous thinking, and once again, in this instance the choice of intervention correctly targeted the problematic symptom. The importance of sharing the case conceptualization with

the client was recommended by 23% of participants in vignettes one and two, and 11% and 35% in vignettes three and four respectively.

Table 6. **Percentage of participants selecting specific structured CBT interventions for the treatment of underlying psychological mechanisms**

underlying psychological mechanisms	V1	*V2*	V3	*V4*
core belief worksheets/focus on core beliefs	23%	46%	42%	69%
share the case conceptualization	23%	23%	11%	35%
"responsibility pie"	4%	4%	38%	8%
positive data log	0%	4%	0%	8%
schema work	0%	11%	15%	15%
cognitive continuum	0%	11%	15%	35%
historical test/data log	0%	4%	11%	11%
focus on childhood	0%	23%	11%	8%

Socio-cultural factors

Socio-cultural factors would include influences such as race, gender, and marital status. Few participants noted this as something they would focus on in therapy (between 11%, $n = 3$, and 27%, $n = 7$). Three participants mentioned the role of the client's husband in vignette one, for example:

"Her husband could unintentionally disrupt therapy and some way of engaging him initially would be helpful". (participant 14)

"Enlist support of husband to monitor progress and enhance practice sessions at home" (participant 16)

"Dependant personality disorder may be masked by supportive husband" (participant 17)

Participant three made reference to the possible role emigration may have played in the client's developmental history recording:

"Find out more re migrant experience (participant three)

Vignette two, had the largest number of participants who emphasized the socio-cultural aspect (27%, $n = 7$). One participant suggested that a social-work emphasis may be in order;

"enlist social worker to contact mother and brother" (participant 13)

This suggestion did not sit particularly well with the information given concerning the client's age, independence, and high level of occupational and intellectual functioning.

The remaining six participants all wanted more information about the relationship the client had with her grandfather. The information in the vignette stated that she became tearful when he was mentioned, and participants queried sexual abuse.

In vignette three, four participants were interested in pursuing factors such as more information about family of origin and relationships between family members. Finally, in vignette four, one participant queried the possibility of including the husband in the therapy.

Biological mechanisms

Between 11% (*n* = 3) and 19% (*n* =5) of participants made reference to aspects such as family history (a genetic component), and the possible role of medication. The role of menopause as a contributing factor was mentioned by two participants for vignettes two and three. Given the ages of these women this was an appropriate factor to consider.

Strengths or protective factors

Two participants considered this as a treatment factor in the first three vignettes. Participant four placed the most emphasis on this aspect, for example for vignette two, she listed the following client strengths as being useful for therapy;

> *"strengths, works hard, can pursue goals, insightful, recognizes that work and life need balance, suitable for CBT, good at working at cognitive level, independent, well organized (participant four)*

Content of CBT case conceptualization results summarized

The descriptive statistics show that as far as content of the four CBT case conceptualizations were concerned, there was a high level of consistency in the distribution of idea units recorded under particular sub-categories of information.

The distribution was consistent for those subcategories attended to by the majority of the participants, and a similar consistency was observed in those sub-categories receiving the least attention.

The emphasis on the psychological mechanisms important in the CBT conceptualization, such as core beliefs about the self, underlying assumptions and compensatory behaviours, was to be anticipated. Biological and socio-cultural mechanisms were by in large neglected, demonstrating possible "blind- spots" in the consideration of the client as a whole.

"Protective factors" and predictions concerning the nature of the" therapeutic relationship" were given the least attention in the inferential category of information.

A majority of participants identified an Axis I diagnosis of some kind.

As far as the treatment category of information was concerned, participants placed emphasis on the use of "specific structured CBT interventions", with the thought record being the most frequently chosen intervention. There was evidence that some participants had correctly selected a particular intervention to target a specific diagnostic presentation (for example using the "activity schedule" in the treatment of depression). The heading, "important aspects of therapy requiring focus", often showed that participants considered drawing up a "problem" and "goal list" important, however attending to the "therapeutic relationship" as a therapy intervention, was rare.

Underlying psychological mechanisms as a dimension of treatment was noted by the majority of participants with the most emphasis in this section placed on core belief work.

The least attention in the treatment category of information was given to socio-cultural, biological factors, and emphasizing the clients' strengths.

CBT case conceptualization quality evaluation

As discussed, content is an important starting point for the consideration of the quality of a case conceptualization, giving a clear picture of the type of clinical information emphasized or ignored. Evaluation of the quality of case conceptualisation goes beyond this, and evaluates the degree to which the information is parsimonious, meaningful, justifiable, and coherent (Kuyken et al., 2004). In the following section the results of a number of measures of quality will be presented.

The measures used in the evaluation of the quality of the case conceptualizations were:

1. The Comprehensiveness scale as measured by the Case Formulation Content Coding Method
2. The Fothergill and Kuyken Quality of Cognitive Therapy Case Formulation rating scale,
3. The CBT Case Conceptualisation rating scale,
4. Four "benchmark" case conceptualizations (Case conceptualizations provided by Lynley Stenhouse).

Table seven summarises the results of the first three quality scales listed above.

The Comprehensiveness scale

Comprehensiveness is considered to be one indication of quality showing the degree to which the trainee is able to attend to different facets of the client's presentation. The "comprehensiveness" of the case conceptualizations was assessed by inspecting the distribution of idea units across the inferential information category (nine subcategories) together with diagnosis category (making a total of ten subcategories) This scale uses the information previously described in the evaluation of content and in this case, a numerical rating is ascribed to the number of categories of information given attention. Participants were given a rating out of ten.

The mean number of subcategories attended to by participants indicating comprehensiveness remained fairly consistent over the four case vignettes (M = 4.8 SD =1.3, M = 4.5 SD =1.4, M = 4.23 SD = 1.5, and M = 4.5 SD =1.7 respectively). This is consistent with the results found in the assessment of content. On average participants attended to less than half of the subcategories of information which could have been considered. The pattern of distribution has been discussed in the previous section. Notable gaps were; the attention given to "therapy interfering behaviours", "positive indicators for treatment", and "underlying biological" and "socio-cultural" mechanisms.

None of the participants achieved the top rating of 10. In vignette one, three participants scored seven, in vignette two, only one participant scored seven. In vignettes three and four, the highest ratings obtained by one participant were eight and nine respectively.

The Fothergill and Kuyken Quality of Cognitive Therapy Case Formulation rating scale

The Fothergill and Kuyken Cognitive Therapy Case Formulation Quality rating scale measures the quality of the cognitive therapy case formulation/ conceptualisation by allocating a single rating (one = very poor, two = poor, three = good enough, and four = good). This rating scale did *not* rate all four categories of information identified in the Case Formulation Content Coding Method discussed above and focused only on the quality of the Cognitive Therapy case conceptualization as the "inferred psychological mechanism". The other eight subcategories included in the inferential category described by the Case formulation Content Coding Method are not considered. In addition the descriptive, diagnostic and treatment aspects of the case conceptualization are also omitted. This scale therefore is very specific and focuses only on CBT case conceptualization. To obtain the top rating, core beliefs, underlying assumptions and compensatory behaviours should be identified to provide an integrated explanation which logically accounts for the presenting problems. Relevant developmental history should be specified, and a number of situational examples showing the situation, thought, mood and behavioural cycles which maintain the problem identified.

Using the criteria outlined above, at least 50% of the participants produced either "good enough" or "good" conceptualizations across all vignettes. The average rating achieved across all four case vignettes, to the nearest rounded decimal point was three with a standard deviation of less than one. Five participants (19%) were rated in the "good" category across all four case vignettes. All of these participants

either used the Judith Beck case conceptualization form or followed the format closely, producing case conceptualizations which were "a coherent and integrated whole with strong links between all the elements" (Fothergill & Kuyken 2002). This format enhanced the quality and enabled them to structure their information and attend to all the aspects of the CBT case conceptualization including the situational examples. In case vignettes one and two, 42% (*n* =11) of the participants used this format, and in vignettes three and four, 46% (*n* =12) and 50% (*n* =13) respectively, used this format, either fully, or in an abbreviated form. The five participants achieving the top score throughout used the comprehensive format, and included situational examples. The remainder had used the format but omitted the situational examples, thus received a rating of 3.5.

Four of the participants (participants six, fourteen, sixteen and twenty-four) were rated between 2.5 and 1.5. In these examples it was clear that the participants understood the dynamics of the case examples but were formulating using more general principles. This meant that the case conceptualizations took many of the recommended categories (as described in the 'content' section) into account, however the more specific CBT focus was not well attended to. For example, participant six produced case conceptualizations which included a problem list, accurate diagnosis, and a grasp of potential therapy interfering behaviours relating to personality traits. The cognitive aspects of the case formulation were not, however, clearly specified. This participant was part of the intervention group and was the only one in this group who did not complete the Self-practice/Self-reflection workbook. Participant twenty-four also specified a problem list, diagnosis and a well targeted treatment plan, but omitted the cognitive aspects of the conceptualization. Her case conceptualizations improved in vignettes three and

four and she produced conceptualizations which were derived from the CBT model, achieving a rating of three which placed her in the "good enough" range.

Participants thirteen, twenty, and twenty-one also achieved ratings of 2.5 and below. Participant twenty was verbose and over inclusive in her presentation listing several core beliefs and copious numbers of compensatory behaviours. In vignette three she misdiagnosed the clients as presenting with Obsessive Compulsive disorder. Although accurate diagnosis was not evaluated by this scale, her conceptualization was compromised by this error which resulted in the information being produced in a confused manner. In vignettes two and four her diagnostic impression was accurate and in these instances the rating improved. Participant twenty-one produced adequate situational conceptualizations but did not go on to make inferences regarding the deeper cognitive processes. Participant thirteen showed some improvement in vignette three and four with more focus on core beliefs and underlying assumptions. However compensatory behaviours were not specified and general presentation remained somewhat vague.

Between four and five participants were rated two (poor) and below (very poor) for vignettes one, two and three respectively. This improved in vignette four, where only two participants received the "poor" rating. (Overall, three participants were rated in the "very poor range"). Reasons for receiving a "poor" rating were: the purely descriptive nature of the information provided (summarizing the information provided in the narrative), sparseness of information, a lack of specificity regarding the cognitive behavioural content of the conceptualization (for example core beliefs, underlying assumptions and compensatory behaviours were not identified), disorganized presentation, (for example scribbled notes and diagrams without sufficient explanation). Participant two used the Judith Beck case

summary worksheet (not the conceptualization form) (Beck, 1995) to record information in vignettes one and two and this should have improved quality. In this instance it did not as this participant provided very little information and was rated in the "poor" category overall.

The CBT Case Conceptualisation rating scale

The CBT case conceptualization quality rating scale was developed specifically for this research and combines an emphasis on the specifically CBT aspects of the case conceptualization namely the "working hypothesis" (inferential category) and the "treatment plan", as well as including "problem list" and "diagnosis" categories.

The "problem list" was the weakest category with 65%, 38%, 57% and 69% of the participants in vignettes one, two, three and four respectively, leaving this category out altogether. A minority of participants (between three and six) scored above six indicating that they had identified most of the problems**.** Only one of the participants, in vignette one, achieved a score of eight. The remaining participants had identified some problems, but did not prioritize, or provide the functional analysis of the specific problems suggested by Persons, as a crucial step in case conceptualisation.

As far as the diagnosis category was concerned most of participants were able to identify a diagnosis of some kind. Between seven and nine participants across the four vignettes did not identify a diagnosis. Those scoring below four either identified broad diagnostic categories such as "anxiety" or noted too many diagnoses. Personality traits were not on the whole recognized with only four participants in vignettes one, two and three recognizing these aspects, although there were indications of personality traits in all the vignettes. Identifying

personality traits has implications for the therapeutic relationship, and the recognition of possible therapy interfering behaviours. As has been noted previously, these aspects are not generally recognized by the participants. Only one participant, (20) proposed an inappropriate diagnosis, Obsessive Compulsive disorder in vignette three.

In the "working hypothesis" category, all of the participants had attempted at least a rudimentary hypothesis, and approximately 65% scored six and above in vignettes one and two, and 69% and 58% respectively in the two final vignettes. The majority of participants therefore identified core beliefs, underlying assumptions, and linked these aspects of the person to relevant developmental or historical experiences. An average of 50% of the participants were rated seven and above indicating coherent and meaningful CBT case conceptualizations which linked most salient factors. To obtain the top score of 10 some meaningful speculation about the effect that the client's underlying cognitions and the resulting compensatory behaviours might have on the therapeutic relationship and the course of therapy were necessary. Only one participant obtained a score of nine in vignette two and three.

In the "treatment plan" category, 69% in vignette one, 61% in vignette two, 54% in vignette three, and 73% in vignette four, of participants were rated above six. These results show that the majority of the participants were able to develop a CBT treatment plan which was guided by an appropriate CBT protocol. Furthermore that they were able to structure the treatment correctly, indicating such aspects as appropriate CBT assessment measures, the development of problem and goal lists, and the application of structured cognitive and behavioural interventions appropriate to the diagnosis. Vignettes one and three described clients with

generalized anxiety disorder, complicated by features of panic disorder, specific phobia and health anxiety. The decision making process regarding treatment selection in these instances may have been more challenging, especially in vignette three. Vignette two and four described depressed presentations. Here the generic CBT model is appropriate, and could have made for easier choices regarding treatment planning.

Table 7. Mean quality ratings obtained in vignettes one, two, three, and four for the three quality rating scales

	Comprehensiveness Scale	Fothergill & Kuyken CT quality rating scale	CBT case conceptualization *RS
	Minimum rating = 0	*Minimum rating = 0*	*Minimum rating = 0*
	Maximum rating = 10	*Maximum rating = 4*	*Maximum rating = 40*
V1	***M = 4.8 ***SD = 1.3*	*M = 2.9 SD = 1*	*M = 18.8 SD = 5.6*
V2	*M* = 4.5 *SD* = 1.3	*M* = 2.7 *SD* = 1	*M* = 18.2 *SD* = 5.5
V3	*M* = 4.2 *SD* = 1.5	*M* = 3 *SD* = 1	*M* = 17.2 *SD* = 6
V4	*M* = 4.5 *SD* = 1.7	*M* = 3 *SD* = 1	*M* =17.3 *SD* = 5.3

**RS = Rating scale*
***M = Mean*
****SD = Standard deviation*

The "benchmark" case conceptualizations as measures of quality

Four "benchmark" case conceptualizations were an additional CBT case conceptualisation quality measure. Table eight records the average percentage of participant and expert agreement for each of the general themes, identified by the expert, across the four case conceptualizations. The general themes are "relevant childhood data", "core beliefs", "underlying assumptions", "compensatory

behaviours", "problem list", "diagnosis", "therapy interfering behaviours", "treatment planning", and the therapeutic relationship.

Table 8. Benchmark CBT case conceptualization quality rating: Percentage of participant agreement with general themes identified by the expert

Vignettes	**V1**	**V2**	**V3**	**V4**
Percentage of agreement	**%**	**%**	**%**	**%**
Relevant childhood data	56%	42%	55%	56%
Core beliefs about self	54%	19%	38%	44%
Underlying assumptions	29%	11%	54%	31%
Compensatory strategies	44%	31%	33%	42%
Problem List	23%	31%	13%	21%
Diagnosis Axis I	61%	54%	50%	58%
Therapy interfering *B/H	0%	2%	4%	5%
Treatment Plan	17%	49%	28%	29%
Therapeutic	0%	0%	0%	0%

relationship

*B/H Behaviours

Overall, the highest percentage of agreement was recorded under "relevant childhood data", "Axis I diagnosis", "compensatory strategies", and "core beliefs about self". Individual aspects of the case conceptualization, registered a greater level of agreement than the percentage recorded for each of the general themes. Appendix G, 1-4, shows the complete benchmark conceptualizations and the participants' percentage of agreement with each of the specific aspects.

Specific aspects, recorded under the general theme "therapy interfering behaviour", registered almost no agreement with only one participant in vignette two and three, and two participants in vignette four, agreeing with the benchmark. Other omissions noted across vignettes two, three and four was any notable reference to the Axis II diagnostic traits identified by the expert. In vignette two, two participants identified Axis II personality disorder traits, and in vignettes three and four, only one participant identified Axis II personality disorder traits. The percentage of agreement regarding the "problem list" was also low, with the average agreement in all four vignettes falling below 30%.

It should be noted that although the expert's benchmark case conceptualizations received high ratings on the quality rating scales used in this research they do not necessarily represent the "only" way to understand and explain the presenting problems, as all conceptualizations are presented as hypothetical explanations (Bieling & Kuyken, 2003).

Quality of CBT conceptualization results summarized

The average ratings obtained on the comprehensiveness scale show that, none of the participants attended to all the possible categories of information relevant to a comprehensive case conceptualization, and that most attended to less than half. Psychological mechanisms and relevant developmental and historical data were generally emphasized. However biological and socio-cultural mechanisms, protective factors, and factors pertaining to the therapeutic relationship were given scant attention.

The results obtained on the measures of quality show that 50% of participants were able, to produce "good enough" CBT case conceptualizations, for the most part paying attention to the cognitive behavioural aspects of the conceptualization. Relevant childhood data, core beliefs about self, underlying assumptions and compensatory behaviours were generally noted. Notable, and consistent gaps were attention to aspects of the therapeutic relationship indicated by the case conceptualization. This applies to both therapy interfering and therapy enhancing behaviours.

As far as developing an appropriate CBT treatment plan was concerned, over 50% of participants were able to develop treatment plans which were consistent with CBT interventions appropriate to the diagnosis.

Weaknesses across all four case vignettes were the failure to pay sufficient attention to developing a clear problem list, with most participants leaving this category of information out altogether. Furthermore, those who did identify problems, failed to prioritise the problems, or relate them to the conceptualization.

The importance of developing a problem list was noted by several participants in their treatment plan indicating that there was an awareness of the relevance of problems which did not show up in the actual conceptualizations.

In the diagnosis category, more than half the participants identified an appropriate Axis I diagnosis. Axis II personality traits, were not on the whole, given any attention.

The level of agreement with the benchmark case conceptualization was averaged at less than 50% for most of the general themes identified by the expert. Once again the therapeutic relationship was a notably neglected area of emphasis.

Overall, the assessment of content and quality, using the four scales, shows a consistent distribution as far as aspects of information perceived to be important, and subcategories of information ignored, or paid cursory attention.

Chapter seven

Self-practice/self-reflection as a training method: A thematic analysis

"A must have for the would-be therapist or practitioner….it is like to light up to understand cigarette smoking" Massey PGDipCBT student 2004 (Haarhoff & Stenhouse, 2004 p. 26)

The second objective in this research was to explore the way in which participants in the intervention group subjectively perceived the effect of the self-practice/self-reflection workbook on their CBT case conceptualisation competency. In this chapter the thematic analysis of the participants' self-reflections is presented, highlighting the advantages and difficulties experienced by the participants' regarding the intervention. The chapter concludes with a summary of the main themes identified.

The self-practice/self-reflection workbook, "Understanding Myself" was structured to systematically expose participants to the experience of constructing their personal CBT conceptualization. In order to do this, they identified the three levels of thought, and the resulting negative emotions and compensatory behaviour patterns associated with a recurring personal problem. Once these patterns were identified, they were required to understand the cycle in a personal historical context, thus leading them towards the construction of a personal individualised CBT conceptualisation.

As discussed in chapter four, existing literature reporting the clinically relevant effects of personal therapy, self-directed experiential work, and self-practice/ self-reflection on trainee psychotherapists, identified a number of recurring themes, such as; increased understanding of the model, self-awareness, empathy for the client, and the consolidation of psychotherapy interventions and protocols. Within the CBT context, participants accepted self-practice/ self-reflection as valuable and important learning experience and thought that they had learned a lot about CBT by practicing the techniques. Bennett-Levy et al. (2001), categorised these general outcomes under the following headings; therapist self-concept, therapeutic understandings, and therapist skills. "Therapeutic understanding" included increased self-awareness, and understanding of the CBT model. "Therapist skill" incorporated the refinement of specific CBT skills, communicating the conceptual framework of CBT, creating a therapeutic foundation for change, and "being where the client is at". "Therapist self-concept" described the self-perception of confidence and belief in CBT. In addition a core process named "a deeper sense of knowing" was identified. This was described as experiencing CBT from "the inside" or a three dimensional process. All of the studies were qualitative and relied exclusively on the subjective report of the participants.

The present study is differentiated from previous studies in that it focuses specifically on the individualised CBT case conceptualisation, exploring the effect of self-practice/self-reflection on the theoretical understanding and clinical use of the CBT case conceptualisation.

Thematic Analysis

Thematic analysis was used to identify central themes related to the overarching research question: "What is the subjectively perceived effect of completing the exercises in the self-practice/self-reflection workbook on the participants' case conceptualisation competency?" The data set analysed, consisted of written responses to the self-reflection questions contained in the workbook "Understanding Myself". Fourteen, of the 16 participants in the intervention group, completed the workbook in its entirety. In a personal communication, participant six explained that she was unable to finish the task because she found the exercises too time consuming. She had done the first three exercises, and then complied with the request to complete the final concluding pages which asked questions to elicit overall feedback about the experience. Participant sixteen's workbook responses failed to arrive through the postal system and were never traced. She was sent, and re-did the concluding exercises. The abbreviated self-reflections of these two participants are included in the thematic analysis. The time specified for the completion of the workbook was three weeks. Participants one, two, and three took, between six and eight weeks, to complete the task. The remainder of the group returned their written responses, more or less, within the required time-frame. There were six males and ten females in the intervention group. Participants' quotations have been selected from the data set to illustrate the relevant themes identified and described below. In order to protect the identity of the participants the personal pronoun "she" will be applied to all. Where a relatively large or small number of participant reflections mirrored a theme, the number of participants is recorded. However, because the participant sample is small, and the personal process of constructing an individualised CBT

conceptualisation highly idiosyncratic, the perspective of single individuals has also been included as offering useful insights into the range of experiences reported by participants.

All of the themes described below relate to the *perceived* effect of the self-practice/self reflection (SR/SP) intervention. The abbreviation SR/SP will be used in an effort to minimise unwieldy headings describing the themes.

Theoretical understanding of the CBT conceptual model

As shown by the following quotes, all of the participants, including the participant who did not complete the workbook, reported the self-practice/self-reflection exercises as helpful in understanding the CBT conceptual model.

> *"The exercises have reinforced for me the whole structure of CBT' (participant eight).*

> *" More awareness of the whole CBT picture and a better understanding of how the individual parts make up the whole" (participant 12)*

> *"It helped me obtain a succinct picture of the things I had learned, it especially helped me organise things in my head." (participant 16)*

> *"The CBT model makes complete sense to me and I use it in a clearer way than in the past" (participant eight)*

"Great to summarise the whole process. Encourages awareness of how it relates to myself and my work. Helps make sense of all the information" (participant 11)

"Helped me clarify the specifics" (participant seven.)

"A valuable experience. Drawing everything together and making sense" (participant 15)

The quotations above show, that for some of the participants, the experience of completing the self-practice/self-reflection exercises had provided an overview of the CBT model, revising and clarifying aspects of the model in a general sense. One of the participants identified as Maori, and found that the self-practice /self-reflection was conducive to integrating a cultural perspective;

"Very useful exercise adapting to reflect my cultural content in inference to core beliefs about self, others and the world" (participant seven)

Others had more specific observations as the following quotes illustrate:

"I am reminded to think more broadly across all the cognitive, affective, and situational domains and hence the interventions become more specific and yet more inclusive" (participant 16)

"I have more awareness of the links between negative automatic thoughts, core beliefs schemas, and behavioural strategies"(participant one)

"It highlighted the significance of assumptions and compensatory strategies for me" (participant 11)

"I have more knowledge of compensatory behaviours and eliciting these – otherwise it consolidated my existing knowledge of CBT" (participant 15)

The quotations above seem to show an enhanced understanding of the structural aspects of the CBT conceptual model. Participants made the link between personally significant negative automatic thoughts, underlying assumptions, core beliefs, and compensatory behaviours, and understood of how these processes were cyclical, maintaining the identified problem.

Understanding the personal problem identified

"Understanding" a personal problem within a CBT conceptual framework was a stated aim of the workbook. However, in addition to achieving an enhanced understanding of the theoretical aspects of the CBT conceptual model, self-practice/self-reflection was also reported by some participants as helpful in solving the personal problem identified in the first exercise. In this exercise, the "Five-Part model" was used to analyse the 'functional' nature of the identified problem, and elicit the first level of the individualized conceptualization, enabling the participants to identify problematic cycles at the situational level, uncovering predictable patterns, for example:

"I have a fairly narrow range of typical responses" (participant nine).

"*I follow predictable patterns" (participant eight)*

The notion that the identified cycles were predictable and repetitive, with negative consequences, was noticed, and for some this generated new insight;

"I don't learn from similar experiences all that well. That I tend to act like this without thinking and then reflect on how I should have responded afterwards" (participant eight)

"That as I become anxious I get more irritated with others because they disturb my thoughts and my situation" (participant nine)

Identifying repetitive cycles is a fundamental building block in developing individualized CBT conceptualization.

After participants had understood how their personal problem played out in a number of cross situational contexts using the Five-Part model, they completed a self-practice/self-reflection exercise aimed at processing the cognitive component of the problem using the "thought record". Eleven of the participants, (69%) found the thought record personally helpful in tackling the cognitive aspect of their identified problem. For example;

"I did experience some sense of cognitive shift" (participant 14)

"Almost always useful for me. They help me hold a more realistic view of the situation. Writing things down consolidates my thinking" (participant five)

> *"Very helpful in reconstructing alternative thoughts/balance. I sensed an immediate reduction in that I can feel pleasant thoughts as a result" (participant seven)*

Participants also commented on the fact that doing the thought record had helped them understand their emotions;

> *"Very helpful. It did help me clarify my thinking and I felt genuinely less anxious and upset after the exercise"(participant 13)*

This was an important insight for one participant who had not previously fully grasped how important the emotional content of the cycle is, she reflected:

> *"I am more attuned to my emotions, I will be more attuned to my clients' emotions. I need to work more in line with CBT as am emotional experience rather than something coming mainly from the intellect" (participant four)*

One participant was able to use the information gained in the thought record to make a practical plan of action to combat her problem;

> *Very helpful to break down what was going on with my thoughts. Helpful to identify situations that counteract my hot thoughts worked through to me – coming up with several action plans" (participant 15)*

Another participant expressed the view that the thought record had been helpful on two levels, the personal and the clinical;

> *"Yes definitely on two levels, self help, but as learning what are helpful questions in the process" (participant six)*

Referring to the questions aimed at uncovering the "meaning "of the hot thought. There is an implication that she would use similar questions in her clinical practice.

At this stage one participant emphasised that it was the act of identifying her *own* processes that gave her a clearer understanding as illustrated by the statement;

> *"When you do it on yourself you have a greater depth of understanding" (participant three)*

Noticing the importance of working with another person also came to the fore as illustrated by the next example;

> *"The process I did find easier when able to talk to others people about it (i..e. someone to bounce ideas off)" (participant two)*

The need for interaction with another person was emphasised by another participant:

"I think I need to connect with someone to give some energy to the process…. I'm struck by the dawning realisation that I need someone to reflect with" (participant 14)

Participant 14 returned to the "need to share with someone else", reflecting on how the self-practice/ self-reflection could be integrated with supervision;

"There's something about the preparation for supervision that draws on the intentionality of supervision" (participant 14)

And

"I wonder if the therapist combination of self-practice/self-reflection could integrate nicely with formal supervision" (participant 14)

The perceived need for support was also evident in participant 14's reflections about her clinical practice which will be reported in the section dealing with perceived effects of self-practice/self-reflection on clinical practice.

The personal experience of engaging with a problem using a CBT perspective appeared to increase participants' belief in the power and utility of the CBT model. This theme is captured in the following quotes;

"It has sharpened my understanding of the CBT model and rekindled my enthusiasm for using it" (participant eight)

"Further validated the therapy and its potential for change" (participant 11)

"reinforced what a great model CBT is".(participant five)

As stated in the introduction to the workbook the aim in this series of self-practice/self-reflection exercises was not to bring about change but merely to aid understanding so the problem resolution for some was an added bonus as reflected in the following.

"I am getting better in making more space for relaxation and leisure in my life but still have room for improvement, in the area ha ha. At least I can take a holiday without feeling guilty for doing that" (participant four),

And,

"I have much more of a handle on why I am always late – I think it's a mixture of early childhood anxiety and coping mechanisms" (participant three)

Increased Self-awareness

"Self-awareness" is variously defined as the "recognition of feeling as it happens", "ongoing attention to one's internal states", "awareness of mood and thoughts about the mood", and "attention to inner states", in a non reactive and non-judgemental manner (Goleman, 1996, p. 47). In this research, self-awareness references these qualities, and specifically refers to the participants' ability to observe their thoughts, emotions, physiological and behavioural reactions to an identifiable trigger, and to use self-awareness to constructively reflect on the

interpersonal aspects of CBT relevant to the case conceptualisation. The recognition that self-awareness had facilitated insight was also important as illustrated by the quotes below.

> *"A valuable experience drawing all the material together and making sense. How it does make sense –lots of penny dropping, lots of head nods" (participant 15)*

> *"Interesting – increasing insight of so many behaviours and the role they serve". (participant 11)*

After the initial identification and functional analysis of a recurrent personal problem using the Five-Part model and the thought record, cognitive themes about self, others, and the world, underlying assumptions, and compensatory behaviours, and patterns of avoidance were identified.

Two participants reported increased self-awareness of their underlying assumptions, core beliefs, and compensatory behaviours in a very personal way, spelling out exactly how their problematic cycles worked, using specific examples. Participant eight reflected;

> *"I realise the extent of my anxiety that inhibits my ability to fully enjoy myself, blunts my humour and creativity at times. I seek approval, approval is important to me, what others think is vitally important. I fear rejection. Some of my compensatory behaviours e.g. wanting to know, checking, thinking of what could go wrong are not very useful and impede my performance in other areas" (participant eight)*

This quotation vividly illustrates an insightful self-reflection linking thoughts about others with the resultant compensatory behaviours and recognising the negative consequences of these behaviours in the long term.

The other participant reflected in a self-critical manner;

> *"An insight as to how much I deceive myself into thinking I am doing things to help others when I really say things for my self gratification and to boost my self-importance. Themes of wanting self-affirmation, wanting to be seen as a worthy person by my partner and workmates" (participant 13)*

Both of these examples convey that, coupled with insight, there is some level of sadness or regret. Other examples were more objectively expressed but indicated that important personal insights had been achieved and related back to the CBT model, for example;

> *"I gained a greater insight into my dysfunctional patterns and personality traits"* and *"That I have some very entrenched beliefs that developed early and get reinforced by my behaviours".(participant 11)*

For some of the participants, identifying underlying structures through the self-practice led them to broader conceptual perspective when considering their core beliefs.

"I already had a good understanding of my beliefs about 'self' and 'others'. But I had not considered the 'world' before. A realisation that I consider the world to be harsh and dangerous" (participant five)

Others commented on the power and longevity of their underlying beliefs,

"A greater understanding about how powerful underlying drivers –schema is and how powerful long lasting core beliefs reside from childhood unresolved" (participant 11)

"Fundamental beliefs I concluded about myself have stayed with me all my life and have been a determining influence on all my behaviours – which has come as a great shock to me." (participant 13)

"I have been able to reflect on my background and the influences that moulded my life in a clearer way than in the past. I am able to identify my compensatory behaviours as they happen which helps me question the less useful ones." (participant eight)

"Doing my own analysis and thought records leading to the conceptualisation was helpful in making me realise the person I am and what drives me". (participant eight)

Becoming sensitised to the ways in which compensatory behaviours are used when coping with anxiety was reflected upon;

> *"My thoughts are all about what could go wrong and how I might miss out on my goals if the worst scenario happened. My behaviours are designed to reassure myself… I seek as much additional information as possible as a way of absorbing my adrenalin and reassuring myself….it confirmed what I know, that I am anxious about many things." (participant eight)*

The third section of the workbook focussed on the deepest cognitive processes, with exercises aimed at identifying core beliefs or schema. This section contained the following exercises, a number of schema, and belief questionnaires, a self-practice exercise matching schema with compensatory behaviours, and an imagery exercise designed to elicit memories and experiences from childhood which may relate to, or explain the underlying belief system.

Opinion was somewhat divided regarding the helpfulness of the questionnaires with some participants finding it a long, tedious, and even frightening process, for example;

> *"I found I had to force myself to do them. I needed enough time free of work pressures to the " (participant eight).*

> *" A bit frightened to find out more about myself not sure what might spring out and surprise me" (participant seven)*

Others experiencing the information gained as extremely interesting and, in some cases, revealing.

"Enlightening completing the schema questionnaires" and "I enjoyed this part of the study the most as it gives me a sense of where I can challenge myself. Fits well with unrelenting standards." (participant 15)

Even those who found the process somewhat tedious generally concluded that it had been a helpful exercise. For example;

"Tedious. What a lot of questionnaires.."(participant nine)

And further on the same participant said:

"I learnt more about myself and consequently more things to be alert for and a greater understanding of my frustration with some clients. Interesting exercise regarding myself and my clients" (participant nine)

"Looking back on the questionnaires I recognise they were valuable in helping me identify underlying beliefs and bracketing them into some sort of context or grouping"(participant ten)

And participant eight found

"It helped me clarify aspects of my underlying schema or core beliefs"

For the two participants quoted below, it was a new experience which they regarded as personally interesting, and as having implications for their clinical practice.

"Interesting exercise both regarding myself and my clients" (participant two)

"Positive reaction. New learning both about self and the questionnaire completion" (participant nine)

For two participants it was an affirming experience,

"Reflecting back was quite a positive experience. Reaffirmed my thoughts about being pretty happy with where I am and who I am" (participant 12)

The other participant had completed the questionnaires before as part of a period of traditional personal therapy and was very pleased with her personal progress;

"I was very pleased to note that the intensity of schema identified when I first completed them have reduced significantly" (participant five)

and

"Very positive it was good to highlight the gains I have made in two years" (participant five)

After this self-practice exercise, the same participant (five) was able to reflect on implications for using the questionnaires in clinical practice. This is discussed under the heading following this section.

A change in the way participants practiced CBT with clients?

In contrast to the participants in the first two studies conducted by Bennett-Levy et al. (2001)(see chapter four), the participants in the present study, the majority of whom were practicing clinicians, were qualified to comment on the impact of the self-practice/self-reflection on their practice of CBT. One of the most important aims of the self-practice/self-reflection intervention was to facilitate reflection on personal experience, using the methods designed to elicit a CBT case conceptualisation, in order to find links between personal experience and professional practice. The recurring question: "Does what I have experienced through the self-practice/self-reflection lead me towards altering or doing something different in my clinical practice, especially as far as CBT case conceptualisation is concerned?" was asked. The two quotes below illustrate the realisation of this central aim.

> *" It has given me a clearer idea of how I am or operate as a person. The CBT model makes complete sense to me and I understand my clients in a clearer way than in the past" (participant eight)*

> *"Seeing strong patterns in oneself gives a greater understanding of the ramification of different client patterns". (participant three)*

After commenting on the personal impact of constructing and reflecting on their personal case conceptualisation, participants went on to reflect on the implications of their idiosyncratic patterns of belief and behaviour on their professional practice. One participant, identified what she termed a "new insight" namely,

> *"New insight around avoidance of new activities which will be exposed to other to evaluate – until I become confident in private" (participant 14)*

This insight led to a reflection on the way in which she introduced new activities or interventions in her professional practice;

> *"How I introduce new things – lots of preparation, this may lead to inflexibility. Part of CBT is its flexibility – this demands some risk taking, this avoidance behaviour of mine may limit my own modelling of empiricism".(participant 14)*

This quote shows the importance of including a self-reflective component, steering the clinician in the direction of considering the impact that her compensatory behaviours may have on practice. In this case preparing well for a session would generally be seen as positive, but when viewed against the backdrop of a personal belief system stemming from some negative beliefs about self and others, the participant was able to consider this in a different light. There is an implied question in the quote and a suggestion that this insight could impact on the participant's clinical practice.

Conceptualising the therapeutic relationship (the therapist's contribution)

The next two quotes show two of the participants recognising personal behaviour patterns, stemming from underlying beliefs, which could negatively affect the therapeutic process;

> *"It reminds me that I cannot 'fix' things nor should I try, I should step back, listen more and talk less to clients. It helps me process my frustration with some clients and realise that it is about me and not them" (participant 12)*

> *"By less trying to impress them with my hard earned knowledge, but be more relaxed and work more with their world scene. Clients don't have to meet my standards of competence in their homework and responses when in session. Good enough in their eyes will be OK." (participant 13)*

Both of these quotations have an element of what Leahy (2001), refers to as "demanding standards" therapist schema. They appear to recognise a "pushiness" to their delivery of CBT, perhaps an expectation that the client should change rapidly and meet their high standards. It is implied that the insight gained in these two instances will be transferred to clinical practice and that both of these clinicians will endeavour to adapt their speed of therapy to the client's pace.

For others identification of their own schema, assumptions, and compensatory behaviours was seen as something which would assist them in managing the therapeutic relationship.

> *"By going into depth of what I do especially in terms of my assumptions and compensatory behaviours I will be able to understand my clients more fully" (participant eight)*

> *"I found out more about myself which is therapeutically useful when working with difficult clients" (participant ten)*

In all of these quotes there is an implication that the self-practice/self-reflection has impacted on their day to day practice. The increased ability to self monitor through self reflection and, through this, to regulate and adjust behaviour in the therapy session, was a specific effect noted. The two quotations below demonstrate the ability to reflect on the therapeutic relationship and consider the way in which their underlying beliefs and attendant compensatory behaviours could directly impact on their therapy.

> *"I will be aware of these areas and be mindful of them being activated if a client has the same tendency or similar compensatory strategies. I might be mindful of them in all my client relationships knowing I have a tendency to take care of client needs. If I think I'm doing all the work it could be a warning that my schema have been activated. I will be mindful of where my responsibilities begin and end" (participant 10)*

> *"On a personal level, I am aware of the potential for my own schema re coping behaviours influencing therapy – in particular taking on too much responsibility in sessions, trying to sort everything out so I am a good enough therapist. I am*

practicing sitting back in my chair and allowing the client to do the work" (participant four)

In both of these examples, compensatory behaviours resulting from common "therapist schema", identified by Leahy (2001) were identified, namely the tendency to do too much of the "work" in therapy, take too much responsibility for the patient's progress, and the need to be perfect. Having identified these patterns both participants resolved to do things differently.

Modifying, adapting or changing CBT interventions?

Modification or improvement of the way in which participants would use CBT interventions or methods for eliciting the CBT individualised case conceptualisation appeared to be recognised as a helpful effect of the self-practice/ self-reflection. For example;

"A great way to gain increased understanding of tools and practices." (participant two)

"It has given me better analytical skills and improved my questioning i.e. obtaining essential information more quickly" (participant eight)

Also the need to ask more often for feedback. Give the person time to think and then listen respectfully" (participant 13)

"I believe that probably I need to spend more time after accessing this data (underlying beliefs) to talk with the client about how they are feeling –even if it means spending longer on the assessment"(participant 15)

The quotes above show that the participants have, through their self-practice/ self-reflection, developed a heightened awareness and sensitivity to communicating the principles of CBT. Improved use of questions, allowing the client time to process new and significant data, along with the importance of obtaining feedback, are all important aspects of CBT which are rated as specific competencies on the Cognitive Therapy Scale (Young & Beck, 1980). The quotes above show that participants were able to see the significance of paying attention to these finer points through their experience in uncovering their personal cognitive conceptualisation.

One participant reflected on how her experience of filling out the questionnaire set included in the workbook had affected her clinical practice directly;

"I ask my clients to fill out these questionnaires as a matter of course. Now I realise they are very challenging to the person and there is a temptation to be less truthful about the answers because of the emotional pain of being exposed as how I really am. Last week an older client refused to fill out the Young Schema questionnaire. She was very anxious and became angry because looking at the questions made her feel more anxious – worse. We negotiated to look at the schema questionnaire later in therapy."(participant13)

In this instance personal confrontation with entrenched schema had induced an initial avoidant response because of the exposing nature of the exercise. Having experienced this, the participant was able to understand and empathise with the client's response and accommodate it in her therapy plan.

Participant five, discussed earlier, reflected thus on how her clinical practice relating to the administration of questionnaires had been influenced in the light of her self-practice/self-reflection;

> *"I remember when I first completed these questionnaires I spent a lot of time revising my initial response to each question trying to 'tone' them down and the validity of my response. I find clients I work with react in the same way so I have experimented with having them come in for an appointment to complete the questionnaires so time is limited and I'm more likely to get 'gut' reactions" (participant five)*

In both of these examples the participants have become aware that clients may be cautious about disclosing significant information by reflecting on their own responses, and have been able to use this personal information constructively in therapy. The questionnaires designed to elicit information about core beliefs and schema, are an important part of the case conceptualisation process, providing additional and confirmatory information. The adjustment reported above would therefore be a valuable addition to managing this part of the ongoing assessment process.

There appeared to be increased sensitivity as to the appropriate time to introduce concepts of interventions to clients, for example:

> *" That beliefs are entrenched and it can take different levels of awareness to challenge their depth. Beliefs don't change overnight so get more feed back from clients when they experiment to change their thinking and behaviour. Spend more time finding out a client's thinking/feeling/behaviour during the experiment to raise their awareness about how old beliefs make it difficult to change" (participant 10)*

Historical information was accessed using an imagery self-practice exercise which aimed to connect the participants' most troubling core belief to childhood experience. Ten participants found it relatively easy to access historical information:

> *"Fairly easy, I'm sure with less distractions I could have accessed more" (participant 15)*

> *"Once I got into visualising, relatively easy" (participant 10)*

> *"Fairly easy – for me visual memories linked by strong emotions" (participant 14)*

> *"It was very easy. I kept remembering stuff and could keep the list going" (participant four)*

Four of the participants reported that they had found accessing childhood memories difficult with one saying that it was "impossible".

> *"Impossible it may speak volumes (!) or it may be related to an over-consumption of drugs /alcohol throughout teenage years but I really don't have any significant childhood memories positive of negative up to about age 16+)"* (participant 12)

As a consequence she reported no strong emotions and did not comment on how experiencing this exercise would impact on her work with clients. In this instance the participant appears to be using humour to distance herself from the exercise. In her concluding reflections she returned to this theme (not being able to remember her childhood).

> *"Making me think – I have always wondered what a lack of childhood memories was related to – just reminded I don't know the answer! A conflict between thinking my behaviour is a result of some long repressed issues/beliefs and thinking that if you look hard enough you will find it regardless. It would have been interesting to do with a therapist although I realise it wasn't the point of the current study" (participant 12)*

Participant eight found it difficult to remember specific instances but recalled having experienced strong emotion reaction in childhood.

> *"Very difficult but there were events in my childhood when I was very anxious and overwhelmed by anxiety. I saw the world as a dangerous place some of it was to do with leading a sheltered existence" (participant eight)*

She went on to express surprise at this fact and appeared to think deeply about it;

> *"I am surprised at how difficult it was to recall the anxiety making experiences in childhood. On reflection familial influences, parental behaviour and my genetic makeup of shyness (possibly) have influenced me" (participant eight)*

She concluded that the experience had influenced her practice thus:

> *" It has made me more sensitive to the connections between childhood experiences, the schema or core beliefs, assumption and compensatory behaviours" (participant eight)*

For one participant it was difficult to begin with,

> *"Difficult to start with but did get easier. Can see how belief system developed over time. Hard to order chronologically. Increased sensitivity in this area (participant two)*

For participant two the imagery exercise although difficult to do at first had increased her understanding of the importance emotions when accessing important information about the origin of underlying beliefs.

> *Great learning exercise. Increased understanding of the emotional aspect of the exercise" (participant two).*

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Participant one reported that it was difficult to access the childhood memories but that it had become easier. She reported very strong emotions connected with the memories when these did arise.

"Fear, panic, frustration, anger" (participant one)

and reflected thus on the importance of emotions in eliciting this kind of information;

"It could mean that it could be better to begin from an emotional memory, rather than simply gathering chronological information (participant one)

A number of participants stated that the manner in which they accessed historical information from clients had been influenced by their experience of self-practice/self-reflection, for example:

"Yes – to be aware they can be strongly affected by emotions around childhood memories – be gentle when taking information in person and warn them if the are doing it themselves that emotions can be aroused. I would get them to approach the whole thing with curiosity and a sense of exploration rather than disappearing under a weight of unresolved emotions" (participant three)

"It is a pretty strong feeling to see the whole picture for yourself put together in writing. The clients must be overwhelmed when doing it in session" (participant four)

"Powerful exercise. Very useful in eliciting beliefs and understanding of origins. Orientate client extensively. Pay particular attention to affect shift check in with

client. Reassure and validate client. Encourage self care strategies following intervention" (participant 11)

"I never thought about setting this for homework – maybe I will now" (participant 14)

The final self-practice exercise involved integrating the information gained from the previous exercises to create a personal CBT conceptualisation. All but one participant found this exercise to be useful and illuminating. Three participants said they had learnt nothing new about themselves. However they still found it valuable as an aid to self-understanding.

"It reiterated what I already knew about myself. Useful to see it so systematically set out though" (participant three)

"Nothing new due to previous therapy, but it was useful to remind myself why I do the things I do, rather than blaming myself because 'I'm not good enough' " (participant five)

One of the participants who had learnt "nothing new" had recently experienced her own personal therapy within the CBT model so it is not surprising that nothing personally illuminating emerged. Although they had learnt nothing new there was a sense conveyed that they valued the process and would use it in their practice.

"I will continue to use try to get the conceptualisation together as early as possible in therapy" (participant five)

Reflecting on how "doing" a personal CBT conceptualisation might affect practice, two participants reflected on the importance of using the conceptualisation in therapy, and sharing it at the right time;

> *"Be mindful to present the conceptualisation to the client at the appropriate time so they can get the full picture/ understanding of their problems and what is maintaining them" (participant 10)*

> *"Confirms the importance of doing it with clients in therapy. Also not leaving it to the end of therapy, more like half way through" (participant 15)*

This participant went on to stress the importance of feedback after the conceptualisation had been shared with the client;

> *"Getting substantial feedback from clients both at the end of the session and in the next session is important (highly likely they would have gone away and thought about it)" (participant 15)*

Obtaining feedback from the client concerning how much they have understood about the process is important in aiding guided discovery, and collaborative empiricism. These are considered guiding principles in the delivery of CBT.

Participant nine reflected that before doing self-practice/self-reflection she had tended to avoid sharing the case conceptualisation;

"I have tended to avoid case conceptualisation in the past or at least avoided sharing them with clients as they seemed a bit harsh whereas in reality clients might enjoy/ be interested in/ relieved etc, to understand themselves in this way." (participant nine)

The quote above shows how her practice could potentially be directly affected by her personal experience of the conceptualisation where she experienced interest in the way the conceptualisation explained her personal psychological process. Sharing the case conceptualisation is widely acknowledged to be important in effective delivery of CBT and this participant would have been told this during her training. It seems that only after doing it herself was she able to clearly see the benefit. She went on to reflect;

> *"I probably don't place enough emphasis on this (probably because doing mostly 'organisational' work with lots of required reports) I will use this more as a means of underpinning therapy" (participant nine)*

Another participant reflected thus;

> *" If there has been a change, it's around presenting the case conceptualisation in a meaningful way that facilitates the client to make links between their current problems and how they are maintained by previous pattern" (participant 10)*

Other effects on practice relating to the sharing of the conceptualisation were:

"Greater use of the conceptualisation as a tool in and out of session" (participant 11)

"To be more empathic to the process and how they are feeling. To acknowledge their potential discomfit more" (participant 12)

One participant was unable to make any link between the personal experience of putting her individualised conceptualisation together with her clinical practice , reflecting on the self-reflective question posed, "How does this relate to your experience with client when doing CBT?", she reflected thus;

"For some reason I have no clear precise sense of the relations (participant one)

This comment is somewhat out of step with the other thirteen participants completing this exercise and appears to indicate a lack of self-awareness in the clinical sense described earlier. This participant made several references indicating some confusion with the self-practice/self-reflection task which will be discussed more fully when the difficulties and problems encountered are outlined later in this chapter.

As far as setting homework for clients was concerned one participant was influenced by her experience of isolation when completing the self-practice/self-reflection and wrote;

> *"I guess in terms of being a therapist I now have some sympathy for my home-working clients – it is good to work alone, but how proximal or distant the therapist may be worth explicitly visiting" (participant 14)*

Two participants commented on how the self-practice self-reflection had impacted on the way they thought about their practice within the context of working with others in community mental health. Participant eight thought that the experience would improve her communication with colleagues, reflecting:

> *"When discussing cases with colleagues I am helped to have a sharper conceptualisation of issues" (participant eight)*

Participant 15 went on to reflect on her practice in a community mental health service thus:

> *"It reinforced the importance of providing not just a lip service of CBT.Mental health service demands e.g. waiting lists and pressure to treat and discharge clients, can I believe 'short change' some clients of full treatment" (participant 15)*

Demonstrating awareness generated from completing her personal conceptualisation of the complexity and richness of a full CBT treatment package based on an individualised case conceptualisation recognising that institutional barriers and constraints could potentially compromise a transfer of clinical skills.

Increased empathy

Appropriate and accurate empathy is regarded as a key component in developing a successful therapeutic relationship by all established models of psychotherapy, and is emphasised in CBT as a central ingredient in successful collaborative empiricism (Burns, 1989),. Empathy can be described as "standing in the shoes of the client" and "knowing/understanding what the client is experiencing". Empathy is closely aligned to self-awareness and in the therapeutic context, should be more than sympathetic reassurance that the client is being heard and understood (Safran and Segal, 1996, p 85). The following quote aptly captures the quality of empathic understanding required of a therapist; "to learn to go down 'the path' with the patient, to see and experience the world from the patient's viewpoint, but then to able to return" (Leahy, 2001, p 239).

Many of the participants commented in a number of different contexts that their empathy for their clients had increased as a result of the self-practice/self-reflection, and recognised this as a positive effect and some examples of this have already been discussed under other thematic headings. An important dimension of empathic expression identified by some participants was the difficulty clients experience when faced with psychological change. For example;

> *"Understanding how difficult it is for them not to live according to their schema, that changes are slow" (participant 13).*

The following quotes illustrate the connection participants felt with the pain and distress clients might experience when confronted with the strength of their beliefs,

and the degree to which their lives may have been negatively affected by these beliefs.

> *"I have a greater awareness of what the client is going through, what the process is like for them" (participant 11).*

The two quotes below mention the word "struggle" in connection with their own confrontation with entrenched schema implying that working with their own process has highlighted this aspect of therapy.

> *"I have an increased understanding of the client's struggle to make links through my own struggle." (participant three)*

> *"I can relate to the difficulty and pain people who have depression and anxiety disorders, low self esteem etc. from believing that their negative schemas say all there is to say about them (through a struggle with my own schema)" (participant 13)*

There was also recognition of the courage involved in undertaking therapy;

> *"It reminded me of the bravery and difficulty in examining one's beliefs". (participant 11)*

Other statements about empathy were more general, such as,

"Increased empathy, more curiosity about how they became who they are".(participant nine)

"Increased understanding and empathy for the client" (participant 16)

"Humbler and more empathic in relating to clients" (participant 13)

Participant seven, responding from a Maori cultural perspective stressed the importance of including significant others.

"I think I would ensure a safety-net to comfort the client, where they could go to someone who they love to embrace them and feel supported after exposing the wounds" (participant seven)

Therapist self-concept

In some cases the increased self-awareness generated by the self-practice/self-reflection led to self-acceptance, for example:

"I don't' have to be perfect in every session of CBT I have with a person – pull myself down, be less on guard with a person, ask them for feedback as to how I am doing – accept mistakes I made – acknowledge them to the person – I'm human too" (participant 13)

And

"The exercise strengthened the belief I have in my ability and who I am as me" (participant 13)

For this participant the heightened self-awareness generated by the self-practice/ self reflection led to her understanding what could be described as "burnout". She reflected:

> *"I understand how it was I became depressed at work two years ago and had to take sick leave" (participant 13)*

She related this incident to her core beliefs which she was now able to understand, stating:

> *"I am glad they are fully exposed now (core beliefs) I don't have to try so hard as to stress myself up to do my work and be a little more caring of myself" (participant 13)*

In this example the self-awareness engendered by the self-practice /self-reflection could have a protective function preventing professional burnout.

Difficulties encountered

As previously discussed, all sixteen participants reported some positive learning experiences gained from the self-practice/self-reflection experience. However a variety of difficulties were reported. A number of participants recorded that they had experienced technical difficulties when practicing some of the interventions designed to elicit the different levels of thought.

Some difficulties with the thought record were noted such as problems with identifying the "hot thought" (the negative thought generating the strongest emotional charge) and finding alternative evidence for the negative hot thought, especially when working alone;

> *"I found it much more difficult to identify the hot thought on my own than helping another person identify his or her hot thoughts in a CBT session" (participant 13).*

> *"Some aspects of hot thoughts seemed difficult, I seemed to have a cluster which felt hot" (participant 14).*

> *"Sometimes it was difficult to identify the hot thought and several were emotionally charged"(participant ten).*

> *Making myself write out the sheet in full with all the evidence for and against rather than thinking I already had it sorted in my head"(participant five).*

> *"Difficult to believe the alternatives, even though the facts were there in front of me I didn't really believe them. The disconfirming evidence was there but it seemed superficial." (participant 12)*

> *Collecting evidence against the hot thought although once I started collecting the evidence proceeded easier" (participant two)*

One participant found the thought record "tedious":

> *"No difficulties as such – just part of me finds it tedious – a bit like doing differential muscle relaxation tapes. You feel better afterwards but there is a reluctance to do it in the first place" (participant nine)*

One participant experienced what she termed "resistance" to doing the thought record, writing;

> *"My resistance manifested itself in tiredness, putting to one side, putting off" (participant one).*

Other difficulties concerning the deeper levels of thought were;

> *"Quite complex at times, particularly when differentiating positive and negative" (Underlying assumptions) (participant 11).*

> *"That it is easy to work out schema but difficult to match up compensatory and avoidance from the list" (participant three).*

Other difficulties associated with the schema questionnaires , and finding it difficult to access childhood memories, have been discussed at length under other thematic headings recorded above.

Several participants reported that the process was time consuming, but only two recorded this as an overall conclusion recorded under "positive or negative effects". Participant six reflected,

> *"I find them useful but time consuming" (participant six),*

Her stated reason for not completing the workbook was "time". However, commenting on one of the self-practice exercises she did complete (the thoughts records) she reported;

> *"A useful exercise when it is done with full attention – however only possible when emotionally strong – additional insight gained in some aspects of behaviour as well as how much effort one needs to invest to understand" (participant six).*

The above quote indicates that there may have been more to her reluctance to complete than simple time constraints. The fact some of the exercises were confronting and painful was reported by a number of participants. In this particular instance the exposing nature of the self-practice/self-reflection may have contributed to this participant's reluctance to complete the intervention.

In the case of participant 14, time was also an issue as noted in the following quote;

> *"Time consuming – and difficult to justify the time unless it links intentionally to a method of self-reflection, doing therapy and personal development" (participant 14).*

In addition to having difficulty making time for the exercises, this participant also experienced a sense of isolation when doing the self-practice/self-reflection, mentioning this as a problem a number of times, for example;

> *"In think I need contact with someone to give energy to the process. I'd like to find some direction to what I am doing here – the goal to complete this for a valued colleague whilst a legitimate one for me is proving difficult without contact. I am struck by the dawning realisation of the value to me of contact, someone to reflect with" (participant 14).*

This participant was unique in that she resided overseas and was therefore geographically distant from both the university and her fellow participants, which may have contributed to, and intensified her sense of isolation. However the insight that contact with another during the self-reflection process is an important one and has implications which need to be considered when considering self-practice/self-reflection as a training method.

Some of the participants reported that they found the exercises to be emotionally exposing and painful, for example, participant 11 reflected on three of the self-practice exercises thus;

> *"Quite revealing, exposing. Felt quite raw and somewhat sad. A very reflective process" (thought record)*

> *"Very powerful, particularly revealing. Reinforced the impact of early childhood experiences" (imagery)*

> *"Seemed a long agonising process at times" (questionnaires)*

Although this participant appeared to experience some personal pain when doing the exercises her overall response to the process was very positive. As far as her own growth as a therapist was concerned she concluded that the exercises had been:

> *"Very useful, challenging to go through CBT interventions for oneself. Increases understanding and empathy for the client and their work" and "Great to summarise the process Encourages awareness of how it relates to myself and my work. Helps make sense of all the information"*

And on a personal level

> "*Increased insights into my personal beliefs and related behaviours and how these limit my life. Introduces the possibility of challenging and changing these "*

Overall the experience appears to have increased belief in the power of the CBT model and engendered a respect for the way in which it should be delivered.

> *"The exposing nature of CBT techniques needs to be managed with much respect on the part of the therapist".*

Participant 13 also found many of the exercises confronting and painful. She reported however that considerable personal insight into her belief system was the result, and reflected that her general psychological health had improved. Some of her reflections about the process have been recorded under previous headings in particular the section referencing "self-care". The quote below is an example of the

way in which she experienced the exercise requiring the completion of schema questionnaires, as confronting.

> *"I found the Young schemas more difficult to fill out than the PBQ. They seemed to challenge me to think reflect deeper and I felt a little sad as they helped me see how my schema had affected my life. I wondered "Am I really as bad as that?" For example my people pleasing, approval seeking and trying to impress behaviour compensate for the schema "I am of no worth, incompetent" (participant 13).*

However the learning or self-awareness generated from this exercise was:

> *"How harsh I am on myself. I have let the thought of incompetence and my belief I am of no worth drive me through my life and I am sick of it" and then "A sense of peace that I had got to the source of my ceaseless pursuit to be competent and from competence have a sense of 'importance'".*

Her final reflection was one of gratitude for the experience

> *"Thanks Bev for this opportunity to work on myself. It wouldn't have happened if you hadn't asked me. I've learnt so much stuff for me"*

All the reflections on the exposing nature of the exercises were positive implying that the participant had experienced increased personal understanding and psychological growth as a result, for example:

> *"I really appreciated the opportunity to discharge and release frustrated, harmful hurtful thoughts about my hapu/iwi/whanau and cry a bit about it" (participant seven)*

Only one participant, participant one, reported some cognitive confusion, and a number of negative emotional, somatic, and behavioural reactions to the self-practice/self-reflection intervention, for example (all the quotations below refer to participant one):

> *"A reluctance to examine my own behaviour"*

> *"Irritation, fatigue boredom, impatience"*

> *"Some of the processes seemed ambiguous, complicated, difficult, but I got there"*

> *"anger, frustration, impatience"*

> *"Difficult to keep going"*

She characterised this as "resistance" after completing the exercises on the thought record (the third exercise). This appeared to indicate a degree of insight which could have been usefully explored and improved self-awareness as described earlier in the chapter. However, as she progressed through the self-practice exercises accessing the deeper cognitive behavioural processes, (underlying assumptions, compensatory behaviours and core beliefs) the confusion seemed to intensify, as illustrated by the following quotes:

"Wow I've got a lot of compensatory behaviours, is that significant?"

"I am not sure that I know or can make any conclusions about the results that are meaningful or have currency for me."

"I uncovered one rule that surprised me, I'm not sure if it's true or not but its interesting".

"I remain perplexed about the avoidant behaviours thinking that I had a happy childhood and good parents whilst still able to hold a view different from this."

Concluding;

"My avoidant behaviours appear very benign"

This could be interpreted as a tendency to become emotionally avoidant when faced with exposure to problematic personal patterns. If this is the case there may be some cause for concern regarding the way in which this participant would process the emotional content of clients in therapy especially in the light of the following reflection:

"Not sure how I can combine the processes and new awareness gained in this book with my own processes of reviewing my practice – good discussion to have with my supervisor"

The positive aspect of this statement is a recognition that at least some form of further discussion may be in order. The reflections of participant one are important when considering how best to integrate self-practice/ self-reflection into a conventional CBT training program, and will be returned to in the final discussion chapter.

Participant one did conclude that the self-practice/self-reflection intervention had some positive effects as indicated by the quote below

> *"The positive effects are that I have more awareness of the links between NAT's core beliefs, schema and behavioural strategies".*

However the final concluding statement *g*ives the impression that this participant would have benefited from the opportunity to discuss her progress through the workbook with a peer, tutor, or supervisor;

> *"The negative could be that awareness means more information to process and consider with clients obviously good but complexity can be distracting sometimes."*

It would have been useful to have uncovered the evidence of 'confusion' conveyed by the statements above during training, and gives support to the idea of including self-practice/self-reflection as part of training.

Summary of central themes identified

Thematic analysis identified six central themes, 1) Increased theoretical understanding of the CBT conceptual model; 2) Increased self-awareness; 3) Increased empathy, 4) Conceptualisation of the therapeutic relationship, 5) Adaptation of clinical practice; and 6) Adaptation of CBT interventions. The themes are interactive with a degree of overlap between some themes. Each of the themes, summarised below, has been described and illustrated with examples.

Increased theoretical understanding of the CBT model

This was the most frequently recurring theme found in the self-reflections. All the participants reported that they understood the components of the model more clearly, had a greater understanding of the links between the three levels of thought and compensatory behaviours, and had recognised the importance of identifying repetitive cycles of situational triggers, thoughts, emotions, behaviours and physiology. Of particular note was increased understanding of the role of compensatory behaviours as a maintaining factor, and, for some, the relevance of including core beliefs about the world and others, in addition to core beliefs about self. Participants reported that it was the act of "doing", or experiencing the impact of the CBT interventions which enabled them to achieve a deeper understanding of the CBT conceptual model.

Increased self-awareness

Participants identified increased self-awareness in cognitive behavioural terms, and reflected that personal insight was the result, particularly concerning the cyclical nature of personal dysfunctional patterns and the role of compensatory behaviours. They reported increased awareness regarding the tenacity of their core beliefs and underlying assumptions. Increased self awareness was seen to

positively influence theoretical understanding of the CBT conceptual model and enhance empathy (standing in the shoes of the client).

Increased empathy

Empathy is understood as "knowing how it feels to be a client". Participants reported experiencing empathy in a number of different areas relating to gathering the information necessary for a CBT case conceptualisation, for example, uncovering underlying patterns of thought such as core beliefs, recognising the emotional impact of certain techniques like the thought record and the various questionnaires designed to uncover conceptually relevant material, recognising the tenacity of core beliefs, understanding how difficult it is to change, experiencing the pain of self disclosure, and realising that it is not always easy to disclose, or even remember significant historical material. The empathic response was reported as having an influence on the way in which they might adapt their practice of CBT.

A clearer conceptualisation of the therapeutic relationship (from the therapists' perspective)

Participants reported heightened sensitivity to the way in which their personal belief system could interact with that of the client within the therapeutic relationship. The ability to reflect upon the way in which their personal schema (self-schema) might impact on the therapeutic relationship, in the form of therapist schema, was reported to be enhanced. The possibility that problematic therapist behaviours could occur because of therapist beliefs was observed. 'Demanding standards' (high expectations of the client) and 'excessive self-sacrifice' ('doing too much' for the client) were two examples of therapist schema identified.

Adaptation of clinical practice of CBT

The importance of taking time to explain aspects of therapy to the client, getting feedback from the client, sharing the case conceptualisation with the client, becoming aware of personal expectations regarding the speed of therapy (expecting change to be rapid) are some of the adaptations to clinical practice commented on by the participants.

Adaptation of CBT interventions

Participants reported that due to the self-practice/self-reflection experience, they would adapt or change the way they utilized some of the interventions designed for eliciting the CBT case conceptualistion, such as questions asked when using the thought record, sharing the case conceptualisation, the administration of related questionnaires, and the use of homework. Some participants reported that they had not thought of using certain methods, for example using imagery to connect relevant historical information to the formation of core beliefs. Experiencing personal difficulties with some of the techniques, such as the thought record (identifying the 'hot thought'), alerted some of the participants to the possible difficulties a client might experience.

In addition to the six themes described above, improved concept of self as therapist, and the role of self-practice/ self-reflection in preventing professional burnout was reported by one participant.

The feedback regarding the self-practice/self-reflection intervention, was for the most part, very positive and the difficulties summarised below were reported by a

minority of the participants, in some cases, only one. The following difficulties were recorded: technical difficulties with some of the interventions, the time-consuming nature of the project, the fact that it was difficult to complete the exercise in isolation, and that some of the exercises had been emotionally exposing and painful. Only one participant reported confusion, lack of understanding, and some difficulty in integrating the experience with clinical practice.

In the following chapter the inferential analysis, comparing the quality of the case conceptualisations produced pre and post intervention (within the intervention group and between the intervention and comparison groups) is presented.

Chapter eight

Self practice/self-reflection and the quality of the CBT case conceptualisations post intervention

In this chapter, the results pertaining to the third and forth research objectives will be presented. Objective three seeks to determine the effect of the self-practice/self-reflection manualised training intervention, on the quality of the CBT case conceptualisations produced by the "intervention group" (n =16). To do this the *quality* of the participants' CBT case conceptualisations, before and after the completion of the self-practice/self-reflection workbook "Understanding myself", was evaluated using three rating scales: the Fothergill and Kuyken Quality of Cognitive Therapy Case Formulation rating scale, the CBT Case Conceptualisation rating scale, and the Comprehensiveness scale (Case Formulation Content coding method).

The aim of the forth and final objective is to compare the results obtained by the "intervention" and "comparison" groups on the quality of case conceptualisation rating scales listed above. The *comparison* group (n =10), completed the case conceptualisation task before and after a designated period of time (this group was not exposed to the self-practice/self-reflection intervention).

Descriptive statistics summarising the pre and post mean ratings obtained by each group across the three case formulation/conceptualisation quality rating scales are presented first, followed by the inferential analysis.

Descriptive statistics

Table 9 summarises the mean ratings obtained for each of the scales.

Pre and post-intervention ratings obtained by the intervention and comparison groups remained fairly constant over time. There was a slight improvement in both groups at time two for the Fothergill and Kuyken Quality of Cognitive Therapy Case Formulation rating scale. On the other two scales, the quality scores decreased slightly over time for both groups. As far as the CBT Case Conceptualisation rating scale was concerned, the comparison group received higher mean ratings, pre and post-test, on average, five points higher than the intervention group. On this rating scale, both groups' post test performance was rated minimally less than the pre test rating (approximately one rating point of difference). The intervention group achieved slightly higher rating than the comparison group on the Comprehensiveness quality scale.

Table 9. Mean ratings obtained by the intervention and comparison groups on the three quality rating scales at pre and post-test

	Fothergill & Kuyken Quality CT rating scale *Highest possible rating 4*		**CBT case conceptualization Rating scale** *Highest possible rating 40*		**Comprehensiveness rating scale** *Highest possible rating 10*	
	Pre-test	**Post-test**	**Pre-test**	**Post-test**	**Pre-test**	**Post-test**
***IG**	*M* =2.7 *SD* =.9	*M* =2.9 *SD* =.9	*M* =16.4 *SD* =4.3	*M* =15.4 *SD* =4.1	*M* =4.7 *SD* =1.2	*M* =4.6 *SD* =1.6
****CG**	*M* =2.9 *SD* =1	*M* =3.1 *SD* =.7	*M* =21.1 *SD* =4.6	*M* =20.2 *SD* =5.2	*M* =4.5 *SD*=1.2	*M* =4 *SD* =1.1

*IG= Intervention group (*n* =16)
**CG= Comparison group (*n* =10)

Inferential analysis

The inferential analyses reported in this section were driven by the questions in bold font. While a Between-S/ Within-S Repeated Measures Anova was arguably appropriate here, I adopted a more parsimonious approach (given the low power and low N situation) to address the questions specified below.

Differences between groups at the start of the study?

An independent t-test was conducted to compare the quality of case conceptualisation ratings obtained by the intervention and comparison group at the start of the study. The groups were compared using three quality rating scales. No significant differences were found for the Fothergill and Kuyken Quality of Cognitive Therapy Case formulations rating scale and the Comprehensiveness scale.

There was, however, a statistically significant difference in the ratings of the intervention group (M = 16.4 SD = 4.3) and the comparison group (M = 21.1 SD = 4.6; t(24) = -2.6 p = .014), when the ratings on the CBT Case Conceptualisation rating scale were compared. The magnitude of difference was eta squared = .22 which shows a large effect (Pallant, 2005). On this scale, the comparison group achieved a significantly higher quality rating on the CBT Case Conceptualisation rating scale, when compared to the intervention group at the start of the study.

Intervention group quality ratings post intervention?

A paired samples t-test was conducted to evaluate the impact of the self-practice/self-reflection intervention. There was a statistically significant improvement in ratings achieved on the Fothergill and Kuyken Quality of

Cognitive Therapy Case Formulation rating scale from time one (pre-test) (*M* = 2.7 *SD* = .91) to time two (post-test) (*M* = 2.9 *SD* = .91, t (15) = -2.66, p<.018). The eta squared statistic was .32 showing a large effect indicating that the manualised training intervention had an effect on the case conceptualisation quality in this instance (Pallant, 2005).

Paired-samples t-tests showed no statistically significant differences achieved by the intervention group on either the CBT Case Conceptualisation Rating scale or the Comprehensiveness scale at time one (pre-test) and time two (post-test). As mentioned earlier, scores on these measures decreased at time two.

Changes in the comparison group quality ratings over time?

A paired- samples t-test was conducted to evaluate the quality of case conceptualisation of the comparison group at time one (pre-test) and time two (post-test). The comparison group did not complete the manualised self-practice/self-reflection training intervention. In these instances no statistically significant differences were found for any of the rating scales.

Between group differences at time two?

An independent–samples t-test was conducted to compare the quality of CBT case conceptualisation ratings obtained by the intervention and comparison groups, found that there were no significant differences between groups on either the Fothergill and Kuyken Quality of Cognitive Therapy Case Formulation rating scale, or the Comprehensiveness scale.

The independent-samples t-test, however, found a statistically significant difference on the CBT Case Conceptualisation rating scale for the intervention group (M = 15.4 SD 4.14) and the comparison group (M = 20.8 SD = 5.3, t(24) = 2.6 , p<.49). The eta squared .2 indicated a large effect size (Pallant, 2005). The comparison group, in this instance, achieved a higher rating.

There was no statistically significant difference between the groups on the sub-scales of the CBT case conceptualisation rating scale (problem list, diagnosis, hypothesis, and treatment plan).

Chapter nine

Discussion

In this chapter, the findings reported in chapters six, seven and eight are summarised. This is followed by a discussion interpreting and contextualising the findings in the following order:

1. The evaluation CBT case conceptualisations (combined group) (chapter six)
2. The thematic analysis of participant self-reflections (intervention group) (chapter seven).
3. The pre and post intervention comparison of the quality of CBT case conceptualisations competency (within the intervention group, and between the intervention and comparison groups) (chapter eight).

The training implications, where they are pertinent, will be addressed at the end of each section. In conclusion, the limitations of the present study and directions for future research in the field will be highlighted.

The first question, "What is the content and quality of individualized CBT case conceptualisations produced by the participants?", was addressed via the systematic evaluation of 104 CBT case conceptualizations produced by a sample of 26 novice CBT clinicians (26X4). The case conceptualizations were evaluated using three quality rating scales and four benchmark case conceptualizations.

There was considerable consistency in the subcategories of clinical information noted by participants in all four categories of information identified in the Case Formulation Content Coding Method, across all four of the case conceptualisations. The four categories of information were *descriptive, inferential*, *diagnostic*, and *treatment planning information* . Subcategories of information receiving most attention were *symptom presentation* and *developmental history* in the descriptive category, whilst *predisposing factors*, recorded as relevant developmental and historical information, and *maintaining psychological mechanisms* were emphasized in the inferential category. Maintaining *psychological mechanisms*, using the CBT model as the proposed theoretical explanation, received the most attention. Core beliefs about the 'self' were identified by at least 80% - 92% of the participants across the four vignettes, (core beliefs about 'others' and the 'world' were given much less attention). Underlying assumptions were identified by between 61% - 74% of the participants, and compensatory behaviours by between 61% - 81% of the participants. *Biological* and *socio-cultural mechanisms*, *protective factors*, and predictions concerning the nature of the *therapeutic relationship* were generally given little attention, with more than half the participants registering no coded idea units under these subcategories.

A majority of participants identified an Axis one diagnosis of some kind and considered the diagnosis when selecting treatment interventions. As far as the *treatment* category of information was concerned, over 90% of the participants placed emphasis on the use of *specific structured CBT interventions*, with the "thought record" the most frequently chosen intervention. The other prominent treatment focus was that of *underlying psychological mechanisms*, and in this

instance, participants highlighted the importance of addressing underlying beliefs or significant childhood experiences. The most common treatment suggestion recorded under this heading was to focus on core beliefs using a "core belief worksheet". The least attention, in the *treatment* category of information, was given to positive or negative aspects of the *therapeutic relationship*, *socio-cultural* and *biological factors*, and emphasizing the clients' *strengths* or *protective* factors.

When the quality of the case conceptualizations was evaluated results obtained on the Comprehensiveness scale showed that the majority of participants did not include all possible categories of information in their case conceptualizations with more than 50% attending to less than half the relevant subcategories. The distribution of subcategories of information identical to that described above.

Results obtained on the Fothergill and Kuyken Quality of Cognitive Therapy rating scale, which had a single rating, relating exclusively to the cognitive behavioural aspects of the case conceptualization, showed between 50% and 65% of participants achieved a *"good enough"* quality rating over the four case vignettes with the higher ratings (more than 60%) achieved for vignettes three and four. As far as the CBT Case Conceptualization rating scale, which consisted of four categories, was concerned, between 58% and 69% of participants achieved ratings of six and above in the *working hypothesis* category (each category was rated out of ten) indicating a satisfactory performance. On average 50% of the participants produced a *"coherent and meaningful"* case conceptualization. The top rating, nine out of ten, was achieved by one participant. The *problem list* category rated poorly with an average of 57%, across the four case vignettes, leaving this category out altogether. On average 71% of participants identified a diagnosis of some kind, and

on average, 64% of the participants produced a treatment plan guided by general CBT principles. Weaknesses shown by participants across all four case vignettes were the failure to pay sufficient attention to developing a clear problem list, with most participants leaving this category of information out altogether. Other areas of neglect were the presence of Axis two personality traits. Consistent with the other measures, there was a failure to attend to conceptually relevant aspects of the therapeutic relationship such as dependency, reassurance seeking, and emotional avoidance.

The level of agreement with the benchmark case conceptualization was averaged at less than 50% for most of the general themes identified by the expert (agreement for individual items was generally higher). The highest rate of agreement occurred for *relevant childhood data*. Once again, the therapeutic relationship, problem list, and Axis two diagnosis, were neglected.

Overall, repeated assessment of the content and quality of CBT case conceptualizations, over time, shows consistency in the aspects of clinical information emphasized.

The second research question, which addressed the evaluation of the impact of a manualised self-practice/self-reflection training intervention on the CBT case conceptualizations of the participants in the intervention group, was analyzed qualitatively, and quantitatively. Thematic analysis of participant self-reflections identified the following six central themes; increased theoretical understanding of the CBT conceptual model, increased self awareness, increased empathy, conceptualization of the way in which participants' identified beliefs which might

impact on the therapeutic relationship, and adaptation of clinical practice (management of the therapeutic process), and clinical interventions (the manner in which particular CBT interventions might be adapted following the self-practice/self-reflective experience experience).

Quantitatively, when the quality of the intervention groups' CBT case conceptualisation were compared, over time, pre and post intervention, a statistically significant difference between time one and time two was found in ratings obtained on the Fothergill and Kuyken Quality of Cognitive Therapy Case Formulation rating scale, showing that there had been some post intervention improvement in the intervention group. The other two quality scales (Comprehensiveness and the CBT Case Conceptualisation rating scale) did not show any significant change over time, decreasing slightly in the post intervention condition, in both groups.

When the two groups were compared, (intervention and comparison groups), the comparison group did significantly better on the CBT Case Conceptualisation rating scale. In this instance, the quality of the comparison groups' pre test case conceptualisations were rated as being of higher quality, when compared to the intervention group, at the pre and post intervention condition. The ratings for the comparison group did not improve at time two, but still remained significantly higher than the intervention group. There were no other significant differences on the remaining measure of quality (Comprehensiveness), or between the sub scales of the CBT Case Conceptualisation rating scale. The results concerning the first research objective are discussed below.

The evaluation of the CBT case conceptualisations

The most important goal of any evaluation is to identify strengths and potential weaknesses or blind-spots. As documented in the literature review, systematic evaluation of case conceptualisations in training programs is unusual, making these findings a useful contribution to best practice as far as training in this key competency is concerned. This research has begun to consider the questions posed in the introductory chapter (what kind of information do novice clinicians include in their case conceptualisations and what do they omit?). The findings on this aspect of the present study will be contrasted with previous research studies and the implications for training highlighted.

The most notable finding was the consistent distribution of the specific sub-categories of information either emphasised or ignored by the majority of the participants. As indicated by the results obtained on the comprehensiveness scale, participants, on average, attended to less than half of the potentially useful aspects of case conceptualisation information. Participants emphasised developmental factors and underlying psychological mechanisms at play in the maintenance of the symptomatology documented in the case vignettes. A high percentage of the participants failed to mention underlying biological and socio-cultural mechanisms, relevant protective factors, and aspects of the therapeutic relationship. Although more than half the participants described presenting symptoms, few developed these into a useful targeted problem list. In addition, although the majority of participants made some reference to Axis one diagnosis, little attention was given to the possibility or presence, of enduring personality styles.

These findings are consistent with the results of the few previous studies evaluating case conceptualisation content and quality, reported in chapter three (Eells et al., 1998; Eells et al., Eells et al., 2003; Eells et al., 2005), which indicate a lack of attention to a number of important case conceptualisation components across different psychotherapy models of conceptualisation (psychoanalytic, existential/humanist and CBT).

An explanation for the general failure to attend to clinically relevant categories of information, outside of the specifically cognitive focus, could relate to a degree of perceptual inflexibility or tunnel vision both in the training and the trainees. Participants were asked to construct a CBT case conceptualization within a specified time-frame. Tunnel vision regarding the CBT focus may have obscured other important factors which should be considered in the construction of a sound case conceptualization. Each of the 'perceptual 'gaps' in identified in the present study are discussed below.

Socio-cultural and biological mechanisms

Socio-cultural mechanisms include ethnicity, socio-economic status, religious beliefs, acculturation, and absence of social support (Eells, et al., 1998). The role of gender and sexual orientation could also be considered under this category. Biological mechanisms would include both genetic and acquired conditions contributing to the problem (Eells et al., 1998). The small amount of attention given to biological and socio-cultural mechanisms by participants in the present study is consistent with the results of an earlier study describing the development of the Case Formulation Content Coding method where it was found that only 1.8% (n=1) inferred a biological, or socio-cultural mechanism in a sample of 53 case

formulations (Eells et al.,1998). This was a naturalistic study where the data set consisted of randomly selected intake reports and the therapists had not been instructed to construct a case formulation. In this example the therapists came from different orientations, (psychodynamic, cognitive behavioural, and existential) indicating that a lack of attention to socio-cultural and biological factors is not limited to CBT practitioners. In a more recent study which compared the quality of case formulation in psychodynamic and cognitive behavioural therapists divided into three groups, novice, experienced and expert, a very similar pattern emerged with participants across the three groups, receiving mean quality scores of less than one, indicating that in this study (even among "experts"), the biological and socio-cultural elements were *not present,* or *present but not elaborated* (Eells et al., 2005).

In the present study, the case conceptualisation task was clearly specified and the participants did marginally better when compared to previous studies. As far as socio-cultural factors were concerned between 8% and 19% of participants registered idea units. Some information which could be considered socio-cultural was recorded as *relevant childhood information*. For example, 58% of the participants noted that the client in case vignette two came from a Roman Catholic background but did not go on to speculate how this could have contributed to her assumptions regarding her personal responsibility and guilt. An even higher percentage, 73% referred to the fact the client in case vignette four came from a well educated, middle-class family but failed to make links to the presentation. The participants did not consider the ethnicity of the clients described, and there was little consideration of the interpersonal milieu. Only one participant considered the possible implications of coming from an immigrant family.

As far as 'biological factors' were concerned, between 4% and 15% of the participants included idea units. Case vignette four was an exception and 46% of participants mentioned the relevance of depression in family members. Two participants queried the role of menopause in case vignettes two and three. The fact that the client in case vignette one, had a sister who was bulimic and a brother who was a loner, was recorded as relevant history by 58% of participants, but not specified as a possible genetic factor.

Interestingly, the expert benchmark case conceptualisations were similarly short on idea units which could be coded as socio-cultural. In this study the expert included some socio-cultural information as relevant history, but, as observed in the participants, did not link these observations to the presenting problems. (This is consistent with the expert formulations coded in the Eells et al., 2005 study).

One explanation for the failure to consider biological and socio-cultural mechanisms could be due to the "availability heuristic" (Wilson, 1995). It is postulated that this is one of a number of "strain reducing" heuristics employed under demanding decision making conditions (such as psychological assessment and case conceptualisation (Waddington & Morley, 2000). It may be that participants' attention was focussed, predominantly, on the idiosyncratic CBT aspects of the case conceptualisation which resulted in screening out other possible contributing factors. To counteract this tendency some authors have proposed that an important part of the case conceptualisation process as a "theory of the case" (Persons, 1989), should include generating alternative explanations, or hypotheses,

outside of a specifically psychological focus, which can be tested (Meier, 2003; Mumma, 1998; Persons & Davidson, 2001).

Another contributing factor leading to perceptual blind spots could be that the cognitive behavioural therapies have distanced their analysis of clinical problems from the social context (Tarrier & Calum, 2002). This criticism could also be applied to the other individualized models such as psychoanalysis. These authors point to the fact that behaviour therapists view the environment primarily as a reinforcement or punishment delivery system, and cognitive therapists have an internalised or cognitive focus which tends to ignore, or obscure the interpersonal context (Tarrier & Calam, 2002, p 320). It is proposed that a pivotal role should be given the interpersonal and social context in understanding factors such as resilience and vulnerability, which are crucial in a useful case conceptualisation. This is also true for biological factors, and it is suggested that clinicians familiarize themselves with epidemiological data on risk factors.

It is a truism to point out that culture permeates all aspects of human experience. There is an increasing emphasis, in the delivery of psychotherapy, on multi-cultural competence, as the demographics of most developed countries become more diverse through immigration (Eells, 2007), and the cultural differences of indigenous and first nation populations are given more attention (Hays, 2006). Both these factors are true of the New Zealand context where there is a burgeoning immigrant population and a strong commitment to bi-cultural considerations pertaining to the significant presence of Maori as the indigenous population. Unfortunately, despite a growing awareness of these factors, there is evidence, suggesting that racism is pervasive in the mental health system in the United States

of America, and that this is probably true of most euro-centric, western mental health systems (Ridley & Kelly 2007). CBT is an individualised therapy which emphasises verbal skill, rational thinking, and logic, all of which are stereotypical of the western epistemological tradition. In addition, diagnosis, using the Diagnostic and Statistical manual of Mental Disorders (DSM-IV, 1994), is considered essential when selecting appropriate, evidenced based, treatment protocols, informed by disorder specific CBT conceptualizations. A mindset, such as this, can contribute to neglecting the communal, family based traditions of many non western cultures. It is important therefore, that CBT training emphasizes culture beyond mere lip service, and offers conceptual direction for the inclusion of this dimension, avoiding what has been characterized as Type One and Type Two error, namely, concluding that a client's presentation is pathological when it reflects a cultural component, or failing to identify pathology when it exists (assuming it to be culturally driven) (Ridley & Kelly, 2007).

The therapeutic relationship

A minority of participants, between 4% (n = 1) and 31% (n = 8), included information pertaining to the role of the therapeutic relationship in the case conceptualisation and treatment plan. There were a number of clear indicators for what could have been both therapy interfering, and therapy enhancing factors, embedded in the narratives of the case vignettes. It was disappointing therefore, that only a minority of participants took cognisance of these. Once again these findings were consistent with the Eells et al. (2005) study, where novice, experienced, and expert clinicians from psychoanalytic and CBT backgrounds, received a quality rating of less than one on this dimension. In the present study,

the benchmark case conceptualisations provided by the expert, included references to the therapeutic relationship in all the "benchmark" conceptualisations

The therapeutic relationship is considered a pivotal "common factor" in the process of psychotherapy and client change (Bachelor & Horvath, 1999), and as mentioned in chapter four, the importance of the interpersonal aspects of the therapeutic relationship have received an increasing amount of attention as CBT has evolved to incorporate treatment protocols for the more complex diagnostic presentations. A number of authors have commented on the importance of clinicians developing an awareness of the manner in which interpersonal aspects of the therapeutic relationship can impact for good or ill on the course of therapy. All of the vignettes contained behavioural and cognitive processes indicating personality traits which could have negatively and positively affected the course of therapy and therefore should have been included in the case conceptualisation.

The following quote sums up the significance of the therapeutic relationship as a subcategory of important conceptual information; "The highly complex, interactive nature of the assessment process does not get the attention it deserves. The fact that a case formulation is the result of a very specific interaction – one could call it co construction – between assessed and evaluating persons, has to be acknowledged" (Westmeyer, 2003 p. 211). Although the case vignettes used to elicit the case conceptualisations could not provide this interactive relational element, the self-practice/self-reflection manualised intervention, used to address the second research question, was designed to facilitate personal self-awareness within the conceptual framework of CBT. It was anticipated that 'conceptualised' self-awareness would generalise to self-reflection regarding the implications of the

clinicians' personal beliefs and resultant compensatory behaviours on the therapeutic relationship, and that this would be reflected in their post intervention case conceptualisations. There was a slight increase, from 12% (n = 2) of participants noting the therapeutic relationship pre test, to 31% (n = 5) post test, but overall it has to be concluded, there was not much change.

Protective factors/resilience

Protective factors are extra therapeutic factors which enhance the probability of a positive psychotherapeutic outcome (Padesky & Mooney, 2006). Multiple factors such as intelligence, good social skills, supportive family relationships, occupational stability can be included under this category. Case formulation is often described as integrating the four "P's" (precipitating, predisposing, perpetuating and protective factors) (Needleman, 1999). Thus it would have been expected that more participants would have made reference to this aspect either as present or absent. In case vignette one, 50% of participants did include protective factors, however this attention was not maintained in the remaining vignettes. All of the clients described in the vignettes had several obvious protective factors which could have been noted.

Cognitive Behaviour Therapy is often described as a problem focussed therapy (Beck, 1995) and it could be postulated that this may obscure protective factors and client characteristics which suggest the presence of resilience. It could be that this mindset prevented the participants from identifying protective factors and strengths in the clients described.

The Problem List

A list of the client's presenting problems is pivotal for the development of a CBT case conceptualisation, providing the clinician with the opportunity to uncover themes and causal relationships. The problem list is a starting point for therapy, providing a focus and a basis from which to develop goals for treatment, a plan of treatment to achieve the goals, and a platform to evaluate the success or failure of a treatment intervention (Persons, 1989; Persons & Davidson, 2001). It is recommended that the problem list should be comprehensive, and include problems that may not necessarily be addressed in therapy (Persons, 1989). Furthermore clinicians should be alert for problems that the client may be reluctant to address such as drug dependency or types of self-harm. In CBT a functional analysis of the main presenting problems should be undertaken to clarify links between situational triggers, cognitions, emotion response and resultant behaviours. This is the basis for the situational case conceptualisation which provides the building blocks for the comprehensive individualised case conceptualisation (see chapter two).

It was surprising therefore, that between 38% and 69% of the participants failed to provide any reference to a problem list across the four case vignettes, and of those who did provide a problem list, only one participant achieved a score of eight (highest possible rating 10). The majority of participants failed to prioritise the identified problems, speculate about problems that may have occurred outside the client's awareness, or might interfere with the therapeutic relationship, or functionally analyse the components of the problem. Interestingly other authors have observed that clinicians often do not produce comprehensive problem lists and frequently leave out important non- psychological information such as medical problems (Persons & Tompkins, 2007). In this study, when suggesting an

appropriate a treatment plan, a majority of the participants (65%-81%) said that they would develop a problem list, indicating that there was an awareness of this important aspect of treatment planning, which did not in this study translate to specifying problems in the conceptualisation section.

In considering why the participants failed to include the problem list in their case conceptualisations, a clear explanation does not readily present itself. All the case vignettes contained very clear descriptions of the presenting problems, and as stated above participants included references to the importance of the problem list in their treatment plans. One explanation could be that once again participants were focussed solely on the cognitive aspects of the conceptualisation.

Axis II Personality Traits

The four clients described in the vignettes all had clear axis one diagnoses which were for the most part identified by the participants. The expert in the benchmark case conceptualisations, however, identified Axis two personality traits in each of the clients, dependency and avoidance being the most prominent. Between 4% (*n* =1) and 8% (*n* = 2) of the participants emphasised these traits, making this the most poorly attended to subcategory of information. Personal experience as a supervisor of a large number of CBT trainees has confirmed an impression that novice clinicians often fail to identify enduring personality traits. My personal observation has led me to consider a number of factors which may account for this. Trainees sometimes express the view that the client cannot have a 'personality disorder' because they appear to be functioning adaquately in society, for example may have a job, or be in a long term relationship. An extreme stereotype of what constitutes a personality disorder is often held, derived from inpatient or community mental health experiences with severely challeged clients given the diagnosis of Borderline Personality Disorder. This stereotype can prevent the novice clinician from recognising the more covert personality traits such as dependency and avoidance. There is also a reluctance to label someone in what has been considered to be a perjoritive manner, and some trainees believe that if personality traits are identified CBT may not be the appropriate intervention.

Recent developments in CBT are increasingly focussed on treating the more chronic and complex client presentations where personality characteristics are prominent and enduring (Beck et al.,2004). Recognising prominent cognitive styles and common overdeveloped and underdeveloped behaviour patterns in the

different personality types can be invaluable conceptual information, particularly regarding the therapuetic relationship (Beck et al., 2004).

The failure of the participants in the present study to identify personality traits may have also contributed to the lack of prominance given to relevant aspects of the therapeutic relationship. The clients described in the vignettes would not have been given a diagnosis of a full blown personality disorder in a real-life clinical setting, however as previously mentioned, in each example there were a number of prominent traits which would have in all probability effected the therapeutic relationship and could have been fruitfully considered in treatment planning.

Case conceptualisation content: Implications for training

The results of the present study, highlight a number of important subcategories of conceptually relavant clinical information consistenly ignored by a majority of the 26 participants making up the research sample. These finding are consistent with previous research findings in the United States. A number of factors have been proposed as contributing to this state of affairs, namely tunnel vision, the availability heuristic, blind spots within the CBT model (individualistic, internalised cognitive focus), a "problem" as opposed to resiliance focus, and a reluctance to consider Axis II personality charactersics due to certain entrenched stereotypical ideas. The fact that all the participants had been exposed to the same training suggests that reviewing current training practices regarding case conceptualisation within the post graduate diploma in CBT may be in order. In addition the similarity between current findings and those of previous studies gives weight to an impression that a neglect of these factors is not limited to CBT training, and that across the various well established psychotherapy models,

insufficient attention is given to factors beyond the immediate psychological dimensions of the case conceptualisation.

The following suggestions could be considered to address the specific recurring ommisions identified. Including measures such as those utilised in the present study to systematically evaluate case conceptualisations produced by trainees as a matter of routine, is an important first step towards identifying strengths and weaknesses, and in practical way, alerting trainees and trainers to ommissions in the type of clinical information receiving appropriate attention. Adapting case conceptualisation formats such as the J.Beck cognitive therapy conceptualisation to include extra psychological elements of relevance. J.Beck has revised her original form to include a box to record clients' therapist related beliefs an a means to focus attention of the therapy relationship (see chapter four), and sociocultural, biological and protective factors could be integrated in a similar fashion. Encouraging trainees to generate alternative hypotheses, beyond the strictly psychological, (Persons & Tompkins, 2007) is also an important way of breaking through the apparent tunnel vision regarding the genesus and maintenance of the presenting problems.

As far as sociocultural factors are concerned, it is important that CBT training emphasizes these aspects and offers conceptual direction for the inclusion of this dimension. Culture needs to be interpreted in the widest possible manner to include older adults, people with disabilities, and homosexual, lesbian, inter-sex individuals, along with the more obvious dimensions of ethnicity, multiculturism, and biculturalism. Finding suitable literature within CBT is difficult, and a review of widely used textbooks in the field reveals a paucity of attention in this field

(Hays, 2006). It follows that training programs need to be vigilant about including references to this important area, which may involve incorporating, and integrating relevant information from other models.

Multicultural therapy and CBT have been reported to be the two most important trends in current psychotherapy (Norcross, Hedges, & Prochaska, 2002) and there is, therefore, good reason to alert CBT trainees to this body of literature, and make sure that these factors are integrated into the individualized CBT case conceptualization, avoiding the sentiments expressed in the following quote, "Given training programs' difficulty in integrating culture and practice it is no wonder that students feel lost as they attempt to incorporate cultural aspects into assessment" (Ridley & Kelly, 2007 p. 34).

The Five-Part model (Padesky & Mooney, 1990) as a method of functional analysis used in the first level of CBT conceptualisation, can be adapted to include a cultural, religious or spiritual dimension within the large enclosing circle which contains all relevant aspects of the client's environment, beyond the immediate triggering situation. The use of such models provides a visual cue for both therapist and client to take cognizance of these wider factors. See Figure eight. A practical example showing the use of the extended Five-Part model can be seen in Appendix O where one of the Massey University PGDipCBT practicum trainees conceptualized a Chinese client within this context (Williams, M.W., Foo, K.H., & Haarhoff, B.A., 2006).

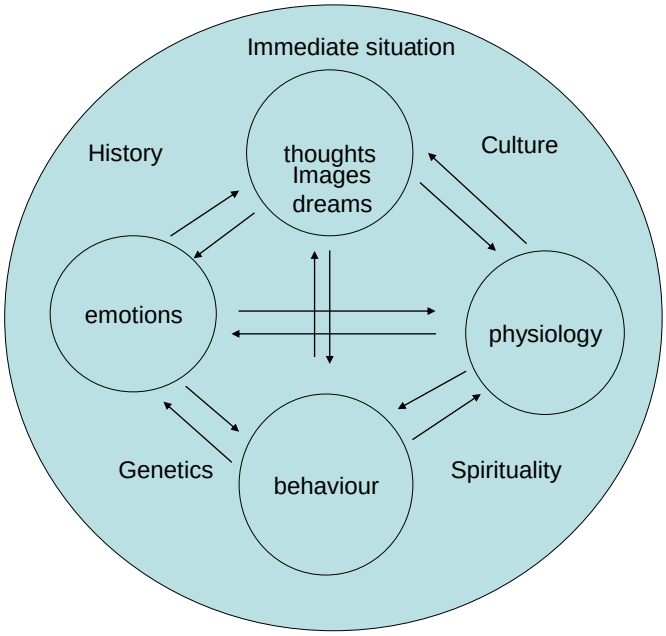


***Figure 8*. The five-part model expanded (adapted from Padesky & Mooney 1990)**

Expanding the traditional assessment protocols which generally consist of symptom measures such as the Beck Depression Inventory (Beck et al., 1961, Beck et al., 1996) and cognitive measures such as the Automatic Thoughts Questionnaire (Hollon & Kendall, 1980), and The Dysfunctional Attitude scale (Weissman & Beck, 1978), to include a more focussed socio-cultural perspective could be considered. Strategies such as the Multicultural Assessment Procedure, which consists of four phases of assessment, could be very usefully incorporated to train culturally sensitive CBT clinicians in the steps towards evaluating and conceptualising clients in a socio-culturally aware manner (Ridley & Kelly, 2007). Very briefly, the measure includes identifying the cultural data through "alert and sensitive clinical interviewing", orientating trainees to assessment measures such as the "Person-in-culture Interview" (Berg-Cross & Chinen, 1995 cited by Ridley & Kelly, 2007);

interpreting the cultural data, incorporating the cultural data, and using confirmatory bias, and disconfirmatory hypothesis testing.

Biological factors were another potentially important aspect of the case formulation generally neglected by the participants. It is important for trainees to develop an awareness of developmental stages and epidemiological factors. Once again trainees should be directed to relevant sources of information, and comprehensive CBT training programs should ideally incorporate a focussed developmental component, considering CBT across the developmental lifespan (Reinecke & Clark, 2004). As the model expands, there is a growing amount of information which can be integrated such as the more recent work considering the adaptation of CBT for older adults (Laidlaw, Thompson, Dick-Siskin, & Gallagher-Thompson 2003) and children and adolescents (Spence & Reinecke, 2004).

It has been predicted that in the future case formulations will focus more on strengths, and resilience (Benjamin, 2003), making protective factors and strengths an important aspect of the CBT case conceptualisation. At workshop sponsored by the New Zealand College of Clinical Psychologists in 2006, the presenters, Christine Padesky and Kathleen Mooney introduced a "Resilience model" using CBT principles and recommended using this model with complex, difficult to treat clients. The model identifies six areas of competence namely, physical, spiritual, moral, emotional, social relational, and cognitive. Clinicians are advised to pay attention to exploring these from the perspective of resilience, and include them in the conceptualisation and resulting treatment plan.

Categories of information such the problem list, the impact of the therapeutic relationship, and identification of Axis two personality traits are generally integrated in the training of CBT clinicians. The importance of the therapeutic relationship is increasingly emphasised in mainstream CBT and a variety of strategies such as the Therapist Schema Questionnaire (Leahy, 2001; Haarhoff, 2006; Haarhoff & Kazantzis, 2007), The Therapist Belief System (Rudd & Joiner, 1997), and the incorporation of structured, tailored self-practice/self-reflection (Bennett-Levy, et al., 2001; Haarhoff & Stenhouse, 2004), discussed in chapter four, are promising methods which could heighten the CBT trainees' perception of the importance of their personal contribution to this dimension. The importance of conceptualising the therapeutic relationship is discussed in the following section.

Contrasting the quality ratings of the present study with those of the only other study considering the quality of Cognitive Therapy case conceptualizations (Kuyken et al., 2004), the ratings in the present study were higher. In the previously reported study, only 44% of a sample of 115 mental health practitioners with similar professional backgrounds to the current study, achieved ratings indicating a "good enough" cognitive case conceptualization, despite extensive training focused on the conceptualisation requirement expected in this study. The evaluation of quality, using the Fothergill and Kuyken Quality of Cognitive Therapy rating scale, showed that on average, at least 50% of the participants in the present study had a "good enough" grasp of the CBT case conceptualisation process. The quality improved for vignettes three and four where more than 61% of the participants were, at least, good enough. The results of the present study indicate that the participant sample, all graduates of the Massey University PGDipCBT, showed a transfer of training superior to that of the British group.

However, disappointingly, only a minority of participants managed to achieve the highest ratings on all the quality scales, and none scored the top rating on the Comprehensiveness or the CBT Case Conceptualisation rating scales. As previously discussed this appears to indicate a good grasp of the CBT model but a general failure to attend to the wider aspects of the case conceptualization as discussed in detail above.

The findings regarding the second research objective; the consideration of the possible impact the manualised self-practice/self-reflection training intervention on the CBT case conceptualization competency of the participants in the intervention group, are discussed below.

The self-practice/self-reflection training intervention

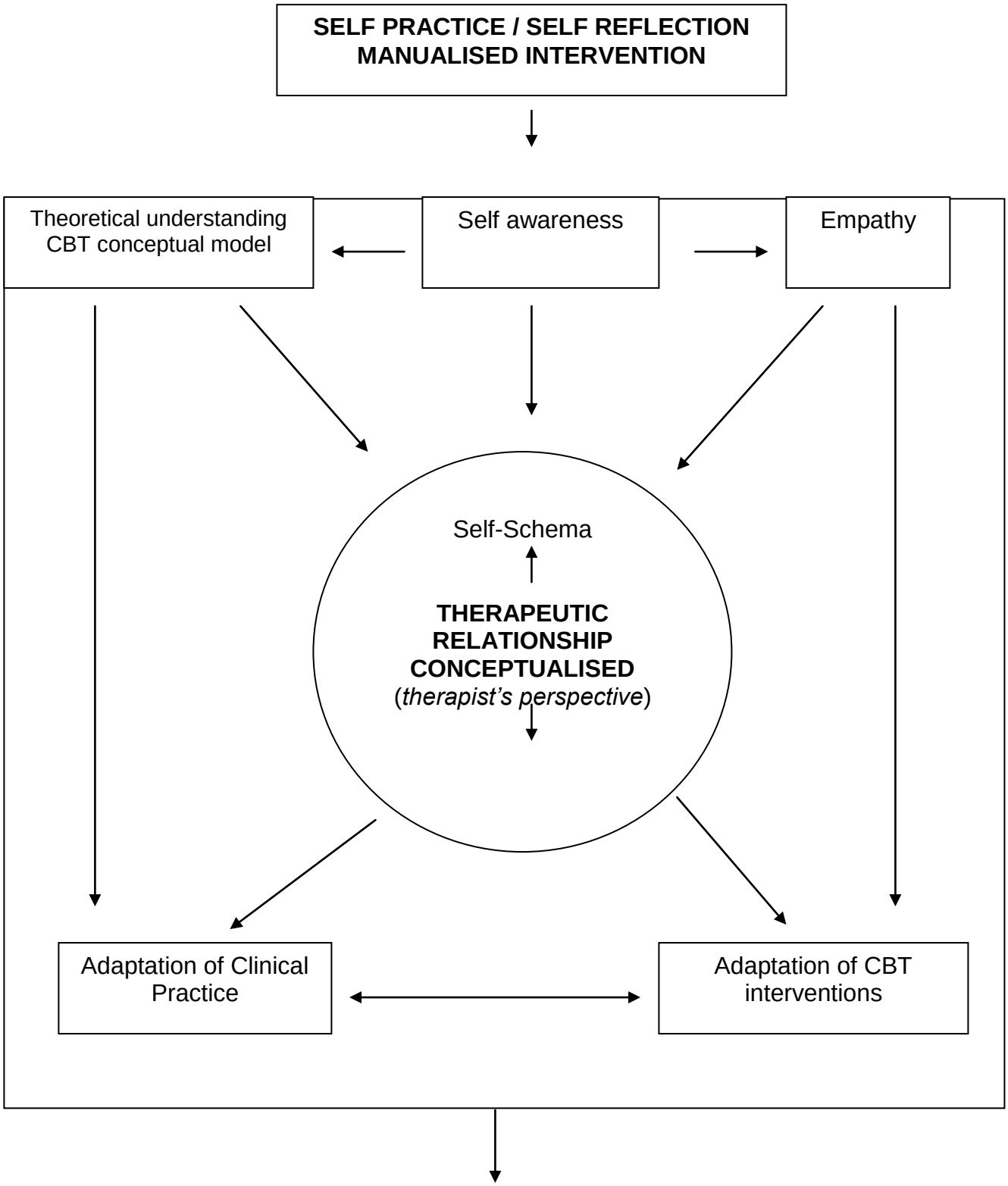
The investigation was two pronged, relying first on a thematic analysis of participants' self-reflections concerning their subjective perceptions regarding the impact of the intervention on their CBT case conceptualization understanding and competency, and secondly by objectively evaluating the quality their CBT case conceptualisations, before and after the self-practice/self-reflection intervention. The qualitative findings are discussed first.

Thematic analysis identified themes consistent with those repeatedly identified by previous studies, investigating both the impact of personal therapy in the more generally accepted sense, and self-practice/self-reflection as a form of personal therapy more consistent with the principles of CBT (see chapter four). Themes, subjectively perceived as effects, such as; considering self-practice/self-reflection

helpful, enhanced understanding of the CBT model, improved self awareness, increased focus on the interpersonal aspects of the therapeutic relationship, increased empathy for the client, and enhanced understanding of protocols and interventions, identified by participants in the present study, are mirrored by most other studies.

Unlike previous studies which have focused on the effect of self-practice/self-reflection on general competency, in the present study, the emphasis was on case conceptualization competency. I have presented the identified themes in a hypothetical model showing the interaction between self-practice/self-reflection and case conceptualization competency. See Figure nine.

Figure 9. Interaction between self-practice/self-reflection and CBT case conceptualisation competency



The large central square emes (theoretical understanding of the model, self-awareness, empathy, therapeutic relationship conceptualized, adaptation of clinical practice, and adaptation of CBT interventions). Arrows indicate the direction of the relationship. The reflective CBT conceptualization of the therapeutic relationship (from the point of view of the therapist) occupies the pivotal position in the model. On the first level, self-awareness is central, as the most immediate result of the self-practice/ self-reflection experience. Self-awareness is reported to increase both theoretical understanding of the model (learning by doing) and empathy for the client (standing in the shoes of the client through directly 'experiencing' aspects of therapy through self-practice). Each of these themes impacts on the participants' perceived conceptual understanding of the therapeutic relationship. Participants reported an increased awareness of their self-schema (beliefs and assumptions about self, others, and the world, pre-dating their training as clinicians) and how this might impact on their self-as-therapist schema. The conceptualization of the therapeutic relationship in this manner was then seen as impacting on therapy practice (they way they "did" therapy), and how they would choose and use therapeutic interventions and strategies. The degree to which the therapist is able to understand the interpersonal emotional and behavioural impact of his or her belief system has been shown to interact with many different aspects of the therapeutic process almost all of which occurs in the interpersonal arena. Lack of self-awareness regarding these factors can often have negative consequences for therapeutic outcome (Leahy, 2001; Leahy; 2007; Rudd & Joiner, 1997; Young et al, 2003).

Participants reported that it was the act of "doing" or experiencing the impact of the CBT interventions which enabled them to achieve a deeper understanding of the CBT conceptual model. The stages they went through appear to parallel the Kolb four stage experiential learning model (Kolb, 1984 cited in Bennett-Levy et al., 2004) (see Figure eight).

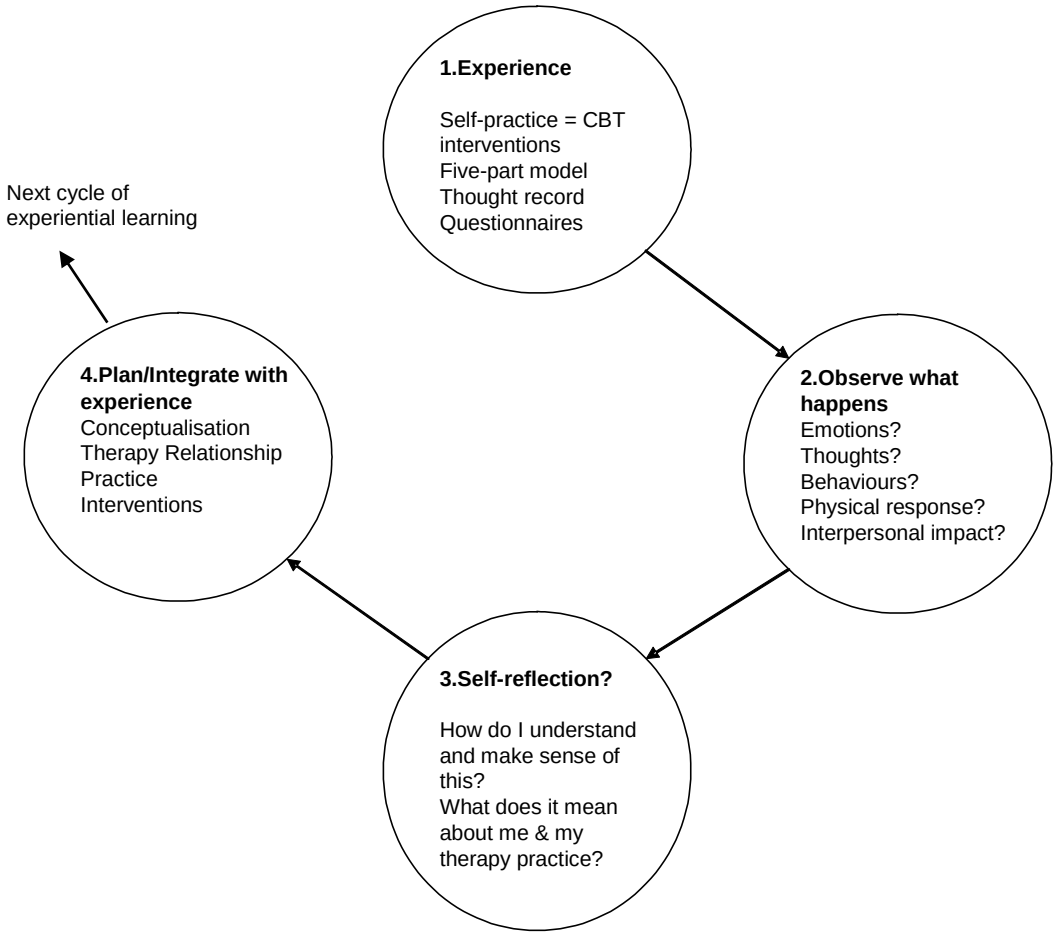


Figure 10. The Kolb experiential learning cycle: Adapted to show the interaction between self-practice/self-reflection and mastering CBT case conceptualisation skills (Kolb model adapted from Bennett-Levy et al., 2004 p 19)

Facilitating the participants' personal understanding of the CBT conceptual model was the stated aim of the manualised self-practice/self-reflection intervention. The

results of the thematic analysis show that the unanimous view of the participants was that it was helpful (in varying degrees) in all the ways described above.

Comparison of quality of CBT conceptualisation pre and post self-practice/self-reflection intervention

The present study went on to ask if there was there any objective evidence to indicate that participants in the intervention group showed an improved quality in CBT case conceptualization post intervention. The findings show that on all the measures of quality the comparison group (not exposed to the intervention) did slightly better on two of the scales. Furthermore, on two out of the three scales the performance of both groups dropped, (very slightly) at the post intervention condition. Inferential analysis confirmed that for the intervention group, a significant difference in quality ratings, in the direction of an improvement, on the Fothergill and Kuyken Quality of Cognitive Therapy rating scale, post intervention. The rating scale, consisted of a single rating, and evaluated only the psychological aspects of the CBT case conceptualization (the other two scales were more general in their capture of relevant information). It could be tentatively argued that increased understanding of the theoretical aspects of the CBT model, reported as a consequence of the self-practice/self-reflection intervention, could have influenced performance on this particular rating scale which required the meaningful integration of core beliefs, underlying assumptions and compensatory behaviours.

No significant differences, post intervention, emerged on the other measures of quality, namely the Comprehensiveness and CBT Conceptualization rating scales. In fact in both groups there was a slight drop in performance post intervention. Both these scales were more comprehensive in the breadth of information targeted and required participants to develop a problem list, record a diagnosis, and in the case of the CBT Case Conceptualisation rating scale, develop a treatment plan. The

Comprehensiveness rating scale also required an inclusion of socio-cultural and biological mechanisms. Consideration of the therapeutic relationship, therapy interfering behaviours and protective factors was also rated in both scales. Omissions in these aspects of relevant information have been extensively discussed in the first section of the discussion, and were prominent in both the intervention and comparison groups. There was no significant difference on any of the rating scales, post intervention, in favour of the intervention group, when the two groups were compared.

Implications for training: the self-practice/self-reflection workbook

It could be tentatively concluded, on the basis of the subjective and objective data, that the self-practice/self-reflection workbook utilized in the present study consolidated, and in some instances enhanced, participants' theoretical understanding of the fundamental building blocks of the CBT conceptual model (the integration of core beliefs, underlying assumptions, and compensatory behaviours, with significant childhood data). However, as far as socio-cultural and biological factors, aspects of the therapeutic relationship applicable to the conceptualization, protective factors, diagnosis, and the development of a relevant problem list were concerned, there is no objective evidence to suggest that the intervention made an impact. Subjectively participants reported that their view of the therapeutic relationship had been influenced by the self-practice/self-reflection experience, but this did not translate to an improved attention to this aspect of the conceptualization post intervention. As previously discussed these conceptual omissions have been observed in previous studies suggesting that training programs should pay more attention to these important dimensions.

A number of recommendations for training have already been presented in the preceding section of this discussion which dealt with the omissions in the content of the CBT conceptualizations produced for the combined group. Turning to the workbook, as offering an experiential approach to learning which could supplement the more traditional didactic approach, a number of adaptations are suggested by the findings in this research.

Adapting the workbook

First, the requirements for a comprehensive case conceptualization could be clearly spelled out as an introduction to the workbook. A checklist could be provided to encourage trainees to actively consider the personal relevance of each category of information. For example "What personal protective factors might help you to address this problem?", and "What personal factors might interfere with your tackling this issue?" How do you plan to integrate these discoveries in your CBT conceptualizations with clients?"

Second, the expanded Five-Part model, (see Figure six) could be included to encourage trainees to think about their identified problem in a more comprehensive manner, considering the impact of culture, spiritual beliefs, and biology/genetics on the identified problem. Questions targeting these aspects could also be included in the questions guiding self-reflection. Similarly personal underlying assumptions and resultant compensatory behaviours could be considered from a more overtly socio-cultural perspective, for example personal attitudes to relationships, work and so forth.

Third, some of the culturally orientated questionnaires previously discussed could be included in the workbook, and questions targeting development and "life-stage" could be posed as self-reflective questions. This could be linked back into the CBT model to consider if these factors impact on cognition and behaviour (the effect of menopause or pregnancy for example).

Fourthly, as far as the therapeutic relationship is concerned, the Therapist Schema questionnaire (Leahy, 2001) could be included and reflected upon. Client scenarios provided and questions asked about personal reactions as conceptualized within the CBT model.

Finally, in the present study the workbook was completed in physical isolation, and was not integrated into the actual training program or ongoing supervision. Although only one participant commented directly on this fact, I believe the potential utility of self-practice/self-reflection could be more fully actualized as part of training and supervision if a dialogue concerning the experience could take place. This would be very useful for all aspects of the process, but particularly for those aspects of information consistently omitted, such as the socio-cultural perspective. In a group situation, particularly in the New Zealand training context there is ample opportunity to reflect personally and with the group, on both bicultural, multicultural and lifespan development. The composition of groups of trainees completing the post graduate diploma are very diverse professionally , culturally, and chronologically and this is a feature of all programs following the Vail scholar/professional model, the model of choice in most CBT specialist programs. The workbook is designed to be integrated as part of ongoing training

where personal insights and difficulties can be constructively discussed, addressed and integrated with professional practice.

It is beyond the scope of this thesis to fully articulate all the possible adaptations which could be made to the current format of the workbook intervention and this will be a focus for future research.

Limitations and future directions

Sample size

As with many clinical studies, the number of suitable participants available to take part in the present study was limited. An important requirement was that all participants had been exposed to similar training experiences. When the study was initiated in 2004, the Post Graduate Diploma in CBT had only been in existence for four years. At this time, there were a total of 38 suitable potential participants, 28 at the beginning of 2004, with an additional ten participants becoming available at the end of the same year (bringing the total to 38). Of this group 26 agreed to take part in the study resulting in a very small convenience sample. The second part of the study required two groups and the original group was divided into two smaller, unequal groups (an intervention group, n =16, and a comparison group n = 10). Time constraints prevented randomly assignment of participants to one or other group (the intervention group was recruited at the beginning of 2004, whilst the comparison group started their participation at the end of the same year), therefore although very similar, the comparison group was more homogenous, all the participants having completed the diploma in 2004. In addition, exposure to the coursework had been more recent and it was therefore likely that their theoretical knowledge base was superior to the intervention group at the

beginning of the study. This speculation is supported by the results of the case conceptualisation evaluation, showing, that on two of the measures of quality, (the CBT Case Conceptualisation and the Fothergill and Kuyken Quality of Cognitive Therapy rating scales) the comparison groups' performance was superior, pre and post intervention. The participants in the intervention group were drawn from all of the previous years that the post graduate diploma had been in existence (2000-2004), consequently individual participants would have had differing learning experiences, and, for some, the exposure to the CBT model was quite distant. Conclusions drawn from the inferential analysis are, obviously, compromised by all these factors. The study would have benefited from a larger more homogenous sample of participants, randomly assigned to two numerically equal groups.

In future research, it would be useful to systematically evaluate the content and quality of case conceptualisation in a in a larger, more diverse group of mental health practitioners in New Zealand. Previous American studies, (Eells et al., 1998; Eells et al.,2003; Eells et al., 2005) investigated, the content and quality of case conceptualisations produced by a large variety of mental health practitioners, with different professional backgrounds. Findings reported in the present study, which are limited to a small sample of novice CBT clinicians, all of whom had been exposed to very similar training experience, are consistent with previous studies showing a lack of attention to the therapeutic relationship, socio-cultural, biological, and protective factors. Evaluating case conceptualisation in a larger more diverse sample would confirm whether similar trends were also observable in the wider New Zealand context.

The case vignette

It has been noted (chapter five), that the case vignette, as a method to elicit the case conceptualisations, was a somewhat distant and not directly comparable to an interview or therapy session with a "real-life" client. As previously discussed, there was both a precedent, (previous studies) and good reasons for choosing the case vignette as an elicitation method (control of information important in an exercise of comparison such as the present research design). Never-the-less the method is a somewhat abstract, and does not allow for the nuances of working with the conceptual aspects of the therapeutic relationship to become as apparent as they might in an actual encounter, requiring the clinician to reflect in purely theoretical manner on these aspects. Clinical information gathered as a consequence of therapist's emotional reaction, so important in understanding the nuances of the therapeutic relationship is absent. Future studies, considering the interaction between self-practice/self-reflection on specific competencies, such as case conceptualisation, would benefit from a more direct and realistic portrayal of clinical information.

The case vignette could be replaced with a more realistic means for eliciting the case conceptualisation, such as a digitally recorded interview with a client which could potentially cue the participant to take cognizance of the areas of omission listed above. It would be interesting to see if this were the case or whether these aspects continue to receive less attention, or conversely, if the psychological aspects of the case conceptualisation become subsumed under other factors, when the physical reality of the client was involved. Using a larger range of recorded client examples (in the present study all the examples were women) would also provide participants with more opportunity to reflect upon the impact of a greater variety of clinically relevant information.

The self-practice/self-reflection workbook: Understanding Myself

Although feedback from participants was universally positive concerning the benefits of completing the workbook, in hindsight, the research expectations were very high, regarding first, the amount of time participants were required to commit to the project and, second the amount of emotional energy that had to be expended in an unsupported context. An impression gained was that by the time the participants were required to complete the post intervention case vignettes, many had simply "run out of steam" in terms of the amount of intellectual and emotional energy required, and this may have compromised their post intervention performance. This is supported by the findings which show a consistent post intervention performance dip, in both groups, for two of the rating scales). Conversely, the initial enthusiasm participants may have felt at the beginning of the study, particularly those in the comparison group who had just completed the diploma, may have led to enhanced performance in the pre intervention conceptualisations.

As discussed previously, under "adaptations to the workbook", using the workbook in the context of a training program would be more a more useful learning experience. This would apply particularly, to trainees experiencing difficulties such as those reported by participant one, who "got lost" and could find no relevance in some of the exercises. In cases such as this one could speculate, the in addition to conceptual confusion, psychological processes, such as emotional avoidance could have been a contributing factor. In this example, it is very likely that this participant would have benefited from support.

Conclusions

This study, the first of its kind in New Zealand, systematically evaluated the content and quality of CBT case conceptualisations of novice CBT clinicians all of whom had completed the requirements of the Massey University PGDipCBT.

Overall, repeated assessment of the content and quality of CBT case conceptualizations, over time, shows consistency in the aspects of clinical information emphasized, or ignored. Most emphasis was given to predisposing factors and psychological mechanisms, however, participants failed to pay attention to socio-cultural and biological mechanisms, protective factors, and the conceptually relevant aspects of the therapeutic relationship.

When the quality of the case conceptualisations was assessed most participants were able to produce a "good enough" CBT case conceptualisation, which provided a meaningful explanation for the presenting problems, in cognitive behavioural terms. However the problem list was not well developed, and the hypothesis and treatment plan failed to take cognisance of predictions about the nature of the therapeutic relationship as an important variable in the individualised case conceptualisation. This part of the study provides guidelines for the systematic assessment of CBT case conceptualisations and information regarding subcategories of information, such as the therapeutic relationship, socio-cultural, biological, and protective factors which require greater emphasis in training.

The second part of the study evaluated the impact of a self-practice/self-reflection training intervention designed to enhance case conceptualisations. Subjectively

participants found the intervention to be helpful in a number of ways relevant to their clinical practice of CBT. Although the quality of the intervention groups' case conceptualisations improved post intervention, on one of the quality measures, objective evidence on the other two more comprehensive quality measures did not however confirm that the self-practice/self-reflection intervention had a significant impact on the CBT case conceptualisation competency of the participants.

In conclusion, the findings of this study signal the importance of identifying and evaluating key psychotherapeutic competencies in a systematic manner. Core competencies, such as case conceptualisation and the ability to understand and use the therapeutic relationship in a conceptually consistent manner, are quite general in their scope and, are often not taught or evaluated in a consistent manner, despite the enthusiastic lip service paid to their importance. This research offers a way forward, by introducing the CBT case conceptualisation rating scale as an assessment measure which allows trainees to pinpoint strengths and weaknesses and progress accordingly. In addition, the self-practice self-reflection workbook as an adjunct or supplement to training and supervision could be used to develop a variety of different competencies beyond case conceptualisation, uniting some of the benefits of traditional personal therapy and experiential learning, with the more pragmatic and empirical orientation of CBT.

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