

Disorder specific and trans-diagnostic case conceptualisation

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ARTICLE INFO

Article history:

Received 10 February 2010

Accepted 22 July 2010

Available online 4 August 2010

Keywords:

Case conceptualization

Case formulation

Cognitive therapy

Cognitive-behavioural therapy

Trans-diagnostic

Resilience

ABSTRACT

Case conceptualisation is the process of integrating the unique experience of the individual with psychological theory and is often described as a central process in effective therapy. Hence, a key question facing a clinician working from a cognitive behavioural perspective is which theory should be chosen as the basis of the conceptualisation with a particular client? We address this question by first considering the strengths and limitations of the disorder specific and trans-diagnostic approaches. From this, the differences between the approaches are framed as a conundrum or puzzle that is solved through a principle based approach to case conceptualisation that allows clinicians to individualise therapy by selecting and incorporating the most appropriate theory and research. Furthermore, by considering how to achieve lasting improvement for the client we emphasise incorporating client strengths and resilience into both disorder specific and trans-diagnostic approaches. To achieve this we necessarily extend beyond consideration of models of disorders, and draw on models of wellbeing, and resilience, and by doing so require theoretical accounts not only of disorders but also of resilience.

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Case conceptualization is a means of individualizing Cognitive Behavioural Therapy (CBT) practice by helping describe and explain clients' presentations in terms of psychological theory in a way that is coherent, meaningful and leads to effective interventions (Butler, 1998; Dudley & Kuyken, 2006; Eells, 2007; Tarrier & Calam, 2002). For this reason, case conceptualization¹ has been described as "central to

the process of therapy as it is the lynchpin that holds theory and practice of therapy together" (Butler, 1998, page 1). This view of conceptualisation emphasises that it is based on a psychological theory or model. Of course, this then begs the question of which models clinicians should draw on.

Consider this question in relation to the case of Martha² (age 21), who lives at home with her parents and is currently unemployed. Her

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¹ We use the terms "case conceptualization," but regard this as synonymous with the term "case formulation."

² Martha is a fictional case, but an amalgam of a number of cases we have worked with over the years. Martha is used here to help illustrate some of the key issues of disorder specific or trans-diagnostic and trans-theoretical approaches.

presenting issues include obsessional checking, worries about her appearance, anxiety about her relationship with her partner, and very low mood. Martha traced the onset of her difficulties to when she was 13 years old. Around this time she was interested in developing a relationship with a boy, but he playfully teased her that he would not go out with her as she had freckles. Actually, she had a clear complexion, but other people started to call her “freckles” as it was known that it caused her to blush and become upset. From this time onwards she had been plagued with worries that she had acquired freckles even by being around people who had this characteristic. This concern about her appearance led to her stopping attending school for long periods of time. Also, she was vigilant for freckles and repeatedly checked her skin for signs of freckles or blemishes. In addition, she regularly used facial products to keep her skin clean, and used sun-screen daily in order to reduce the chance of the sun causing freckles. Despite these efforts she continued to feel at risk of acquiring freckles from every day contact with other people who may have this characteristic.

When describing her current difficulties Martha was worried that her concerns about her appearance, and low mood would result in her losing her relationship with partner, Brett. She described a common pattern whereby she spent a long time getting ready in the morning, making a great effort with her appearance. During this process she would often notice her skin looked different, or she noticed a blemish or feature on her skin she had not seen before. This led to her checking in the mirror for long periods of time, and feeling unattractive. She would be concerned that Brett would not want to be with her. She would ask him if he found her attractive. He would state she looked fine and he found her attractive. Whilst she felt better in the short term, soon the concerns would resurface which led her to doubt if she could entirely trust what Brett said. Owing to this doubt, she was repeatedly checking his mobile phone for evidence of relationships with other women, seeking reassurance from him that he cared for her, as well as that he thought her skin was not freckled, and that he thought she was attractive. Martha recognised that this led to Brett becoming angry sometimes, which led to arguments between them that then made her think he did not want to be with her, which in turn lowered her mood. When low in her mood, she withdraws from other people, ruminates on why she is not like other people, and becomes more preoccupied with her appearance.

Martha's history indicated that she was an only child. Martha's parents had to work long hours in order to provide for their daughter. Her father regularly worked away from home. When Martha was in primary school her mother also took a job away from home for a period of six months, which meant Martha lived with her grandmother, with whom she was very close. However, her grandmother was quite frail, and she described how even at this young age she had to take responsibility for looking after the house, and making sure it was locked up and safe at night. Even when she returned home to live with her mother, Martha found herself still checking doors, taps and switches before leaving the house as she found it reassuring to know everything was in the right place and safe.

Martha understood that her mother and father had to work but reported feeling that it made her feel second best or somewhat unloved whilst growing up. Throughout childhood Martha saw studying and music as a refuge, and she described enjoying time with a group of friends who shared her love of music. However, Martha missed a considerable amount of school owing to her worries about her appearance and left without formal qualifications. She maintained some friendships with people from school, but mainly via social websites and texting, rather than through face-to-face contact. Later, Martha tried to study at a local college where she met Brett, but dropped out quite quickly as she was concerned about her appearance and her checking symptoms also spiralled out of control.

She had not asked for professional help with these difficulties, preferring to try and cope on her own, but over the last year or so she

developed very low mood and eventually she decided to seek help. She traced the onset of this particular episode of low mood to a number of recent stressors including that Brett had talked about going to College at a town some 150 miles away. She had seen her GP and asked about having cosmetic surgery to improve her appearance. However, during the consultation Martha described how for around a year she had felt very low, and lacked energy and motivation and saw herself as ugly, unlovable, useless and as a failure. Owing to this presentation she was diagnosed with Depression, and prescribed an antidepressant. She was referred for CBT with the GP wondering whether she was also suffering with Body Dysmorphic Disorder (BDD).

Given this history and presentation a therapist working with Martha has a number of questions to address. First, given Martha's presenting issues, what should be the primary focus of therapy? Second, how do Martha's presenting issues relate to one another, if at all? Third, given the range of presenting issues she brings what CBT protocols are relevant here? Finally, it is important to consider what is the goal of the therapy? Is alleviation of her symptomatic distress sufficient or is it important to support Martha in engaging in meaningful and rewarding activities that promote a sense of wellbeing, and even to include a goal of helping promote more successful functioning in the future?

For many clinicians the answer to such questions is that “it depends upon the case conceptualisation”. Therefore, a key issue is whether a disorder specific or trans-diagnostic model is chosen as the basis of the conceptualisation.

This paper describes a principle driven model for case conceptualization for CBT that helps a clinician optimally select an appropriate model, and then utilise both disorder specific and trans-diagnostic approaches in order to address the needs of the person they are working with. To this end, we first briefly consider the strengths and limitations of the disorder specific approach in comparison to the trans-diagnostic approach and illustrate some of these using Martha as a case example. From this we highlight some of the tensions between the two positions. These tensions are framed as a conundrum for a clinician who has to select a model that will be most useful to the client. Then we describe a new approach to case conceptualization which we define, and that uses the metaphor of a case conceptualization crucible in which a client's particular history and presentation is synthesized with theory and research to produce a description and understanding of clients' presenting issues that can be used to inform therapy. We use these principles to illustrate how they allow the optimal selection of disorder specific and trans-diagnostic approaches. Once a model is selected, the principles are utilised to create a coherent, meaningful, shared conceptualisation that serves to understand the presenting issues, and optimally select high value interventions. By this process we aim to enable readers to draw on the strengths of both the disorder specific evidence base, and that of the trans-diagnostic approach to help alleviate client distress. Finally, by considering how to achieve lasting improvement for the client we emphasise incorporating client strengths and resilience. To achieve this we necessarily extend beyond consideration of models of disorders, and draw on models of wellbeing, and resilience and by doing so develop trans-theoretical conceptualisations that incorporate broader theories and approaches than are currently considered within CBT.

1. Disorder specific models

The development of CBT has been characterised by the careful observation of specific disorders (i.e. depression; Beck, Rush, Shaw, & Emery, 1979; anxiety disorders; Clark & Beck, 2009; Wells, 1996; the personality disorders; Beck, Freeman, Davis, & Associates, 2003; schizophrenia; Beck, Rector, Stolar, & Grant, 2008; Bentall, 2003 and substance misuse disorders: Beck, Wright, Newman, & Liese, 1993).

Close consideration of these diagnostic groupings has drawn attention to potentially important cognitive and behavioural processes that are presumed to distinguish one disorder from another. These unique differences are empirically tested between people with the disorder and those without (commonly healthy and psychiatric control groups) and the differences targeted with specific interventions (Salkovskis, 1996; Wells, 1996) the value of which are evaluated using manualised treatments in Randomised Controlled Trials (RCTs).

Based on these disorders specific approaches, CBT has established an evidence base for a range of psychological and emotional difficulties (Beck, 2005a; Butler, Chapman, Forman, & Beck, 2006; Stewart & Chambless, 2009). CBT therapists use the process of conceptualization to adapt these manualised disorder-specific models and treatments and incorporate client specific information (for examples, see chapters in Tarrier, 2006) and direct treatment with real world impact, equivalent to that seen in RCTs (Ghaderi, 2006; Persons, Roberts, Zalecki, & Brechwald, 2006; Strauman et al., 2006).

2. Limitations of the disorder specific approach

However, a disorder specific diagnostic based approach faces a number of key challenges. First, diagnoses can be quite limited in their application to the individual (Persons, 1986). Notwithstanding the issues about reliability of diagnoses (Bentall, Jackson, & Pilgrim, 1988; Bentall, 2009), it is important to recognise that diagnosis and conceptualisation serve different functions (Kuyken, Padesky, & Dudley, 2008). Diagnosis draws attention to commonalities between presentations, whereas conceptualisation aims to understand and guide intervention at the level of the case (usually the individual³). For example, Martha meets criteria for Major Depressive Disorder but we are less certain as to the specific way in which it is manifested. For one person, depression may reveal itself as a loss of motivation, appetite and drive, whereas for another it may be characterised mainly by pessimistic and negative cognitions (Beck et al., 1979). Such differences in presentation may lead to different psychological conceptualisations and treatments for two people with the same diagnosis.

A related issue is that not all disorder specific approaches have a robust evidence base. In fact, there is a spectrum of evidence from the mood and anxiety disorders for which there are many RCTs and consistent evidence of moderate to large effects of treatment (Butler et al., 2006; Stewart & Chambless, 2009) to those with fewer studies and smaller effect sizes (e.g., personality disorder; Davidson et al., 2006; or psychosis; Wykes, Steel, Everitt, & Tarrier, 2008). In effect, not all disorder specific approaches have the same empirical support. Hence, in such situations we are faced with having to draw on a more limited evidence base both for the specific features of the model, and for its value in treatment (Turkington, Dudley, Warman, & Beck, 2004). In Martha's case the evidence base for CBT is strong for depression (Butler et al., 2006), and Obsessive Compulsive Disorder (OCD; Stewart & Chambless, 2009), but less so for BDD (Veale, 2001) and would be less supportive still if Martha's presenting issues occurred in the context of severe physical health problems, or characterological difficulties.

Despite the success of CBT, it is still the case that there are a considerable number of people who do not respond to disorder specific manualised treatments (Barlow, 2002). This implies that, at present, our models and associated targeted treatments are not able to fully account for all aspects of the presenting issues, particularly where the evidence base is less robust (Bentall et al., 2009; Oei & Boschen, 2009). Moreover, it must be borne in mind that many of the diagnostic frameworks do not provide complete descriptions of a disorder, as there is often a need to utilise not otherwise specified (NOS) categories (Zimmerman, McDermut, & Mattia, 2000). This may mean that clinicians may have to try and

help someone with an unusual presentation of an emotional disorder in the absence of a robust evidence base. In Martha's example it may be difficult to disentangle whether her concern about acquiring freckles from people with this characteristic is best understood as a form of BDD, a specific Phobia, a form of OCD or even as a delusional disorder. Good assessment and diagnosis is an important part of this process, but it may well result in her being diagnosed under the NOS category of one or more of these categories.

An additional challenge is that the majority of psychotherapy outpatients meet criteria for more than one disorder (Brown, Antony, & Barlow, 1995; Brown, Campbell, Lehman, Grisham, & Mancill, 2001). Co-morbidity is the norm rather than the exception. Consequently, there is an absence of evidence based treatments that address each and every combination of co-morbid presentations even in a well researched field such as the mood disorders (Whisman, 2008). This raises the issue of where to start with someone and also whether there may be common lynchpin processes across co-morbid disorders (Barlow, 2002) which if targeted may produce change in several presenting issues. As we can see with Martha there are potentially two or three disorder specific models (OCD, Depression, and BDD) that may well be suitable to utilise. Are they utilised sequentially, or can common processes be identified across these disorders?

Of course, diagnostic systems have been criticised for encompassing more and more of every day human experience under the umbrella of mental health problems (Bentall, 2009). Nevertheless, it is also the case that clinicians may be asked to help people in distress in the absence of established disorder specific evidence base, simply because the presentation is not recognised within existing diagnostic frameworks. Consider for example the efforts to offer early intervention services (Edwards, & McGorry, 2002). Here treatments may be targeted at people who are distressed and seen as at risk of transition to a problem such as depression (Allen, Hetrick, Simmons, & Hickie, 2007) or psychosis (French & Morrison, 2004; Morrison, Bentall, French et al., 2002) but who's presenting issues fall outside of existing diagnostic systems. In Martha's example, if she had presented as a child with emergent obsessions and compulsions she may not have met criteria for OCD and may not likely have been offered an appropriate treatment. However, the benefit of helping her at this early stage is unknown but potentially extremely valuable (Thienemann, Martin, Cregger, Thompson, & Dyer-Friedman, 2001).

Second, whilst there is evidence for the effectiveness of CBT for some disorders, it is not consistently demonstrated that CBT targets and changes the key features described in the disorder specific models. It is assumed that targeting these processes leads to more effective, and more efficient improvement. This is the cognitive mediation hypothesis. It is important to note that the evidence for the cognitive mediation hypothesis is not as strong as would be desired (Hollon & DeRubeis, 2009). In fact, it is not well established that the disorder specific processes are the ones effectively targeted and changed in treatment across all emotional disorders (DeRubeis, Brotman, & Gibbons, 2005). So we cannot know that the changes that occur in disorder specific CBT are a result of change in the key targeted processes as opposed to some of the other changes that arise from another process such as the development of a valued therapeutic alliance. In part, this may arise owing to the confusion between the perceived effectiveness of CBT, with the evidence of the cognitive mediation hypothesis. To date, CBT has been shown to be effective in treating a range of emotional disorders but the evidence across disorders is not equivalent. For instance, exposure and response prevention for OCD (Fals-Stewart, Marks, & Schafer, 1993) and CBT for panic disorder (Clark, 1986) have shown that they are more effective than a plausible alternative psychotherapy. This implies that the treatment developers have considered the presentations particularly well, and devised interventions that address key features of these disorders more effectively than treatments that rely on change via non-theoretically relevant features such as alliance (DeRubeis,

³ We illustrate these principles in relation to an individual but acknowledge their applicability to working with couples, groups, families, and systems.

Brotman & Gibbons, 2005). With other disorders, such as depression there is a robust evidence base for the effectiveness of CBT, but not one that shows a particular advantage over other psychological therapies such as Interpersonal Psychotherapy (Cuipers, van Straten, & Warmerdam, 2007; Elkin, Parloff, Hadley et al., 1985; Elkin, Shea, Watkins et al., 1989; Luty et al., 2007) and in some cases may be less effective than other treatments such as behavioural activation (Jacobson et al., 1996). Here, it may be harder to argue that CBT targets and changes key cognitive and behavioural processes which is the basis for the disorder specific approach (Hollon & DeRubeis, 2009), or it may be that CBT does address these key issues but not in a way that leads to improvements in outcome. Of course, demonstration that CBT is more efficacious than another psychological approach in itself would not provide compelling evidence in support of the cognitive mediation hypothesis. Ideally, greater efficacy would be associated with greater change in key cognitive and behavioural processes that are understood to mediate treatment gains (Emsley & Dunn, 2010).

Hence, it is difficult to argue that it is necessary to target the key cognitive and behavioural processes described in CBT based disorder specific approaches as they do not always bring advantages to the person receiving the treatment. A corollary of this is that the effects of CBT apparently generalise to non-treated disorders implying it may be acting on trans-diagnostic processes (Tsao, Lewin, & Craske, 1998; Tsao, Mystkowski, Zucker, & Craske, 2002; Dudley, Dixon, & Turkington, 2005).

Third, whilst disorder specific models emphasise the differences between the disorders, treatment manuals are often strikingly similar. Understandably, they all emphasise assessment, engagement in a therapeutic relationship, but they also commonly describe socialisation to the model, development of a conceptualization, identifying and recognising thoughts and behaviours, behavioural methods to overcome avoidance and inactivity, cognitive restructuring, behavioural experiments to test ideas and assumptions and relapse prevention work. Such interventions can be common across a range of difficulties (Bennett-Levy et al., 2004; Padesky & Greenberger, 1995; Wells, 1996). Hence, whilst the model may be unique there is often commonality in the treatment approaches. For Martha, receiving treatment for mood disorder, BDD, and OCD would involve considerable repetition if each approach were undertaken sequentially (Wilson, 1997).

3. Transdiagnostic approaches

Owing to the limitations of the disorder specific approach an alternative (potentially compatible) view has emerged in which shared cognitive and behavioural processes across disorders are emphasised (Harvey, Watkins, Mansell, & Shafran, 2004; Mansell, Harvey, Watkins, & Shafran, 2008). People with emotional disorders tend to report higher levels of neuroticism, negative affect, and lower positive affect. Moreover, processes like self focussed attention (Ingram, 1990; Woodruff-Borden, Brothers, & Lister, 2001), attention to external threat (Weierich, Treat, & Hollingworth, 2008), intolerance of uncertainty (Dugas, Gagnon, Ladouceur, & Freeston, 1998; Dugas & Ladouceur, 2000) are commonly increased in people with a range of psychological difficulties. Also, how people respond to their distress can be similar, with people engaging in unhelpful repetitive negative thinking whereby they may ruminate and brood (Ehring & Watkins, 2008; Nolen-Hoeksema, 2000) or worry (Borkovec, Ray, & Stober, 1998) or try to suppress their thoughts (Markowitz & Purdon, 2008; Purdon, Rowa, & Antony, 2005). In addition, across a range of psychological difficulties people are seen to engage in avoidance and safety seeking behaviour in order to reduce or prevent anxiety (Salkovskis, 1991; 1996). In these trans-diagnostic accounts the specific content or focus of concern may differ across disorders, and individuals, but the processes are understood to be similar.

The trans-diagnostic approach then suggests that there is value in understanding and treating these common factors across disorders (Barlow, Allen, & Choate, 2004). This would be an approach that would certainly help address some of the problems Martha faces, whereby she is prone to scan for threats (be they; freckles, perceived blemishes, that her features are not symmetrical or possible signs that her partner is unfaithful). Also, she struggles with coping with the uncertainty of not knowing whether her partner will always be with her, or whether she can prevent acquiring freckles. She also spends a great deal of time dwelling, ruminating about her worth as a person and relies on avoidance particularly of social situations to help reduce her distress. These commonalities across disorders could well be an early target for change particularly when dealing with co-morbid presentations (Persons, 1989).

4. Limitations of the trans-diagnostic approach

Whilst there are a number of arguments for a trans-diagnostic approach the acid test is whether this approach helps clients address their presenting issues, move towards their therapy goals and resolve emotional disorders. Whilst there is robust evidence for trans-diagnostic processes such as vigilance or the use of avoidance, the evidence for trans-diagnostic treatments is at present quite limited (McEvoy & Nathan, 2007; Norton, 2008; Norton, Hayes, & Hope, 2004; Norton, Hayes, & Springer, 2008; Norton et al., 2004; Norton & Philipp, 2008). In the studies to date it is not clear from the evaluations whether it is trans-diagnostic aspects of the treatment that are the key component of change, or perhaps some other aspects that may be common to all psychological therapies (DeRubeis et al., 2005; Stiles, Barkham, Mellor-Clark, & Connell, 2008). Hence, the trans-diagnostic models need to demonstrate they have additional value to disorder specific models particularly in addressing some of the instances in which disorder specific models are lacking.

5. Conceptualising disorder specific or trans-diagnostic processes

From this brief overview of the strengths and limitations of both the disorder specific and trans-diagnostic approaches it is evident that both approaches have value. In the original understanding of conceptualisation it emphasised that it is a shared understanding based on a psychological model. However, we return to the question of which model or approach to choose?

At this point in time we simply do not know how clinicians reconcile the desire to utilise evidence based disorder specific models, as would be recommended by bodies such as the National Institute for Health and Clinical Excellence, with the often co-morbid presentations and complexity that their clients bring. It is possible that they draw on generic CBT conceptualisation models (Beck, 1995; 2005b; Padesky & Greenberger, 1995). Alternatively, clinicians may draw on models that are developed from consideration of cognitive science that attempt to provide broad (trans-diagnostic) theoretical accounts of cognitive and emotional processing such as the Interacting cognitive subsystems model (Barnard & Teasdale, 1991) or Self Regulatory Executive Function model (S-REF (Wells & Matthews, 1996)). Whilst these latter approaches have a strong empirical foundation they have not yet been routinely translated into clinical practice (i.e. Gumley, White, & Power, 1999; Solem, Myers, Fisher, Vogel, & Wells, 2010; Wells, 2008; Wells et al., 2010). So, a key challenge for clinicians is in the selection of an appropriate model for their client.

Of course, regardless of the exact model chosen a second challenge is to develop with the person a shared, acceptable, and viable conceptualization in which there is an agreement of the linkage between elements of the model that explains the persistence of the distress. This in turn provides a rationale for breaking these cycles with an appropriate intervention.

Regardless of whether a disorder specific or trans-diagnostic model is selected, it is still necessary to map trans-diagnostic features to those specifically relevant to the particular individual. The devil is in the detail and it is generally the case that the disorder specific models very quickly direct us to these key details.

We now consider how a principle based approach to conceptualisation can help the clinician both select an appropriate model on which to base the conceptualisation and develop this with the client.

6. A new approach to case conceptualisation

We define CBT case conceptualization as a process whereby therapist and client work collaboratively to draw on a CBT theory to first describe and then explain the issues a client presents in therapy. Its primary function is to guide therapy in order to relieve client distress and build client resilience.

Kuyken, Padesky, and Dudley (2008; 2009) use the metaphor of a crucible to emphasize several aspects of our definition. A crucible is a strong container for combining different substances so that they are synthesised into something new. Typically heating the crucible facilitates the process of change. The case conceptualization process is like that in a crucible as it synthesizes a person's presenting issues and experiences with CBT theory and research to form a new understanding, original and unique to the client. CBT theory and research are key ingredients in the crucible. It is this integration of empirical knowledge that differentiates case conceptualization from the natural processes of deriving meaning from experience in which people engage all the time (Frankl, 1960).

The crucible metaphor further illustrates three defining principles of case conceptualization that are shown in Fig. 1. First, heat drives chemical reactions in a crucible. In our model, collaborative empiricism generates the heat that drives the process of conceptualisation and encourages transformation within the crucible. The perspectives of therapist and client are combined to develop a shared understanding that accounts for the development and persistence of the presenting issues, is acceptable and useful to the client, and informs the selection of therapeutic interventions. Empiricism is a fundamental principle in CBT (Beck, 1995). It refers to the empirical research and relevant theory that underpins therapy as well as to the use of empirical methods within and between therapy appointments. An empirical approach is one in which hypotheses are continually developed based on client experience, theory and research. These hypotheses are tested and then revised based on observations and client feedback.

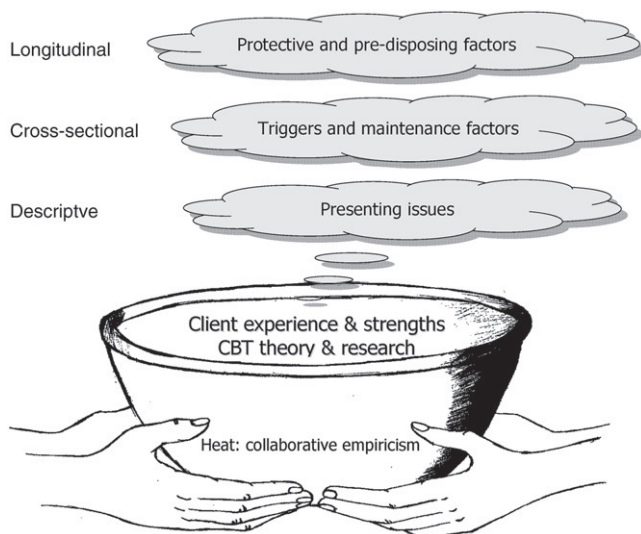


Fig. 1. Case conceptualization crucible [reprinted with permission from Kuyken et al. (2009)].

Second, like the reaction in a crucible, a conceptualization develops over time. Typically conceptualization begins at more descriptive levels (e.g., describing presenting issues in cognitive and behavioural terms), moves to include explanatory models (e.g., a theory-based understanding of how the symptoms are maintained) and, if necessary, develops further to include an historical explanation of how pre-disposing and protective factors played a role in the development of the issues (e.g., incorporating key developmental history into the conceptualization).

Third, the substances formed in the crucible are dependent on the properties of the ingredients placed into it. A client's experiences along with CBT theory and research are vital ingredients in a conceptualization. Within CBT the emphasis has been on client problems and distress. Whilst these are naturally included in our model it also incorporates client strengths at every stage of the conceptualization process. Regardless of their presentation, disorder and history, all clients have strengths that they have used to cope effectively in their lives. Incorporation of client strengths into conceptualizations increases the odds that the outcome will both relieve distress and build client resilience. Consequently, client strengths are part of the crucible's mix.

To recap, our crucible metaphor incorporates three key principles to guide therapists during case conceptualization: levels of conceptualization, collaborative empiricism, and incorporation of client strengths. We illustrate these principles with particular reference to how they help inform the decision as to which model to select and then how to utilise disorder specific and/or trans-diagnostic approaches to optimally help the client.

7. Principle 1. Levels of conceptualization

Preliminary conceptualizations are usually quite descriptive. Therapists assess clients' presenting issues and help the client describe these issues in cognitive and behavioural terms. As described earlier, whilst a diagnosis may direct a clinician to a disorder specific model there is still a challenge in helping understand in what ways the disorder manifests itself for the specific individual. From this initial description goals of treatment are articulated (Padesky & Greenberger, 1995). Martha and her therapist agreed to focus on four goals a) to feel less of a failure and feel less sad, b) to reduce her concern and worries about her appearance, c) to reduce her checking of taps, locks and the oven, and d) to remain well into the future. Martha's greatest distress was associated with the depression symptoms. Thus, Martha and her therapist chose low mood as the initial focus of therapy. Hence, in answer to the first question facing a therapist as to where to begin to help Martha, part of the answer is in the close description of the presenting issues in cognitive and behavioural terms and the generation of a presenting issues list that is collaboratively reviewed and prioritised (see principle two).

In Martha's case she met diagnostic criteria for Major Depressive Disorder, BDD and OCD. Whilst disorder specific approaches exist for these difficulties it is important to work to gradually map the presenting issues on to a model, that may be informed by but not limited to the model. Initially when eliciting a person's presenting issues it is vital to draw on an appropriate model such as a functional analysis (Kohlenberg & Tsai, 1991) a five factor model (Padesky & Greenberger, 1995) or even a version of the vicious flower model (Moorey, 2010) to establish to what extent the person's experiences are compatible with a cognitive behavioural framework. In this way the model is not preselected and the client is not fitted to the model. Rather, the common starting point is to map the terrain of the presenting issues, and develop an initial understanding that is not limited by a specific model but is one that is able to incorporate person specific reported processes, that may not be emphasised in the disorder specific model. Obviously, in some cases this approach will quickly take you to a disorder specific model, particularly where there is not co-morbidity and the model is well supported by research.

However, where there is co-morbidity this development with the client of an understanding encourages the incorporation of trans-diagnostic processes (vigilance, rumination, avoidance and so forth). In Martha's case (Fig. 2), an ABC model helped begin to reveal that the low mood was intimately tied into her appearance concerns and that these two presenting issues may be closely related to each other.

Following initial descriptions of presenting issues, case conceptualizations become more explanatory, identifying triggers and maintenance factors. Here disorder-specific models are typically used and may take the clinician quickly to the key maintaining processes. However, as we have seen with Martha she meets criteria for a number of disorders, and this may encourage a focus on more trans-diagnostic processes. For instance, Martha reported using rumination, checking and avoidance in the context of depression and appearance related worries and these were incorporated into the developing conceptualization. This understanding of how these processes may maintain both her low mood, and appearance concerns then provides a strong rationale for targeting these processes with specific interventions for overcoming avoidance, rumination (Watkins et al., 2007; Wells et al., 2009) or checking (Fals-Stewart et al., 1993). Success in dealing with rumination in the context of depression can then be drawn on in turn to help overcome difficulties with worry about her relationship and future risk of developing freckles (Wells, 2008) owing to the similarities between these processes (Fig. 3).

In middle and later stages of CBT, conceptualizations increasingly draw on theory and inference to explain how predisposing and protective factors contribute to clients' presenting issues. Predisposing factors help explain what led to a client being vulnerable to his or her presenting issues. Each disorder specific model indicates the key beliefs and assumptions that are thought to help account for the particular disorder. Of course, this then helps us address the second question we set ourselves as to how, if at all, the presenting issues were linked. Naturally, it is possible that any co-morbidity is completely coincidental. However, one disorder may be a consequence of the other. For instance, having a problem like OCD for a long time may lead to a reduced social life and difficulties maintaining employment that acts as vulnerability to and precipitant of depression. Where appropriate, a conceptualization may find a common lynchpin process that can account for the development of the co-morbidity. In Martha's case, repeatedly checking her appearance was a way of guarding against being seen as unattractive and being negatively judged by other people. This helped link the concern about appearance (as others would have seen her as unattractive and may tease her), her depression (if I am unattractive then I will be rejected and left by Brett) and her OCD (if things are symmetrical and ordered then I feel okay). At this level of conceptualisation all the interventions converge on helping Martha develop a more accepting view of herself when she notices features that others would not necessarily notice, or take to mean that Martha is unattractive or unloved. Protective factors highlight strengths that can be used to build resilience as described in our third principle below.

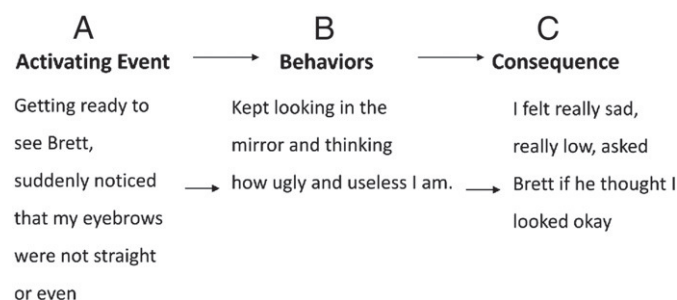


Fig. 2. Descriptive conceptualization for Martha's behaviour.

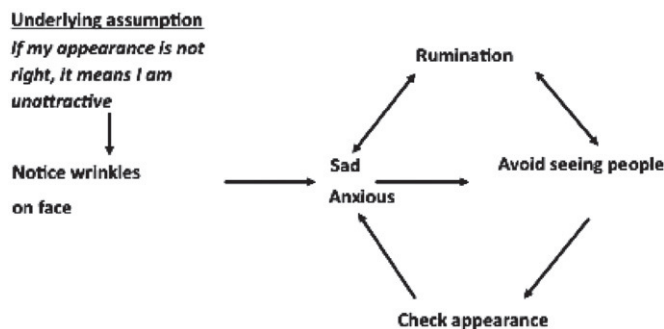


Fig. 3. Preliminary maintenance conceptualization for Martha's behaviour.

8. Principle 2. Collaborative empiricism

Collaboration refers to both therapist and client bringing their respective knowledge and expertise together in the joint task of describing, explaining and helping ameliorate the client's presenting issues. The therapist brings his/her relevant knowledge and skills of CBT theory, research and practice. The client brings his/her in depth knowledge of the presenting issues, relevant background and the factors that he or she feels contribute to vulnerability and resilience.

We argue that when conceptualization is developed and shared in this collaborative manner, clients are more likely to: provide checks and balances to therapist errors, feel ownership of the emerging conceptualization, and thereby have a better understanding of the process of change. As was seen with Martha, by discussing with her where she wanted to begin treatment she identified her depression was the most disabling issue and the one that led her to seek treatment. Collaboration led to an agreed starting point. Agreement on goals is a key process in the development of an effective therapeutic alliance, which is a robust predictor of outcome (Martin, Garske, & Davis, 2000). Of course, the therapist may suggest that it would be advantageous to begin with another presenting issue, perhaps owing to knowledge about the likelihood of achieving success. In such an instance, the evidence for this suggestion may be shared with the client and together the benefits and costs of starting with another presenting issue would be considered. Here the valuable role of empiricism is evident.

Empiricism refers to: (i) making use of relevant CBT theory and research in conceptualizations and (ii) using an empirical approach in therapy which is one based on observation, evaluation of experience, and learning. At the heart of empiricism is a commitment to using the best available theory and research in case conceptualization. Given the substantial evidence base for many disorder-specific CBT approaches we argue that with many clients a relatively straightforward mapping of client experience and theory may be possible. For example, a person presenting with panic attacks in the absence of other issues can normally benefit greatly from jointly mapping these panic experiences onto validated CBT models of panic disorder (Clark, 1986; Craske & Barlow, 2001).

Nonetheless, even when a CBT model is closely matched to a client's presenting issues it is important to collaboratively derive the case conceptualization so the client understands the applicability of the model to his or her issue. When clients experience multiple or more complex presenting issues it is often not possible to map directly to one particular theory and still provide a coherent and comprehensive conceptualization that is acceptable to the client. Here the trans-diagnostic approach can bring particular value. By drawing on processes like rumination, worry, and avoidance for which there is empirical evidence for the processes across disorders, complex presenting issues like those Martha reported can be understood and addressed.

Another aspect of empiricism is the use of an empirical approach to aid clinical decision-making. Therapists and clients develop hypotheses,

devise adequate tests for these hypotheses and then adapt the hypotheses based on feedback from therapy interventions. This makes CBT an active and dynamic process, in which the conceptualization guides and is corrected by feedback from the results of active observations, experimentation and change.

For Martha, the way that this empirical approach is experienced is in the curiosity expressed by the therapist to see if the models of disorders such as depression, or BDD are applicable to Martha's unique experience. The therapist may introduce an element of a model, such as the potential maintaining role of mirror checking (Veale & Riley, 2001) and then encourage Martha to gather evidence of whether this plays a contributory role in her case. The therapist may ask Martha to record over the coming week how often she checks in the mirror and to also record to what extent she is concerned with her appearance. By jointly reviewing the outcome of this homework using Socratic questioning the therapist could establish whether mirror checking has a legitimate role in the emerging conceptualisation of her appearance concerns. Where there is no evidence, it would not be incorporated even if the model emphasised its importance.

Case conceptualization involves integrating large amounts of complex information within the case conceptualization crucible. Moreover, typically as therapy progresses therapists and clients make greater inferences as they develop explanatory conceptualizations using information from the client's developmental history. Where conceptualisations develop to incorporate disorder specific and trans-diagnostic features we propose that collaborative empiricism must be practiced effectively to manage this complexity. It acts as a check and balance on the problematic heuristics that clinicians can understandably resort to when faced with complexity (Kuyken, 2006).

9. Principle 3. Include client strengths and conceptualize resilience

Most current CBT approaches are concerned either exclusively or largely with a client's problems, vulnerabilities and history of adversity. We advocate that therapists should identify and work with client's strengths at every stage of conceptualization. A strength-focused approach helps the alleviation of a client's distress and builds a person's resilience which are the primary purposes of CBT within our case conceptualization model (Kuyken, Padesky, & Dudley, 2008). A strength focus is often more engaging for clients and offers the advantages of harnessing client resilience in the change process to help create the conditions for lasting recovery.

Identifying and working with clients' strengths and resiliency begins at assessment and continues at each level of conceptualization. Strengths can be incorporated at each stage of therapy. For example, goals can be stated as not only as reducing distress (e.g., feel less anxious about my appearance) but increasing strengths or positive values (e.g., be more able to enjoy time with my partner, friends and family) as well. Accordingly, clinicians can routinely ask in early therapy sessions about positive goals and aspirations and add these to the client's presenting issues and goals list. This is not merely a technique designed to encourage engagement as there is an empirical basis for this process. We know that problems like depression and anxiety can be considered in terms of motivational systems (Gray, 1982). People with anxiety are motivated to avoid unpleasant states whereas people with depression may lack clear sense of what they are trying to achieve and lack meaningful goals (Dickson & MacLeod, 2004a,b; 2006). Hence, goals for people with anxious symptoms may need to be phrased not only in terms of reduced distress, but also as an increased ability to feel comfortable in avoided situations. For people with mood difficulties, the aim is similarly not only reduced distress, but engagement in meaningful and valued activities.

Specific discussion of positive areas of a person's life may reveal alternative coping strategies to those used in problem areas. These, presumably more adaptive, coping strategies can be identified as part

of the same process that identifies triggers and maintenance factors for problems. When the therapist and client devise interventions to alter maintaining processes identified in the conceptualisation cycles, the client can practice alternative coping responses drawn from more successful areas of life.

Owing to Martha's low mood she easily overlooks or undervalues the strengths that she can utilise to help her overcome her difficulties. In the early stages of assessment and treatment the therapist purposefully asks about those areas of his life in which she manages more effectively, and even enjoys. Additional questioning of times that Martha manages effectively her low mood, reveals many strengths that Martha can utilise in helping herself feel better. Her close relationship with her partner, and her mother, and grandmother, her thoughtfulness towards her friends from school, and her love of music are all utilised to help interrupt maintenance processes, and to help increase positively valued activities and interests (Dimidjian et al., 2006). These strengths can be used in the emerging formulation as methods to disrupt the maintenance cycle as illustrated in Fig. 4.

As part of the elicitation of strengths and values it is also important to broaden the assessment and enquire about cultural values or identity that can also serve as potential sources of strength. People's values may be based on influences from their faith, sexual orientation, or other cultural, leisure or sporting activities, and can provide valuable resources in helping achieve an understanding of values accounting for the vulnerability for the onset of the difficulties (in Martha's case that women are valued for their attractiveness) as well as providing a resource to help create change. Throughout therapy, client values, longer-term goals and positive qualities can serve as a foundation to build toward long-term recovery and full participation in life.

For Martha rumination, checking and avoidance are understood to be key maintaining factors of her low mood, and her anxiety. However, the content of these processes reveals much about the areas she invests in and is intrinsically linked to her strengths and her values. A person's values can be understood as beliefs about what is most important in life. These beliefs are typically relatively enduring across situations and shape a person's choices and behaviours. Incorporating values into conceptualizations as part of client's belief system enables us to better understand clients' reactions across different situations. People worry about work, family, attractiveness or health owing to their high value (Wrosch, Scheier, Miller, Schultz, & Carver, 2003). Martha is worried about losing her relationship as it represents an important domain and one in which she is heavily invested (Barton, Armstrong, Freeston, & Twaddle, 2008) in part

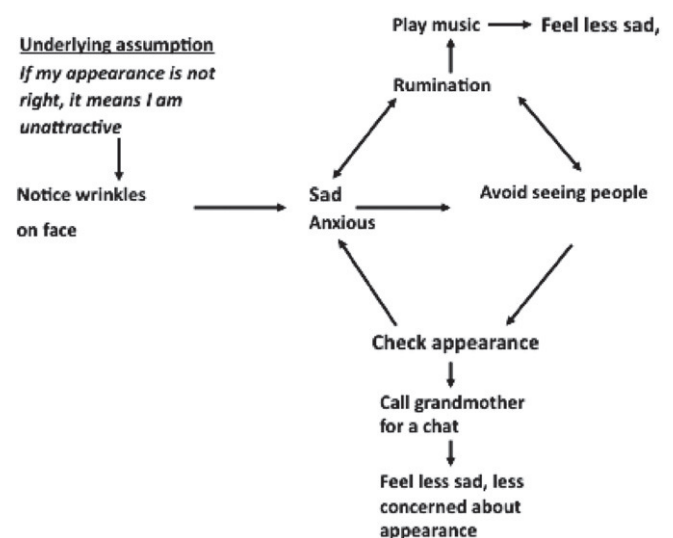


Fig. 4. Disruption of maintenance cycle by addition of strengths to the conceptualization.

owing to the difficulties she experienced in her mixing with other people during her schooling.

Discussion of the events leading to the person seeking help often reveals a person trying to achieve important and valued goals, by utilising previously helpful strategies (in Martha's case her efforts to make herself look attractive, and her thoughtfulness as demonstrated by her taking care of her grandmother at an early stage) to an excessive degree (becoming vigilant and checking) and/or in the context of too many additional demands (Nuechterlein & Dawson, 1984) meaning they are not able to maintain the same level of functioning. For Martha a key trigger was the potential threat to her relationship when Brett was considering going away to study. This precipitated low mood, and anxiety about her appearance that led to her checking her appearance more and more, and then seeking cosmetic surgery to further improve her appearance. Clearly, one goal of successful treatment is to find more adaptive ways to engage constructively with these valued domains. For Martha, this was defined as her ability to take care of her appearance, and to invest in her attractiveness, but without the crippling anxiety and sadness that this vigilance for blemishes was causing. A second important goal for Martha was to remain well even if faced with further potentially excessive demands. In short, the goal was to help Martha be more resilient.

Resilience is a broad concept referring to how people negotiate adversity. It describes the processes of psychological adaptation through which people draw on their strengths to respond to challenges and thereby maintain their well-being (Rutter, 1999). Masten (2001), considers resilience to be a common phenomenon and understands resilience to be associated with "a short list of attributes These include connections to competent and caring adults in the family and community, cognitive and self-regulation skills, positive views of the self, and motivation to be effective in the environment" (p.234).

Resilience has multiple dimensions. There are many pathways to it and people do not need strengths in all areas to be resilient. Thus, perhaps resilience is commonplace because there are many different combinations of strengths that help someone become resilient. Masten (2001; 2007) draws an important distinction between strengths and resilience. Strengths refer to attributes about a person such as good problem solving abilities or protective circumstances such as a supportive partner. Resilience refers to the processes whereby these strengths enable adaptation during times of challenge. Thus, once therapists help clients identify strengths, these strengths can be incorporated into conceptualizations to help understand client resilience.

The crucible is a helpful metaphor for understanding how to conceptualize an individual's resilience (Fig. 1). Appropriate theory of resilience and wellbeing can be integrated with the particularities of an individual case using the heat of collaborative empiricism. As resilience is a broad multi-dimensional concept, therapists can either adapt existing theories of psychological disorders or draw from a large array of theoretical ideas in positive psychology (Seligman, Steen, Park, & Peterson, 2005; Snyder & Lopez, 2005). By conceptualising wellbeing and resilience, the models underpinning the conceptualization change from being problem focussed disorder specific or trans-diagnostic ones to models and theories outside of the current focus of cognitive behavioural therapy. The conceptualisation becomes trans-theoretical.

Resilience can be conceptualized using the same three levels of case conceptualization described earlier: (1) descriptive accounts in cognitive and behavioural terms that articulate a person's strengths, (2) explanatory (triggers and maintenance) conceptualizations of how strengths protect the person from adverse effects of negative events, and (3) explanatory (longitudinal) conceptualizations of how strengths have interacted with circumstances across the person's lifetime to foster resilience and maintain well-being.

Relevant theory and research can be integrated with the details of an individual case using the heat of collaborative empiricism. As

resilience is a broad multi-dimensional concept, therapists can either adapt existing theories of psychological disorders or draw from the theoretical ideas related to resilience found in the positive psychology literature (see e.g., Snyder & Lopez, 2005).

A growing body of evidence suggests that people who are resilient positively interpret events and employ adaptive strategies in both challenging and neutral situations (Lyubomirsky, 2001; Lyubomirsky, Sheldon, & Schkade, 2005). Seemingly then CBT may help equip people with the capacity to at least consider positive interpretations of events.

Seligman conceptualizes three domains of happiness: the pleasant life, the engaged life, and the meaningful life (Seligman, 2002). While Seligman's goal is to conceptualize happiness, his framework also provides a potentially helpful way to think about client strengths and resilience, how efforts change over the different stages of CBT, and how to assess therapy outcomes. The first domain, the pleasant life, refers to people's natural desire to maximize pleasant and minimize unpleasant experiences. It encompasses the experience of positive emotions associated with pleasurable activities. In the early phases of therapy clients typically express considerable distress. The amelioration of symptoms is a key initial goal. Positive therapy outcome for distress is typically assessed using symptom measures. Symptom relief and maintenance of these gains is usually a pre-requisite for a return to normal levels of functioning. In this way, CBT helps clients to redress the balance toward a more pleasant life.

The engaged life is Seligman's second domain of happiness and describes people who use their strengths to fulfil personally meaningful goals. Seligman describes strengths as personal qualities such as kindness, integrity, wisdom, the capacity to love and be loved, and leadership. As CBT progresses, therapy goals can shift to helping clients identify and deploy their strengths to work toward an engaged life in which they experience psychological, physical and social fulfilment. Improvements at this level can be assessed by instruments that measure broader quality of life like the WHOQOL (Ryff & Singer, 1996). Martha's concern for her partner, and family are important strengths. Martha's wish to be more at ease with her partner and family and further develop her interest in music and friendships reflects her commitment to living an engaged life.

The third domain is the meaningful life; belonging to and serving positive institutions including families, communities, work settings, educational settings, political groups or even nations. Helping others is often cited as one pathway toward positive mental health and resilience (Davis, 1999). In later phases of CBT, therapists may help clients identify values and goals that can enable them to lead more meaningful lives.

Peterson, Park, and Seligman (2005) identified that the most satisfied people were those that actively pursued happiness from all three routes or sources. However, the greatest weight for sustained wellbeing was towards the engaged and meaningful life. Hence, a key challenge for CBT to help people not only feel better (the pleasant life) but also to remain well into the future (engaged and meaningful lives) requires active consideration of the domains and the appropriate use of evidence based methods to help people achieve effectiveness functioning in these areas (Seligman et al., 2005).

In Martha's example an important goal was for her to re-engage in rewarding interaction with her family, friends, and to reactivate her love of music. These strengths and resources were initially utilised to help provide an interruption to her rumination and checking. However, these also became important to build into her life, to broaden and build on her intellectual, physical and social resources. Through this process Martha identified that if she were to play music again she would likely feel better about herself, and have in place some resources to cope with any future setbacks. Once there was some symptom improvement her goals were reviewed and additional ones identified that included supporting her family and acquiring work, which were seen as a means to provide meaning in her life. She did

not need the therapist's help in identifying areas that mapped onto a meaningful life but did seek help in achieving some of these once her functioning improved. Towards the mid to later stages of treatment when Martha was less depressed, and had stopped checking her appearance so much that she was able to leave the house more often, she identified a goal of enrolling at a local college to complete her education. Martha identified improving her relationship with Brett as important as well. Of course, this needs to be balanced between encouraging her to work towards this important domain, but also to ensure that Martha has in place the resources to manage effectively any future threat to their relationship. Martha needs to be helped to cope resiliently if her relationship ended. Hence, the therapist is working with Martha to reduce her symptomatic distress, but also to engage in more meaningful activities such as education and employment, and to enable her to be more able to manage future difficulties, which we all face, of problems with work, family and relationships. Clearly, services want to see people in a short space of time in order to get people back on track, and commonly assess this with measures of symptom change. However, the client may want to a) feel better, b) understand better what led to these difficulties, c) prevent future relapse, d) broaden and enjoy life to a fuller extent. A therapist may not be the one to work with a client to achieve these broader goals but they may help the client identify the goals, and identify ways to achieve them.

This focus on strengths, resilience, and positive psychology raises an important point about where this may interface with the theories and models of CBT. By this process of considering future wellbeing, we are developing trans-theoretical conceptualisations and potentially helping bridge the divide between the positivist approaches and the more social constructivist understanding of distress (House & Loewenthal, 2008). Once we work with people to help them develop and grow it may be considered to be a value judgement as to whether the domains that they wish to invest in are important or acceptable. However, by drawing on an empirical approach the therapist may caution against over investment in a limited range of domains or of excessive expectations in any one (Barton et al., 2008), but would encourage the person to identify which areas of life are the most valued and rewarding to that individual based on a model of resilience and wellbeing (Seligman, 2002). In Martha's case further investment in appearance as a way to maintain her relationship with Brett may make her more at risk of future problems, as she is not learning she is valued for other aspects of herself, and reduces her ability to develop functioning in the engaged and meaningful domains.

At first glance it may appear that CBT models of emotional disorders are irreconcilable theoretically with understanding of happiness, resilience and wellbeing. However, as we have outlined here CBT may help people develop a pleasant life, one where there is reduced distress, and disability, and enable them to move towards more engaged and meaningful lives. This process is also compatible with recent developments in CBT such as Mindfulness, and Acceptance and Commitment Therapy (ACT), which in part may help provide a theoretical integration of CBT and resilience. ACT and Mindfulness approaches demonstrate an evidence base for their effectiveness with some emotional disorders (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Powers, Vording, Maarten, & Emmelkamp, 2009; Kuyken et al., 2008) and share in common a focus not on changing the content of thought but of changing the function and relationship to these experiences through strategies such as acceptance, mindfulness or cognitive defusion. Moreover, within models such as ACT it is a commitment to values that is regarded as critical for therapeutic change. However, at a broader, and perhaps simpler level, it seems that these approaches view people as essentially goal driven, with goals ordered according to a hierarchy. Alleviating distress, and overcoming disability are important, necessary short and medium term goals, and ones that CBT is well placed to help people achieve. Here we are helping people develop a pleasant life. Whereas, building a meaning-

ful, rewarding, enriching life that promotes wellbeing, remaining well, and preventing future relapses is seemingly a higher order goal, one that over-arches and interweaves with these earlier goals and is more consistent with the meaningful and engaged domains of functioning.

At the outset we set ourselves some challenges that included identifying the primary focus of therapy, understanding the relationship between the presenting issues and establishing which protocols to utilise in helping Martha overcome her difficulties. By drawing on the principles of collaborative case conceptualisation (Fig. 1) we have identified that Martha wanted help initially with overcoming her low mood. So collaboratively we agreed to address this issue. The use of descriptive, maintenance and longitudinal formulations helped build a picture of how to understand and overcome the presenting issues of mood, and anxiety difficulties, and by this process reveal the subtle interconnection between her concerns about appearance, and how this was related to her checking, and ruminative difficulties. In terms of protocols, rather than sequentially draw on manuals for CBT for depression, or OCD, or BDD the careful description and understanding of her presenting issues led to the utilisation of interventions that disrupted rumination (Watkins et al., 2007) and prevented checking through the use of exposure and response prevention (Fals-Stewart et al., 1993).

A key aim of the paper was to consider how a clinician decides whether to utilise a disorder specific or trans-diagnostic model when trying to help a person like Martha. Here we try and articulate a guide or rubric that may enable clinicians to consider how and when to select disorder specific approaches or adopt a trans-diagnostic approach. It is not intended to be a prescriptive approach or an algorithm, more a heuristic aide and one that will change over time in light of further empirical evidence for disorder specific and trans-diagnostic approaches.

Our starting point is that where the evidence exists and the presenting issue maps on well to a single disorder we would always encourage the use of a disorder specific model. Where there is a single disorder, perhaps with an unusual presentation or one where the evidence is less robust we would still support the use of a disorder specific approach as this adapted appropriately to the presenting issue may provide more benefit than a trans-diagnostic approach. Where we start drawing on more trans-diagnostic approaches may be where we are faced with disorders with limited or no empirical support and or, where dealing with co-morbidity, where one or both of the disorders have a limited evidence base. Of course, these decisions are made in the context of collaborative agreement with the client as to what is most important for them to work on. A further guiding factor is the breadth of impairment and disability. When faced with a more restricted lifestyle and fewer areas of functioning, more consideration may be needed by the therapist to identify areas of strength and more thought given as to how to utilise these strengths to help maximise the engaged and meaningful lives, even with limited or moderate improvements in symptoms. Table 1 outlines some potential presenting issues and how these may inform the selection of disorder specific, trans-diagnostic and trans-theoretical approaches.

10. Research on case conceptualisation

We have not reviewed the research on case conceptualization as this is well covered in previous work (Bieling & Kuyken, 2003; Eells, 2007; Kuyken, 2006; Kuyken et al., 2008). However, it is important to acknowledge that there is a paucity of research around the real world use of conceptualisation in treatment (Kuyken, et al., under review). We do know from less representative but more controlled studies that the rate of agreement between therapists is generally low (Dudley, Park, James, & Dodgson, 2010; Kuyken, Fothergill, Musa, & Chadwick, 2005; Persons & Bertagnolli, 1999; Persons, Mooney, & Padesky, 1995), the quality of the formulations are often poor (Eells, 2007; Eells, Lombart, Kendjelic, Turner, & Lucas, 2005; Kendjelic & Eells, 2007) and that conceptualisation has only limited value in treatment

Table 1

A guide to the selection of disorder specific or trans-diagnostic models.

Presenting features	Levels of conceptualisation	Collaborative approach	Empirical approach	Strengths and resilience	Selection of disorder specific or trans-diagnostic approaches
Single disorder such as panic	Clear match between presenting issue and model	Client agrees that working on panic is important	Strong evidence base for effectiveness	Client demonstrates effective functioning in a wide range of domains	Disorder specific approach
Single disorder such as schizophrenia	Clear match between presenting issue and model	Client agrees that working on psychosis symptoms is important	Limited evidence base for effectiveness of CBT	Client demonstrates limited functioning in a wide range of domains	Disorder specific approach with emphasis on broadening and building domains
Single disorder but one that is NOS	Some match between presenting issue and model	Client agrees that working on presenting issue is important	Limited evidence base for effectiveness of CBT for that issue	Client demonstrates effective functioning in a wide range of domains	Disorder specific approach but with potential trans-diagnostic features incorporated
Two or more presenting disorders (i.e. OCD and Social Phobia)	Good match between presenting issues and models	Client identifies that working on one of the presenting issue is most important	Good evidence base for effectiveness of CBT for both issues	Client demonstrates effective functioning in a wide range of domains	Disorder specific approach but with potential trans-diagnostic features incorporated
Two or more presenting disorders (i.e. OCD and personality disorder)	Good match between presenting issues and models	Client identifies that working on one of the presenting issue is most important	Mixed evidence base for effectiveness of CBT for both issues	Client demonstrates limited functioning in a number range of domains	Disorder specific approach but with potential trans-diagnostic features incorporated
Two or more presenting disorders (i.e. psychosis and personality disorder)	Moderate match between presenting issues and models	Client identifies that working on one of the presenting issue is most important	Limited evidence base for effectiveness of CBT for both issues	Client demonstrates limited functioning in a number range of domains	Disorder specific approach but with potential trans-diagnostic features incorporated or a trans-diagnostic approach

planning (Dudley, Siitarinen, James, & Dodgson, 2009; Eells, 2007). On balance, the research to date does not provide a strong rationale for value of conceptualization in the outcome of cognitive behavioural therapy (Dudley & Kuyken, 2006; Ghaderi, 2006; Kuyken et al., 2008; Mumma & Mooney, 2007; Mumma & Smith, 2001).

How do we reconcile this conclusion with our extended argument for the importance of case conceptualisation? One of reasons we consider that case conceptualisation has a role to play is owing to the limitations of the current research. This area has been covered in detail elsewhere (Kuyken, 2006; Kuyken et al., 2009). However, it is important to note that to date conceptualisation and outcome have been considered in terms of brief, static snapshots of formulation, that are then linked to change in symptoms (Chadwick, Williams, & Mackenzie, 2003; Schulte, Kunzel, Pepping, & Shulte-Bahrenberg, 1992). These initial studies are valuable but we argue that the relationship between formulation and outcome needs to be understood in terms of a fine-grained analysis of the potential beneficial effects of the process of formulation. How the formulation is built with the client, how this engenders hope and optimism for change, how it impacts on therapeutic alliance, and confidence in the therapist, and how this together leads to a rationale for the selection of an intervention strategy may be more valuable ways to consider the impact of conceptualisation. This would to some extent, separate the impact of case conceptualisation from other aspects of treatment such as the competence with which an intervention was designed and delivered. Hence, it is possible that the research examining the impact of conceptualization on therapy process and outcome might be more robust and informative if the research was carefully considered in terms of the outcomes that are measured. Also, in our view the research may be more informative if conceptualizations included greater consideration of the three principles outlined in this review. If conceptualizations were developed from descriptive to more explanatory levels, and that the client was seen as an active contributor to the development of a conceptualization the reliability and value of conceptualization may be improved. For example, we propose that clients are less likely to find conceptualization overwhelming and distressing (Chadwick et al., 2003; Evans & Parry, 1996; Pain, Chadwick, & Abba, 2008) when conceptualization is as much about what is right with them as about the problematic issues that lead them to seek help (Kuyken et al., 2009).

11. Conclusions

We, like others (Beck, 1995; Butler, 1998), regard case conceptualization as a key process in CBT. However, we argue that we need a

principle based approach to case conceptualization that directly addresses some of the clinical and empirical challenges therapists face. One such challenge is whether to select a disorder specific or trans-diagnostic model on which to base the conceptualisation. To answer this question we ask what model or understanding best meets the needs of the client? We advocate that a principle based approach to conceptualisation helps in the selection of disorder specific or trans-diagnostic models in light of the needs of the client. Once selected, these principles promote working from a descriptive to an explanatory level of understanding and by encouraging the client to be active in the development of the conceptualisation then this acts as a check and balance on the process that helps create a person specific account of the presenting issues. We consider trans-diagnostic approaches to be particularly helpful in identifying common higher order processes especially in the context of co-morbid presentations. In addition, by purposefully considering a person's strengths and values throughout it encourages conceptualisations that incorporate theories of resilience that may help them remain well in the future. Therefore, we need to go beyond models of distress, and even symptom relapse prevention to consider resilience based conceptualisations of wellbeing.

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