

Client experience of the formulation
within
Cognitive Behavioural Therapy

by

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Declaration

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Section I: Literature Review

A literature review examining the relationship between the formulation and the therapeutic alliance in cognitive behavioural therapy. Various ‘definitions’ of the formulation are reported, and the relative roles and merits of ‘nomothetic’ and ‘idiosyncratic’ formulations considered. The function of the formulation is considered in relation to its development in conjunction with the therapeutic relationship and alliance. Research and clinical case reviews are critiqued.

Section II: Research Report

An Interpretative Phenomenological Analysis of clients’ experience of the formulation within cognitive-behavioural therapy. A sample of (N=8) of clients with depression and/or anxiety were interviewed following the ‘acute phase’ of CBT during ‘follow-up’. Interviews provided five master themes: Somebody that listened and understood – trust in therapist; Understanding what happens; A Foundation and Direction – Something to start from, something to work on; Working to a plan; and Effectiveness and Self–efficacy. These master themes and associated sub-themes represent clients’ experience of progress through therapy and the experience and process of formulation.

Section III: Critical Appraisal

A critical appraisal describing the origin, planning and process of the research, personal reflection and experience gained.

For Rose –

my beloved and longsuffering wife.

For John, Philip and Matthew –

my three boys

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The relationship of the formulation with the development and maintenance of the therapeutic relationship and alliance in cognitive-behavioural therapy

The relationship of the formulation with the development and maintenance of the therapeutic relationship and alliance in cognitive-behavioural therapy.

F.G.Burchardt

This review examines the relationship between the formulation and the therapeutic alliance in cognitive behavioural therapy. Various 'definitions' of the formulation are reported, and the relative roles and merits of 'nomothetic' and 'idiosyncratic' formulations considered. The function of the formulation is considered in relation to its development in conjunction with the therapeutic relationship and alliance. Research and clinical case reviews are critiqued.

Within psychotherapy, the formulation provides a theoretical and evidence-based description of a client's presenting problem(s) and a direction and framework for the therapeutic process (Beck, 1995). The method of formulation has not been the exclusive possession of one school of psychotherapy, and has been applied within psychodynamic (Hingley, 2001), humanistic (Honos-Webb & Leitner, 2002) and the various cognitive and cognitive-behavioural approaches (Beck, 1995; Greenberger & Padesky, 1995). The formulation has also been used across various disorders in cognitive-behavioural therapy (CBT), including anxiety (Riskind, & Williams, 1999; Wells, 1997), obsessions (Freeston, Leger & Ladouceur, 2001) depression (Hess, 2001), psychosis (Renton, 2002) and personality disorders (Freeman & Jackson, 1998).

The therapeutic relationship and alliance is likewise considered vital within the various psychotherapeutic models (Fowler, Garety & Kuipers, 1998). It is regarded as one of the 'common' or 'non-specific' factors considered effective in the psychotherapies (Rector, Zuroff & Segal, 1999).

The following review will consider whether the literature relating to the formulation and to the therapeutic relationship and alliance within CBT indicates an

association between these factors. Accordingly, the review will consider the formulation in terms of its role and utility within CBT, what is understood by the therapeutic relationship and alliance, and reflect on the development and maintenance of the therapeutic relationship and alliance in relation to the formulation.

Literature Search

Several searches were made on PsychInfo using the criteria: formulat* and relat* and cognitive thera*, which produced 44 references; formulat* and alliance and cognitive therap*, producing 4 references; cognitive therapy and conceptuali* and relationship, producing 73 references; and cognitive therapy and conceptuali* and alliance, producing 10 references. The search was limited to articles written in English, 1990 – 2003. Articles were subsequently excluded which did not investigate cognitive-behavioural therapy (CBT), such as psychodynamic approaches and counselling. Studies comparing different therapeutic models were generally excluded, although one or two comparative articles are included in view of their reference to CBT and their relevance to the review question. Group and systemic approaches were excluded, although articles referring to social and cultural systems as factors informing the formulation and/or therapeutic relationship were retained. Articles relating to children and adolescents were excluded, but those relating to Axes I and II disorders in adults were considered. Following this discrimination, articles from the searches were collated, providing 20 articles. Further hand searches were made from the references of the selected articles, producing another 22 articles considered relevant to the question. The final collection of articles represents a range of psychological disorders and research methodologies. In addition, three ‘core’ texts (Beck, 1995; Hawton et al, 1989; Persons, 1989) are referenced in terms of representing the basic theory and methods of cognitive-behavioural therapy.

The formulation in cognitive behavioural therapy

Although the formulation is considered fundamental to CBT (Chadwick, Williams & MacKenzie, 2003), there is a need to operationalise the term due to varied conceptions and emphases in the literature regarding its nature and function. In view of CBT's origins in learning theory and its experimental methods such as functional analysis (Bruch, 1998) and the empirically supported cognitive models (Beck, 1995), the formulation may be regarded as an initial hypothesis (Kirk, 1989) derived from interview with and assessment of the client. This hypothesis accordingly provides the basis of intervention "based both on a cognitive formulation of a specific disorder and its application to the conceptualisation of the individual patient" (Beck, 1995, p2). This proposes that the formulation represents two complimentary factors, i.e. what is general or common to the disorder and what is specific to the client. This might be variously represented as the theoretical and the clinical, the model and the individual, or the condition and the case. Different authors have emphasised or argued in favour of one or the other of these. Accordingly, Bruch (1998) distinguishes between 'case' and 'problem' formulations, this distinction broadly representing the distinction between an idiosyncratic and a nomothetic or common formulation (Mumma, 1998).

Persons (1989) conceives the formulation in terms of two levels: the overt difficulties, expressed at a "macro" level in nosological terms such as depression and at a "micro" level as cognitions, behaviours and mood; and the underlying psychological mechanisms involving irrational core beliefs and assumptions. Beck (1995) conceptualises these factors as three time frames, viz. presenting problematic cognitions and behaviour, precipitating factors, and predisposing patterns of interpreting developmental events. Persons later conceives three levels of the case formulation: the level of the case, the level of the problem or syndrome, and the level of the situation (Persons & Davidson, 2001). At the case level the formulation describes the case as a

whole, involving the relationships between the person's problems. At the problem level a particular clinical problem or syndrome is conceptualised according to an existing theoretical model. At the level of the situation a person's responses are considered in the context of the environment and particular circumstances. Persons and Davidson (2001) propose five components to the case formulation: the Problem List, Diagnosis, Working Hypothesis, Strengths and Assets, and Treatment Plan.

The cognitive-behavioural case formulation has also been described in terms of seven factors (Persons, Curtis & Silberschatz, 1991). This involves a 'problem list' of overt difficulties; hypothesised psychological mechanisms underlying these difficulties; how the mechanisms lead to overt difficulties; environmental and circumstantial precipitants activating vulnerability, leading to current distress; developmental and historical origins of the vulnerability; a treatment plan founded on the formulation; and the use of the formulation to predict problems within the therapeutic relationship. This description notably describes the function of the formulation as much as providing a 'definition', perhaps reflecting the premise of the article that the comparable effectiveness of psychotherapies should be explained in terms of matching interventions to the underlying psychological problem. the 'formulation hypothesis'. This is illustrated by comparisons with a psychodynamic formulation of the same client (Persons, Curtis & Silberschatz, 1991). The authors conclude that effectiveness of therapy depends on adherence to an accurate formulation rather than a theoretical orientation.

Persons and Davidson (2001) advise that the formulation is a hypothesis and as such should be revised as therapy proceeds (Kirk, 1989; Scott, 1998). Perhaps it should be no surprise therefore that the formulation as a concept and a factor of therapy has evolved over time if the formulation is conceived as intrinsically dynamic and developmental. It would seem, in view of the above references, that Person's own

model has been adapted and revised over time, although these changes represent more of an elaboration (Persons & Tompkins, 1997) and development of emphases within the model than fundamental changes.

Debate between idiosyncratic and nomothetic formulations

Although some authors recognise both the individual and the typical aspects of a formulation in all forms of cognitive therapy (Beck, 1995), a debate exists between the relative merits of a ‘formulation-based’ versus ‘standardised treatment’ (Mumma, 1998; Tarrier & Callam, 2002; Wilson, 1996). In this debate ‘formulation-based’ appears to equate with the Persons and Davidson’s (2001) idiosyncratic ‘case level’, ‘standardised treatment’ representing generalised and manualised treatments at the level of the problem or syndrome. Although the terms ‘formulation’ and ‘case formulation’ might be used interchangeably, the debate is not merely one of semantic preference but of conceptual and theoretical orientation. Proponents of the ‘case formulation’ / ‘formulation based’ approach purport it to be a model (Clark, 1999) as much as a method or ‘technical factor’ of CBT, albeit based on “nomothetic (general) cognitive-behavioural theory” (Persons & Davidson, 2001 p86).

Ward et al (2000) argue that the case formulation model needs to be clearly identified and its efficacy researched, contesting the adequacy of “intuition or vague generalisations” (p262), and contending that the chain of clinical decision should be rooted in established theory and data. Tarrier and Callam (2002) agree that clinical assessment should not be based on speculation but on empirical evidence, Bieling and Kuyken (2003) proposing criteria against which to assess the extent to which the formulation approach follows the process of scientific inquiry. This rationale cannot be disputed. However, the debate and objections to case formulation should not forget the origins of theoretical models in single-case methodology and case studies. Neither should the investigative scientist-practitioner ethic be disregarded and continuing

scientific psychological approach prohibited by assuming that consummate knowledge has been achieved in relation to a psychological problem and its treatment in a manualised format.

Ward et al (2000) allow that formulation-based treatment may be more appropriate than manualised treatment for complex cases because of its greater flexibility and individualistic approach; although this begs the question as to how complexity is determined. There is however a growing literature reporting the case formulation approach to 'complex cases' such as psychosis (Chadwick, Williams & MacKenzie, 2003; Haddock & Tarrier, 1998), personality disorder (Freeman & Jackson, 1998), and chronic depression (Scott, 1998). Alternatively, manualised-based treatment is supposed to represent greater standardisation and less bias by "clinicians' (flawed) judgments" (Ward et al, 2000 p251).

The debate is somewhat curious since it is to be supposed that the decision to adopt a manualised procedure would be determined on the basis of a rigorous assessment and conceptualisation of a client's problems according to a theoretical-clinical model. It also infers that case formulation either makes no reference to theoretical models, or is at least less theoretically and empirically robust. However, Clark (1999) assumes the case formulation to be a theory-driven hypothesis about the psychological processes maintaining a person's problems. Mumma (1998) contends that the formulation and standardised approaches are not mutually exclusive, more flexible manualised approaches requiring a formulation as part of the treatment plan. Bruch's (1998) proposal that the initial interview and assessment are driven by research and evidence towards conceptualising each client's peculiar problem(s) implies that the debate may therefore be "and/or" rather than "either/or" (Persons & Fresco, 1998).

The role and utility of the formulation

The formulation, which in CBT is considered a way of collating and synthesising clinical data according to cognitive models of psychopathology, has been contrasted with the psychiatric interview, which is principally guided by a categorical classification system with a view to diagnosis (Bruch, 1998). The formulation provides a framework for the therapist's understanding of the client and for consequent interventions (Beck, 1995; Haddock & Tarrier, 1998), and has the function of psycho-education in allowing clients to see that variation in their distress is predictable and therefore controllable (Kirk, 1989).

What may initially have been seen by clients as an overwhelming plethora of problems might be condensed into a few conceptually linked factors. The formulation enables clients and therapists to identify and prioritise problems, seeing how they link together, and to focus interventions efficiently and effectively (Beck, 1995). Tompkins (1999) similarly considers the case formulation, which he describes as "generally theory driven", problems being "explained on the basis of the structures and processes of a particular psychological theory" (p318), as a guide and focus to therapy. Addressing obsessional problems, Salkovskis et al (1998) advise that although CBT is structured, it should not be practised prescriptively.

Therefore, considered semantically, theoretically or clinically, the formulation comprehends both *description* and *prediction* of a client's problem(s). From a descriptive 'problem focused' perspective the client's 'presenting problem' is understood in terms of an existing theoretical model which is potentially testable and treatable (Haddock & Tarrier, 1998). From a predictive perspective the clinician adopts an investigative approach to the predisposing and precipitating factors, considering historical and social influences that might inform not only the nature of the presenting problem but predict the future course for the person. These two aspects of the

formulation are not mutually exclusive, and it is supposed that most clinicians assume both *description* and *prediction* when they make a formulation.

In terms of prediction, the therapist might use the formulation to anticipate the client's behaviour during therapy. In relation to clients with 'borderline' problems Arntz (1994) suggests that the recognition of core schemas might explain and help gain therapeutic control over baffling and complicated problems, since these are often enacted in therapy. The formulation might therefore inform the therapist's attempt to nurture a therapeutic alliance.

The therapeutic relationship and alliance.

The therapeutic alliance is assumed to include "three interdependent components: the relational bond between client and therapist, the specific tasks of psychotherapy, and the goals of psychotherapy" (Tompkins, 1999 p322). Wright and Davis (1994) claim that therapy process and outcome research suggest that the therapeutic relationship strongly influences treatment results, although Bieling and Kuyken (2003) argue there is a need for further research to clarify this assumption. Rector, Zuroff and Segal (1999) describe the therapeutic relationship as one of the "non-technical elements" of therapy (p320). The therapeutic relationship is regarded as a key ingredient in treating personality disorder (Freeman, 2002), and Overholser and Nasser (2000) propose that development of a sound therapeutic alliance should be the initial focus of therapy for clients with generalised anxiety disorder (GAD). Gluhoski (1994) provides evidence from the literature emphasising the importance of the therapeutic relationship in response to misconceptions that it is irrelevant in cognitive therapy.

Within CBT the therapeutic alliance is supposed to be collaborative (Beck, 1995), therapist and client assuming equal responsibility for solving the client's problems (DeRubeis, Tang & Beck, 2001). However, Freeman (2002) argues that

collaboration is not necessarily or always equal, and that therapists will often need to bear the greater burden. Nevertheless, it may be supposed that the quality of the alliance depends on greater equivalence of responsibility (Tompkins, 1999). Similarly, 'equal responsibility' does not mean equivalence of role or understanding, and consideration needs to be given to how clients' perception of status and unequal power relations in society might affect the therapeutic relationship (Hagan & Donnison, 1999). Within the therapeutic relationship, DeRubeis, Tang and Beck (2001) regard the client as the 'expert' of their own experience and their associated meanings, whilst the therapist remains the 'expert' of the cognitive model. However, both parties work as a team (Beck, 1995), the client actively involved in their own therapy, the therapist helping the client adopt an empirical approach in examining their beliefs.

Implicit in this concept of collaborative empiricism (Morrison, 1998) is the notion of 'doing with' rather than 'doing to'. It is supposed that 'doing with' will depend on 'being with' and the process of carefully listening to the client (Fowler, Garety & Kuipers, 1998) and establishing rapport, involving basic counselling skills of warmth, empathy and genuine positive regard (Beck, 1995).

The relationship between the formulation and therapeutic alliance

In view of the significance attributed in the literature to both the formulation and to the therapeutic relationship and alliance, it might be asked whether, or what kind of, a relationship exists between these two factors. The understanding of this relationship is complex and not well explored in the literature. This review will continue to consider the literature's description of the nature of this relationship and how it develops and is maintained within CBT. These issues will be considered under various sub-headings, although it will be observed that there is considerable overlap between these, reflecting their complexity and inter-relatedness.

Reaching a shared understanding

It has been recommended that during the initial stages of therapy the therapist should conduct a thorough assessment, working with the client to develop a comprehensive account and shared understanding of their problems (Salkovskis et al, 1998; Warwick, 1995). Overholser and Nasser (2000) share this view, recommending three basic goals in relation to initial therapy sessions for cognitive-behavioural treatment of generalised anxiety disorder (GAD), viz. establishing a therapeutic alliance, educating the client about anxiety and its treatment, and conducting a comprehensive assessment of the client's strengths and weakness. Accordingly, the assessment stage not only involves client self-monitoring of symptoms, but also reporting symptom free periods. This enables the incorporation of strengths into the assessment and formulation, and lays the basis for a collaborative therapeutic relationship and alliance.

Overholser and Nasser (2000) consider the development of the therapeutic relationship and alliance as the initial focus of and foundation for future therapy, the alliance depending on the therapist's skills and ability to establish a good relationship. However, the therapeutic alliance is not only nurtured by therapist skills, such as rapport, trust and empathy (Deffenbacher, 1999), but is dependent on and characterised by collaboration between therapist and client (Salkovskis et al, 1998).

Facilitation of alliance through prediction of schema enactment

An initial nomothetic formulation, based on information provided at referral and during the assessment, may enable the therapist to predict typical client behaviour during therapy in terms of the enactment of schemas. Accordingly, therapists will anticipate potential difficulties or barriers in attempting to facilitate a therapeutic alliance based on a shared conceptualisation of the client's problems. For example, it is

expected that clients with GAD will be anxious, and will benefit from a supportive and calming relationship (Overholser & Nasser, 2000). This recommendation is clearly informed by a problem formulation and theory relating to GAD. Accordingly, whilst establishing a shared formulation is dependent on the therapeutic relationship and alliance, the formulation equally informs the development of the alliance in terms of the descriptive and predictive characteristics referred to.

Overholser and Nasser's (2000) recommendation of a comprehensive biopsychosocial assessment of the client's problems also assumes the utility of corresponding and inter-dependent idiosyncratic and problem formulations. Similarly, Wells (1998) proposes the value of a disorder specific model of social phobia in informing and guiding individual case formulations in severe social phobia. He advises that therapy itself represents a social encounter which will be affected by the client's social phobia. This is supported by Deffenbacher (1999), who recommends attention should be paid to client characteristics and to the therapeutic relationship in the conceptualisation and treatment of anger. Conceptualising a client's anger in terms of her externalising problems, so that others were regarded as incompetent or abusive, helped account for her ambivalence in therapy.

Collaboration – Compliance and resistance

The notion of the impact of elements of the formulation, such as schemas, on the therapeutic relationship and alliance has also been considered in relation to 'non-compliance' in therapy. Tompkins (1999) considers how the cognitive-behavioural (CB) case formulation can both secure and maintain client therapist collaboration, and maintain 'compliance' with therapeutic tasks. On the basis of a case study of a client with 'multiple problems' he illustrates how a shared conceptualisation was established. His report demonstrates some tactful negotiating, influenced by his hypothesis of the

client's condition, in reaching a shared understanding and intervention strategy based on this conceptualisation. This involved recognising how the activation of the client's core beliefs may impinge on the working alliance and 'compliance' with therapeutic tasks. Tompkins' (1999) accordingly demonstrates a pragmatic application of cognitive theory in understanding a client's problems, engaging and collaborating with the client, anticipating and managing difficulties.

This premise that a CB case formulation points to potential difficulties in which 'maladaptive core beliefs' may be activated as "therapy intervening behaviours" (Tompkins, 1999 p321) infers that although the formulation is established collaboratively and explicitly, a therapeutic relationship and working alliance can be developed despite an imbalance in the level of understanding. Indeed, there will inevitably be variance between therapist and client understanding as the formulation is being developed. This is implied by the author's proposition of the working hypothesis being purely functional, so that a recursive process ensues of formulation, intervention based on the formulation, measuring outcome, and revising the formulation on the basis of the outcome. The corollary of this proposition would be that greater concurrence between client and therapist understanding and acceptance of the formulation would suppose ruptures in the alliance are less likely to occur. Conversely, 'non-compliance' with therapeutic tasks may infer client acquiescence and 'compliance' rather than collaboration and a shared understanding of the formulation.

Whilst Tompkins' (1999) case study demonstrates a pragmatic and 'successful' application of (his understanding of) the formulation, some unfortunate and paradoxical statements are used. The notion of "compliance" (Tompkins, 1999 p317) suggests passivity and obedience as much as collaboration. Although it could be argued that this objection is merely semantic, there is an inference in the language of the powerful / expert therapist status. This does not militate against the earlier deduction that 'equal

responsibility' does not mean equivalence of role or understanding, but rather the objection to the use of words corresponds with the author's own premise of anticipating potential ruptures and non-engagement with therapeutic tasks. Kimerling, Zeiss and Zeiss (2000) also caution that the use of language such as 'compliance' and 'resistance' may be indicative of therapists' "emotional responses related to intentional attributions" (p316). However, these 'cautions' are partially anticipated in the author's proposition that the quality of the therapeutic alliance is dependent upon the degree of congruence between therapist and client (Tompkins, 1999).

It might be argued that Tompkins (1999) presents clinical and anecdotal rather than empirical evidence of the influence of the formulation, his inferences being based on premise, i.e. that the case formulation is the effective factor in managing a therapeutic relationship and overcoming 'treatment non-response'. Methods therefore need to be adopted to tease out whether it is the (case) formulation in particular that is responsible for developing and maintaining the therapeutic alliance (see Chadwick, Williams & Mackenzie, 2003), or other specific or non-specific factors. This is complicated by the variance in understanding of the case formulation already referred to, such as whether it is a therapeutic model or a clinical method, or whether it is restricted to a specific stage or represents a process of therapy. Although the generalisability of Tompkins' (1999) conclusions might be questioned, his study provides ecological validity of the effectiveness of formulation driven therapy which could be supported by a multiple case study method following a similar clinical approach.

The possibility is considered that the 'treatment failure' and the failure to develop or maintain a therapeutic alliance may be the result of an inadequate or incorrect formulation (Hess, 2001; Tompkins, 1999). In a review relating to case conceptualisation and 'treatment failure', Clark (1999) reports the view that 'treatment

resistance' has also been proposed as symptomatic of the client's problems and to be understood in terms of a decision-making model in which a cost-benefit analysis is made between responding to the therapist's attempts to maximise the client's gain, and the client's concerns about emotional risk. In this respect 'resistance' can be anticipated in terms of a general model of a specific disorder, and Clark (1999) sees this as potentially less blaming for clients who do not change. However, this possibility should not be divorced from the principle of making a thorough assessment and attempting to reach a shared understanding, so that the therapist does not become 'resistant' to change and refining the formulation (Haddock & Tarrier, 1998). Clark (1999) also proposes that 'treatment resistance' might be more situation specific than trait-like, which he judges is implied in the literature, as well as recognising that the therapist's style and or approach may not suit the client's preferences.

Engagement and collaboration

Deffenbacher (1999) considers a client in relation both to problem and idiosyncratic formulations, but within the idiosyncratic conceptualisation takes account of the client's readiness for change in terms of the 'stages of change' model. This is considered a vital prerequisite in terms of engagement and future therapy.

Dunn (2002) describes two aspects to engagement. The first is the engagement of the client with the therapist. The other is the client's engagement with therapy. Although Dunn (2002) suggests that these can be established concurrently, she cautions that a weak therapeutic relationship would be expected to hinder socialisation to the cognitive model. A positive perception of the therapist by the client, for example, as believable, trustworthy and expert, is expected to facilitate engagement Dunn (2002).

Moorhead and Turkington (2001) consider how the case formulation can facilitate engagement and help heal alliance ruptures. Endorsing information-

processing models of delusions they assert the relevance of both the content of symptoms and the process of their development in relation to clients with psychosis, thematic links being hypothesised with early psychosocial stressors. The authors argue that these links are considered the basis of the individual case formulation, which is “the bedrock of therapy among non-psychotic patients: facilitating engagement, guiding interventions, and healing alliance ruptures” (Moorhead & Turkington, 2001 p420). The authors advocate that in conceptualising psychotic symptoms in this way the client is more likely to be engaged in the change process. In their case study, the key to engagement is purported to be that the formulation was understandable and personally relevant, resulting in the reinforcement of the collaborative nature of the therapeutic relationship (Moorhead & Turkington, 2001). The collaborative CBT approach involved an empirical examination of the evidence of the client’s assumptions and attributions rather than contradicting them from the position of theory and expertise.

Moorhead and Turkington (2001) were guided both by a clear and extant cognitive model of delusions and a cognitive-behavioural conceptualisation regarding the formation and influence of schemas, whilst also establishing the idiosyncratic nature of the client’s beliefs and attributions. Accordingly, the case formulation involves the individual application of theoretically driven problem formulations. They further affirm that intervention is crucially based in the context of the therapeutic relationship and development of a formulation.

Maintaining the alliance through a shared formulation

The question remains as to the relative merits of the development and maintenance of the formulation and the therapeutic alliance, and to what extent the one affects the other. Persons’ (1992) description of how a case formulation provided a framework for thinking about the therapeutic relationship for a client with chronic

anxiety and panic attacks, as well as guiding homework assignments and dealing with 'non-compliance', might imply that the therapeutic alliance depended on the formulation. However, she also describes how she commenced working with this client in order to uncover the sources of her anxiety and develop a formulation, the rationale for "understanding the cause" (Persons, 1992 p470) making sense to the client, who consequently agreed to work with her therapist. This alternatively suggests that the formulation was dependent on the working therapeutic relationship and alliance. Both issues have some basis in this case study. Although it is not possible to establish direction or causation on this matter in this case, it might be inferred that the process is cyclical or recursive.

Bieling and Kuyken (2003) argue that research concerning whether aspects of case formulation are associated with improved therapeutic relationship is equivocal and that there is a need for further research into the relationship between the formulation and the therapeutic alliance. However, on the basis of Tompkins (1999) and Moorhead and Turkington (2001) the proposition appears to be that the developmental relationship between them is reciprocal, the therapeutic relationship, in terms of rapport and other basic counselling skills of warmth, empathy and genuine positive regard (Sanders & Wills, 1999), being the mediating factor. This needs further clarification. However, in terms of the therapeutic alliance being characterised by collaborative intervention, this appears to be based on a working, albeit evolving (Kinderman & Lobban, 2000) formulation.

Complex cases

In the literature search, CBT with psychosis was well represented, the case formulation approach being favoured by many clinicians/researchers in dealing with the complexity of the clients' presenting problems, authors reporting case examples to support and test theoretical and conceptual discussions (e.g. Brabban & Turkington,

2002; Haddock & Tarrier, 1998; Kinderman & Lobban, 2000). Fowler, Garety and Kuipers (1998) propose four key factors for changing delusional thinking, viz. “the establishment of a working therapeutic relationship... collaborative discussion of a shared formulation of the client’s beliefs, cognitive restructuring of specific delusional interpretations, and work on negative evaluations of self and others” (p130). As with the Moorhead and Turkington (2001) case study, these four factors represent an alliance of the idiosyncratic nature of the client’s beliefs and difficulties with the standardised CBT conceptualisations and methods of intervention.

In their review and critique of the literature and historical conceptualisations of delusions, Fowler, Garety and Kuipers (1998) contrast the generally prevailing ‘scientific’/psychiatric assumptions of delusions as “fixed, immutable, inexplicable and resistant” (p131) to change with the view that they represent psychological processes which may be amenable to therapy. Their article provides empirical and clinical evidence of the mutability of delusional beliefs in the form of a brief review of the literature supportive of this view and some case examples of working with clients with delusional beliefs. Longitudinal studies are cited in which variability in the nature and quality of delusional beliefs is demonstrated, as well as recognising the similarities between commonly held beliefs within the general population and patients holding what are regarded as delusional ideas. The case for positioning delusional ideas along a continuum is intriguing and meriting of further consideration. However, this need not be pursued in this current review beyond the recognition that it represents a conceptualisation of delusional beliefs within a CBT model, and the extent to which this formulation may facilitate the therapeutic relationship and alliance, and vice versa.

In terms of establishing a therapeutic relationship, Fowler, Garety and Kuipers (1998) make several pragmatic observations based on their theoretical understanding of the content and nature of the presentation of delusional beliefs and their clinical

experience of working with clients with delusional ideas. For example, it is to be presumed that clients with paranoid ideas will be highly suspicious of the therapist, which will make the establishment of a therapeutic relationship and alliance difficult. The authors propose the need for flexibility and the application of “sophisticated therapeutic skills” (Fowler, Garety & Kuipers, 1998 p134) to contain clients’ anxiety and build therapeutic relationships, as well as a clear theoretical framework to help them understand clients’ beliefs and behaviours. This also implies that a clear theoretical framework and formulation will help contain the therapist’s own anxieties and uncertainties.

Fowler, Garety and Kuipers (1998) further recommend a collaborative rather than an argumentative approach to reaching a shared understanding, advocating a developmental or historical approach to delusions as a useful starting point, which may enable the client to adopt new perspectives to their problems. This will be nurtured within a relationship in which the client feels understood and is involved. In terms of engaging clients who might hold very entrenched and supposedly ‘fixed ideas’ such as delusions, the authors describe how they empathised with a client and his attempt to make sense of difficult experiences and circumstances, gradually offering an alternative perspective as a possibility to be considered. The client’s delusional beliefs were proposed as a way he had understood things in order to cope, whilst being offered the opportunity to consider the therapist’s theory so as to explore which explanation was most useful.

Although Kinderman and Lobban (2000) assert that “formulations are *more than simple* enumerations of problems and cognitive processes” (p307, emphasis added), and are intended to link theory and phenomenology, they advocate that initial formulations *should be simple*. These may be elaborated collaboratively throughout the therapeutic process. Accordingly, they propose an incremental increase in complexity and

understanding of the formulation throughout therapy, formulations being developed and presented sequentially and progressively (Kinderman & Lobban, 2000). This proposition is based both on the premise of the complexity of case formulations and the high prevalence of cognitive deficits in terms of poor abstract reasoning, mental flexibility and comprehension amongst clients with psychosis.

The principles of this approach need not be limited to this client group. Clients with anxiety and/or depression often have problems concentrating, and ‘irrational’ beliefs in general are typically resistant to change or alternative evidence across all disorders. Kinderman and Lobban’s (2000) approach may thus be adopted as a *modus operandi* for presenting formulations to clients, whether the more complex case formulation or standard nomothetic formulation is adopted. Kinderman and Lobban’s (2000) incremental increase in disclosing complexity of the formulation to clients compliments the position that the formulation develops throughout therapy as more information is acquired.

Kinderman and Lobban (2000) further advise that interventions evolve in parallel with the formulation, indicating that interventions are informed by the formulation. The authors have already advocated a collaborative approach in developing the formulation, so it may be assumed that interventions that evolve in parallel with the formulation will likewise be established collaboratively. Although the word ‘intervention’ has the unfortunate connotation of one person acting on another, it is assumed from the authors’ discussion of the “therapeutic contract” (Kinderman & Lobban, 2000 p310) that this too is intended to be established collaboratively.

Kinderman and Lobban’s (2000) discerning application of cognitive models of psychosis in informing the collaborative development of a case formulation provides an interesting corollary in terms of the debate relating to evidence based practice and practice based evidence. In terms of the former, the authors were informed by existing

cognitive theories from which they inferred that deficits in abstract reasoning, mental flexibility and reasoning would inhibit engagement in therapy based on a shared understanding of the formulation. However, their case study demonstrates that these deficits were either overcome or managed by an incremental increase in complexity. This 'allows' the possibility that 'deficient' cognitive functioning within psychosis is amenable to change, and may help determine the extent to which psychological and/or biological factors are influential. This advocates a reciprocal and recursive approach between 'evidence based practice' and 'practice based evidence' in informing theory and practise.

Empirical studies of the relationship between formulation, alliance and outcome

Impact of case formulation on therapeutic relationship in psychosis

Although there is a paucity of controlled trials in relation to the question of the relationship of the formulation with the therapeutic relationship and alliance (Bieling & Kuyken, 2003), several experimental studies examine the evidence of the effectiveness of the formulation proposed in the previous critiques and case studies. Chadwick, Williams and Mackenzie (2003) assessed the impact of a case formulation in CBT for psychosis. They conducted two experiments. Firstly they assessed the impact of the case formulation (CF) in CBT for psychosis on the perception of the therapeutic relationship. This involved measuring the assumptions that the CF enhances the therapeutic alliance, and that the CF eases distress. Experiment 2 assessed the impact of the CF on the three main outcomes in CBT for psychosis: distress, distressing secondary delusions, and negative beliefs about the self. Both experiments investigate the assumption that therapeutic outcome / reduction in symptoms is influenced by the CF, but as Experiment 1 relates more directly to the question of the current review regarding

the relationship of the formulation to the therapeutic relationship and alliance comments will be limited to this.

Experiment 1 involved a within-subjects repeated measure design, as well as qualitative semi-structured interviews relating to clients' experience of the formulation. A standardised self-report questionnaire of the therapeutic alliance, the Helping Alliance Questionnaire (HAQ), was used. Chadwick, Williams and Mackenzie (2003) describe this as measuring the "attributes central to CBT" (p672) such as collaboration, goal setting, and shared understanding. This compares with Tompkins' "three interdependent components of the therapeutic alliance: the relational bond between client and therapist, the specific tasks of psychotherapy, and the goals of psychotherapy" (Tompkins, 1999 p322). The HAQ, which has parallel client and therapist rated versions, has established reliability and validity. Symptoms were measured using the Hospital Anxiety and Depression Scale (HADS).

A baseline phase, during which there was no sharing of a cognitive model, case formulation, or challenging of beliefs, involved gathering information to inform the CF. This was followed by a CF phase of two sessions devoted to exploring an individualised CF. Accordingly, this constituted four consecutive sessions. The CF phase of two sessions involved the use of a diagram and letter. Letters included possible risks to the therapeutic alliance, such as mistrust of the therapist. HAQ and HADS data were analysed from the two baseline sessions prior to formulating and the two subsequent CF phase sessions. Semi-structured interviews were also conducted independently with clients and therapists subsequent to the formulation to discern their experiences of the formulation.

Chadwick, Williams and Mackenzie (2003) conclude that despite general improvements in clients' scores the hypothesis that the CF has a significant impact is not supported. However, these inferences may be based on methodological limitations.

For example, if the HAq measures the therapeutic alliance, of which one of the features is a 'shared understanding', it is questionable that this measure should be used during the baseline phase before the formulation has been shared. It should also be observed that mean HAq scores during the baseline phase, i.e. prior to presentation of the formulation, already fall within the positive perception category. Therefore, although neither significant statistical or clinical change can be confirmed from the data, neither can it be inferred that clients did not have a positive perception of the therapeutic alliance. It may be that the demand effects of therapy and of the research interview questions prompted positive responses. A demand effect may also have been prompted by the inclusion in the CF letter of the risks to the therapeutic alliance, such as mistrust of the therapist. This may have suppressed scores to the extent that statistical difference was not achieved, albeit categorically scores supposed 'positive perception' of the alliance remained.

It is possible that an interaction of a positive expectation of therapy and therapist with the remarks of 'potential mistrust' may have created some ambiguity and ambivalence which therapists may not have had the opportunity to explore with clients in the 2 sessions in which they shared the CF. Furthermore, inasmuch as scores were recorded merely for 4 consecutive sessions, two prior to the sharing of the CF and two after, it is difficult to generalise the findings of this study, since in clinical practice formulations may be developed and shared beyond two sessions (*cf* Kinderman & Lobban's, 2000, 'evolving formulation'). This objection is anticipated by Chadwick, Williams and Mackenzie (2003), who recognise that in clinical practice the formulation "is not presented in one go" (p675).

It is paradoxical that a controlled trial and mean scores should be used to evaluate the idiosyncratic case formulation. However, consideration clearly needs to be given to how descriptive statistics and measures of central tendency, such as mean

scores, are to be used to represent idiosyncratic formulations and meanings. In terms of their qualitative findings, 11 of the original sample of 13 consented to participate in the semi-structured interview. Nine of these spoke about the formulation increasing their understanding of their problems, whilst 3 felt that the therapist understood them. Six reported positive emotions, such as feeling more optimistic, although six clients also reported negative emotions, such as feeling upset. However, 4 of those reporting negative feelings had also provided positive remarks. Two clients found the formulation complicated. For therapists, however, the experience of the CF was much more positive, including the general sense of it enhancing the alliance and sense of collaboration.

Chadwick, Williams and Mackenzie (2003) conclude that although ratings for the alliance were positive, their data do not support the hypothesis that this was due to the CF. The limitations of the methodology have already been considered. However, the authors offer an interesting and provocative consideration: in view of the CF being assumed by therapists to have an impact on the alliance whereas several clients reported negative emotional reactions, if these findings were to be replicated it may infer the CF to be a “a point of therapist-client distance” (Chadwick, Williams & Mackenzie, 2003 p675). Whilst this appears to be a bold challenge of current theoretical assumptions, and an admirable consideration of negative results and unsupported hypotheses (much under-represented in clinical journals), it may nevertheless miss the point, failing to set the negative emotions in the same context as the co-existing positive emotions these clients experienced. It may be that an alliance can be established despite negative emotions being experienced by clients. This issue is often contemplated in discussing ‘informed consent’ with clients at the beginning of therapy, e.g. ‘no guarantee you will get/feel better; you may (at times) feel worse before you improve’.

Effect of case formulation on process and outcome in depression

In view of research demonstrating that psychotherapy works compared to no therapy, but failing to show the superiority of one therapy above another, Hess (2001) emphasises the need to demonstrate *how* therapy works rather than *if* it works. She adopted a multiple single case experimental design in a sample (N=7) of clients with depression, testing Persons' (1989) case formulation model of cognitive therapy. This proposes that lasting therapeutic change occurs through changes in core beliefs. Accordingly, an idiosyncratic formulation is developed of the underlying mechanism maintaining the client's cognitive, affective, and behavioural symptoms. It is proposed a collaborative exploration of this formulation will lead to interventions intended to challenge and change the underlying core belief, leading to symptom reduction. Hess (2001) predicted that there would be a significantly greater decrease in client symptoms as a result of proposing the underlying mechanism, as well as significant positive changes in ratings of the therapeutic alliance, perceived therapist empathy, and ratings of the quality of the sessions.

During a baseline phase clients were 'socialised' to therapy, in terms of informing them of therapeutic tasks such as homework and working on specific problems during sessions, and to the cognitive model of depression, therapists attempting to establish a therapeutic alliance by nurturing a collaborative approach. In this context, detailed information was gathered concerning thoughts, mood and behaviour. Family history, including relationship patterns, was also elicited, with a view to supporting the hypothesised core belief. Accordingly, it might be inferred that a case formulation is established in the context of and dependent on a developing therapeutic alliance. However, it can equally be seen that the alliance was established in the context of being educated about the cognitive model. It may be difficult to distinguish cause and effect in this question (*cf* DeRubeis & Feely, 1990) but it may be

suggested that interrelationships exist, as is also proposed by Rector, Zuroff and Segal (1999) in relation to the association between the alliance, cognitive change and outcomes.

The sharing of the case formulation, in terms of making explicit the underlying mechanism / core belief, marked the beginning of the treatment phase of therapy. The case formulation guided the therapist and client as to which problem behaviours and cognitions to attend to. Repeated measures included the Outcome Questionnaire (OQ-45), a self-report instrument of client progress; the Stages of Change Scale (SCS), which measures the four stages in therapy: Pre-contemplation, Contemplation, Action and Maintenance; the client and therapist versions of the Working Alliance Inventory (WAI), providing scores on Task Agreement, Goal Agreement, and Bond Development, as well as an overall alliance index; the Empathy Scale (ES), in which clients rate therapists for perceived warmth, care and empathy; and the Session Evaluation Questionnaire (SEQ), measuring two independent dimensions of clients' perceptions of their sessions, viz. Depth and Smoothness, and two dimensions of their post session mood: Positivity and Arousal. These measures represent the dependent variables.

Data analysis, involving visual inspection of graphs to determine whether changes occurred as a result of treatment (which is the traditional method of analysis for the methodology used) failed to show any distinct patterns on any of the dependent variables. In her presentation and discussion of the results, Hess (2001) notes that three of the clients reached the ceiling on the ES measure either immediately before or shortly after the treatment phase. This trend was compared with the WAI-Bond scale to determine whether this was actually indicative of clients reaching a positive stable level of therapeutic alliance. Graphed data suggest that this was the case for two clients, but not for the third, whose ratings fluctuated widely during both baseline and treatment phases. Hess (2001) considers the lack of discernable change for each dependent

variable respectively following the presentation of the formulation of the core issue.

Space does not permit comment on all of her considerations. However, the following considerations are noteworthy in view of their relevance to the review question, both from a clinical and from a research perspective.

In the majority of cases, the presentation of the core issue did not change the working alliance from how it was developing during the baseline phase, so the formulation may not be considered to have had an impact on the alliance. This begs the question as to what was responsible in those cases where there was a positive alliance before and/or after the introduction of the formulation. One possibility could be the demand effects of taking part in therapy and the questions about therapy. Hess (2001) proposes that the client responses may have reflected “an investment in viewing their therapists as good and competent” (p89), which was contradicted by post therapy interview responses, such as, “I think I sometimes wanted to give the right answer, more than the true answer” (Hess, 2001 p89). This might be considered in relation to the possibility that the therapists’ formulation of the core issue was flawed, so that despite a nominal willingness to re-examine and revise what was proposed as a hypothesis, in actual fact none of these initial hypotheses were altered for any of the clients. Hess (2001) considers the possibility that these limitations might have been minimised by encouraging more sessions before presenting the formulation. If this were to occur the treatment phase might need to commence from the final collaboratively established formulation of the ‘core issue’. It may also be that less structured interviews and questionnaires would have reduced demand effects. What is apparent from reference to transcripts of client interviews is the lack of consensus between clients and therapists on the nature of the core issue, so that it is difficult to be certain from this study whether the formulation is facilitative of the working alliance, or vice versa.

Relationship between technical and non-technical factors

The articles reviewed thus far have focused primarily on the case formulation (CF) approach, and mostly in relation to complex cases. Alternatively, following a manualised cognitive-therapy approach, Rector, Zuroff and Segal (1999) considered whether a reciprocal interaction exists between 'technical' and 'non-technical' aspects of cognitive therapy in a sample of clients with depression and/or anxiety disorder. 'Technical' factors were understood as the therapeutic skills, such as Socratic dialogue and guided discovery, employed to produce change in maladaptive cognitions. 'Non-technical' factors included the quality of the therapeutic relationship in terms of warmth and mutual liking (Rector, Zuroff & Segal, 1999). The authors propose that technical skills such as Socratic questioning are as likely to nurture a therapeutic alliance as produce cognitive change. Their study addresses the little researched question as to whether the 'technical' and 'non-technical' aspects of therapy are "mutually facilitative" (Rector, Zuroff & Segal, 1999 p320), and proposes that they interact reciprocally throughout therapy. In considering this study it is assumed that the 'technical skills' are based on a manualised problem formulation of depression, and the results are viewed in this context.

Firstly, it was predicted that clients with higher pre-treatment depressogenic scores, as measured by the Dysfunctional Attitude Scale (DAS), would report a poorer therapeutic relationship in the early stages of therapy, as measured by the Working Alliance Inventory. Correlations were conducted between the DAS and a two-dimensional alliance scale: WAI-Goal/Task and WAI-Bond, representing the distinction between the work of therapy and the trust and closeness of the therapeutic relationship. A significant negative relationship between DAS and WAI-Bond scores supported the hypothesis. However, pre-treatment DAS scores were unrelated to WAI-Goal/Task scores. This suggests that clients may find difficulty forming a trusting relationship

with the therapist without it affecting the tasks of therapy. This might be compared with the inference from Tompkins (1999) that the quality of the therapeutic alliance depends on the degree of congruence between therapist and client. It is interesting that in discussing these findings the authors propose that dysfunctional beliefs not only affect the “processing of personally relevant information” but also provide a “blueprint for how interpersonal interactions are processed and interpreted” (Rector, Zuroff & Segal, 1999 p326). This implies that an understanding of idiosyncratic beliefs is important, and that these aspects of the formulation provide predictability for therapy (Persons, Curtis & Silberschatz, 1991). This again supports the value of establishing individualised formulations in concert with nomothetic approaches.

Secondly, to test whether a positive therapeutic alliance (a ‘non-technical’ factor) facilitates the implementation of the technical aspects and subsequent change in depressogenic cognitions, it was hypothesised that greater agreement by clients on the goals and tasks of therapy, which may equate to the ‘treatment plan’ in Persons’ (Persons, Curtis & Silberschatz, 1991) seven factor case formulation, would predict subsequent engagement in specific therapeutic tasks (Rector, Zuroff & Segal, 1999). WAI dimension scores were examined in relation to residualised DAS scores. DAS scores served as the dependent variable, WAI-Bond and WAI-Goal/Task as predictor variables. Results showed the WAI-Goal/Task dimension to be the single predictor of DAS change, suggesting the extent of client agreement with the goals and tasks of therapy was predictive of change in dysfunctional beliefs. However, the WAI-Bond dimension was not related to facilitation of cognitive change. These results suggest that implementation of cognitive change strategies depends on acceptance of the goals and tasks of therapy, and by implication the formulation.

Thirdly, a regression analysis determined whether aspects of the therapeutic alliance and the degree of cognitive change across therapy were predictive of depression

outcome. This involved final BDI scores as the dependent variable, with WAI-Bond, WAI-Goal/Task, DAS-Change scores, and the two-way interactions between WAI-Bond and DAS-Change scores, and between WAI-Goal/Task and DAS-Change scores, as independent predictors. Results indicated reduction in dysfunctional thinking was related significantly to a reduction in depression only when there was a strong therapeutic bond. Rector, Zuroff and Segal's (1999) results indicate the positive benefit of a strong therapeutic bond, although the relationship with the formulation is less apparent and more implied than in the articles already reviewed.

Investigation of the review question is made more difficult in reviewing outcome studies, such as Rector, Zuroff and Segal (1999) and DeRubeis and Feely (1990), inasmuch as the issue of the formulation is less explicit than in those reporting case formulation. It is also complicated by the variance in the terms and concepts used and measured. Rector, Zuroff and Segal (1999) report 'technical' and 'non-technical' aspects of therapy, whereas DeRubeis and Feely (1990) speak of 'concrete' and 'abstract'.

DeRubeis and Feely (1990) found reduction in depression following 'theory-specified actions' of therapists. In particular, this outcome was predicted by the "cognitive therapy-concrete methods" (CT-Concrete) factor, which had been determined by factor analysis of the Penn Helping Alliance scale and the Collaborative Study Psychotherapy Rating Scale. This factor includes such items as 'examined evidence concerning beliefs' and 'asked patient to record thoughts'. It represents pragmatic aspects of cognitive therapy in engaging clients in scrutinising their problems, conducting simple and specific tests of their beliefs. The other cognitive therapy subscale identified in the factor analysis, CT-Abstract, was less focused. It included items such as 'explored personal meaning of thoughts' and 'therapist explained direction in session'. The CT-Abstract factor did not relate to outcome. However,

DeRubeis and Feely (1990) observe that CT-Abstract did not show a negative effect, simply the lack of a positive one.

Conclusions

The current literature review has considered the role and utility of the formulation within CBT in relation to the therapeutic relationship and alliance. The formulation has been described as a way of collating and synthesising clinical data according to cognitive models of psychopathology, providing a theoretical and evidence-based description of the client's problem, and a framework and direction for therapy. The relative merits of 'nomothetic / problem' and 'idiosyncratic / case' formulations have been considered. These may not be mutually exclusive either in principle or in practice. Therapists may be guided by problem formulations and cognitive models in developing case formulations with 'complex clients'. The formulation has also been seen to have utility in developing and maintaining the therapeutic relationship and alliance. Although research evidence relating to the nature of this relationship is equivocal, clinical report and review suggests a dynamic reciprocal and interdependent evolution of the alliance and the formulation, which develop concurrently and in interaction with each other throughout therapy. The therapeutic relationship, in terms of basic therapist skills, such as empathy and positive regard nurturing client trust and confidence, may be the mediating factor. Further research is needed to differentiate these factors and their relative contribution and relationships within CBT.

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Clients' experience of the formulation
within cognitive-behavioural therapy: An
Interpretative Phenomenological Analysis

Clients' experience of the formulation within cognitive-behavioural therapy: An Interpretative Phenomenological Analysis

Abstract

This study explored clients' experience of the formulation within CBT from the clients' perspective in order to provide a clearer understanding of its use and influence on therapy. Data collection and analysis involved Interpretative Phenomenological Analysis allowing clients' perspective to be reported. A sample (N=8) of clients with depression and/or anxiety disorders who had completed the 'acute phase' of therapy was interviewed. Transcripts of semi-structured interviews produced five master themes: Somebody that listened and understood – trust in therapist; Understanding what happens; A Foundation and Direction – Something to start from, something to work on; Working to a plan; and Effectiveness and Self –efficacy. These master themes and associated sub-themes, representing clients' experience of progress through therapy and the experience and process of formulation, are seen to have reciprocal and recursive relationships. The general experience of clients was of a collaborative and trusting relationship with their therapist. Clients reported a positive experience of gaining an understanding and control of their problems, improvement and increased confidence being related with the 'finding an answer' and the ongoing relationship with their therapists.

Introduction

Within cognitive-behavioural therapy, the formulation offers a theoretical and evidence based description of a client's problems (Beck, 1995). It has been contrasted with the categorical diagnosis (Bruch, 1998) inasmuch as it attempts to collate and synthesise data describing the dynamic interaction of a person's cognitions, mood and behaviour (Persons, 1989), emphasising in particular the mediating influence of the

person's cognitions (Beck, 1995). These thoughts typically reflect underlying schemas (Wells, 1997) and are characterised by biases common to a particular psychological disorder in the form of negative expectations and interpretations (Clark, 1989). It is assumed that challenging and changing these specific cognitions will bring change in the person's mood and conduct, alleviating distress and 'maladaptive' behaviour (Greenberger & Padesky, 1995).

Various paradigms of the formulation have been proposed. These include conceptualising a person's problems in terms of overt difficulties at a macro / nosological level; and at a micro level, referring to specific cognitions, behaviour and mood, and underlying beliefs and schemas (Persons, 1989). Alternatively three time frames are considered, representing present problematic thoughts and behaviour, proximal precipitants or triggers, and distal predisposing factors, such as early experience and family values (Beck, 1995).

Particularly with more complex presentations, case formulations may be developed which attempt to represent the idiosyncratic nature of the person's problems. Although it has been claimed the case formulation approach lacks the validity and empirical integrity of the standardised/manualised formulation (Ward et al, 2000; Wilson, 1996), the two approaches may not in fact be mutually exclusive either in principle or in practice (Mumma, 1998).

For the present purposes, the 'formulation' will be assumed to denote a theory-driven hypothesis about the psychological processes relating to a client's difficulties (Tompkins, 1999). Kirk (1989) describes the formulation as an initial hypothesis derived from interview and assessment, driven by research and evidence (Bruch, 1998; Tarrier & Callam, 2002) towards reaching a shared understanding with the client of their problems (Salkovskis, et al, 1998; Warwick, 1995). A collaborative approach is adopted in reaching this shared hypothesis / understanding (Fowler, Garety & Kuipers,

1998). Similarly, the formulation may be refined (Haddock & Tarrier, 1998) and/or elaborated (Kinderman & Lobban, 2002) collaboratively, either as additional information becomes available, or the client becomes more able to deal with greater complexity.

The formulation is said to have utility as a guide and focus for therapy (Beck, 1995) and in “securing and maintaining client-therapist collaboration” (Tompkins, 1999, p317). In terms of the assumption that the formulation is dependent on a collaborative relationship it might be supposed to be inextricably linked with the development of the therapeutic alliance, which is similarly dependent on and characterised by collaboration between therapist and client (Salkovskis et al, 1998). Accordingly, the therapeutic alliance and the formulation have been described as “mutually facilitative” (Rector, Zuroff & Segal, 1999 p320), the alliance and the formulation developing concurrently and in interaction with each other throughout therapy.

Two reciprocal relationships are apparent in this respect: that between the formulation and the therapeutic alliance (Rector, Zuroff & Segal, 1999), and that between the therapist and client. Whilst it has been proposed that the mediating factor between the formulation and alliance is dependent on basic ‘counselling skills’, such as rapport, empathy, trust and genuine positive regard (Sanders & Wills, 1999), it should not be forgotten that the client is also essentially active in this interactive collaborative relationship.

It would be incongruous if a model purporting to alleviate emotional distress, recognising in the formulation the interpersonal context of clients’ problems, e.g. social phobia (Wells, 1998), should fail to take account of emotional responses within the interpersonal encounter of the therapeutic relationship. Cognisance of the interpersonal and emotional aspects of CBT is to be found in the literature, despite allegations

cognitive therapy ignores these factors. Gluhoski (1994) cites references emphasising the importance of the therapeutic relationship in response to misconceptions that it is irrelevant in cognitive therapy, affirming, for example, the importance of therapists addressing transference reactions, as well as recognising that an intense emotional reaction in the client is indicative of the activation of a critical cognition (Gluhoski, 1994).

This suggests that client experience within CBT is a source of significant and relevant therapeutic enquiry. The nature and content of these experiences, in the form of emotions, thoughts and behaviours, have been described by clinicians. These might be explained in terms of 'the formulation'.

Equally, the formulation might predict experiences and reactions within therapy. This is predicated by Arntz (1994) in relation to clients with borderline personality disorder (BPD). In view of a nomothetic formulation of BPD he anticipates clients will be ambivalent, both desiring help but fearing rejection, consequently avoiding engagement. In view of this assumption he proposes clients be allowed as much control as possible, within clearly defined therapeutic boundaries, as well as being given choice in the use of therapeutic method. His report of a 'successful' outcome in a female client with BPD might imply that her experience of therapy involved a sense of control and of choice. It is debateable to what extent this could be supposed to represent the client's experience of the formulation rather than therapy per se or some other aspect of therapy. The association might be inferred on the basis of the shared formulation and therapist assumptions, although in this example the evidence is tenuous and circumstantial.

With respect to engagement, Dunn (2002) supposes two aspects: the engagement of the client with the therapist, and the client's engagement with therapy. Dunn (2002) proposes that "engagement is not just liking somebody or something" (p43), but involves understanding, respect and shared goals. A positive perception of the therapist

by the client, for example, as believable, trustworthy and expert, is 'expected' to facilitate engagement and socialisation to the cognitive model. Dunn (2002) describes the development of an initial formulation based on Beck's cognitive model. She reports her client's desire to be understood and her subsequent appreciation of the collaborative nature of therapy and consequent confidence and hope (Dunn, 2002).

Salkovskis et al (1998) similarly describe therapists and clients working towards a shared understanding. In this process they assume the use of a diagram as a summary of the formulation, as well as using the client's own words. The shared understanding assumes that the formulation enables the client to understand the rationale for interventions. Warwick (1995) describes one of the common areas of dissatisfaction amongst clients with hypochondrias prior to therapy as being due to an unsatisfactory explanation of their problem. Although clients' own conceptualisations and misconceptions might have contributed to this dissatisfaction in terms of a lack of a shared understanding, the CB therapist's attempts to formulate the problem in psychological terms, checking clients' understanding by asking them to repeat it back, might prevent further dissatisfaction. This might give clients the sense that they have been listened to (Fowler, Garety & Kuipers, 1998; Moorhead & Turkington, 2001).

In terms of prediction, reference has been made to the formulation providing a guide for therapy (Beck, 1995). This might be used by the therapist when the client is not 'responding' to therapy (Tompkins, 1999). The formulation has similarly been described as a working map *of* the client (Sanders & Wills, 1999). This begs the question, from a client perspective, whether it similarly provides a guide or map *for* the client, although Sanders and Wills (1999) assert that therapy is explicit and therapists share their hypotheses and formulations with their clients.

Caution may be needed in presuming the validity of these reported client experiences and in attempting to generalise them as they are often inferred from the

therapist's perspective on the basis of clinical outcome, and may be based on conjecture and premise. In such cases client experience may be presumed as much as reported. There is a need to enquire from the client perspective what their experience of therapy and of the formulation has been.

Adopting a multiple single case experimental design in a sample of clients with depression, Hess (2001) predicted that there would be a significantly greater decrease in client symptoms as a result of proposing the case-formulation, as well as significant positive changes in ratings of the therapeutic alliance; perceived therapist empathy, and ratings of the quality of the sessions. Inspection of the data failed to support the predicted benefits of the formulation on the alliance or any of the other dependent variables across the sample. A qualitative analysis of transcripts was also conducted to determine clients' reaction to the introduction of the formulation, as well as its impact on the process of therapy. This indicated a general lack of consensus between clients and therapists on the nature of the core issue. Despite methodological limitations of the measures used (Hess, 2001), it might be inferred that a general lack of a shared understanding of the formulation accounted for the failure to observe the expected benefits of sharing the formulation. However, respondents' experiences were more likely to be ambivalent than negative, for example, feeling heard and supported but not fully understood.

Chadwick, Williams and Mackenzie (2003) similarly conducted a within-subjects repeated measure design for clients with psychosis, as well as qualitative semi-structured interviews relating to their experience of the formulation. Whilst they also concluded that the formulation failed to have a significant impact on the therapeutic alliance, they also reported co-existing and ambivalent positive and negative emotions.

Wright and Davis (1994) favoured a qualitative approach, using open-ended enquiry as a method of assessing client expectations from therapy, asking clients to

discuss what they wanted mental-health professionals to learn about them. This provided a list of basic requirements from the client's perspective regarding client satisfaction. These included a provision of a safe and professional setting; being treated seriously and with respect; feeling the therapist is knowledgeable and experienced, providing appropriate information; and feeling empowered and able to make independent decisions.

There is an evident paucity of research into client experience of CBT from the client perspective in general, and of their experience of the formulation in particular, despite the universal acceptance amongst therapists of the formulation being essential to CBT. Client experiences, both positive and negative, have been largely assumed from the therapist's perspective, inferred from analyses of outcomes of case studies. Some attempts have been made to introduce more controlled investigation in terms of within subject repeated-measures and multiple single-case experimental designs. These may be limited by constraining client responses to the repertoire prescribed in standardised measures, although they have been complimented in those studies cited by semi-structured interview. More open-ended and non-directive approaches might be more appropriate in soliciting client's own experiences from their perspective.

Aims

In view of the lack of qualitative research of the clients' perspective and experience of the formulation within CBT, the principle aim of this research will be to focus on participants' experience. This might provide a clearer understanding of its use and influence on therapy.

Method

Participants:

A purposive sample of 8 clients was recruited from a specialist NHS psychotherapy and adult mental health service. Seven clients were female, one male. Ages ranged from 28 – 63. Client characteristics are shown in Table 1.

Table 1: Client characteristics (names have been anonymised)

Client	Sex M/F	Age	Status	Presenting problem
Brenda	F	63	Divorced, previously widowed. Lives alone	Depression, anxiety and panic attacks. Previous alcohol problems
Dorothy	F	36	Married	Panic attacks
Gail	F	40	Single. 'Never married'	Panic attacks
Susie	F	33	Married	Health anxiety, OCD and post-natal depression
Clare	F	29	Lives with partner	Depression
Alan	M	58	Married	Needle/blood phobia
Paula	F	28	Married	Panic – speech difficulty
Denise	F	43	Married	Depression / OCD

Participants were recruited by their therapist at the end of the 'acute-phase' of CBT, and interviews conducted by the researcher within one month during the 'follow-up' phase prior to discharge. Accordingly, participants were able to contact their therapist for any reason related to the research interview, for example, experiencing distress. Recruitment was undertaken by therapists during the closing therapy sessions to avoid contaminating either therapy or the study by 'demand effects'. The rationale of recruiting clients at the end of therapy was to avoid experiences relating to time and the development and experience of the formulation during therapy from being precluded.

The psychotherapy service involved has consistent protocols for assessment, formulation and intervention. Therapists were all trained in cognitive-behavioural therapy, which was used as their main orientation in therapy with the clients recruited to the study. Therapist adherence to CBT was ensured by communicating the research protocol to therapists, verbally and in writing, prior to recruitment. Therapists

confirmed their adherence to this protocol involving adherence to the CBT model in terms of a formulation informed intervention both during this initial consultation and at the subsequent referral. The final sample of eight clients was recruited by five different therapists. One therapist recruited four clients, each of the other four therapists recruiting one client each.

Data collection

Client recruitment took place at the penultimate therapy session of the acute phase of therapy. Therapists requested client participation, outlining the nature of the research question and procedure. Clients who indicated their willingness to participate were given the Client Information Sheet (appendix 1). The penultimate session was preferred for recruitment as this provided the opportunity to discuss any concerns with their therapist prior to contact with the researcher and signing the Consent Form (appendix 2). In view of ongoing difficulties recruiting participants, enquiry was made relating to the assumed difficulties and reasons for clients' refusal to participate. A questionnaire was forwarded to each therapist requesting feedback regarding the number of clients approached, and the circumstances and reason of client refusal. In view of the failure of any therapists to respond to this questionnaire, no information is available regarding the nature of or reason for refusal.

Data were gathered using semi-structured interviews. Semi-structured interviews are consistent with the ethos of qualitative analysis, allowing more flexibility, and greater novelty and individuality, than structured interviews (Smith, 1995). This was consistent with the aims of the study and method of data collection and interpretation adopted: Interpretative Phenomenological Analysis (IPA). Subsequent qualitative analysis attempted to capture the richness of emergent themes from client responses (Smith, 1995).

Interviews lasted 45 – 60 minutes. Questions were designed to allow participants to describe in their own words their experience of the formulation (see ‘Interview Schedule’, appendix 3), the emphasis being non-directive, allowing participants to say how they saw things (Seale, 1998). Issues that arose that seemed of particular relevance and interest were probed (Smith, 1995; Smith, Michie, Stephenson & Quarrell, 2002). Interviews were audiotaped and the audiotapes subsequently transcribed by an independent transcriber, who was required to sign and comply with a Confidentiality Form (appendix 4).

Data analysis

Choosing a method / Reason for choosing IPA

IPA was considered the most appropriate method of data collection and investigation of client experience of the formulation within CBT. This approach focuses on the client’s perceived meaning (Smith, 1995; Willig, 2001), avoiding presumptions about responses. IPA is concerned with trying to understand how clients make sense of their experiences and the meanings those experiences hold for them. IPA tries to explore an individual’s personal perception of an event as opposed to attempting to produce an objective record of the event itself (Duncan, 2001; Smith, 1996). However, it acknowledges that this is dependent on the researcher’s own conceptions which are required to make sense of the other person’s world through a process of interpretative activity (Smith, 1996: Smith, Jarman & Osborn, 1999).

Other qualitative methods which might have been used include Grounded Theory and Discourse Analysis. The emphasis in Grounded Theory is on theoretical development (Charmaz, 1995), IPA focusing on a detailed analysis of an individual’s perception and perspective (Smith, 1995). It was not supposed in this research to elicit new theory but to explore the experience of theoretical and clinical assumptions. IPA

was also preferred above Discourse Analysis because, although both emphasise the importance of respondents' language, IPA is more inclined to recognise cognitions associated with verbal responses (Smith, 1996; Smith, Jarman & Osborn, 1999). This was considered important in view of the significance of cognition within CBT.

Quantitative methods using reliable and standardised questionnaires may have provided frequency and degree of particular prescribed experiences, but would have precluded novel and idiosyncratic responses.

The process of IPA

Key themes were elicited and interpreted by examination of interview transcripts. The initial stage of analysis involved reading and re-reading a transcript, making notes reflecting initial thoughts and observations. At this stage all themes were treated as potential data. Emergent themes were identified and labelled in the right-hand column of the transcript (appendix 5). These were listed on a separate sheet, and relationships between these themes were observed, allowing them to be clustered and subsequently labelled. Clustered themes were subsequently checked against the original transcript to ensure reliability of the observation and validity of the theme title (Smith, 1995; Smith, Jarman & Osborn, 1999). Stiles (1993) proposes that *reliability* refers to "the trustworthiness of observations" and *validity* to the "trustworthiness of interpretations or conclusions" (p601). Reliability and validity was further ensured by credibility checks with other qualitative analysts (Elliot, Fischer & Rennie, 1999), including the research supervisor. Clustered themes were examined producing a further master list of superordinate themes. These master themes and their related subordinate themes were collated in tabular form, and referenced to the transcript by key words, page and line numbers.

This process was repeated independently for each transcript. Ultimately, the master themes from each transcript were collated, producing a consolidated list of master themes across the sample. Again, these were referenced to and checked against each transcript to ensure reliability and validity of the theme.

Smith, Jarman and Osborn (1999) propose that with more than one transcript it is permissible to use the master-theme list from the first interview to look for examples in the next, being ready to identify new themes, or alternatively to repeat the process used in the first analysis with each subsequent transcript. In this case, a consolidated list of master themes is produced for the group. The latter approach was preferred in this study. It was felt that this would limit researcher bias and imposing interpretations onto subsequent transcripts. This was considered consistent with the rationale of avoiding presuming client experience on the basis of what was reported in the literature. In adopting this approach the researcher was aware that previous themes were inevitably remembered. However, attempts were made to minimise any bias by grounding theme titles as much as possible in the participant's own language. It was thus supposed that concordant themes would be representative of the sample.

Results

Analysis of the transcripts identified five master themes and six sub-themes which encapsulate the general experience of therapy for each participant, representing participants' progress through therapy and the process of formulation. The connections between the themes and their relationship with existing theory will be considered in detail in the 'Discussion'. Figure 1 illustrates and summarises how these themes appeared to the researcher to be linked in participants' experience. The five master themes are placed along the vertical axis, and generally represent participants' progress through therapy:

- Somebody that listened and understood – Trust in therapist
- Understanding what happens
- A foundation and Direction – Something to start from, something to work on
- Working to a plan – stopping the circle
- Effectiveness and Self-efficacy

The complimentary parallel vertical arrow is intended to depict the recursive nature of participants' experience of therapy and its various 'tasks' further informing their understanding of their problems and reinforcing their trust in the therapist.

The outcome of therapy is described by the master theme 'Effectiveness and Self-efficacy'. This represents participants' experience of varying degrees of increased confidence, self-efficacy and symptom relief. The sub-theme, 'A matter of time' represents participants' references to time scales, such as how long they had had their problems, or how long they had been in therapy.

The three sub-themes depicted along the horizontal axis represent the process and experience of participants in reaching an understanding of their problem:

- Putting things in perspective
- Putting it into context (understanding why it happens)
- Descriptions and Diagrams

This is depicted in Figure 1 by the arrows linked with the master theme 'Understanding what happens', which represents a reciprocal and recursive relationship between these themes. In terms of 'Descriptions and Diagrams', two additional sub-themes might be included:

- Something practical and non-technical
- Perception / Image of formulation

The former refers to participants' acknowledgement of the use of language and descriptions they could understand, the latter to the mental image some had of the description and explanation of their problem.

The results section will reference these themes derived from analysis of the transcripts with extracts from the transcripts. The narrative of participants' experiences will be presented according to the five master themes describing their experience of progress through therapy with its complimentary relationships with the therapist and the shared understanding.

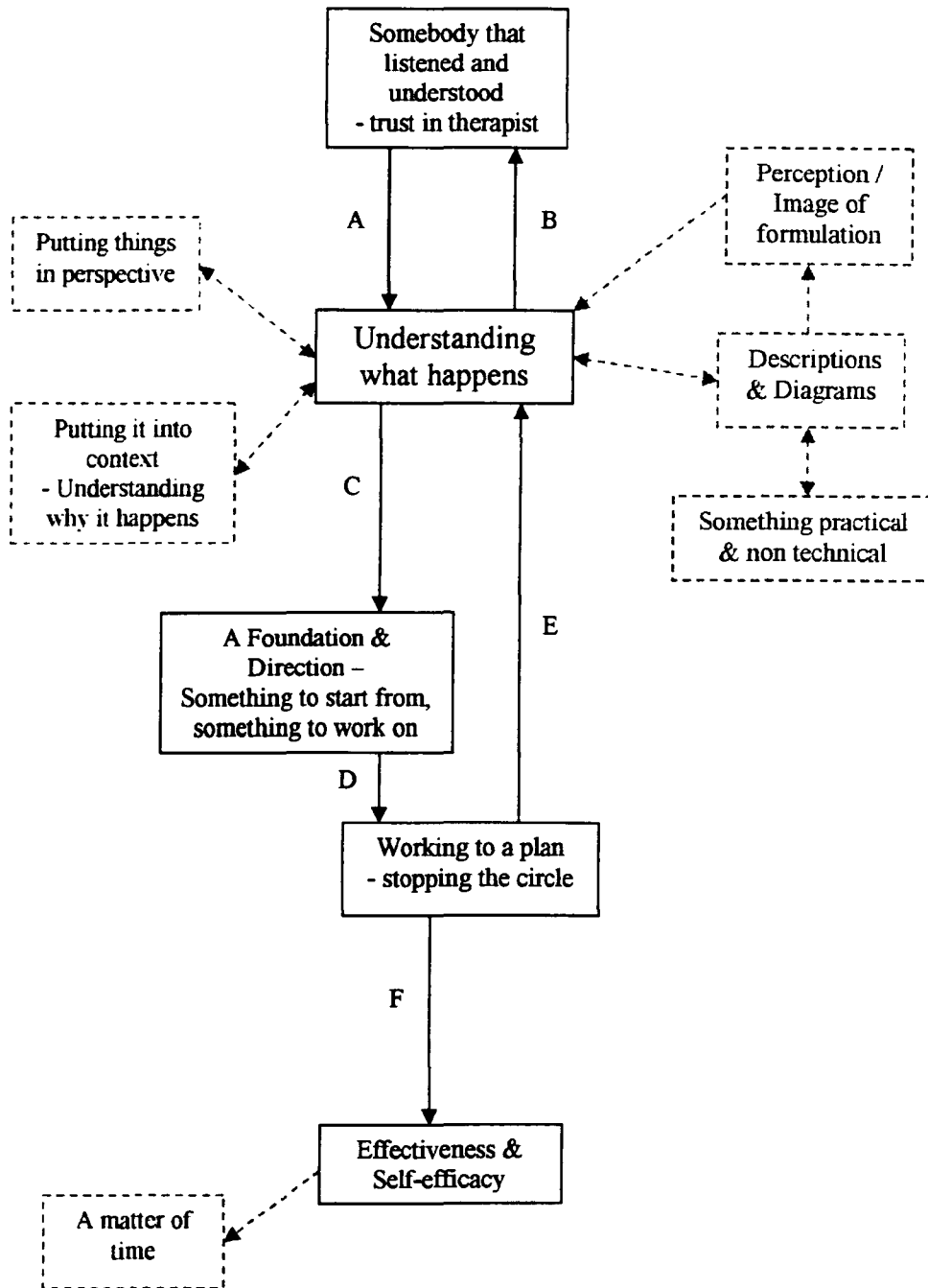


Figure 1. A summary of Master Themes: relationships between Master Themes and Sub-themes (connections and relationships depicted by arrows labelled A-F are reported and referenced from page 71)

Somebody that listened and understood: Trust in therapist.

Prior to therapy participants had attempted to manage their difficulties, but for each there was either little or no improvement, or else their problems were becoming

worse. As she felt less able to cope, Dorothy, who had been prescribed anti-depressants by her GP, but because of side-effects preferred to manage without, came to therapy looking for somebody who could help:

'these last couple of years ...I don't seem to have managed as well on my own, so I thought well perhaps there 's somebody who can help'

Participants, who had experienced difficulties over many years, hoped to be free of the symptoms and experiences that brought them to therapy, although there was initial apprehension:

*'Well to be quite honest I were just a mess, and I have been for years one way or another you know, these muddled up feelings.....
I just want to get better, so I will do what I have to do' (Brenda)*
'it's a bit unnerving, you know, to go somewhere like that... ..when I had my letter, 'mental health wellbeing.....' that's quite scary... and going's quite scary. But then, I suppose you just get a bit more used to it, and gradually you think 'well it's going somewhere, you want to get better' (Susie)

Participants' experience of therapy was different to what they had previously experienced either from friends or medical professionals. As they engaged with their therapists, they felt listened to and appreciated having somebody who understood and was able to explain their problems:

'it is good having somebody to work through with that, rather than the usual sort of 'well pull yourself together' which you'd often get from family maybe or friends that don't understand' (Paula)
'it would have been harder for me if it'd been...more of a doctor patient, relationship, ...where you have ...the expert clothed in his own speciality, dispensing wisdom over medicine to the patient, who just... has to accept it' (Alan)

Paula felt that the '*long assessment time*' was useful, helping her therapist work out what was maintaining her problems '*rather than going straight in and just doing therapy on something you don't understand*'.

Denise was happy to talk to somebody '*who wanted to listen*', even though '*reliving it again and talking about it in the first few sessions*' was upsetting for her.

Like Paula she appreciated these early assessment sessions, during which her therapist made *'sort of a formulation'*:

'And he's listened to what I've said, and he's understood what I've said, and there's something there that he knows that I can get rid of this'
(Denise)

The help participants were looking for was initially found in the ability of therapists to listen to and convey a sense that they understood their clients' problems:

'when I got talking and when I got to know her it were, somebody were listening to me' (Brenda)
'basically just having somebody that understands. Somebody there that can help you and explain it to you just gave me a big sense of relief'
(Gail)

This ability to listen and to explain participant's difficulties characterised therapy, and nurtured increasing trust and confidence in therapists. Therapists were perceived as professional and experienced, yet willing to work collaboratively to solve these difficulties:

'I think one element of therapy is to, is to have confidence in the therapist' (Alan)
'he explained that ...he'd heard it all before, and he'd heard this and... And that just made me feel a bit better' (Susie)
'it's just working together really in't it?' (Dorothy)

Understanding what happens

Following this initial contact with their therapist and the experience participants described of feeling listened to and having their problems explained, participants began to understand what was happening. This was often described in terms of a *'vicious circle'* and of connections between thoughts, feelings and behaviour:

'Well I could see that the, you know, the vicious circle, or the downward spiral as he calls it, which is what it is, I mean if you think about it, really what it is, it just so accurately describes what is happening'
(Paula)
'Well a lot of the automatic thoughts I was having were all negative for myself..... which was making me feel all...all the low things I was

*feeling... and it was, I think (****) showed me ...what was happening ...' (Clare)*

'she sort of explained things a bit more, you know, like these automatic thoughts and that, you know, like I said we've got a vicious circle about what you feel' (Dorothy)

However, participants' understanding developed differently in terms of time, but consistently in the methods of making descriptions. For example, for Dorothy *'it took a while'* to understand, but by constantly going over *'the same thing'*, things began to fit into place. For Clare understanding came relatively early in therapy as she found CBT to be consistent with how she perceived her own personality and interests:

'the main thing is just going over the same thing over and over again, you know what I mean, and trying to understand it... ..It were like, probably like a piece of a jigsaw sort of thing, you know' (Dorothy)

'part of my sort of personality and my makeup is, I like reading things and understanding things and going through a process that's quite logical. Which I think is why I liked this sort of therapy, because although I'd never thought about it before, nothing in there was rocket science, it all made sort of perfect sense if you just do it seemed to work' (Clare)

Similarly, for Denise her therapist's formulation *'brought it all together'*, providing her an accurate and simple explanation:

'it was sort of a formulation of the first three sessions that we did, talking about what I thought had caused it... ..he brought it to the fourth session and allowed me to read it and keep a copy of it...that's when I thought 'this is spot-on'.'.....it made it so simple for me really I suppose'

Descriptions and diagrams

What was consistent for participants was that explanations were given in a way that was logical and understandable, and the language and methods used perceived as non-technical and practical. This was the experience of Susie, who was not only helped by the explanations and information, but also the manner in which this was given:

(Interviewer) *'It sounds like you remember some of the words that he used?'*

(Susie) *'Yeah, but nothing was greatly technical.'*

(Interviewer) *'No?'*

(Susie) *'He used to explain everything. Mmm, yeah.'*

(Interviewer) *'...so how...how do you feel he did explain things then?'*

(Susie) *'Very well, yeah... he always used to do things matter of factly...
...he kind of give you information and it makes you believe, he doesn't
seem false, he seems sincere.'*

For Susie, therefore, the manner in which things were explained reinforced her trust in the therapist. Regarding the explanations of her own problems, in which her reassurance seeking was explained to her in terms of maintaining the *'vicious circle'*, Susie was able to see that she had *'to be on her own'*, not seeking reassurance from the therapist and ultimately from others, and she was able to differentiate reassurance and explanations given about her anxieties:

'...things with health anxiety and that, and he said he'd heard, you know, heard it all type of thing (laughs). So, I shouldn't say reassurance, but that does really reassure you really (quiet laugh)'

What was also consistent was the use of diagrams and written exercises.

Participants described the benefit of therapists drawing the *'vicious circle'*:

'he drew it on the paper. He just sort of said 'this is the start of it, then it goes to this next point, and you do such and such a thing, which comes back to this point here, and then we're back at the starting point, and then you're sort of off round again. (Gail)

'he used to write quite a lot down, you know, umm, like agenda and what he thought, like a cycle of, you know, what the behaviour was to a...a thought type of thing, and how it went round in a circle' (Susie)

For Dorothy it was not only reassuring to see her vicious circle written down, but she also had a mental image of it. This helped her understand and cope with further anxiety provoking thoughts:

'Well I just, I could just see it in my head now, you know... .. if I think back I can just see this circle now in my head with 'trigger,' 'anxiety,' and then your 'scanning,' and then your 'safety behaviours,' your 'reassurance,' 'full blown anxiety' and round you go again... And that's what I can see in my head, and it's quite nice actually to see that'

For Clare rather than a vicious circle the metaphor was of a floodgate. Her therapist had described her problems in terms of a build up of things reaching a critical point and opening the floodgates. This imagery had a similar impact for Clare as the vicious circle for Dorothy:

'I think that, sort of, there's a, sort of, mental picture of having a gate which you don't want the floodgates to open' (Clare)

Putting things in perspective

The process of beginning to provide explanations and descriptions to participants of their problems commonly involved 'normalising' and social comparisons. This is described by the sub-theme 'Putting things in perspective'. Gail was relieved to know that her problem was not unique:

'when I realised there was something out there, somebody out there that could help me...and I'm not the only one, it...it's quite common, more common than you think...that was just a huge relief in itself, that I'm not a useless waste of space and, you know, it is quite common, it's not unusual at all. So that was like a weight off my shoulders in a way'

Again, this realisation was based on and nurtured by her therapist's explanation and her sense of somebody being there for her:

(Interviewer) *'So that was when you first came to therapy you felt that way?'*

(Gail) *'Yeah. By knowing that there was someone there... ..'*

(Interviewer) *'Uh huh'*

(Gail) *'Obviously I wasn't the first person that had had these sort of problems. Umm, there must have been like hundreds and thousands before because people specialise in this sort of thing'*

In terms of normalising intrusive thoughts, participants were told, for example, that *'everybody has weird thoughts'*. However, normalisation and social comparison were used not only to explain what had seemed inexplicable and provide evidence to participants that they were not going 'mad', but also by participants as a standard of relief from symptoms:

'I felt more normal, I've felt a little bit like I see other people' (Brenda)
'I think what the therapy's got me back to, is a point where, umm, I'm outwardly normal again (quiet laugh)' (Clare)

Accordingly, normalisation was a two-edged sword, defining the 'abnormal' as normal, but also the normal to be the absence of the 'abnormal' (symptoms).

Putting it into context

Participants' problems were not only conceptualised in the context of and by comparison with social norms, but also in the context of their own individual experiences and circumstances. Participants described the relevance attributed to early experience both by themselves and by their therapists. Experiences referred to included childhood memories and relationships, and difficult and traumatic experiences, such as loss and bereavement.

For Brenda, her current problems were attributed to her failure to come to terms with the bereavement of her first husband who she dearly loved, and she had the further misfortune and indignity of a violent and abusive relationship when she remarried:

'obviously it's something to do with losing my husband I think that's triggered things off, you know what I mean, because I'm, I just can't, I just can't get him out of my mind, he's just with me all the time'

However, early experiences and relationships were referenced by participants in terms of varying importance and significance to themselves, as well as recognising different emphases and relevance attributed to them by therapists. Some participants, like Paula, felt it was important to see the significance of the past on their current problems:

'I needed to understand why..... it was important to me... when it comes to cognitive therapy, I understand it's not so important in the treatment, cos obviously it's what's maintaining it that's the problem. But for me as an individual, I needed to know why I'd gone from this to this.....'

The relevance of the past to therapy was reported by Paula and Denise more in terms of constituting part of the ‘background’ during the assessment but not being vital to the intervention:

‘we went through, umm, obviously speaking as we are now, finding out the background to it, and things like that. Umm, and I am the type of person that... I felt as if I needed to know as much about it as possible to be able to handle it myself’ (Denise)

However, despite recognising the relevance given by their therapists to what was maintaining their problems, Paula and Denise felt that their therapists recognised the importance of their pasts for them ‘*as individuals*’. As a result, they felt understood as well as able to understand:

‘to me, understanding what caused it, was important, although I understand to the therapist, it’s not that important, ...it’s breaking the chains maintaining it now, as opposed to what started it then’..... it made me feel a lot better to understand what was maintaining it, because I think I agree with him, once he’d said it and I sat and thought about it, I thought ‘no he’s right, that is what’s happening’ (Paula)

Susie similarly remembered discussing her childhood with her therapist, but was aware that he was more interested in the present and helping her to challenge and change her thoughts:

‘we discussed like my childhood and things. But he didn’t dwell on a lot of that..... and I think that’s good, I think that’s more... obviously if you’ve got something upsetting in your past and want to talk about it, fair enough. But he was more interested in what you did now to change what you think about’

Clare was told by her therapist that there were reasons from her past which contributed to her current low self-esteem and feelings of worthlessness, accounting for her recurring depression:

‘I think there’s a lot, a lot of what I feel like stems from sort of automatic thoughts and beliefs that are quite negative, and sort of not really very well balanced, umm, which have probably come from...from how I grew up’

Clare was careful to qualify this appraisal by saying that her family's failure to show love didn't necessarily mean they didn't love her:

'Them not showing love didn't mean they didn't necessary not love me'

Therefore, in considering with their therapists where their problems came from, participants were not made to feel any guilt or personal blame attributed to themselves or to their families.

Although Dorothy found it interesting to compare past and present feelings, she felt that in her case her past did not have a major impact. As with Clare, Dorothy's therapist seemed to take a non-judgmental approach. The relative significance of the past was considered interesting, but not the principle focus of therapy:

*'although I enjoyed going back and thinking about it and talking about it, and perhaps thinking about the person I am, cos perhaps my dad were a bit strict and this and that, and like (****) said not blaming anybody, but being a bit sort of nervous and being a bit like that, it is interesting to...to see how that does carry on into how you are now. But we only probably did one session on that So for me and my problem, although it was interesting going back, and on one or two things I thought 'oh yeah that perhaps accounts for how I am now with other things,' I don't think it was a major part of therapy for me as such'* (Dorothy)

A Foundation and Direction – Something to start from, something to work on

The previous themes have recognised how participants experienced reaching a shared understanding with their therapist of their presenting problems. However, for participants this understanding was also of pragmatic value, being likened to a foundation on which to build and a point from which to start therapy.

'I suppose really it gave us some kind of direction to go, something to work on.... And that's where I keep seeing this vicious circle, because really that's where we worked from most of the time' (Dorothy)

This theme emphasises participants' experience of continuing to progress through therapy. Following on from the initial engagement with the therapist, who

made an assessment and provided an explanation of their client's problems, nurturing in the process increased trust and confidence, participants felt they were at a point from which to move forward. For Paula, this was a starting point:

'what we'd established was the downward spiral if you like, of what was happening now...that's what was maintaining the problem. And so we started to work with that, umm, and try and break the spiral'

For Alan there was a clear sense of wanting to know where he was going in therapy and wanting to make progress. For him his therapist's explanation of his problems and the associated intervention plan involving a graded hierarchy of exposure to feared stimuli provided a clear signpost to where he was going:

'I would imagine with other techniques like psychoanalysis, that...that you actually go on and on and you just wonder where you're going and...and whether there was any progress here or if there is some further measure of self awareness is...is it significant, is it coping? Umm, and there's no, I've not been through it, but perhaps there's no real structure so you don't know how long it's going to take and, what...what the final outcome might be'

Likewise, the perceived accuracy of her therapist's explanations engendered Denise's belief that therapy would work, providing a clear direction and objective:

'He...wrote it down for me that has been so spot-on, so exact to how it's been with me... I've got more belief in the fact that the treatment will work, and every time I've been, it's been more ...I can see where the plan's going'

Working to a plan – stopping the circle

If in the previous master theme participants indicated how they found their understanding of what happens to be a starting point, the current theme reflects more the experience of how this acted as a map to orientate therapy and the ongoing therapeutic tasks. Participants' responses suggested varied experience in this respect, some indicating a clear understanding of the rationale of interventions, making specific links with how they understood their problems in terms of thoughts, moods and behaviour,

others reporting more the benefits of following a plan without indicating a conceptual relationship with how their problems developed or were maintained.

For Gail, her therapist's way of seeing things was helpful. This gave Gail confidence, enabling her not only to understand what was happening and why, but also understand how to deal with her physical symptoms. Working with her therapist on '*stopping the circle*', Gail was able to reattribute physical sensations. Intervention involved reversing what was depicted as a downward spiral:

'the understanding of the symptoms, the vicious circle that I'd got myself into, and the spiral that I was going down under, trying to turn round and to come up ... come out of, and only by doing things was I gonna be able to conquer it... But umm, it was giving me the encouragement as well to... to do things, and to try things'

Being able to understand was also helpful for Dorothy in managing her problematic thoughts:

'I don't really think I'll ever be free of these thoughts or these things, whatever, but, it's understanding where they come from and how to manage them, is a help'

whereas Brenda was able to engage with her therapist and therapeutic tasks, benefiting more from the success of the outcomes than understanding the reasons why it worked.

For her the emphasis was on changing her behaviour, '*doing the doing*', in order to feel better:

'I did feel as though I'd got the answers yeah because she told me how to cope with these feelings. She like, umm, you know, just ... says, you've to 'do the doing' and not let this...this horrible thing what it is, this depression rule you, because, I forget what name she calls it now, umm, but just 'do the doing,' you know.....I've got to do the doing...to feel different'

The experience for Paula and Susie was of '*stopping the cycle*'. Their therapists had linked their thoughts and safety behaviours with their mood on a '*vicious circle*'. Therapy involved an 'empirical approach' between therapy sessions enabling them to

reappraise their thoughts and behaviour. This helped Paula discount her safety behaviours and Susie deal with her intrusive thoughts:

'he sort of asked me, he said 'well what, umm, progress have you made by getting your partner to ring up or, you know, not...not doing the things you should be doing?' And obviously the obvious answer is...is 'well nowhere, nothing, it's not getting any better at all.' So it's not working, don't use it (laughs), you know, you've got to start using, doing it yourself, umm, and try to overcome, you know, the panics' (Paula)
'I were going to the doctors nearly every week for every little daft thing, so he told me to stop that, and I have. I mean I still have weird thoughts, but they're kind of, I know how to deal with them a little bit better' (Susie)

A similar empirical approach was also a factor for Clare, who spoke about the importance of reversing 'safety behaviours' (Susie). Recognising how she has tended to withdraw from social situations when she is feeling low, Clare said that, although she did not remember discussing the reasons why this happened, her therapist encouraged her to reverse this behaviour.

'the sort of 'doing things'...the sort of experiments... if you were finding it difficult to make telephone calls or answer the phone, or, it was to actually put myself in a situation that was quite safe, umm, and make a telephone call' (Clare)

Clare was able to apply the analogy of 'a floodgate' her therapist had used in describing her problems to gain control, and spoke of having 'coping strategies' in place:

'it's a, sort of, keeping the gate closed, and if you feel it being nudged, to sort of be aware that that's happening. I think that's what's happened in the past, I haven't been aware that I've been going down... heading towards becoming depressed again'

For Alan 'the plan' provided a clear structure for therapy, as well as enabling assessment of progress. His plan involved a clear hierarchy, likened to a 'ladder kind of thing', upon which he would make progress toward his goal. This fitted with the nature of his 'simple' needle/blood phobia, which Alan said was clearly definable in terms of outcome and the typical intervention strategy:

'one particular part of the treatment is to establish a hierarchy of umm, stimuli, umm, starting with the very lowest level and working up to the highest...the goal would be to take me through those various stages so I could reach the particular concern, the giving of blood'

The experience of this for Alan was of predictability and knowing what to expect:

'the sessions weren't something to dread, a couple of the later sessions, knowing what was planned, I wasn't particularly looking forward to, but umm, as I say ...the sessions weren't something to be avoided, some were quite umm, pleasant, there was a good atmosphere between us'

This transparency and predictability described by Alan seemed to enhance his trust in the therapist. Clients' trust in therapists facilitated and was strengthened by the shared understanding of problems and the working plan.

It is noteworthy that although plans were reached collaboratively, participants' experience of the planned interventions was often quite stressful, particularly in the early stages. For Brenda and Paula this had been predicted from the start of therapy, in terms of providing informed consent, and it was implicit to the shared understanding that there would be increased anxiety:

*'she did tell me that when I went into this therapy that it would be hard, very hard, and so did (Doctor ****). Umm, so I knew... it were going to be hard, and it has been'* (Brenda)

'we sort of talked about that at the beginning, that some of the...the homework like, or solutions, might be quite painful (quiet laugh) if you like to think about or whatever, and he said are you, do you understand that, are you prepared, do you still want to go through with this? ' (Paula)

Paula agreed to put herself through the pain:

'what a lot of the therapy has involved, is actually biting the bullet and going ahead and doing it myself, and sort of fighting through the pain if you like... .. it's not nice at the time, but it is getting umm, you know, life's a lot better'

Continued engagement depended as much on participants' own motivation as their trust and confidence in their therapist, and the clarity of the description of their problems and the therapeutic plan. This was described by Gail:

'you've got to want to get, beat it yourself, as well as somebody helping you out'

This strength of relationship might also account for Gail's tact and self-determination when she felt her therapist was being too demanding and directive:

(Gail) 'he was sort of pushing me a bit too much towards the end, 'right you've got to go out like five times next week and you've got to go in different places... .. And I thought 'there's no way I can do that. I'd rather just do it gradually, ...there's no way I'm gonna force myself into a situation where I might have a panic attack.' Cos I thought it might put me back a bit, because I seemed to be doing quite well, ... doing it gradually at my own pace. Where as all of a sudden it was like 'come on, '...'

*(Interviewer) 'So you thought that to yourself, did you share that with (****), ... that idea that you wanted to go at your own pace?'*

(Gail) 'No I don't think I did (quiet laugh). No'

Effectiveness and Self-efficacy

Participants had each completed therapy, and therefore reported the outcome of their experience. Their responses provided a retrospective reflection of therapy and of the impact of their understanding of their problems on this experience. For Gail the outcome of therapy was of increased self-efficacy and confidence. She related this to *'finding an answer'*, and the support of her therapist and her family:

(Gail) 'So I've become more positive about things and I'm a lot happier in myself.'

(Interviewer) 'So being clear and more positive. What...what would you attribute that to then?'

*(Gail) 'I think it's... . I'm realising that I've got the capability or the power within me to...to do things. Like I've had this problem for two or three years, and I've gone and done something about it and I've found an answer to it and it's worked, and I've, and with (****)'s help, and with my family as well, they've been brilliant, I...I've come through something like this'*

Gail attributed her increasing confidence to her experience of working with somebody who understood and explained her problems, and encouraged her to do things. Her increase in confidence was a gradual process, and closely related to the shared understanding of her problems and a trusting relationship with her therapist:

'...just by somebody understanding ...the symptoms and explaining them, every, you know, the smallest little thing was...was helping ...like just chipping away a bit each week. Umm, if you like, another realisation that I don't look forward to going out anymore..... So I think gradually week by week, I think he gave me the confidence to do these things like'

The experience of therapy and the relative improvements she experienced were keenly attributed by Brenda to her therapist. For her the relationship was immensely important, and she reiterated throughout therapy how much she has improved since she had known her therapist. Brenda benefited from what her therapist told her, although she was not always able to remember what she had actually been told:

*(Brenda) '...it were just taking notice of (****), umm, and knowing after a while like that, you know, when I did get on this bus and I thought 'I can't believe that I've been to (****) and come back on another bus,' because I hadn't dared to do that. So something must have been working.'*

*(Interviewer) 'So taking notice of (****) helped anyway?'*

(Brenda) 'Oh yeah.'

Susie was not able to pinpoint a specific incident or 'magic word'. Her experience was one of gradual improvement during the process of therapy, the therapist's description of her problems in terms of a cycle, and subsequent engagement in the therapeutic tasks:

'I think just gradually, like I said it's not, I couldn't pinpoint a magic word he's said, or a magic thing, I think gradually it's just, you know.....just going a bit better.'

For Susie this gradual improvement began with her expectation based on her perception of her therapist's professional status, and was reinforced by her experience of being assessed by somebody who was able to convey a sense of understanding her problems:

(Susie) 'being assessed by somebody professional, who knows what they're doing, knows what they're looking for, when you think you're going mad or think, you know, all these awful things are going to happen, umm, you feel better. And I think by going to see somebody all this time, you just begin to feel better yourself.'

(Interviewer) 'What was it that made you come to the conclusion that he was the person that knew what was going on, knew what he was doing?'

(Susie) 'Because, well for a start what his job is. I mean obviously you know, umm, if somebody's, umm, a psychologist in't he, a trained psychologist, you know that he knows what he's, umm, doing. But a lot of the things we talked about, he knew what I was thinking. Like especially with the obsessive things, like he...he just knew such a lot (laughs) and umm, daft things with health anxiety and that, and he said he'd heard, you know, heard it all type of thing'

The perception of time was clearly related to participants' experience of therapy and its outcome. As has been noted, reference has been made to gradual improvement. Therapy was perceived as a kind of landmark, participants speaking about what things were like for them before therapy, during therapy, and post-therapy. Dorothy compared what things were like between 'now' and 'before':

'Before I just thought 'oh my god I'm having a heart attack, I'm panicking, there's no reason, I'm either a complete nutcase or I'm gonna die,' do you know what I mean. And it went from one, right round and that were it, no in-between, whereas now I can see what's happening, you know'

Some spoke about the number and frequency of sessions, others about 'each time' they went to therapy, recognising that they had 'more time' to deal with their problems than with a General Practitioner:

'he assessed me, and then I've been for about...eight times I think. So I've been like a month, umm, last week, and before that it was a month before, so it was like a longer time. So the last few have got longer, and I'm not as worried about going each time. Like the first few I used to think (gasps) 'got to go there,' you know, 'I feel so weird this week,'

whatever. And now it's gradually getting to a point where, when I get there I don't really know what to talk about' (Susie)
'as time went on the problem got smaller and smaller.....it was shrinking as the sessions went on. It just sort of got better each time, like I say, it...it gave me that confidence each time' (Gail)

Finally, the end of therapy for Clare was to have arrived at a point she felt able to build on. If, therefore, the experience of reaching a shared understanding of their problems with their therapists offered participants a foundation and point to build on, there was a sense also that the end of therapy was a point to continue using the skills learned during therapy:

'therapy's got me back to a point where everybody else would think I'm the normal happy-go-lucky confident assertive person that everybody at work think...thinks I am. so I've got to a point where I'm much better there, which hopefully I can then build on' (Clare)

Connections and relationships between themes

Arrow A

Participants' responses from which the major themes were identified also appear to indicate reciprocal relationships between these themes, as illustrated in Figure 1 (page 55). The arrow 'A', linking 'Somebody that listened and understood – trust in therapist' with 'Understanding what happens', illustrates how participants' experience of the process of the therapist listening to them and beginning to explain their problems facilitated their understanding of what happens. This has already been referenced in the transcript extracts quoted (see page 57). For example, Gail and Susie's comments:

'somebody that understands. Somebody....can help you and explain to you' (Susie)
'he explained that... ' (Gail)

Susie made further references to her therapist providing explanations and information:

'so he's really more or less, you know, made me think "... it's just this thing, if you have it again that's what it is....so he explained a lot'

During her interview Dorothy, who had spoken about understanding her problem, was asked what had led to her understanding:

*(Interviewer) '...you spoke a little bit about your understanding... ..what brought that understanding on? Can you tell me a bit more about that? (Dorothy) 'it's (****) that's helped me... ..she said...you're anxious all the time...so it was understanding where my symptoms were coming from'*

Arrow B

The possibility of using Dorothy's quote (above) to illustrate both 'Somebody that listened and understood' and 'Understanding what happens', reflects participants' understanding depending on the perception that their therapists understood their problems, and vice-versa, 'Understanding what happens' / participants' perception they understood their problems also reinforced the belief that their therapists understood and could be trusted, as illustrated by Arrow B.

Participant perception of their therapists' understanding was not therefore in terms of the therapist having exclusive, inexpressible or inaccessible knowledge of their problems, but of communicating and explaining this understanding to them, as is illustrated by Alan's comments:

'I think that the umm, the treatment, umm, was the suitable treatment for me. It was...also backed up with quite a lot of explanation of the background theory, umm, the process itself, which was useful for me... .. 'There wasn't any mystique... The treatment was explained beforehand'

Participants' report of the process of gaining this understanding of what happens, depicted by the sub-themes depicted on the horizontal axis in Figure 1, was again often made in the context of reporting trust in a therapist who listened and seemed to understand:

'it sort of brought it all together...it made it so simple for me...and it made me feel like, umm, somebody actually understands (laughs), and somebody actually believes' (Denise)

The way explanations and information were made reinforced participants' trust in their therapists:

he always used to do things matter of factly... ..he kind of give you information and it makes you believe, he doesn't seem false, he seems sincere.' (Susie)

Arrow C

Participants' 'Understanding' of their problems, as communicated by their therapists, was also understood as providing a basis for interventions. This can be seen in Dorothy and Paula's quotes under the master theme 'A Foundation and Direction – Something to start from, something to work on':

'it gave us some kind of direction to go, something to work on... ..And that's where I keep seeing this vicious circle, because really that's where we worked from most of the time' (Dorothy)

'what we'd established was the downward spiral if you like, of what was happening now...that's what was maintaining the problem. And so we started to work with that' (Paula)

Arrow D

Paula's claim to a shared understanding of what was happening, in terms of 'what we'd established', also provided a rationale for trying to 'break the spiral' ('Working to a plan – stopping the circle'). Therefore, participants' understanding of their problems, which they reported in relation to therapists' explanations, provided the basis of an initial foundation or 'starting point' for intervention:

'we sort of worked out together what was going on...I understood that... ..but half of it was trying to find something to make it stop... ..the spiral, the downward spiral... ..we started to work with that' (Paula)

and continued to act as a plan for therapeutic tasks, with participants 'going over the same thing again and again' (Dorothy) with their therapists.

Arrow E

This process described by Dorothy of going over the same things involved an incremental progression in her 'Understanding':

'we did this vicious circle thing and talked a lot...we sort of concentrated a lot more as we got further on...once I realised how not to use my safety behaviours...then moving on to spot that I was getting anxious... ..

'it took a while...we've gone over the same things...but it's understanding where they come from and how to manage them is a help... ..now I can see what's happening...my 'reassuring' and my 'safety behaviours... ..all those things I tend to stop a bit more now and I realise what I'm doing'

Therefore, continuing to work on *'stopping the circle'* appeared to reinforce the

'Understanding' participants' had of their problems:

'the vicious circle...so accurately describes what is happening... ..and with the therapy, with the things we started doing...although at first some of the anxiety levels were recorded quite high...the speech got better, the confidence has got better' (Paula)

Arrow F

The connection between improvements, in terms of increased confidence and reduced anxiety reported by participants', and the 'plan' of 'stopping the circle' is illustrated by Paula and Gail:

'there is a spiral again now, but it is going up, it's starting to break the thought mould, if you like' (Paula)

'it gave me confidence, umm, because I knew what was happening to me... .. I'm realising I've got the capability...to do things...I've gone and done something about it and I've found an answer to it, and it's worked' (Gail)

Discussion

The themes identified represent participants' generally reported experience of progress through therapy in connection with the process of developing a shared understanding with therapists of what was maintaining their problems, and of knowing how to deal with these problems. The experience most consistently reported was of feeling listened to and understood: 'Somebody that listened and understood – trust in therapist'. This was experienced very early in therapy, often at the initial assessment, and helped establish a trust and confidence in the therapist that characterised therapy. This resembles the importance attached to the therapeutic relationship in the literature

(e.g. Dunn, 2002; Sanders & Wills, 1999) and Gluhoski's (1994) defence of the importance of the therapeutic relationship in CBT, which she advises is fostered by the therapist through trust and acceptance.

The importance to clients of feeling listened to and having their problems explained to them in establishing this trust has been generally advocated (e.g. Beck, 1995; Fowler, Garety & Kuipers, 1998; Wright & Davis, 1994). Whilst basic therapist counselling skills were significant in this respect (Deffenbacher, 1999; Sanders & Wills, 1999), it was essentially in relation to therapists' ability to demonstrate that they understood clients' problems that a robust therapeutic relationship and alliance was established. The importance of establishing a therapeutic alliance and educating the client about their problem and its treatment has been considered by Overholser and Nasser (2000). Accordingly, participant responses in this study and the literature both infer the significance of beginning to relate clients' problems according to a coherent conceptualisation in laying the basis for engagement with the therapist, as well as subsequent intervention.

The relationship of trust based on listening and conveying a sense of understanding was often contrasted with previous encounters with GPs and other mental health practitioners, particularly in terms of unsatisfactory or nonexistent explanations of presenting problems. This was similar to the dissatisfaction of clients with hypochondriasis reported by Warwick (1995). This suggests it may be helpful to educate other and referring agencies in terms of psychological perspectives and of being explicit about lack of expertise. Essentially it requires the CB therapist to clearly and concisely formulate and communicate clients' difficulties.

Although participants, with the exception of Denise, did not talk explicitly about 'their formulation', the themes clearly infer the use of a shared formulation, which participants tended to refer to in terms of '*understanding what happens*'. Participants'

frequent references to a '*vicious circle*' and the need to '*reverse*' these '*cycles*', their awareness of the impact of '*negative automatic thoughts*' on their mood and behaviour, the realisation of the need to prevent '*reassurance seeking*' and '*safety behaviours*', the relevance of past and present experience and circumstances, are all consistent with components of cognitive behavioural formulations and interventions (Beck, 1995; Kirk, 1989).

The perception that therapists understood their problems generally helped participants develop a shared understanding: 'Understanding what happens'. This understanding was evident not merely in terms of acquiescence. Participants indicated an awareness and appreciation of theoretical aspects of their formulation, and an understanding of how these related to the maintenance and treatment of their problems. For example, Dorothy referred to '*triggers, safety behaviours, reassurance and anxiety*' in relation to a '*vicious circle*'.

Despite using these 'technical terms', demonstrating participants' collaboration in what have been called 'technical factors' of therapy (Rector, Zuroff & Segal, 1999), there was a general perception that '*nothing was greatly technical*'. This supports the concept of 'socialising to the model' (Wells, 1997), so that with the possible exception of one person, participant 'understanding' generally represented a shared theoretical cognitive-behavioural conceptualisation of the interaction of thoughts, mood and behaviours in maintaining difficulties (Greenberger & Padesky, 1995; Persons, 1989). However, this conceptualisation was not merely shared on a theoretical-intellectual level, but was of practical value to participants, as the themes 'A foundation and Direction' and 'Working to a plan' indicate.

The variation described by participants regarding their level of understanding and/or the time it took to be able to develop and understand this conceptualisation did not prevent the ability to work collaboratively in therapy. The imbalance of

understanding and responsibility in relation to working collaboratively has been recognised by Freeman (2002) and DeRubeis, Tang and Beck (2001). It would seem from this research, and what has been previously reported in the literature, that participants are able to engage according to their level of understanding on the basis of trust and the quality of the collaborative relationship (Rector, Zuroff & Segal, 1999; Tompkins, 1999).

This may also have implications in relation to the 'time-limited' nature of CBT (Beck, 1995). Although time scales are often predicted or prescribed for the treatment of specific disorders, there may be a case for taking account of a client's ability to understand and the length of time this involves in determining the length of therapy. However, it should not be forgotten that the formulation is generally regarded as a process rather than an event (Persons & Davidson, 2001; Scott, 1998). It may also be helpful to take account of a client's individual circumstances and experience, such as socio-economic status and education, as indicated by Wright and Davis (1994). This consideration also supports the view of including the 'level of the situation' in the formulation (Persons & Davidson's, 2001).

The value of an iterative approach in helping participants understand was emphasised in this study. Understandable, non-technical explanations, including the use of metaphor and diagrams, were regarded as helpful, and helped reinforce the therapeutic relationship ('trust in therapist') by reaffirming the perception of the therapist's sincerity. Diagrams and 'handouts' have been widely used in CBT, using for example, Clark's (1986) diagrammatic model of anxiety. Personalising these models has been advocated (Wells, 1997). The experience of the formulation in bringing things together and making them simple was a 'turning point' allowing participants to make progress. This is consistent with typical views, such as Beck (1995).

It is significant that while themes represent common experiences, there was some variation within themes. This may be of importance in relation to the need for flexibility within the model adopted, taking account of what is common to the disorder and what is specific to the client (Beck, 1995). This might include the consideration of the relative significance attached by therapists to predisposing factors such as childhood experience and relationships. In this study, idiosyncratic aspects were acknowledged principally in assessment and 'background' information. They were not considered vital to therapy from either therapist or client perspectives, although participants' perception may have been influenced by the theoretical perspective of the therapist. However, participants with a particular 'interest' or 'need to know' about their past ('Putting it into context') felt respected and were not inhibited in working with therapists in dealing in the 'here and now' with what was maintaining their problems. The sub-theme 'Putting things in perspective' indicates that participants found it helpful to be able to gauge their problems both against what was typical of their particular psychological disorder and what is 'normal' or not uncommon to people in general.

The shared understanding was described by participants as providing a clear focus and direction: 'A Foundation and Direction – Something to start from, something to work on', and a 'Working plan', as supposed by Beck (1995), Sanders and Wills (1999) and Tompkins (1999). Participants' references to the experience of '*experiments*' supports the concept and value of 'collaborative empiricism', and there was evidence in participants' reports of the positive impact of technical CBT factors such as Socratic dialogue (Morrison, 1998; Wells, 1997) in facilitating interventions and reaffirming the formulation. Although anxiety was experienced throughout therapy as participants were exposed to feared stimuli, informed consent and the formulation provided predictability and a context for these emotional reactions maintaining the therapeutic relationship and alliance.

Participants generally reported a successful outcome, describing improvement, feeling ‘much happier’, and increased confidence: ‘Effectiveness and Self-efficacy’. In relating improvement to *‘finding an answer’* it is reasonable to assume the formulation had a significant influence on the outcome of therapy. It is worth noting that although there was acceptance of theoretical conceptualisations and collaborative engagement in therapeutic tasks that clients experienced anxiety. Although this may be predicted in terms of informed consent and a CB conceptualisation it may be helpful not to assume consent but revisit and confirm this throughout therapy (Lucas, 2003).

Limitations to this study may include the self-selecting nature of the sample. It is difficult to know how this might be overcome in qualitative research. One participant clearly stated the reason for her participation:

‘the reason I agreed to umm, do this, was I thought if, you know, by helping you out, it could then go on and help somebody else’ (Susie)

Willingness to participate may have been indicative of the strength of the therapeutic relationship, which would account for the theme ‘Trust in therapist’. Accordingly, this study only describes the relative contribution of the formulation in CBT for ‘successful’ outcome in clients who experienced a strong therapeutic relationship. Inevitably it may not represent the experience of clients who did not experience a strong bond with their therapist or successful ‘outcome’

The small sample size may represent a further limitation. The generalisability of the current findings would depend on replication in similar studies, although Willig (2001) reasons that an experience identified in qualitative study is thereby known to be available within society. Inasmuch as eight participants recruited by four different therapists had the common experience of overcoming or managing their psychological problems in the context of a positive therapeutic relationship and formulation informed

intervention, it might be inferred that those two factors rather than a specific therapist were responsible for the results.

It might be thought the lack of homogeneity of the sample is a limitation, so that future research might wish to focus on specific disorders. However, as it is common for clients to present with co-morbid difficulties, and because the therapeutic method and the use of a formulation were consistent, it is not felt that the variance of presenting problems will have biased the results. Rather, the similarity of experience across the disorders suggests that the experiences are more likely to be due to the use of a formulation within a trusting therapeutic relationship.

It is possible the researcher's current clinical training and experience of using formulations in CBT had some influence both on interviews and interpretations of transcripts. This clinical experience may have had the advantage of facilitating participants to talk about their experience (Thompson, Kent & Smith, 2002) although it is possible that awareness of the researcher's clinical and professional status may also have produced a demand effect in participant responses. This was controlled as much as possible by the non-directive interview schedule and approach adopted during interviews (Seale, 1998).

The researcher's experience and understanding of the formulation in CBT may similarly have both facilitated and biased interpretations. However, the process of IPA acknowledges preconceptions which may have influenced attempts to explore the personal perceptions of the participants in this study (Smith, 1996). To preserve the reliability/"trustworthiness of observations" and validity/ "trustworthiness of the interpretations and conclusions" (Stiles, 1993 p 601), Elliot, Fischer and Rennie's (1999) guidelines were adhered to regarding owning one's own perspective; 'grounding in example' by use of verbatim quotations to illustrate interpretations; and credibility checks with other qualitative analysts.

Much has been written about the theory and methods of the formulation in CBT based largely on clinical experience and case reviews (e.g. Persons, 1992; Salkovskis et al, 1998). Research has also attempted to measure the effectiveness of the formulation in process and outcome studies (Hess, 2001). This study has the advantage of having investigated clients' experience of the formulation using a non-directive qualitative approach. Although the results support many of the clinical and empirical assumptions relating to the use of the formulation in CBT, in adopting IPA it has been possible to elicit client experience from the clients' perspective. Accordingly, results report the general experience and personal significance to clients who had completed a time-limited course of CBT rather than the relevance of the formulation assumed from a clinical or theoretical perspective. It is not known that IPA has been previously used to investigate client experience of the formulation.

Conclusions

Five master themes were identified from participants' accounts of their experience of CBT. Participants reported their experience of progress through therapy in relation to the establishment of a shared formulation and related therapeutic tasks. The theme 'Somebody listened and understood' represents how participants felt listened to and that the therapist understood their problems. It was essentially in the therapists' ability to demonstrate they understood that a trusting therapeutic relationship was established. Participants developed a shared understanding in relation to the maintenance of their problems: 'Understanding what happens'. The relative importance of predisposing factors to participants and its relevance to their understanding of CBT was acknowledged. The shared understanding provided the basis upon which therapy progressed ('A Foundation and Direction'), providing a clear focus and 'plan' for therapeutic tasks: 'Working to a plan'. This involved a recursive and iterative process of 'going over the same things'. Simple and understandable explanations and

illustrations facilitated understanding. There was variation within these themes, participants taking different lengths of time to develop an understanding, yet working collaboratively with their therapist's according to their level of understanding. Despite experiencing anxiety in engaging in 'experiments' the formulation provided predictability and containment of these emotions in the context of a positive therapeutic relationship. The general outcome of therapy was of improved mood and ability in relation to having found an answer: 'Effectiveness and Self-efficacy.

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Critical Appraisal

Critical Appraisal

Origin of the project

My interest in the research topic was raised at the research fair at the Clinical Psychology Unit, Sheffield University and subsequent discussion with Andrew Thompson and Gillian Hardy in July 2002. Andrew had proposed 'the formulation' within cognitive-behavioural therapy (CBT) or cognitive analytic therapy (CAT) as possible topics of research, suggesting areas of enquiry might include the processes involved. I had already been impressed during my clinical training of the fundamental significance of the formulation within psychotherapy and thought that this would be a valuable area to research.

Following discussion with Andrew and Gillian I decided to investigate the use of the formulation in CBT. My preference for CBT was guided by several considerations. At the time of submitting my proposal my previous experience had been in CBT. My understanding from the literature and discussion with CAT therapists was that, although the formulation is supposed to be fundamental to both models (Chadwick, Williams & MacKenzie, 2003; Ryle, 1995), the Reformulation is possibly a more explicit stage of CAT than the formulation in CBT. As I wished to explore the role of the formulation from the client's perspective I felt that it would be interesting to explore the experience of the formulation within CBT where its influence may be more implicit by comparison.

Planning

Initial Research Proposal

An Initial Research Proposal was submitted, followed by the allocation of my University research supervisor. My research supervisor recommended an NHS supervisor from a local specialist psychotherapy service. He subsequently agreed to act

in this capacity following a meeting with my research supervisor and myself in which we outlined the purpose and benefits of the research and his expected role and responsibilities. He consented to participants being recruited from his service.

Peer Review

The next stage involved a review of my Initial Research Proposal by a group of peers at a Research Workshop on 20th January 2003. This process of peer evaluation was extremely valuable in clarifying issues within my proposal, questioning matters such as the appropriateness of methodology, ethical considerations, and anticipating potential practical difficulties.

The Final Proposal

The peer reviews of my proposal helped me prepare the Final Proposal. This was subject to further scrutiny by my research supervisor and ultimately a Research protocol review with two members of the Research Sub-Committee on 25th March 2003. Written confirmation of the alterations and additions needed to my Final Research Protocol was received on 12th April 2003. Following the satisfaction of the Research Sub-Committee that these alterations had been met, the Research Protocol was submitted for ethical approval on 1st May 2003 to the appropriate Ethics Committee.

Consultation with NHS supervisor

During the period between my first meeting with my NHS supervisor and submitting my Final Research Protocol, I attended several meetings with my NHS supervisor and the psychotherapy team in order to identify a client group for the interviews, and to engage the therapists in the project. It was intended to identify a homogeneous sample from the waiting list and referral information regarding problems.

Following reference to this information it was felt that there would be sufficiently large numbers of clients with depression who would be commencing therapy in September 2003 when I hoped to commence interviews. Subsequent difficulties in recruitment meant the criteria had to be broadened to accept any client who had completed therapy on condition this was their first experience of CBT and a formulation had been used. It was agreed, following discussion with my research supervisor, that because in clinical practice depression and anxiety occur together so frequently that this would be acceptable.

Ethical Approval, Governance and Indemnity

I attended the Ethics meeting on 2nd June 2003. Further to minor modifications, the Committee delegating authority to the Chair/Honorary Secretary to sanction these modifications, a formal letter of approval was issued on 24 June 2003 (appendix 6). I was required to specify the maximum number of participants I expected to interview, i.e. instead of 'at least 8' I was advised to alter this to 'a purposive sample of between 8 and 12 clients'. The recommendation to include a larger number than I expected for IPA research satisfied the Ethics Committee's criterion since if I needed to interview more clients than specified in the proposal I would need to submit another proposal. The other modification of significance was to produce the consent form in the standard format already approved by the Ethics Committee.

In conjunction with ethical approval being established I also ensured research governance from the University and research protocol indemnity from Sheffield Care Trust. I had quite mixed emotions during this whole process, feeling the procedure was sometimes pedantic, yet reminding myself of the importance of maintaining ethical criteria and integrity. It provided valuable experience of the actual procedures involved. It also created a perception of being part of a system and of 'belonging', in terms of

'my' research belonging to and being for the benefit of a much larger organism than my own vested interests in the research. It provided a sense of my research actually being valued by and of value to others.

Working with and relying on others

Engagement of therapists in the research involved attending a team meeting, providing a copy of the research protocol, describing my proposed research to them and explaining what they would be required to do in terms of recruitment, and discussing with them any questions and concerns. As I anticipated that there might be 'suspicion' of data being used to audit personal competence of therapists, I assured them of their own anonymity being respected, and that the research was not necessarily about what clients remembered of the facts and details, but more about their experience and perception of the formulation.

During the general planning stage, although there was a lot of work involved, I felt reasonably in control as the responsibility was largely my own in terms of meeting appropriate methodological and ethical criteria. I was encouraged that I had obtained ethical approval very early. However, I anticipated that the remainder of the process might not be as efficient as I was depending on other people to recruit on my behalf. I was aware that the research was probably 'more important to me' than to the therapists, at least in terms of priorities, apart from which they probably had busy schedules and may have been concerned about accepting additional responsibilities.

To allay such fears and minimise commitment I provided as much information as possible regarding recruitment and arrangement of interviews. I ensured there were sufficient copies of the Client Information Sheet available, which therapists were required to provide before client contact with myself. However, it was necessary to revisit the team meeting on several occasions to remind therapists of the need for

recruits, inviting opportunity to discuss any difficulties. Some therapists admitted that they had genuinely forgotten to ask. Others had asked but the client had not wanted to participate. I took advantage of pigeon holes and the staff notice board to advertise my continued need for participants. Whilst my experience was that therapists were generally supportive, I felt that it was wise to employ tact and discretion in this process, not wanting to make a nuisance of myself by badgering people, which may have compromised their engagement in the process of recruitment.

From start to finish

As indicated, I obtained ethical approval fairly soon and was in the position potentially to commence interviews ahead of schedule in July 2003. In reality the first research interview was not conducted until 3rd December 2003. I had then to wait until February 2004 before seeing any more participants, but was able to conduct four interviews within a fortnight. One interview on 19th April was followed by the two final interviews on 15th and 16th of June, almost 12 months after receiving ethical approval.

Interviews

Interviews were an interesting experience in terms of my own perception of having 'two hats', one as a researcher, in which capacity I was sitting with 'participants', the other as a clinician, listening to 'clients' describing the problems they had experienced, and their experience of therapy. I was acutely aware that I was there in the capacity as a researcher and not a clinician, but there was an instinctive urge at times to want to provide clarification and further conceptualisations regarding participants' responses. I am satisfied that I was able to suspend my role as a clinician, remaining with the interview schedule and probing only those areas that participants

introduced. However, I felt that my clinical experience helped in terms of demonstrating empathy and a positive regard for the participants.

There were one or two occasions in particular when I felt it was appropriate to apply these clinical skills. For example, when recalling the recent anniversary of the death of her husband Brenda appeared emotional. Making a 'clinical' comment, I reflected that there *'must be a lot of memories for you this time of year mustn't there?'* allowing Brenda time to respond at her own pace. I felt that it was important in this event to demonstrate empathy, applying my clinical skills, and not remain merely an objective researcher.

Brenda also expressed concerns during the interview about the usefulness of her responses. I reassured her that this was *'not an examination'* and there were no right or wrong answers. I explained that I was interested in her experience of therapy. Following the interview Brenda again sought this reassurance. I explained the rationale of the study, and the importance of eliciting her experience rather than wanting her to uphold my own ideas.

Several participants gesticulated in relating how their therapist had described their problems. So as not to lose the benefit of what literally 'appeared' relevant information, for the benefit of the tape-recorder it was important to seek clarification from participants, commenting on their non-verbal responses, using probing questions to encourage them to clarify their points.

The Literature Review

The Literature Review provided the opportunity to reappraise my own initial assumptions regarding the role of the formulation in CBT. It also enlightened me to the debate and assumed conflict between nomothetic and case formulations. My impression in reading about the assumed differences between these two approaches was

of the unhelpfulness of polarised views, and trying to equate theoretical contention with clinical and practical application.

In practical terms the Literature Review was a time consuming exercise, involving library searches via the internet, visits to the library, application for inter-library loans, and visits to the British Library at Boston Spa. However, it emphasised to me the interface and relationship between research and clinical practice.

Analysis and Writing-up

Tape recordings of the interviews were transcribed by a professional transcriber who supplied a word-processed 'hard copy' and an electronic copy on a floppy disk. The method of analysis using IPA has been outlined in 'Methods' in the Research Report. It is worth reflecting on the process of the analysis, both in terms of my interaction with the transcripts and my interaction with my supervisor in relation to the validity of the themes and my interpretations.

Smith (1995) describes how respondents' meanings and experiences are not transparently available, but "obtained through a sustained engagement with the text and a process of interpretation" (p18). Although attempts are made to capture the respondent's experience and perspective, it is recognised that "such an exploration must necessarily implicate the researcher's own view of the world as well as the nature of the interaction" (Willig, 2001 p53). It is supposed that attempting to access another person's experience is complicated by the researcher's own experience, although this is equally required to make sense of the respondent's experience. However, it is supposed that by being immersed in the text, using the respondent's own language, and following the procedures of analysis described in the 'Methods', it is more likely the respondent's perspective of their experience will be accessed, or at least represented.

In terms of my own initial attempts at adopting this method and identifying themes in the manuscripts, although I was very much engaged in the text I possibly

allowed too much of my 'own view of the world' to influence the labels I attached to themes, so that theme titles were more representative of CBT theory than participants' actual responses, failing to respect the principle of IPA being data driven rather than theory driven. This may have occurred due to my failure to differentiate sufficiently between evidence and experience, CBT being assumed to be a very structured and theoretical evidence-based therapy, IPA being more 'person-centred' in participants' perspective and experience.

In providing early drafts of my themes and analysis to my research supervisor for validity checks this bias was identified. I consequently revisited the transcripts, re-labelling them using language more consistent with participants' language. I was a little alarmed by my initial bias as I have generally felt that I adopted the approach of basing a formulation on a client's self-report, supposing that I would fit the model to the client rather than the client to the model. My initial shortcomings in grounding my themes in participants' responses challenged my perception of how sincere I am to this principle in clinical practice. However, I have always valued supervision within my clinical training, and in terms of reflective practice felt that this provided a valuable opportunity to evaluate both my clinical and research skills.

Supervision has therefore been a very significant aspect throughout the process of analysis and writing-up, and I would judge to be appropriate to the process of IPA. In this respect I would be cautious about engaging in research independently since this precludes the asset of critical peer review and validity checks.

What have I learned?

Reference has already been made throughout the preceding sections to personal learning and reflection. However, in summary the following key points of learning might be listed:

- The significance and value of research in informing clinical practice.

- The importance and meaningfulness of exploring participants' experience of theoretical assumptions, so that these hypotheses can be supported or challenged on the basis of empirical research.
- The value and integrity of ethical procedures in respecting participants' interests in participating in clinical research.
- An awareness of the experience and emotions of clients to the processes of therapy, such as the influence of the formulation.
- The importance and responsibility of the therapist in establishing client trust and helping to establish a therapeutic relationship to enable clients deal with emotional distress.
- The relevance of clinical skills, such as establishing rapport and demonstrating empathy in research interviews.
- The ability to adopt a neutral stance in listening to participants' criticisms of other professionals, realising that their complaint may not be factual but their experience or interpretation of events. That is not to confuse or excuse unprofessional or unethical practice, but to recognise that if, for example, a GP is accused of 'not listening' it may actually be that the GP either does not understand or feel experienced or competent in psychological problems, and may actually have been the reason the GP made the referral for CBT.
- The importance of respecting the integrity and sincerity of others collaborating in research.
- The importance of supervision and peer review in research.
- The importance of self-reflection and reflective practice in research and clinical practice.

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Appendices

Appendix 1: Client Information Sheet

Appendix 2: Consent Form

Appendix 3: Interview Schedule

Appendix 4: Confidentiality Form

Appendix 5: Illustrated example of *IPA analysis*

Appendix 6: Ethical approval

Appendix 7: Notes for contributors

Appendix 8: Letter of approval for specified journal



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Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualific
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CLIENT INFORMATION

You are invited to take part in a research study. Before you decide, it is important to understand what is taking place and what the research will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Who is conducting the study?

The study is being conducted by Franz Burchardt. I am a Trainee Clinical Psychologist based at the Clinical Psychology Unit, Dept. of Psychology, University of Sheffield, Western Bank, Sheffield, S10 2TP (phone number: 0114 222 6632).

What is the purpose of the study?

I am interested in clients' recent experiences of psychotherapy and the meanings they made of those experiences. It is hoped that this will help therapists learn more about what is helpful for clients in therapy, and enable therapists to further improve their clinical practice. The current study will contribute towards my Research Thesis, and Doctorate in Clinical Psychology.

What will be involved if I agree to take part?

You will be asked to attend for a private and confidential interview. I will ask you questions about your recent experience of therapy.

Where and when will the study take place?

Interviews will be conducted at the Specialist Psychotherapy Unit, Michael Carlisle Centre, Nether Edge Hospital, Sheffield. Travelling expenses incurred in attending for interview will be reimbursed.

What information will be gathered?

You will be asked certain questions relating to your experience of therapy: why you went to therapy and what happened. The interview will last about 60 minutes, and will be recorded on audiotape.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and asked to sign a consent form.

Can I withdraw at any time?

If you decide to take part you are still free to withdraw at any time and without giving a reason. You also have the right to withdraw consent for the use of the information you have provided. You can withdraw at any time without it affecting your future care.

Will there be any effects on my treatment?

A decision not to take part, or a decision to withdraw at any time, will not affect the standard of any current or future medical treatment or psychological therapy you may receive.

Will information be kept anonymous and confidential?

The contents of your taped interview will be discussed with my research supervisor at the University of Sheffield. We will treat the information confidentially and your anonymity will be maintained. Tape recordings will be kept in a secure place where they cannot be heard by others. Written transcripts of the tape recordings will likewise be treated confidentially, and will maintain your anonymity by ensuring no identifying features (such as your name, where you live or work) are included. At the end of the project the tape recording of your interview will be destroyed.

Who do I contact if I have any questions?

If you require any further information you may contact Franz Burchardt (Trainee Clinical Psychologist) at the Clinical Psychology Unit, Dept. of Psychology, University of Sheffield, Western Bank, Sheffield, S10 2TP (phone number: 0114 222 6632) or Tom Ricketts, Principal Behavioural Psychotherapist, Specialist Psychotherapy Unit, Michael Carlisle Centre, Nether Edge Hospital, Sheffield (phone number: 0114 271 8688)

What do I do if I have a complaint about this research?

If you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study please contact, in the first instance, the project co-ordinator Gillian Hardy at the Clinical Psychology Unit by phoning 0114 222 2651/6632. If this is not satisfactory you can also use the normal hospital complaints procedure through Chris Welch, Medical Director, on 0114 271 2178.

What if I wish to speak to somebody else?

If during the interview you should feel upset and wish to speak somebody else there will be other therapists available on the premises. You may also request another appointment with your therapist.



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CONSENT FORM

Title of Project: CLIENTS' EXPERIENCE OF THERAPY

Name of Researcher: FRANZ BURCHARDT

Please initial box

1. I confirm that I have read and understand the information sheet dated June 2003 (version 3) for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.
3. I understand that sections of any of my medical notes may be looked at by responsible individuals from Sheffield Care Trust or from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records.
4. I agree to take part in the above study.

 Name of Client

 Date

 Signature

 Name of Person taking consent
 (if different from researcher)

 Date

 Signature

 Researcher

 Date

 Signature

1 for client; 1 for researcher; 1 to be kept with hospital notes

INTERVIEW SCHEDULE

I am interested in your recent experience of therapy ...

- What were things like before you saw the therapist?
[How did you understand or make sense of these things / (your problems) before you saw the therapist?]
 - How did your therapist understand or make sense of these things (problems)?
 - Were there any differences in how you and the therapist saw things?
 - (How) did your therapist link your problems and circumstances together?
 - Was your therapist's way of seeing things important to you at the time? [(How or why) did your therapist's description help or not help?]
 - How do you see things now?
 - What do you think now about the way your therapist saw things?
 - How are you feeling now?
-

Doctorate in Clinical Psychology

University of Sheffield

Confidentiality Form

Type of project: Clinical Skills Assessment Research Thesis

Project title **Clients' Experience of the Formulation Within Cognitive Behavioural Therapy**

Researcher's name **Franz Burchardt**

The tape you are transcribing has been collected as part of a research project. Tapes may contain information of a very personal nature, which should be kept confidential and not disclosed to others. Maintaining confidentiality is of utmost importance to the University.

We would like you to agree not to disclose any information you may hear on the tape to others, to keep the tape in a secure place where it cannot be heard by other people, and to show your transcription only to the relevant individual who is involved in the research project. If you find that anyone speaking on the tape is known to you, we would like you to stop transcription work on the tape immediately.

Declaration

I understand that:

1. I will discuss the content of the tape only with the individual involved in the research project.
2. I will keep the tape in a secure place where it cannot be heard by others.
3. I will treat the transcription of the tape as confidential information.
4. If the person being interviewed on the tape is known to me I will undertake no further transcription work on the tape.

I agree to act according to the above constraints

Your name

Signature

Date

Occasionally, the conversations on tapes can be distressing to hear. If you should find it upsetting, please speak to the researcher

WORKED EXAMPLE of IDENTIFYING MASTER THEMES in TRANSCRIPT (Extracts taken from two parts of transcript)

<p><i>(Interviewer) What...what do you remember about when you first came to therapy then, the first impression?</i></p>	
<p>(Gail) Umm, I felt, umm, quite relieved, cos I thought I was useless and I thought I were cracking up and....when I realised there was something out there, somebody out there that could help me....and I'm not the only one, it...it's quite common, more common than you think....that was just a huge relief in itself, that I'm not a useless waste of space and, you know, it is quite common, it's not unusual at all. So that was like a weight off my shoulders in a way I thought, and umm.....</p>	<p>Trust in therapist</p> <p>Putting things in perspective</p>
<p><i>(Interviewer) So that was when you first came to therapy you felt that way?</i></p>	
<p>(Gail) Yeah. By knowing that there was someone there.</p>	<p>Trust in therapist</p>
<p><i>(Interviewer) Uh huh.</i></p>	<p>Putting things in perspective</p> <p>Somebody that understood</p>
<p>(Gail) Obviously I wasn't the first person that had had these sort of problems. Umm, there must have been like hundreds and thousands before because people specialise in this sort of thing, so. And again just knowing that somebody understood aswell, cos a lot of people, unless they've experienced it, don't understand. So basically just having somebody that understands. Somebody there that can help you and explain it to you just gave me a big sense of relief.</p>	<p>Putting things in perspective</p> <p>Somebody that understood</p>
<p><i>(Interviewer) So how did, umm, (M***) explain things to you?</i></p>	<p>Understanding what happens</p>
<p>(Gail) Umm, a lot of it was like physical, how your body reacts to, umm, anxiety, and umm, one thing can trigger another. Sort of like if I'm feeling a bit nauseous, then I start getting anxious, because I'm getting anxious my heart might start beating faster, which might make me feel a bit more anxious, that'll make me feel a bit more nauseous. And he sort of explained about all these circles, vicious circles, and, (Pause) it...it was like my sort of feelings were snowballing and I'd got to break this circle somewhere.</p> <p style="text-align: center;">----</p>	<p>Understanding what happens</p>
<p>(Gail) ...within this downward spiral. And he said 'what we need to do is reverse it and start coming the other way.'</p>	<p>Working to a plan – stopping the cycle</p>
<p><i>(Interviewer) Yeah.</i></p>	
<p>(Gail) Which, (Pause) **** eventually got my positive head on,</p>	

<p>it's not 'oh my god what's gonna happen, I don't want to do this,' and kind of 'right I'm gonna, I'm gonna go out there and I'm gonna have a life and I'm gonna be, you know, positive about it, I'm going to enjoy it.' He sort of said 'you're coming back out of this downward spiral, you're starting to come up and you're coming...coming...coming out of it.' So that was, although I couldn't see it myself at the time, but when he sort of explained it to me, ****.</p>	<p>A foundation & a direction</p> <p>Somebody that understood Understanding what happens</p>
<p><i>(Interviewer) You've mentioned the, with the...the circle and also with the spiral, you seem to be pinpointing symptoms, umm, linking the symptoms, am I correct in, that's...that's.....</i></p>	
<p>(Gail) Yeah.</p>	
<p><i>(Interviewer).....how...how you saw things?</i></p>	
<p>(Gail) Yeah, yeah, yeah. And how I was reacting to them aswell. I was being negative about what was happening, 'my god I'm useless and I'm no good, I'm a waste of space,' that kind of thing, instead of thinking 'it's quite common, it happens to a lot of people, lots of famous people even. You're not, there's nothing wrong with you, its just sort of a, not a rut you've got into, but, just a phase in your life that you, the thoughts that you're having and....' Having suffered from depression aswell, I always tend to look on the negative side, whereas, understanding it and knowing that there's other people aswell, famous people who...who've got everything, they're in the same situation, and they're, sort of, **** this confidence ****, getting your confidence to tackle **** go out and do things again.</p>	<p>Understanding what happens</p> <p>Putting things in perspective</p> <p>Understanding what happens Putting things in perspective</p> <p>Effectiveness & self-efficacy</p>
<p><i>(Interviewer) What was the actual, your actual experience like when, in using these diagrams, these, umm, explanations that you've mentioned. What sort of **** did you experience that in therapy, what sort of impact did that have?</i></p>	
<p>(Gail) (Pause) I think it...it just, it just showed it in black and white, and what, I wouldn't say it simplified it, I suppose it did simplify it in a way. (Pause) It made it easy to understand what was happening to me, or why it was happening to me, and what I needed to do about it **** to break this circle. You'd got to, got to pick a point, you'd got to break this circle, vicious circle. So, I needed to do that (laughs) thinking 'right I'm not gonna do, **** my friends I'm not doing such and such,' which is what I did before. But in the end I got to the stage where I...I didn't even think about it before I went out.</p>	<p>Descriptions & Diagrams</p> <p>Something practical and non-technical Understanding what happens</p> <p>Working to a plan – stopping the circle</p>

North Sheffield Ethics Office
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S5 7AU

CMHN/AD/02/06/03

Hardy/NS2003 6 1679

Please quote this number on all correspondence

19th June 2003

Franz Burchardt
Trainee Clinical Psychologist
Clinical Psychology Unit
Department of Psychology
Western Bank
SHEFFIELD
S10 2TP

Dear Mr Burchardt

Re: Clients' experiences of the formulation within Cognitive-Behavioural Therapy: A qualitative study of the clients' perspective.
Our ref: NS2003 6 1679

The Chair/Honorary Secretary of the North Sheffield Research Ethics Committee has considered the modifications submitted in response to the Committee's earlier review of your application on 2nd June 2003 as set out in our letter dated 5th June 2003. The documents considered were as follows:

- Protocol dated June 2003.
- Client information sheet dated June 2003.
- Consent form dated June 2003.

The Chair/Honorary Secretary, acting under delegated authority, is satisfied that these accord with the decision of the Committee and has agreed that there is no objection on ethical grounds to the proposed study. I am, therefore, happy to give you the favourable opinion of the committee on the understanding that you will follow the conditions set out below.

Conditions

- You do not recruit any research subjects within a research site unless favourable opinion has been obtained from the relevant REC.
- You do not undertake this research in an NHS organisation until the relevant NHS management approval has been gained as set out in the *Framework for Research Governance in Health and Social Care*.

- You do not deviate from, or make changes to, the protocol without prior written approval of the REC, except where this is necessary to eliminate immediate hazards to research participants or when the change involves only logistical or administrative aspects of the research. In such cases the REC should be informed within seven days of the implementation of the change.
- You complete and return the standard progress report form to the REC one-year from the date on this letter and thereafter on an annual basis. This form should also be used to notify the REC when your research is completed and in this case should be sent to this REC within three months of completion.
- If you decided to terminate this research prematurely you send a report to this REC within 15 days, indicating the reason for the early termination.
- You advise the REC of any unusual or unexpected results that raise questions about the safety of the research.
- *Correct the spelling mistake on the information sheet – confidentiality should read confidentially.*
- *Remove “name of patient” from the consent form and replace with “name of client”.*
- *Remove office formatting from the footer of the consent form (this contains an incorrect date).*
- *Provide a signature for the nurse manager.*
- *Clarify whether or not indemnity is required from Sheffield Care Trust, forward a copy of the details.*
- *Ensure any modified documents are referenced with an updated version number/date.*

A full record of the review undertaken by the REC is contained in the attached REC Response Form. The project must be started within three years of the date on which REC approval is given.

Yours sincerely



PP Dr C M H Newman
HONORARY SECRETARY - NORTH SHEFFIELD RESEARCH ETHICS COMMITTEE
Senior Lecturer in Cardiology/Honorary Consultant Physician

Cc Dr G Hardy, R & D Consortium

Encs

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CMHN/AD/02/06/03

Hardy/NS2003 6 1679

Please quote this number on all correspondence

25th June 2003

Franz Burchardt
Trainee Clinical Psychologist
Clinical Psychology Unit
Department of Psychology
Western Bank
SHEFFIELD
S10 2TP

Dear Mr Burchardt

Re: Clients' experience of the formulation within Cognitive-Behavioural Therapy: A qualitative study of the clients' perspective.

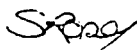
Our ref: NS2003 6 1679

Thank you for your letter dated 23rd June 2003 with the following enclosures:

- Protocol version 3 dated June 2003.
- Client information sheet version 3 dated June 2003.
- Consent form version 3 dated June 2003.

I note that the modifications made to these documents are as requested in our letter dated 19th June 2003, these are now the approved versions of protocol, information sheet and consent form. I would be pleased to receive the indemnity details from Sheffield Care Trust and the letter from Tom Ricketts when available.

Yours sincerely



Dr C M H Newman
HONORARY SECRETARY - NORTH SHEFFIELD RESEARCH ETHICS COMMITTEE
Senior Lecturer in Cardiology/Honorary Consultant Physician

Cc Dr G Hardy, R & D Consortium

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Hardy/NS2003 6 1679

Please quote this number on all correspondence

11th August 2003

Franz Burchardt
Trainee Clinical Psychologist
Clinical Psychology Unit
Department of Psychology
Western Bank
SHEFFIELD
S10 2TP

Dear Mr Burchardt

Re: Clients' experience of the formulation within Cognitive-Behavioural Therapy: A qualitative study of the clients' perspective.

Our ref: NS2003 6 1679

Thank you for your letter dated 9th July 2003 with the following enclosures:

- Letter from Tom Ricketts dated 7th July 2003 confirming that he is acting as local NHS Research Supervisor to the above study.
- Details of research protocol indemnity from Sheffield Care Trust dated 25th June 2003.

I note that the above documents are as requested in our letter dated 25th June 2003, this information is acknowledged and noted and is now stored in your study file.

Yours sincerely



pp Dr S R Brennan
CHAIRMAN - NORTH SHEFFIELD RESEARCH ETHICS COMMITTEE
Consultant Physician



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British Journal of Clinical Psychology

Notes for Contributors

The *British Journal of Clinical Psychology* publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

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2. Length

Pressure on Journal space is considerable and papers should be as short as is consistent with clear presentation of the subject matter. Papers should normally be no more than 5,000 words, although the Editor retains discretion to publish papers beyond this length.

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4. Submission requirements

- Four copies of the manuscript should be sent to the Editor (Professor Karin Mogg/ Professor Brendan Bradley, BPS Journals Department, St. Andrews House, 48 Princess Road East, Leicester, LE1 7DR, UK). Submission of a paper implies that it has not been published elsewhere and that it is not being considered for publication in another journal. Papers should be accompanied by a signed letter indicating that all named authors have agreed to the submission. One author should be identified as the correspondent and that person's title, name and address supplied.
- Contributions must be typed in double spacing with wide margins and on only one side of each sheet. All sheets must be numbered.
- Tables should be typed in double spacing, each on a separate piece of paper with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be

Appendix 7

- placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures are usually produced direct from authors' originals and should be presented as good black or white images preferably on high contrast glossy paper, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Paper clips leave damaging indentations and should be avoided. Any necessary instructions should be written on an accompanying photocopy. Captions should be listed on a separate sheet.
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Moore, R.G., & Blackburn, I.M. (1993). Sociotrophy, autonomy and personal memories in depression. *British Journal of Clinical Psychology*, 32, 460-462.
 - Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
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6. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusion. There should be no more than one Table or Figure, which should only be included if it conveys information more efficiently than the text. Title, author, name and address are not included in the word limit.

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9. Proofs

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11. Checklist of requirements:

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- Double spacing with wide margins
- Tables/figures at the end
- Complete reference list in APA format
- Four good copies of the manuscript (or an e-mail attachment)

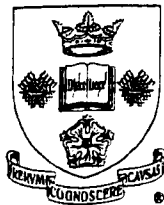
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THE UNIVERSITY OF SHEFFIELD
Clinical Psychology Unit
Department of Psychology

Doctor of Clinical Psychology (DClin Psy) Programmes (Pre-registration and post-qualification)
Clinical supervision training and NHS research training and consultancy



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Clinical Practice Director: Ms Joyce Scaife
Course Administrator: Carole Gillespie
Prof Nigel Beail

1st March 2004

Franz Burchardt
Third year trainee
Clinical Psychology Unit
University of Sheffield

Dear Franz

I am writing to indicate our approval of the journal(s) you have nominated for publishing work contained in your research thesis.

Literature Review: British Journal of Clinical Psychology

Research Report: Option A

Please remember to bind in this letter and copies of the relevant Instructions to Authors with your thesis.

Yours sincerely

A handwritten signature in black ink, appearing to be 'AT', written over a horizontal line.

Andrew Thompson
Chair, Research Sub-Committee