The Conceptualization Process in Cognitive Behavioral Therapy. Commentary on Chapter "Case Formulation in Standard Cognitive Therapy"

Arthur Freeman

Contents

CBT Conceptualization Process and Patient's Life Goals

In 1977, the late Dr. Michael J. Mahoney called Cognitive Behavior Therapy (CBT) as the barbarians at the gates. The basic psychodynamic establishment saw CBT as simplistic, mechanistic, overly prescriptive, technique focused, and while being logical, lacked the essence of being psychological, and lacking in the elegance of the psychodynamic formulations. These mistaken notions are used as reasons to deride CBT.

In this comprehensive chapter, the case formulation methodology of CBT is described and discussed in detail, comparing and contrasting with Rational Emotive Behavior Therapy and the Constructivist approach of Mahoney, Guidano, and Liotti. The conceptualization process is one of model-building and is among the most sophisticated skills of the therapist. Whenever an artist create a painting they start with a basic outline or sketch of the goals and plan for the creation.

What is interesting is that the ability to develop a conceptual framework for the patient's problems, strengths, challenges, and perceived threats is the key to effective CBT. Rather than trying to apply specific techniques (or classes of techniques) to help the patient develop a more adaptive style requires the clinician do several things, which are:

- First, the clinician needs to develop a working model of the patient's problems.

A. Freeman (✉)
Philadelphia College of Osteopathic Medicine, Philadelphia, PA, USA

G. M. Ruggiero et al. (eds.), *CBT Case Formulation as Therapeutic Process*,
https://doi.org/10.1007/978-3-030-63587-9_3

- Second, the therapist -working collaboratively with the patient- needs to refine and sharpen the conceptualization.
- Third, the patient's input and feedback is an essential issue in that it reflects how the patient sees and understands their life issues.
- Fourth, the therapist and patient develop specific targets for change that can help the patient to alter their present style to one that is more adaptive.
- Fifth, the therapist and the patient establish a direction and symptom cluster upon which to focus.
- Sixth, through a series of cognitive and behavioral experiments the patient works to alter their present life picture.
- Seventh, the patient and therapist evaluate the success of the experiments and make any mid-course alterations to the patient's life direction.
- Eighth, the therapist and the patient explain the data gleaned from the experiments.
- Ninth, second and third experiments, collaboratively developed can be introduced to gather further data.
- Tenth, the therapist establishes the therapeutic atmosphere based on the patient's life experience and both stated and implied therapeutic goals.
- Finally, the patient can assess their new set of actions and goals.

The patient must be socialized to the CBT model, discuss the therapist's role, the patient's role in therapy, the patient's expectation of therapy, a setting of therapeutic boundaries, assessment of the patient's therapeutic and life skills, and the time parameters and constrains for the therapy The therapeutic focus and the conceptual framework must focus on the patient's goals. The patient, in accord with their goals must learn how to process thoughts, feelings, and actions and the interaction between the seemingly disparate.

Essentially, the patient can make the sequential steps needed for them to more closely approximate their life goals. They learn to ask themselves the question, "is this where I want to be? Is this the direction that I want to take? Does this set of actions get me more (or less) of what I would like for myself, my relationships, my family, my work, and my friendships. The conceptualization helps the therapy to be more proactive than reactive in the therapy work.

Two key constructs are moderation and structure. The patient needs to be moved from an extreme view toward a more moderate view, and they learn to structure both the therapy, overall, and the session, in particular. This structure helps the patient gain greater control of their life-goals and the focus of their desired life changes.

Both therapist and patient can check on the purpose and value of the conceptualization in a very direct manner by asking three questions. First, does the conceptualization as developed explain the patient's past behavior? Second, does the conceptualization make sense of the patient's present behavior? And third does the conceptualization help to predict future behavior?

Elements of the CBT Approach

In many ways, the term "Cognitive Behavioral" is a misnomer (and has also become a target for criticism). It implies that CBT examines the way in which people process information (cognitive) and how this processing both influences, and in some cases, directs how one acts (behavioral), In point of fact the CBT approach examines how what one thinks and perceives will influence how they feel. In addition, CBT includes neurological and biological influences, general and specific skill deficit, and behavior.

Our experience has been that many of the so-called psychological problems are the result of a lack or poorly developed skills which can be taught, learned and practiced. For example, I recall when my youngest son started school we placed him in a private school inasmuch as when he was ready for kindergarten he had learned to read, knew his numbers, etc. Rather than have him bored by a repetition of his already mastered skills we enrolled him in a private school. At the end of each day, every boy in the school had to "check-out" with a teacher. They were required to state their name (My name is Aaron Freeman. And then, had to hold eye-contact with the teacher and say, "have a good day. And shake the teacher's hand) If the child lost eye contact, the teacher would gently point this our. "Aron, look at me. Have a good day. When he mastered that he got into my car and we drove home. What is interesting is that for many years, when introducing my three sons to another adult, it is Aaron who would step forward and introduce himself. These early social skills have eventuated in my eldest son being a computer academic, my middle son working for a large corporation and Aaron owning his own business where his social skills have served him well.

The CBT approach seeks to address four elements. What is the style, content, and goals of evaluation both internal and external events. While the CBT therapist accepts that some thoughts are not easily or immediately accessible to consciousness, and the cognitive shifts can be used as indirect signs of change. The therapist and patient want to first explore the patient's *phenotype* (that which is viewed and evaluated by others, *the genotype*, the basic constitutional factors, the s*ociotype*, how the individual interacts with others, and the *schematype,* the influence of the patient's schema. It is this last element that is at the heart of the CBT approach. The patient's schema (also termed rules or requirement. These rules most often derive from family of origin. They may be family rules, cultural rules, gender-related rules, age-related rules, geographic rules, group dictated rules, and religious rules. These schema serve as a filter for life experience and for how one responds to the schema. The earlier the schema is acquired, the credibility of the rule-maker or rule-enforcer, the more powerful the rule and the greater effect on the individual. If, for example, a child learns that they lacked value (You are no good), intelligence (You are stupid, (social skills (don't you know how to greet people), they may carry those rules as part of broader rules or as simple negative self-statements.

Beck and others developed the idea that rather than view problems in their totality, the targeted issues needed to be broken up to smaller, more workable elements.

The CBT therapist starts with identifying the approximate time/ setting of the experience, a description of the experience, the patient is then asked what thoughts, ideas, percepts they have regarding the experience. A key ingredient is the attachment of both the emotion and the level of the emotion. The initial assessment of the emotion becomes the baseline against which change can be assessed. This is followed by the patient identifying the nature of the distortions and how believable they see the ideas to be. (This also serves as a baseline). The patient is then encouraged to challenge the negative ideas and distortions and the changes in emotion, if any, can be assessed.

Unlike the REBT approach (discussed later in this volume) the CBT therapist does not debate, confront, challenge or try to dispute the patient's ideas. The technique is the Socratic Dialogue which uses a questioning format to help the patient to identify their thoughts. The questioning format is very much like the examination procedures used in school examinations. This helps to make the questioning format familiar to the patient. For example, After the therapist teaches and demonstrates the Socratic Dialogue the patient can learn to use it on themselves. (1) The answer to the question might require a long example. (2) Some questions require a brief description and answer, (3) The answer can be a true/false answer. (4) The use of the missing word (when you think those thoughts, it makes you feel…? (5) The use of a matching strategy (which of these pieces go together? (6) The use of metaphor (7) The use of story, fable, myths, or literature references.

Probably the most useful and economic intervention is the use of the "Critical Incident technique." Rather than long stories and the retelling of previous experience, the patient can be asked, "Tell me one incident that will shown me exactly what you experienced. Each critical incident has to have a moral. The therapist can ask, "What did you learn from that experience?

The chapter stresses the importance differentiating between the working alliance and the alliance and the working relationship. The alliance is the sum of the goals of therapy and the working relationship is the way in which the patient and therapist interact. Clearly they are related but are, at the same time, different, each being an important part of the overall therapeutic alliance. If there was a key word to describe this chapter it would be that it is comprehensive and offers a concise review of the conceptualization process in Cognitive Behavior Therapy.

Reference

Mahoney, M. J. (1977). Cognitive therapy and research: A question of questions. *Cognitive Therapy and Research, 1*, 5–16.