Collaborative Case Conceptualization Rating Scale & Coding Manual

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Collaborative Case Conceptualization Rating Scale Coding Manual

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Overview

This manual and its rating scale operationalize the model of case conceptualization developed by Kuyken, Padesky and Dudley (2009) in their book *Collaborative Case Conceptualization: Working Effectively with Clients in Cognitive Behavioral Therapy.* Its functions are to enable:

- Supervisors / consultants to provide formative feedback to therapists learning case conceptualization
- Researchers to evaluate if and how case conceptualization competency is related to therapy processes and outcomes
- Trainers and researchers to assess therapist conceptualization competence

The case conceptualization model is described fully in Kuyken, Padesky & Dudley (Kuyken, Padesky, & Dudley, 2009). This manual operationalizes the three principles articulated in the book as being fundamental to effective case conceptualization:

1. Levels of conceptualization
2. Collaborative empiricism
3. Strengths/resilience focus

The defining content of each of these principles is described so that raters can examine the presence / absence of these features and rate the extent to which competency in this area is demonstrated in a given therapy session. Collaborative empiricism is divided into its two sub-domains; collaboration and empiricism are each described and rated. The extent to which these principles are related or distinct was examined through the development process described below, including expert peer review as well as psychometric criteria of reliability and validity (Streiner & Norman, 1989; Campbell & Fiske, 1959).

Development process

This manual and its rating scale are designed to operationalize competency in CBT case conceptualizations as described in the book *Collaborative Case Conceptualization* (Kuyken, Padesky & Dudley, 2009). It's design is informed by prior research on case conceptualization, especially the Quality of CBT Case Conceptualization Scale (Kuyken, Fothergill, Musa, & Chadwick, 2005), the Case Formulation Content Coding Method (CFCCM) (Eells, Kendjelic, & Lucas, 1998) and the Conceptualization Rating Scale (Easden & Kazantzis, 2007). Our goal is to produce an assessment tool that can reliably and comprehensively rate the conceptualization process and skill of CBT therapists. Each version of this manual was developed by the authors of the model (Padesky, Kuyken, & Dudley) in collaboration with (a) researchers who evaluate the impact of case formulation on therapy processes and outcomes as well as (b) colleagues involved in training and rating CBT therapists.

Step 1. Describing the domains
The initial phase (March – August, 2010) established criteria to assess each principle or sub-domain of case conceptualization competency. The model's authors were instrumental in setting out these criteria. Peer review and input was received from experienced CBT practitioners, including Michael Easden, Sheena Liness, Freda McManus and Jacqueline Persons.

Step 2. Testing the face validity of the scaling
The face validity of the proposed approach to scaling competency in case conceptualization was evaluated (Sharpless & Barber, 2009) by the model's authors rating sample session recordings (August – October, 2010). This scale appeared to have good face validity based on the ease with which ratings could be made, the number of sessions falling into each category and raters' judgments about each item's ability to quantify competence in case conceptualization. Items were revised and combined based on raters' feedback. Ratings of additional session recordings led to articulations of fine grained differentiations in the descriptors provided for different levels of competence for different domains.

Step 3. Establish inter-rater reliability
An important criterion of interest is whether raters can agree in their differentiations of competency in case conceptualization, both overall and in relation to each domain and sub-domain. To establish the inter-rater reliability of the CCC-RS, intra-class correlations (ICC) were calculated for six session recordings coded independently by a pair of raters, one new to the scale, Phil Gower and one of the developers of the scale, Willem Kuyken (October, 2010). For the CCC-RS total score, ICC = .97 p = 0.001 and for the CCC-RS subscales the ICCs were: Levels of conceptualization ICC = .91, p = 0.01; collaboration ICC = .91, p = 0.01; empiricism ICC = .93, p = 0.006; strengths and resilience Focus ICC = .92 p = 0.009. Reliability of the global subscale fell in the substantial agreement range (ICC = .95, p = 0.003) as did all ICCs (0.81 – 1.0; Shrout, 1998), demonstrating that following appropriate training, high levels of inter-rater agreement can be established on the CCC-RS.

Step 4. Establish internal consistency and validity
Ongoing research is examining whether the CCC-RS actually assesses what it sets out to measure, by examining its convergent, discriminant and predictive validities. The first study was conducted by Philip Gower as his doctoral dissertation research under the supervision of Willem Kuyken (Gower, 2011). That research examined the CCC-RS, it's correlation with a measure of CBT competence, as well as its association with therapy outcomes.

The CCC-RS' internal consistency was computed from ratings of 40 session recordings. It showed high internal consistency for the full scale (Cronbach's α = .94) and each of the sub-scales; Cronbach's α for the levels of conceptualization, collaboration, empiricism and strengths / resilience focus subscales were .92, .89, .86, and .88 respectively. This suggests the scale has good internal consistency across items in its total and sub-scale structure.

The CCC-RS also showed good convergent validity with a general measure of CBT competence, the CTS-R (Blackburn et al., 2001; Milne, Claydon, Blackburn, James, & Sheldon, 2001). The CTS-R is a 12-item observer-rater scale widely used in the measurement of CBT therapist competence. There was a significant and positive relationship between competence in case conceptualization and therapists' overall CBT competence. Significant and positive correlations were also found between CBT competence and our four subscales on the CCC-RS: level of conceptualization,

collaboration, empiricism, and the therapists' focus on client's strengths/resilience. The CCC-RS scales expected to correlate highly with individual CTS-R items which most closely measure case conceptualization were also examined. Total score on the CCC-RS correlated significantly with the 'conceptual integration' item in the CTS-R ($r = .44$, $p = 0.002$). The CCC-RS collaborative conceptualization sub-scale correlated significantly with the general 'collaboration' in CBT Item in the CTS-R ($r = .44$, $p = 0.002$).

To examine whether competency in case conceptualization as measured on the CCC-RS is linked to therapy outcome, forty audiotapes selected from an ongoing study (CoBalT: Cognitive Behavioural Therapy as an adjunct to Pharmacotherapy for Treatment Resistant Depression in Primary Care: a randomised controlled trial) were rated for competency in case conceptualization using the CCC-RS. Ratings were made blind to treatment outcome. Therapy outcome was measured using The Beck Depression Inventory II (BDI-II; Beck, Steer & Brown, 1996).

Significant associations were found between all the CCC-RS scales (total score, levels of conceptualization, collaboration, empiricism, strengths / resilience focus) and change in BDI-II scores from baseline to end of treatment. Regression was used to find out whether competence in case conceptualization could predict therapy outcome. Due to high correlations among the subscales of the CCC-RS only the total score on the CCC-RS was used to predict outcome to minimize the risk of co-linearity. The regression suggested that therapists' competence in case conceptualization predicts variance in client outcomes (Gower, Kuyken, Padesky, Dudley & McManus, 2011).

While these initial research findings are encouraging, additional research is necessary to extend these findings to additional clinical populations and to further examine the validity and utility of the CCC-RS.

In July 2011 we decided to post this manual on the internet so other research groups could collaborate with us on further developments of this conceptualization rating scale (http://www.padesky.com/resouces).

Rater Guidelines

Principle 1. Levels of Conceptualization

Conceptualization changes over time depending on the phase of therapy (early, middle, late, booster sessions) and the function of conceptualization (e.g., socialization to the model, rationale for behavioral experiments, relapse prevention).

Initial conceptualizations are typically quite descriptive; therapists assess clients' presenting issues and help the client describe these issues in cognitive and behavioral terms (**Descriptive Level**). This early conceptualization activity is sometimes called "socialization" to CBT. Following initial descriptions of presenting issues, case conceptualizations become more explanatory, identifying triggers and maintenance factors using cognitive behavioral theory (**Cross-sectional Level**). Here disorder-specific models or generic approaches like functional analysis (e.g., Kohlenberg & Tsai, 1991) are typically used. In middle and later stages of CBT, conceptualization uses higher levels of inference to explain how predisposing and protective factors contribute to clients' presenting issues (**Longitudinal Level**). Predisposing factors help explain why a client is vulnerable to their presenting issues. Protective factors highlight strengths that can be used to build resilience as described in our third domain below. Clients' compensatory strategies, conditional assumptions, core beliefs and developmental history are typically drawn out into an account of their presenting issues understood through the lens of their developmental history.

Therapists exercise judgment in progressing through levels of conceptualization; gathering data, formulating descriptive hypotheses, inferential hypotheses and treatment plans in an iterative way (See, e.g., Eells, Lombart, Kendjelic, Turner, & Lucas, 2005). When done well, these decisions are made collaboratively and matched to client needs. For example, early in therapy and/or with a client who feels overwhelmed, the therapist is likely to use simpler and descriptive levels of conceptualization to match client needs and ability to accommodate new information. A cross-sectional level of conceptualization is used when the client wants to understand why patterns of thinking or behaving are pervasive and/or persistent. When the client's developmental history and protective/predisposing factors seem relevant to the therapy goals, client and therapist co-develop a longitudinal conceptualization.

There is a seamless movement through levels of conceptualization across therapy. It is not necessary to use all three levels of conceptualization with each client. It is more important to assess whether the most helpful level(s) of conceptualization are used at each stage of therapy and that the conceptualization evolves as therapy proceeds.

When rating, keep in mind that each of the three levels of conceptualization can be usefully employed at any point across the span of therapy. Descriptive case conceptualization may be done late in therapy if a new issue is discussed. Some issues (such as anxiety disorders) lend themselves to cross-sectional case conceptualizations of triggers and maintenance factors as soon as a diagnosis has been made. A client presenting with post-traumatic stress symptoms dating from early abuse experiences may well require some exploration of early developmental experiences and this may lead to the beginnings of a longitudinal case conceptualization early in the course of therapy. However, the beginnings of a longitudinal case conceptualization will still have a present-focus and will primarily work through levels of description and maintenance with the goal of alleviating client's distress towards early therapy goals.

For an in depth description of "levels of conceptualization," see Kuyken, Padesky & Dudley (2009), pp. 29-44. A detailed case example is provided on pp. 121-247.

Key features

At all three levels of conceptualization look for the therapist to:

- Identify and link behaviors, cognitions (automatic thoughts, underlying assumptions and core beliefs), emotions, and physiological experiences with particular situations and experiences in ways that are a "good fit" to client experience
- Infer the elements above appropriately from what the client reports
- Use accessible and appropriate language, metaphors, stories and imagery in the case conceptualization
- When the therapist does case conceptualization well, it usually helps the client better understand his/her problems

In addition, at the Descriptive Level the therapist will ideally:

- Differentiate thoughts, moods, physical reactions, behaviors, and situational aspects of client experience
- Explain the rationale for a CBT-based description of presenting issues
- Demonstrate understanding of the principles and processes of common descriptive case conceptualization models (e.g. Beck's generic model, Padesky & Mooney's (1990) 5-part model, functional analysis, or other individualized methods)
- Draw on appropriate theoretical models (e.g., OCD) to gather the most relevant information related to a presenting issue

At the Cross-sectional Level:

- Identify triggers, responses and maintenance cycles
- Recognize key trans-diagnostic processes such as rumination, avoidance and safety behaviors
- Recognize and incorporate recurrent themes across situations in the client's life where the presenting issue occurs
- Use the conceptualization and treatment choices in an iterative way

At the Longitudinal Level, therapist is expected to:

- Demonstrate awareness of CBT theories of personality development (e.g. Beck et al, 2004)
- Gather only developmental information that is relevant, linked to presenting issues and goals, beliefs and/or behaviors
- Recognize and attend to evidence of client resilience
- Communicate the rationale for linking developmental history, presenting issues, relapse management, and resilience
- Infer relevant developmental information from client data and integrate it well into the case conceptualization

Principle 2. Collaborative Empiricism

Sub-domain: Collaboration

Collaboration refers to processes that ensure the therapist and client work as interactive partners in therapy. In CBT, therapist and client are expected to work as a team to achieve client goals. Collaboration is enhanced when there is genuine curiosity and respect for each others' ideas. There are several rationales for collaborative co-construction of the case conceptualization:

- Client involvement enhances client understanding of the presenting issues as well as the treatment rationale. Greater understanding and participation in case conceptualization and treatment planning may increase therapy motivation.
- Therapist and client typically each hold only part of the information necessary for a useful conceptualization. The therapist is often knowledgeable about psychological theory and evidence-based models of client issues. At the same time, the client knows the relevant information about his or her own personal experiences and circumstances that give rise to the presenting issues.
- The synthesis of therapist and client information is the best way to reduce cognitive biases that can distort the conceptualization if done by either the therapist or client on their own. The relevance of client personal experiences and broad psychological findings can be weighed and balanced through collaborative discussions, observations, and experiments.

For an in depth description of "collaboration" in case conceptualization, see Kuyken, Padesky & Dudley (2009), pp. 52-54; 61 – 68.

Key features

Collaboration describes both therapist and client behaviors (often directly observable) and also a spirit of engagement and involvement (which may need to be inferred from nonverbal cues or facial expressions).

Examples of COLLABORATIVE BEHAVIORS include:

- Both parties writing on or pointing to the model
- Questions followed by a silence that suggests the answers are truly important and of interest
- Therapist prompts such as, "How would you say that in your own words?"
- Client questions such as, "What do you think?" (after offering an idea)
- Both parties speaking often, but based on active listening, constructively and without speaking over each other
- Evidence that each is listening to the other (e.g., use of a common language; images and metaphors used by one person are picked up by the other)
- In session experiments, followed by mutual discussion

Examples of a COLLABORATIVE SPIRIT include:

- Facial expressions that demonstrate a keen interest in discussions and the other person
- Eye contact that appears lively and engaged
- Vocal tones that express a high degree of interest, at times enthusiasm
- Willingness to change the conceptualization based on ideas or observations offered by the other person

Sub-domain: Empiricism

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

Of course, therapists also face situations where there is little or only emerging evidence for CBT. Also, clients can experience multiple or more complex presenting issues that make it difficult to map directly to one particular theory and still provide a coherent and comprehensive conceptualization that is acceptable to the client. Under these circumstances, a generic or trans-diagnostic approach may be an appropriate choice.

Even when a disorder specific CBT model is closely matched to a client's presenting issues it is important to develop the case conceptualization with the client, so the client understands the applicability of the model to his or her own experiences. This entails gathering detailed information about client experiences (thoughts, emotions, behaviors, physiological reactions, and circumstances) and purposefully comparing these to the emerging conceptualization. Empiricism also involves an active search for examples that do not fit with the emergent model, experiences which might challenge its utility.

Another face of empiricism is that the therapist takes an empirical approach to clinical decision-making. Therapists and clients develop hypotheses, devise adequate tests for these hypotheses, and then adapt these hypotheses based on outcomes of therapy interventions. This makes CBT an active and dynamic process, in which the conceptualization both guides treatment and is corrected by feedback from the results of active observations, experimentation and intervention.

For an in depth description of "empiricism" in case conceptualization, see Kuyken, Padesky & Dudley (2009), pp. 44-51; 68 – 83.

Key features

Conceptualization that is empirical will include evidence of the following:

- Use of the best available CBT theories and models to inform the conceptualization
- Comparison of the conceptual model with client observations and experiences
- Individualization of the conceptualization to tailor it to this particular client
- An active search / inquiries regarding client experiences that do not fit the model
- Understandable links between the conceptualization and treatment plan
- Modification of the conceptual model and / or treatment plan when unexpected outcomes occur in session, during homework, or during naturalistic life events

Principle 3. Strengths / Resilience Focus

Most current CBT approaches are concerned either exclusively or largely with a client's problems, vulnerabilities and history of adversity. We advocate therapists identify and work with client strengths at every stage of conceptualization. According to our case conceptualization model, a strengths-focused approach helps achieve the two primary purposes of CBT: alleviation of client distress and building client resilience (Kuyken, Padesky & Dudley, 2009, p. 3). A strengths focus is often more engaging for clients and offers the advantages of harnessing client resilience during the change process to pave a way toward lasting recovery. Identifying and working with clients' strengths and resiliency begins at assessment and continues at each level of conceptualization.

Client strengths come in many forms. Common areas therapists can consider include: specific skills (such as musical ability or knowledge of engine repair), beliefs (*If I stick with something, I will be able to get through it)*, hobbies or passionate interests (football, gardening), personal values (*love* or *loyalty* toward others*)*, character assets (honesty, kindness), physical or mental abilities (intelligence, endurance, good health), social supports (friends, family, colleagues), spirituality (belief in God and/or meaningful values) and emotional assets (ability to self-soothe, delay gratification).

Often these strengths are "hidden" in the sense that the client may not recognize his or her strengths and does not directly describe them. For example, a mother who says, "I struggle to feed and clothe my children on my disability income," is conveying both a problem and a myriad of hidden strengths. Her statement implies she is somehow managing most of the time to feed and clothe her children on a very small sum of money. This suggests she could have hidden strengths in the areas of creativity, budgeting, delay of gratification, meal planning, and even humor.

Therapists with a strengths focus will:

(i) recognize hidden strengths

(ii) **bring these strengths into client awareness through questions** (e.g., *How DO you manage to feed and clothe your children on such a limited income?*) **and strengths-focused summaries** (e.g., *It sounds like you know how to stretch a budget by being a creative cook and seamstress. It also helps that your children know you are a loving mother and you are able to enlist their cooperation even when the family needs to delay things you all would like*)

(iii) **incorporate strengths into case conceptualization and treatment planning** (*Where do you think we could put your strengths we just identified on this model we are using to understand [your presenting issue]? Can you think of any ways you might use these strengths to help with this issue?)*

Resilience is the ability to bounce back in the face of adversity. Resilience is closely linked to strengths because people often draw on their strengths in challenging times in order to adapt and thrive (Rutter, 1999). There are many paths to resilience and even people with just a few strengths can use these as a springboard to greater resilience. A resilience focus in therapy asks client and therapist to consider how this client's particular strengths can help the client adapt to life challenges. Resilience-based strategies can be incorporated into the conceptualization of a presenting issue.

Just as presenting issues are conceptualized, therapists and clients can develop conceptualizations of resilience. These can describe and link resilient behaviors, cognitions, emotions, physical responses (descriptive conceptualization). Or they might show how strengths protect the person from adverse events that might otherwise trigger and maintain presenting issues (cross-sectional conceptualization). A

longitudinal conceptualization of resilience can summarize how strengths have operated across a lifetime to foster resilience and promote well-being. Because resilience is a broad multi-dimensional concept, therapists can inform these conceptualization models of resilience by drawing from a large array of theoretical ideas in positive psychology (See e.g., Snyder & Lopez, 2005).

For an in depth description of a strengths and resilience focus in case conceptualization, see Kuyken, Padesky & Dudley (2009), pp. 93 - 120.

Key features

Therapists who conceptualize with a strength and resilience focus are likely to:

- Express as much interest in strengths as difficulties (e.g., *we've been talking about difficult issues in your life. What are some of the things you enjoy or that bring you a sense of accomplishment?)*
- Use guided discovery to draw out hidden strengths
- Highlight what the client is doing well to enhance client self-efficacy and resilience
- Incorporate strengths into case conceptualizations
- Consider with the client how current strengths and resilience can help foster desired change and progress toward client goals
- Use language that communicates hope and the possibility of change.

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Collaborative Case Conceptualization Rating Scale

Rate each item below on a 0 – 3 scale. Sample criteria are provided.
Use the rating most closely matched to therapist performance.

LEVELS OF CONCEPTUALIZATION (see guidelines pp. 4-5)

1. _____Conceptualization is linked to client presenting issues, priorities, and goals for therapy in the context of the session agenda,

0 = Conceptualization activity is either completely absent or seems divorced from the agreed goals of therapy, the agreed day's therapy agenda and/or therapeutic agenda.

1 = Conceptualization is tenuously linked to the client's presenting issues, priorities and goals for therapy and the day's therapy agenda, or has to be inferred from the therapist's behavior.

2 = There is a good enough and explicit linking between conceptualization, client presenting issues, priorities and goals for therapy and the day's therapy agenda.

3 = There is a seamless integration between the agreed goals of therapy, the day's therapy agenda, therapeutic goals and the conceptualization. The conceptualization is a key part of the client moving towards his/her goals for therapy and/or for a particular session as evidenced by links drawn by the client and/or therapist.

TIP: To receive a rating greater than zero, the conceptualization must be explicitly shared with the client. The client's involvement and reaction to in session conceptualization activity provides clues about how well it is woven in with client's priorities / goals. Only assign a higher score if the conceptualization is effective. Client acceptance and willingness to use the conceptualization might be a part of this. The sense that conceptualization activity moves the session through agenda items and towards client goals is another indicator. E.g., Therapist: *Are you willing to test this rule, "if I say hello to other parents at the school gates, they will ignore me";* Client: *I can see that it makes sense for me to at least try to get to know the other parents, even though it's scary.*)

2. _____Therapist provides a clear explanation and rationale for the elements included in the conceptualization

0 = Therapist provides either no rationale or an incorrect or incomprehensible explanation for elements of the conceptualization. The therapist's conceptualization activity lacks a clear/compelling therapeutic rationale or if s/he has a therapeutic rationale there is no evidence that the client understands or agrees with this rationale.

1 = Therapist provides some rationale for elements included in the conceptualization, but this may be incomplete, incorrect in important respects, or is presented in a way that is difficult for the client to comprehend. Nonetheless, there is some evidence of beginner or novice level competency in providing a rationale for the conceptualization process overall, and an explanation of the elements within it.

2 = Therapist provides a clear rationale for the elements of the conceptualization (e.g., *so in this upsetting situation, let's see if we can separate your feelings from your thoughts and images and see how these might be connected.).* It is possible to observe or clearly infer the therapist's therapeutic rationale for conceptualization activity (e.g., *Learning to notice and respond to upsetting images can help you understand your reactions and cope with them.)* Client seems to understand the rationale or, if confused, the therapist works to ensure client understanding.

3 = Therapist provides clear rationales for elements included in conceptualization and uses client language, metaphor, imagery and/or other vehicles to aid client understanding and engagement. There is evidence that the client is fully on board and engaged with the conceptualization activity (as much as is possible given client presentation). The therapist checks client understanding of the rationale either directly (e.g., by asking the client to summarize) or indirectly (e.g., by asking the client to make inferences or predictions from the model). Alternatively, the therapist is able to elicit a clear rationale / understanding from the client regarding pertinent and specific thoughts, emotions, behaviors, underlying beliefs and copings strategies related to their conceptualization

TIP: The therapist's behavior must be observable (not inferred). Observe client's reactions to see if what the therapist says is understood. If so, the client is likely to appear interested rather than lost.

3. _____Coherent, meaningful and relevant account of presenting issues using a level of conceptualization that appears well-matched to the client's ability to understand, stage of therapy, and the issue being conceptualized. The therapist uses cognitive-behavioral models or approaches appropriate to the stage of therapy and issue conceptualized. Beliefs, emotions, behaviors and/or physical responses are linked, embedded in specific situations and a "good fit."

0 = Therapist either: (i) misses all opportunities for conceptualization, or (ii) the conceptualization does not fit what the client is saying, (iii) it is so poorly linked with the client's concerns that it is meaningless, incoherent and/or unhelpful to therapy, or (iv) the conceptualization is assumed or left implicit. Alternatively, the client presents his or her own conceptualization which is unhelpful and, even though it is inconsistent with data, the therapist works with this client model without any question.

1 = Conceptualization shows minimal integration of the elements into a coherent whole or key models appropriate to the client's presentation are not used or are misapplied. The conceptualization is a basic summary of the presenting issues and includes irrelevant information on an equal basis with relevant information.

2 = Conceptualization effectively links cognitions, emotions, behaviors and/or physical responses in a way that is **coherent and meaningful** to understanding the client's concerns and moving towards the client's goals. The therapist selects an appropriate model-specific, descriptive, cross-sectional and/or longitudinal conceptualization that is driven by the client's level of understanding, the stage of therapy and the issue that is being discussed. However, there is a sense that this could have been done either more simply or directly.

3 = The conceptualization is a meaningful and coherent account of the presenting issue(s), with a seamless integration of emotions, beliefs, behaviours and/or developmental context. All the information in the conceptualization is relevant and drawn from client experience; it may build on earlier work. Therapist demonstrates excellent judgment in selecting the appropriate level of conceptualization model in the context of client's ability to understand, stage of therapy, and issue being conceptualized as evidenced by client understanding of what is discussed.

TIP: Raters must use their knowledge of CBT to judge whether a conceptualization is well-matched to the stage of therapy, and the issue being conceptualized. For example in CBT for depression, as therapy proceeds the conceptualization may move from simpler cognitive and behavioral conceptualizations aimed at socialization and engagement, to understanding negative automatic thoughts, to conditional assumptions and deeper level unconditional core beliefs. The client's engagement with conceptualization, non-verbal communication or own summary of the session (if elicited) will provide good evidence. In some cases progression through levels may be evident within a session (e.g., in working with some anxiety disorders it may be possible to move through both descriptive and cross-sectional maintenance models within the same early session). It is not necessary to use a custom-made conceptualization model – the choice of how to conceptualize with clients is determined more by the client's ability to understand, stage of therapy, and the issue being conceptualized.

4. _____The conceptualization is as simple as possible given the stage of therapy. There is evidence that the parsimony in the conceptualization helps the client understand his/her presenting issue(s) and use the conceptualization to effect change

0 = Conceptualization is either so complex that it is incomprehensible to the client at this point in therapy or so simple as to be vacuous.

1 = Therapist attempts to distil conceptualizations, but there is nevertheless more information than is essential to enable client understanding or so simple that information that is key to a descriptive / explanatory account is missing.

2 = Conceptualization is as simple as possible given the data available at a given time in therapy and, at the same time, captures the most central elements.

3 = The conceptualization conveys complex ideas concisely, distilling information into the essential parts necessary to describe or explain what is needed at this stage of therapy for this client. The therapist is highly attuned to what will help the client make sense of his/her presenting issues in as simple a form as possible. S/he may use well chosen metaphors, images or stories that are simple but rich in meaning to enable client understanding. While s/he may hold a complex conceptualization, in the session this is distilled into a simple and functional conceptualization.

TIP: The client's engagement and reactions suggest whether the therapist has pitched the simplicity about right. If too simplistic, there may be evidence the client feels patronized and is switching off. If the conceptualization is too complex there may be evidence the client does not understand, feels overwhelmed or is humoring the therapist. Therapists must assess each client's needs. What is simplistic and obvious to one may take another client several sessions to assimilate. Therapists adapt to the needs of each client. The client's summary of the session also provides clues about what they have understood from the session.

COLLABORATION (see guidelines p. 6)

5. _____Conceptualization is collaboratively developed. The client is actively engaged: generates ideas, writes things down or directs the therapist what to write down, and answers questions rather than being told the details by therapist. Client and therapist ideas are equally valued in figuring out conceptualization.

0 = Client or therapist is a passive observer or recipient of the conceptualization. The therapist does nothing to engage the client's participation in its development or discounts client ideas. Therapist ignores differences in opinions or insists the therapist's point of view is the correct one. Alternatively, a very passive therapist who lets client drive the agenda including conceptualization (e.g., "*My depression is entirely chemical*" is accepted without discussion).

1 = While both contribute to the conceptualization, there is an obvious imbalance. The therapist may do most of the work and only ask for client agreement or ignore/omit relevant client ideas. Differing views are ignored, misunderstood, or left out, without resolution of differing perspectives. It appears the therapist is guiding the conceptualization to a therapist-determined content and/or structure. Client seems mildly interested in the conceptualization and participates occasionally but mostly sits back and lets the therapist do the work. The therapist accepts the lead role. Alternatively there is evidence of a client dictating the session and the therapist does not manage the situation well enough to bring in appropriate conceptualization activity.

2 = Both therapist and client are actively involved in conceptualization; each one's ideas are incorporated in a meaningful way. Therapist seeks and attends to client's ideas. Differences of opinion are welcomed; both client experiences and relevant theories and research are used to resolve these. Even if the conceptualization is model-driven, the therapist engages client in its construction so that, from the client point of view, this is a co-created model drawn from the client's experience.

3 = Therapist and client are highly interactive and co-create the conceptualization; ideas are added or deleted from the conceptualization based on mutual agreement. The therapist recognizes elements from evidenced-based models in the client's experience and incorporates these into the conceptualization using the client's own words, so the conceptualization appears highly individualized, even if fairly standard in content. Differences in opinion are actively welcomed and discussed. Client is highly engaged in the conceptualization and offers ideas even when not asked -- actively interacting with the therapist throughout the conceptualization process.

TIP: Observations of the client and therapist during conceptualization provide important information for this item. Do both appear active and interested? Is there a balance in contributions? Is there evidence of mutual respect and interest in each others' ideas? Ideally, the client seems interested in the conceptualization and shows nonverbal signs of engagement (looking closely at the paper or whiteboard, pointing to the conceptualization during discussions) and offers frequent verbal input, questions, and/or suggested modifications.

6. _____Relevant cultural aspects of client's experience are incorporated and/or conceptualizations use language, metaphors, and images individualized to this client.

0 = Client language, metaphors and images are ignored and/or therapist uses language for the conceptualization that is mismatched to this client by its nature, complexity (or lack thereof) or content. Even when relevant cultural references are made in the session (e.g., "boys in my family did not admit to having feelings"), the therapist neglects to include these in the conceptualization.

1 = Therapist uses client language, metaphors and images and also misses important opportunities to do so. Alternatively, therapist changes client language in ways that make it less the client's own. Obvious aspects of culture are either not considered or left out. The therapist may inquire about culture in a way that is insensitive to the client's cultural frame of reference (e.g. "*Is this something about your Hindu faith?"* when the client is discussing idiosyncratic gender roles in her family of origin).

2 = Therapist incorporates client language and also appropriate client images and metaphors in the conceptualization. The therapist asks the client to state ideas in his/her own words to ensure client language is captured. When discussed, client cultural experiences are incorporated in ways that help make the conceptualization more useful or personalized. Therapist inquiries or client comments draw out aspects of the client's culture that have particular relevance for the conceptualization. The final conceptualization is in language easily understandable to this client.

3 = Therapist is extremely adept; not only is client language favored, but the therapist accurately detects and uses a nuanced understanding of client phrases and imagery to make the conceptualization a custom fit. Relevant aspects of client culture are centrally incorporated into the conceptualization so these are not "added on" but are a seamless part of the fabric of the conceptual model developed. The therapist is sensitive to the multiple cultural dimensions of conceptualization (e.g., ethnicity, gender, age cohort, sexual orientation, spirituality, etc.)

TIP: Cultural context is broadly defined, and includes the client's social background, economic background, ethnicity, age cohort, sexual orientation, religious background, spirituality and other relevant cultural factors. Whether the client's culture appears similar or different from the therapist's, the therapist is expected to inquire about cultural factors and use client language, imagery and metaphors in the conceptualization. Client culture may not be explicitly discussed in every session; pay attention to the language used to see if therapist and client use similar, culturally sensitive language (e.g., sports metaphors with an athletic adolescent girl). If so, this may signal culture has previously been explored and is integrated into the discussion.

7. _____The therapist demonstrates a genuine curiosity and interest in understanding and seeing experience through the client's eyes. Socratic methods are used as appropriate (balance is Socratic more than didactic).

0 = Therapist does not express any curiosity or interest in the client's view of experiences. Therapist may speak over, contradict the client, or even insist that the client's report cannot be accurate. Either no use of Socratic methods or these are misused to pressure the client to say what the therapist wants.

1 = Therapist seems interested in the client's view of experience but only in a narrow or limited way. The therapist may appear a bit off balance when the client's report does not match therapist expectations. Or the therapist may ask about client experiences and then interrupt the client or inaccurately summarize what the client says. While Socratic methods are used at times, the conceptualization is mostly presented in a didactic fashion. Therapist may neglect to listen, summarize, or ask the client how ideas fit together.

2 = Therapist displays curiosity with eye contact, nonverbal and verbal expressions of interest, and follow-up questions and comments which suggest a genuine desire to accurately understand what the client is saying. When the client hesitates or is unsure about something, the therapist makes encouraging remarks and allows time for the client to figure things out. Therapist uses Socratic methods appropriately to help construct the conceptualization (asks questions with curiosity, listens empathically, ensures written summaries, and asks the client to fit ideas together). When didactic methods are more appropriate, the therapist pays close attention to client understanding and encourages interaction and inquiry.

3 = Therapist expresses a high degree of curiosity, interest, and *detailed* questions to ensure s/he understands the client's perspective fully. Questions and silences are well-timed to help the client elaborate his/her perspective. Emerging understandings are examined (*Let me see if I have this right…. Am I missing anything?*). Therapist comments and questions go beyond mere reflection and demonstrate *active efforts to see things from the client's view* (e.g., *If I thought …., then I might be inclined to…. What is that like for you?)* The therapist *welcomes novel responses* from the client as eagerly as more typical replies. (Those phrases marked in bold italics typically differentiate a score of 2 and 3 on this item.)

TIP: When skillfully used, Socratic methods help the client take ownership of the conceptualization even when it is drawn from an evidence-based model. Didactic methods can be interwoven with Socratic inquiry to create a shared sense of discovery. This item can be scored when therapists show genuine curiosity even if a more fully formed conceptualization is not developed in this session.

EMPIRICISM (see guidelines p. 7)

8. _____The conceptualization reflects the most appropriate evidence-based theories. If a good evidence-based model exists, the therapist uses that issue-specific model. If no specific model exists, the therapist uses the most appropriate generic CBT model. A trans-diagnostic model may be used with co-morbidity. In each case, the choice can be justified given the nature of the presenting issue and the ability of the client to understand and relate the model to his or her experience. Where the focus is on resilience, an appropriate model is selected (e.g. Fredrickson's broaden and build model)

0 = Therapist does not utilize a model at all. Alternatively, the evidence-based models referenced are clearly inappropriate or presented inaccurately.

1 = Therapist attempts to utilize a CBT model, however there are significant difficulties in the selection and use of the chosen model. The therapist may struggle to link the model and the client's presenting issues. Or key information from the client's experience is neglected or forced to fit a model that is not the best match. Alternatively the model is used in a limited or partial way that misses opportunities for it to fully match clients' presentation and inform interventions.

2 = The therapist competently introduces and/or employs a model well-matched to the client's presenting issues. If an evidenced-based model exists, the therapist uses it. If a generic CBT model is used, it is used to its full potential. Client's reported experiences are readily compatible with its key features and the client seems to understand the model developed and find it helpful.

3 = The therapist seamlessly introduces and/or employs the most appropriate model (evidence-based, if possible) for the client's presenting issues. The model is well matched to the client's unique experiences. The therapist utilizes the model to identify and highlight key processes identified in the model that are consistent with the client's own personal experience.

TIP: Effective use of a model will quickly establish that there is a close match between it and the client's presenting issues. This fosters client confidence that the therapist understands the presenting issue(s) and can help.

9. _____The conceptualization is based on specific client experiences and is *individualized* to fit this client based on appropriate data, inferences and testing. Therapist and client test the "fit" between the conceptualization and client experience. Therapist uses conceptualization to make predictions and/or test hypotheses; Socratic approaches are used (e.g., testing out hypotheses in session, setting up and debriefing behavioral experiments). The therapist recognizes and explores aspects of client experiences that do or do not fit with conceptualization and encourages the client to notice and describe experiences that are consistent or inconsistent with the conceptualization (in session and/or as homework).

0 = Therapist does not elicit client's specific experience. There is no attempt to link specific client experiences to the conceptualization. Once a model is chosen, there is no test for "fit." Therapist does not use the conceptualization

to make predictions or test hypotheses within or between sessions. Spontaneously reported examples of how the model does or does not "fit" client experience are ignored. Examples recorded in homework are also overlooked.

1 = Therapist attempts to personalize a model, but does not fully incorporate person specific information. The therapist may omit relevant experiences reported by the client or may use an example that is not representative of his/her presenting issue. Therapist and client seldom reference the conceptualization and **there are few attempts to make predictions based on the model.** In session tests or experiments regarding the conceptualization are limited or may be conducted in a didactic rather than experimental or Socratic fashion. Although some mismatches may be noted, other discrepant client experiences are missed, explained away or discounted.

2 = Client experiences are woven into a person specific formulation. Effort is taken to inquire about elements of the model (thoughts, feelings, behaviors) allowing a careful mapping of experience onto a model and the use of Socratic methods. Client's own words are used most of the time. If an "off the shelf" conceptualization is used as a starting point, an effort is made to map this onto client experiences. The need to test and check the adequacy of the formulation is explained in an open-minded manner, demonstrating to the client that the emerging conceptualization is a "work in progress" that needs to be actively tested against real experience. The results of such efforts are reviewed to consider if this reveals any limitations in the conceptualization.

3 = Client experiences are the starting point in this process and are seamlessly mapped onto a model from an apparently free flowing conversation. Whenever possible, client's own words, metaphors, and cultural references are chosen to increase "fit." Therapist openly tests the conceptualization by seeking counter examples or exceptions to the rule. Therapist is alert to notice when client experience is consistent or inconsistent with the conceptualization. Such client experiences are explored to reinforce, refine and revise the conceptualization. Therapist and client compare the model to present and past experiences. Changes are made to the conceptualization based on client feedback. The therapist is adept at maximizing the learning regarding hypotheses tested. What can distinguish a score of 2 and 3 is the extent to which the therapist *very explicitly* uses clients' experiences and the model to inform one another.

TIP: In an effective individualized conceptualization, client experiences rather than the model will determine the overall completeness of the formulation; the result may omit or add elements outlined in a standard model without sacrificing a complete understanding of the experience. Individualized conceptualizations offer an accurate and rich understanding that often enhances the therapist's genuine empathy toward the client. If this process is done particularly proficiently the therapist spends equal time on examples that do and do not fit the conceptualization. The client is encouraged to actively seek disconfirming examples in the spirit of discovering whether the emerging conceptualization is sufficiently robust to guide understanding and intervention selection. Supporting data and discrepancies are actively discussed in ways that convey both are welcome. Discrepancies are not viewed as a threat to the therapist's status or the therapy but rather as useful information to ensure the best and most helpful understanding of client issues.

10. _____Treatment planning is linked to the conceptualization. When appropriate, intervention results are reviewed in light of the conceptualization.

0 = Therapist does not make reference to the conceptualization when considering treatment options. Expected and unexpected treatment outcomes are not examined in relationship to the conceptualization.

1 = Therapist selects one or a number of tasks that are related to processes identified in the conceptualization but there is little consideration of "key" processes that may be maintaining the distress. Results of interventions are seldom considered in relation to the conceptualization.

2 = Therapist and client select key or lynchpin processes in the conceptualization (if an evidence-based model applies) or those that appear to maintain or predispose the client to difficulties. Chosen interventions are clearly appropriate and closely linked to these identified processes and fit well with treatment goals. Intervention results are carefully considered in relation to the conceptualization

3 = In addition to the qualities included in a "2" rating, interventions chosen are efficient (in light of evidence-based treatments that apply) and most likely to create new learning and desired changes at the appropriate level of conceptualization (descriptive, cross-sectional, longitudinal). Intervention outcomes are closely considered in light of the conceptualization; revisions or changes to the intervention are guided by the conceptualization.

TIP: If a range of interventions are considered look for them all to be clearly appropriate to client issues and closely linked to key processes in the conceptualization and not reflect a scattergun approach. More expert therapists will pay particular attention to client experiences and treatment outcomes that do not fit with predictions of the conceptualization; these unexpected outcomes are used to revisit and revise the conceptualization and/or treatment plan.

STRENGTHS & RESILIENCE FOCUS (see guidelines pp. 8-9)

11. _____Therapist is interested in client strengths and uses guided discovery to draw these out. This includes identification of "hidden" strengths which the therapist brings into client awareness (e.g., "I notice you do many things to protect your friends. Let's make a list of what you do and see how these strategies might help with this issue.")

0 = Client strengths are absent from the discussion. Obvious client strengths are ignored. If the client mentions strengths or positive interests, the therapist steers the conversation back to a problem focus.

1 = Inquiries are made about client strengths. These are either not successful (e.g., client denies strengths and therapist drops the line of inquiry) or the therapist misses opportunities to tie strengths to session topics or the therapist asks about strengths and then drops the discussion. Obvious hidden strengths are missed by the therapist.

2 = Client strengths are identified and linked in a meaningful way to session topics. Therapist seems to recognize client hidden strengths and makes efforts to bring these to client awareness. If the client talks about positive personal activities the therapist asks questions and demonstrates interest. If a client denies strengths or positive interests, the therapist continues to ask questions and explore avenues in which strengths might be identified.

3 = Therapist identifies, highlights, and incorporates client strengths *consistently and effectively*. Therapist artfully uses guided discovery to help client recognize obvious and hidden strengths. Client strengths and positive experiences are referred to in the context of discussions of problems; there is an integration of these differing aspects of the client's life.

TIP: When rating this item it can be helpful to ask yourself, "Do I have a good sense of this client's strengths?" Strengths can include many aspects of the client's life (hobbies, spiritual beliefs, character virtues, skills, values). Look for the therapist to be alert to these varied strengths and explore them. The client often shows a positive shift in mood when strengths are discussed.

12. _____The working case conceptualization includes client strengths. Strengths inform the treatment plan. (Note: Item 13 refers to identification and interest in strengths. This item assesses how well these strengths are incorporated into the case conceptualization <u>and</u> treatment plan.)

0 = Strengths are not explicitly included in the case conceptualization or treatment plan. Therapist may miss opportunities to draw on client strengths or positive interests in assigning homework.

1 = Strengths are included in the conceptualization and/or treatment plan but are not highlighted as such or are mentioned in a way that minimizes their usefulness. For example, adaptive behavior is linked to a thought or mood without commenting on it as something positive or helpful.

2 = Strengths are included in the conceptualization and recognized as such. These may be incorporated directly into the conceptualization or listed beside the conceptualization as an add-on perspective and are incorporated into treatment plans with explicit discussion of their value for facilitating change. For example, the therapist may propose that familiar strengths are often easier

to practice than new behaviors. Then s/he may ask the client to consider how a particular strength could be used to encourage change along a desired path.

3 = Strengths are consistently incorporated into conceptualizations and treatment plans, often in meaningful and creative ways that are likely to improve treatment response and resilience. For example, there may be several paths within the conceptualization with strengths leading the way on one or more of the paths. A client hobby might be used as a metaphor to remember change options (e.g., a creative cook might think, *when I am missing the ingredients I want for a positive day, I will check and see what ingredients I have and figure out how to make something from them.*)

TIP: Note that this item refers to the conceptualization and treatment plan. Observe the client's response to these discussions. Look for the client to fully participate in discussions of strengths and creative brainstorming for how to use these to reach therapy goals. It is not sufficient for the therapist to didactically identify strengths and prescribe client activities if the client is not in agreement.

13. _____Client aspirations and positive goals are discussed vs. problem focus only (E.g., therapist asks Q's to prompt client consideration of how s/he would like things to be)

0 = Session is completely problem focused with no discussion of positive goals or aspirations even though it would be appropriate to include an aspirational perspective.

1 = Therapist asks client about positive goals or aspirations in a manner that does not encourage or facilitate consideration of these issues. Therapist may look or sound bored, disinterested or skeptical when client discusses positive goals (*Do you really think that is possible*?). Or therapist expresses little interest in these areas relative to a problem focus (*We can talk about these things if there is any time left at the end of the session*). Positive goals are not linked to case conceptualization or problem resolution.

2 = Therapist shows as much interest in and gives equal weight to positive goals and aspirations as to problem-related goals. Therapist encourages client consideration of these issues, allowing silence for the client to consider what s/he wants if the client is not immediately aware of this. Once positive goals are identified, therapist uses these to frame solutions to problems (e.g., *Since you would like to have greater intimacy, perhaps we can consider how this goal might be linked to overcoming your social anxiety.)* When client is pessimistic or hopeless about achieving positive goals, therapist acknowledges perceived barriers and expresses hope on the client's behalf.

3 = Therapist makes positive goals center stage, actively and overtly supporting the client's attainment of positive goals and aspirations (*I can see how important this is for you. Let's work very hard to try and make this happen in your life.)* Therapist demonstrates a great deal of interest in positive goals and aspirations, incorporates these into case conceptualizations, and expresses enthusiasm for these to a degree that matches or increases client's own expressed interest in them. Therapist balances empathy for problems with enthusiasm for positive goals (e.g., *I realize X is quite painful. I wonder how we can find a way through that difficulty so you can achieve Y which means so much to you.)* Even when client expresses hopelessness regarding positive goals, therapist is able to engage client to consider them.

TIP: Look for active therapist expressions of interest and enthusiasm for the client's positive aspirations. If the client wishes for something that is not adaptive (e.g., someone with agoraphobia who wishes to always have a safe companion nearby), the therapist can actively explore what would be good about it and how it would make the client feel. The therapist might support the client's desire to have those outcomes and positive feelings and explore the benefits wanting something even more (i.e., the ability to have these experiences even when alone).

With some presentations (e.g. bipolar, psychosis), therapists will need to adapt their style in line with agreed therapy goals, client values and the therapist's therapeutic agenda.

14. _____ Conceptualization processes highlight what the client is doing well and enhance the client's self-efficacy and/or resilience (E.g., point out ways the client is already resilient; therapist asks about prior resilience, *if we can figure out what worked in similar situations before, we might be able to figure out what you could do here***.)**

0 = Client resilience is not mentioned or highlighted in the session even though there are opportunities to do so. Therapist approach to conceptualization shows little awareness or interest in client self-efficacy and resilience. Focus is entirely on client problems and what the client is not doing well.

1 = Therapist or client acknowledges efficacy and/or resilience but this is not used in any meaningful way in the session. Therapist does not use observations of the client doing well to foster self-efficacy or resilience. For example, the therapist might say, *you handled that situation really well*, but not refer to this again in the session or during conceptualization. Therapist seems to lack understanding of resilience models (e.g., does not recognize that resilience comes in many forms, including acceptance of what cannot be changed).

2 = Therapist highlights client resilience on one or more occasions and includes these ideas in conceptualization. Client resilience is linked in a meaningful way to session topics or therapy goals. Therapist makes comments or asks questions to highlight the client's efficacy and/or resilience (e.g., *How did you figure that out? Are you always so persistent? It strikes me that you have been very resilient as a parent. Do you think some of the qualities that make you a resilient parent could help you solve this current difficulty?)*

3 = Therapist consistently captures opportunities to highlight efficacy and/or resilience and links these to therapy issues in ways that move the client toward goals. Awareness of client self-efficacy and/or resilience is in evidence in conceptualization discussions (e.g., by examples given). Therapist is especially adept at capturing self-efficacy and resilience in language that can be easily represented in conceptualizations, including metaphors, images and memorable phrases ("Where shall we put your 'can-do spirit' on this model?)

TIP: Look for therapist and client to actively seek examples of self-efficacy and resilience and incorporate these into conceptualizations. Is there any evidence the client develops a better appreciation in this session for his or her own resilience and how it benefits him or her?