

TWO The Therapeutic Alliance and Case Formulation

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Learning objectives

After reading this chapter and completing the activities at the end of it you should be able to:

- 1 outline key aspects of the historical significance of the therapeutic alliance in the CB approach
- 2 describe the main alliance issues related to maximising the potential of the approach
- 3 understand the historical development and significance of the case formulation concept in CB work
- 4 describe the relationship between thought, emotion, behaviour, physical reactions and environment in case formulation
- 5 outline models of case formulation used in the CB approach
- 6 describe the main issues involved in enhancing client motivation for the approach.

The therapeutic alliance in the CB approach

The notion that the CB approach fails to attach importance to the quality of the therapeutic relationship (sometimes called ‘therapeutic alliance’) is an enduring myth (Leahy, 2001). A brief and highly selective look at the relevant literature of the last decade suggests that authors and practitioners have been increasingly concerned about factors in the therapeutic alliance that may negatively impact on CB interventions.

Warmth and friendliness versus control

Wright and Davis (1994), summarising relevant contemporary research, argued that the therapeutic relationship and techniques were integrated aspects of a

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Forms of resistance	Appropriate considerations for practitioners
<ul style="list-style-type: none"> The client fails to complete agreed homework tasks. 	<ul style="list-style-type: none"> What function does the client's resistance serve?
<ul style="list-style-type: none"> The client reacts to improvement with scepticism. 	<ul style="list-style-type: none"> How does the specific form of resistance fit into the client's developmental/historical pattern of resistance?
<ul style="list-style-type: none"> The client shows high levels of expressed emotion towards the CB practitioner. 	<ul style="list-style-type: none"> What specific beliefs are influencing the client's resistance?
<ul style="list-style-type: none"> The client subtly avoids things within sessions. 	<ul style="list-style-type: none"> What does the client fear might happen if they comply with the intervention?

single process rather than separate domains in the CB approach. The authors asserted that the quality of the client's involvement is crucial to the outcome of therapy, which, in turn, is dependent on the warmth and friendliness displayed by the practitioner. They stressed that overly controlling practitioners who, for example, coerce clients into case formulations or engaging with techniques were highly likely to experience client drop-out or poorer therapeutic outcomes.

Wright and Davis stressed that problems in the therapeutic alliance can and should be viewed as opportunities to explore and develop the case formulation and relationship rather than as irritants. In short, a technique-oriented approach to CB practice that minimises or trivialises the importance of the therapeutic alliance is likely to lead to poor client compliance and a high drop-out rate (Raue and Goldfried, 1994).

Client resistance

A useful way to begin to explore and deal with problems in the therapeutic alliance is to consider the ways in which client resistance to engaging in the CB change process has been conceptualised in the literature. Newman (1994) outlined four high-frequency forms of client resistance and appropriate responses, as shown in the table above.

Newman argued that, after an exploration and understanding of the above four questions, CB practitioners could usefully use the following interventions for reducing client resistance and increasing motivation:

- providing education about the approach, to increase the client's understanding
- using the Socratic method – sometimes referred to as guided discovery (see Chapter 4)
- providing the client with choices rather than one fixed approach
- reviewing the advantages and disadvantages of change
- collaborating and compromising with the client
- providing accurate empathy for the client's resistance.

Client's beliefs about practitioner	<i>Victimiser:</i> She will hurt, reject or abandon me. <i>Collaborator:</i> She will work with me to help me. <i>Saviour:</i> She will protect and save me.	Practitioner's beliefs about client	<i>Hostile aggressor:</i> He is trouble and a threat to me professionally. <i>Collaborator:</i> He is capable of working collaboratively with me. <i>Helpless victim:</i> He is incapable of helping himself.
Client's beliefs about self	<i>Victim:</i> I'm helpless and vulnerable. <i>Collaborator:</i> I can work with someone towards my goals. <i>Caretaker:</i> I don't deserve help; others do.	Practitioner's beliefs about self	<i>Victim:</i> I must protect myself so that others don't see my incompetence and inadequacy. <i>Collaborator:</i> I'm competent and capable of working with this client to help them. <i>Saviour:</i> I'm the only one who can help this client.
Client's beliefs about the intervention	<i>Hopeless:</i> This approach won't help me. <i>Maintenance:</i> This approach will keep me just as I am. I won't change. <i>Productive:</i> This approach can help me improve and solve problems.	Practitioner's beliefs about intervention	<i>Hopeless:</i> This approach won't help them. <i>Maintenance:</i> This approach will keep them just as they are, but won't help them change. <i>Productive:</i> This approach can help them to improve and solve their problems.

In addition to the above, Newman suggested that, in the interests of improving client motivation, it is important for the practitioner to repeatedly discuss the evolving case formulation with the client, in the client's own language. Finally, he argued that it is useful for the practitioner to gently and persistently help 'stuck' clients locate their own sense of self-direction.

Cognitive factors

More recently, Rudd and Joiner (1997) explored the ways in which the 'therapeutic belief systems' of both practitioner and client influence the therapeutic alliance. The main thrust of their argument was that both parties in the relationship may experience beliefs about themselves, each other and the intervention that effectively act as hindrances to progress. Forms of maladaptive therapeutic belief systems outlined by Rudd and Joiner are illustrated in the table above, with adaptive beliefs highlighted in bold type.

It clearly emerges from the table that practitioners using the CB approach would do well to monitor the quality of their relationships with their clients in terms of maladaptive and adaptive beliefs at play, during the course of interventions. An essential vehicle for this task is ongoing clinical supervision from more experienced CB practitioners (see also Chapter 5).

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Task	Skills needed
<p><i>Elicit the client's view of their relationship with the practitioner</i> On the basis of available research, the client's perspective is most predictive of positive outcome of an intervention. However, the client's and practitioner's views of the relationship are often different.</p>	Practitioners need to constantly monitor the quality of their relationships with their clients. This can be achieved by seeking feedback on a regular basis from clients and using client ratings of the relationship. Using clinical supervision to focus on the quality of the relationship is also essential (see Chapter 5).
<p><i>Use the therapeutic relationship to generate hope</i> Hope for positive change is an essential factor in psychotherapeutic work generally.</p>	Practitioners should encourage clients to believe in the possibility of change in interventions that are oriented towards the future (see this chapter).
<p><i>Use cognitive skills to establish a good therapy relationship</i> A central overriding skill is the development of a collaboratively agreed case formulation.</p>	From the basis of the formulation, practitioners can employ any of the specific skills mentioned later in this chapter, and throughout the book, to explore the quality of the relationship. Guided discovery and thought records, for example, may be useful tools (see Chapter 4).
<p><i>Attend to ruptures in the therapeutic relationship</i> Attendance to ruptures in the relationship is critical to outcome.</p>	Instead of viewing problems that emerge in the relationship as an irritant, practitioners would do well to explore the significance of them in the ways described in this section.
<p><i>Aim for positive therapist characteristics</i> The personal adjustment of the practitioner is related to positive outcomes.</p>	Practitioners will benefit from working on their own personal issues. Two useful texts to aid this process are Persons (1989) and Greenberger and Padesky (1995).
<p><i>Attend to generalisation from the therapeutic relationship</i> The relationship the practitioner has with the client should be viewed as a template for exploring the client's relationships with others.</p>	Practitioners can explore the extent to which issues, ruptures and positive features of the relationship happen with other individuals in the client's life. This exploration may be useful in helping the client both modify their perceptions of, and improve the quality of, their relationships with others.
<p><i>Attend to individual client issues in the therapeutic relationship</i> Again, this points to the need for a carefully and collaboratively developed, individualised case formulation.</p>	In addition, practitioners should explore and attend to the client's view of the specific ways in which they feel that the worker has been helpful.
<p><i>Use clinical supervision to monitor the practitioner's relationship skills</i> The importance of the client's satisfaction with the alliance suggests the need for supervision to provide a strong focus on relationship issues.</p>	The factors identified in this section can be used as a basis for focusing on relationship issues in clinical supervision.

Maximising the therapeutic potential of the relationship

To complement the discussion so far, and round off this section of the chapter, the work of Waddington (2002) is briefly mentioned. In the conclusion of an extensive review of the therapeutic relationship in cognitive psychotherapy, Waddington provided eight tasks for practitioners keen to maximise the therapeutic potential of their relationships with clients. Regarding each task, we suggest the skills that need to be developed are as set out above.

Case formulation and the CB approach

Historical development and specific assumptions

The roots of case formulation can be traced to the mid-1960s. This marked the beginning of an era that has continued to date, within which psychological formulations to account for mental health difficulties have been offered as an alternative to psychiatric diagnosis and medical models of conceptualising emotional distress (Tarrier and Calam, 2002). Reflecting the development of CB approaches over the last 40 years, early versions of case formulation were concerned with the relationship between an individual's problems, expressed as 'problem behaviour', and environmental factors that were assumed to play a triggering and maintaining role in these (Tarrier and Calam, 2002). In contrast, more recent years have seen CB practitioners and writers being much more concerned with the pivotal role of thinking and information processing in the maintenance of mental health difficulties (Hawton et al., 1989).

Two specific assumptions underpin contemporary CB case formulation construction (Wells, 1997). These are that:

- emotional disorders arise from an individual's interpretation of events
- the way in which an individual behaves in relation to how they interpret events plays an important role in the maintenance of their problems.

It follows from these assumptions that all CB change methods used to help clients should proceed from a well-developed case formulation and constitute experiments to challenge beliefs (Wells, 1997). This is an important issue to stress as too many practitioners routinely and uncritically overuse strategies such as progressive muscle relaxation, distraction and thought stopping – frequently in the absence of a case formulation (Short et al., 2004). Another major problem is that, although they may be subjectively experienced by clients as helpful, the routine use of 'relaxation and distraction techniques are unlikely to produce optimal changes in belief in misinterpretations since patients could attribute the non-occurrence of catastrophe to use of their relaxation strategy' (Wells, 1997: 43). In other words, clients may use these strategies to feel safer each time they worry about something. By *doing* such 'safety behaviour', clients fail to find out that what they worry about either doesn't come true or is out of proportion to what actually happens (see Chapter 14).

Case formulation in practice: the interaction between thoughts, emotions, behaviour, physical reactions and environment

When a person experiences a distressing problem, it often feels like an overwhelming, complicated tangle of reactions. The involvement of others, such as family and friends, means that mental health problems affect more than just the individual. One way in which the CB approach first seeks to reduce this confusion is by mapping out the problem.

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This usually involves following a recognised structure, based on psychological theory, to piece together various aspects of a person's difficulties. The result should be a clearer understanding of the problem, which then becomes a central source of information in the helping process. Approaches to case formulation can be usefully considered on a continuum from simple to complicated. Simple approaches include the use of naturally emerging 'vicious circle' formulations (see Chapter 8) and the three systems approach.

The three systems approach to case formulation

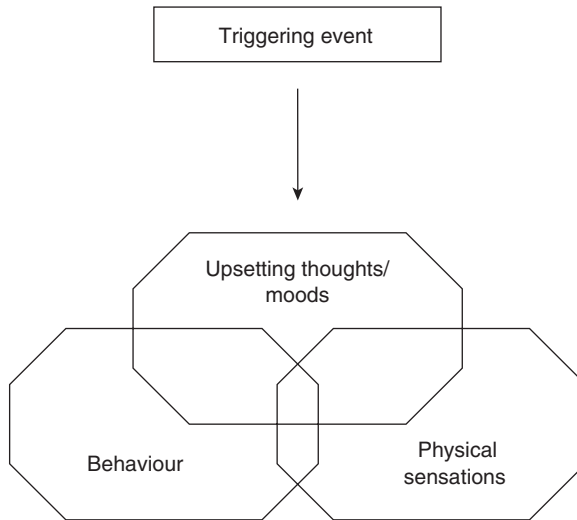
This approach, originating in the 1970s (Rachman and Hodgson, 1974), is useful for understanding emotional problems in terms of three linked areas (Hawton et al., 1989). These are:

- behavioural – what the individual does
- cognitive/affective – how the individual processes information and how this affects changes in mood
- physiological – the physical sensations the individual experiences, from head to feet.

All three areas relate to each other in that what someone does when they are emotionally distressed will correspond to how they think about events, themselves and others on a day-to-day basis. Each part of the system has an influence on each other part, and all in turn are triggered by events that are current or have occurred in the past. It is important to emphasise that environmental triggering events are significant to the individual in terms of activating emotional distress, so that events seemingly trivial or unimportant to others can be experienced as hugely upsetting by the person concerned. It is convenient to consider such events as either 'external' or 'internal' to the individual, which are anticipated (events that are coming up) or remembered (events that have happened). External events are day-to-day encounters with others, tasks, social events and the like, whereas internal events include triggering thoughts/mood, physical sensations and behaviour.

Once the three systems are activated, how an emotionally distressed individual thinks and behaves will, in turn, influence the kinds of (often distressing) physical sensations that they experience. It should be stressed that, as well as thoughts influencing behaviour, the reverse can occur. For example, an agoraphobic man who avoids busy public places for a period is likely to think more distressing thoughts about the possibility of collapsing in public if he has a panic attack in a supermarket than would be the case if he went into them on a regular basis and found that what he feared failed to happen. Similarly, just as how someone thinks and behaves will affect the physical sensations they experience – for example, fearful thoughts and avoidant behaviour triggering physical sensations of anxiety – such sensations will in turn influence fearful thoughts and avoidant behaviour. The panic feelings the agoraphobic man experiences when he gets close to a supermarket may well trigger thoughts such as 'I'm bound to have a panic attack and make a fool of myself if I go inside.'

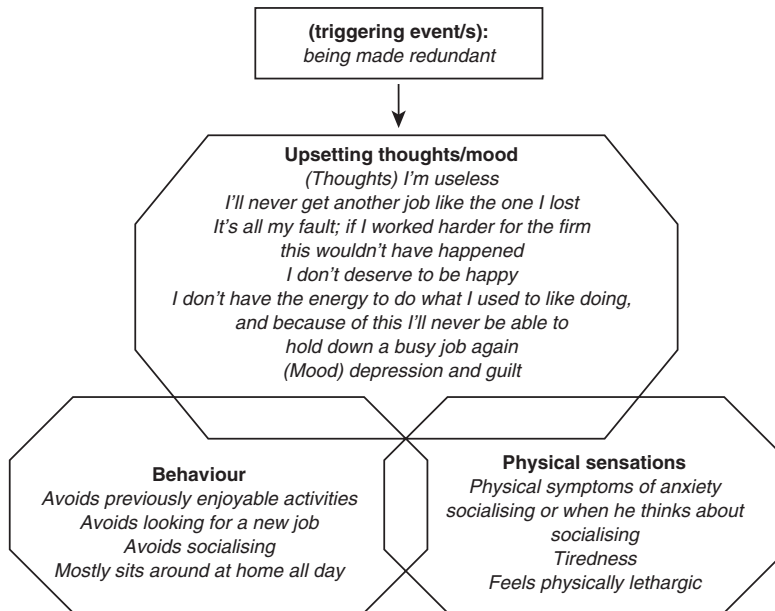
As with more complicated examples of case formulation, the three systems approach is best expressed diagrammatically, as shown below.



To illustrate the approach in action, we will consider the experiences of a client.

'David'

David is a 32-year-old man presenting with depression following redundancy from a job he loved. Here is his three systems case formulation.



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It will hopefully be clear at this stage that David's presenting problem of depression is neatly summarised using the three systems approach. Prior to seeking help, he has already found solutions to his problems based on how he thinks about them. The trouble is that these solutions serve to maintain his problems in a vicious circle. Because he believes it was his fault that he was made redundant, and that he'll never find a job equal to the one he lost, he avoids looking for one. By avoiding, he never finds out whether his beliefs are true or not. Equally, because he believes that he doesn't deserve to be happy, he has stopped doing the kinds of activities that previously gave him pleasure. This results in him feeling unhappy, which, in turn, confirms his beliefs that he is undeserving of happiness. The fact that his activity levels have greatly reduced contributes to his low mood, tiredness and lethargy, and this strengthens his belief that he doesn't have the energy to do the kinds of things that he used to enjoy or cope with a demanding job in the future. Because he does very little, he has a lot of time on his hands to think self-damning and guilty thoughts. He feels anxious when out with other people as he fears that they may be judging him in exactly the same way he judges himself. He therefore avoids old friends, believing that they must feel contemptuous of him, but, by avoiding them, never finds out if this is true or not.

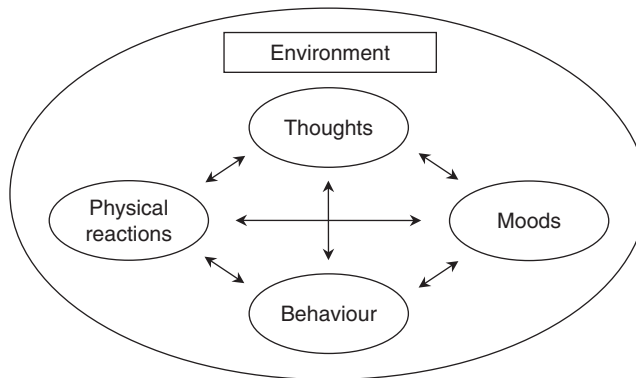
Some advantages and disadvantages of the three systems approach The three systems approach has proved useful in accounting for the experiences mental health service users report (Hawton et al., 1989), and is often a sufficient basis for providing CB help. As with more complex examples of case formulation, the approach helps the client and practitioner develop a shared understanding of the client's problems. This understanding can be tested out for accuracy by introducing behavioural experiments (to be discussed more fully in Chapter 4). For example, David, the depressed client mentioned above, could be helped to consider finding out whether or not his old friends *really* feel contemptuous of him by meeting them again. This would, of course, depend on a successful therapeutic alliance within which David feels reasonably comfortable with this task.

Having experienced and worked with the three systems approach to case formulation, practitioners may begin to realise that it fails to adequately capture the shifting environmental factors that help to explain the onset of emotional distress in one particular period rather than another. In view of this criticism, it is appropriate to next explore Padesky and Mooney's (1990) five aspect model as published in Greenberger and Padesky (1995).

The five aspect model

The five aspect model is also a straightforward structure for developing a conceptualisation. As the following diagram (Greenberger and Padesky, 1995: 4)

illustrates, this model can be extremely helpful in achieving a clearer understanding of how elements of difficulties experienced in the here and now interact and is a useful way in which to introduce some key CB skills.



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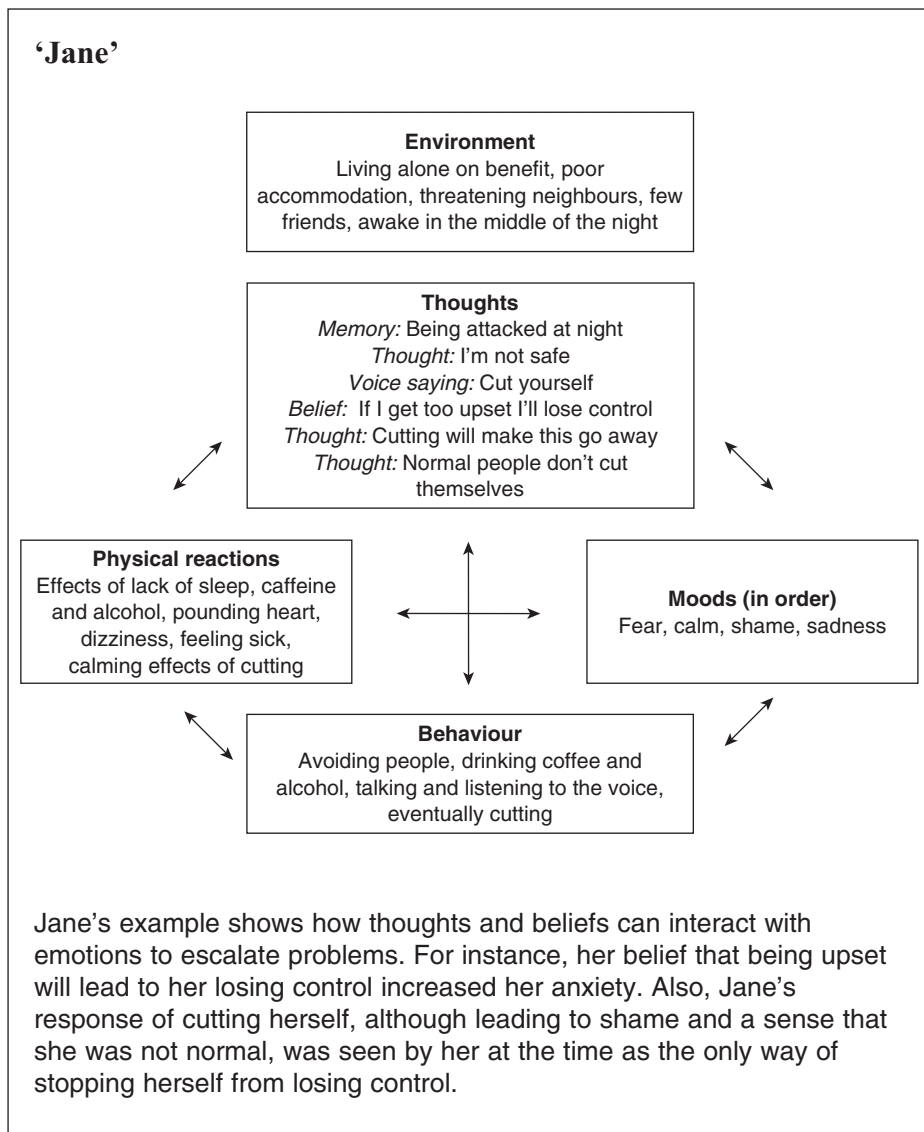
Environment

The environmental aspect is the overall context in which other aspects are experienced. This context refers to both specific and more abstract meanings of the term 'environment', including past and present influences. For instance a person's ethnicity, sexual orientation, family upbringing, socio-economic, accommodation and work status may all count as environmental aspects of life in this model. More specific environmental aspects of a problem would include being alone or in a crowd, darkness or being close to or far from home.

Thoughts, moods, behaviour and physical reactions

'Thoughts' includes memories, attitudes, images and beliefs (and, as in the example below, heard voices), as well as everyday conscious 'automatic' thinking (described below). 'Moods' refers to emotional experience, such as fear, sadness, guilt, anger and shame. 'Behaviour' refers to the person's specific actions in the problem situation and will often include avoidance or repeated patterns of behaviour. Physical reactions might well take the form of anxiety experiences, such as a churning stomach or more chronic experiences, such as lack of sleep or symptoms of substance misuse. The example below of 'Jane's' problem with cutting herself shows the vicious cycles that can result from the interactions between these five aspects.

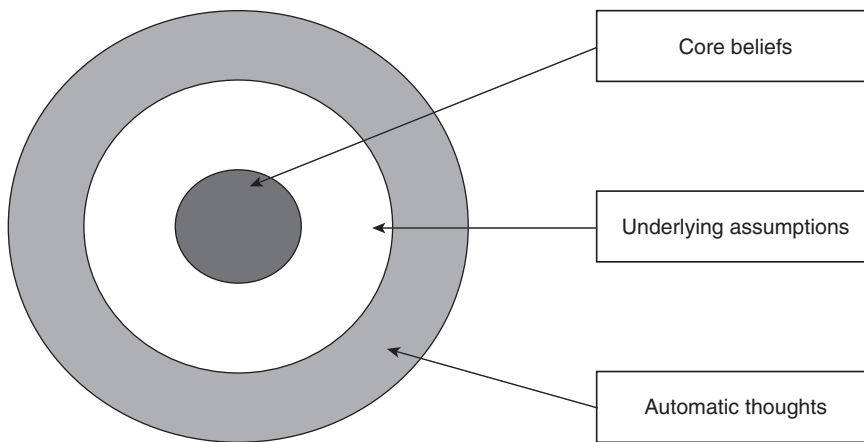
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Three levels of cognition – core beliefs, assumptions and thoughts

The cognitive model of mind describes three levels of related thoughts and beliefs. These are presented by Padesky (1998) in the form shown below.

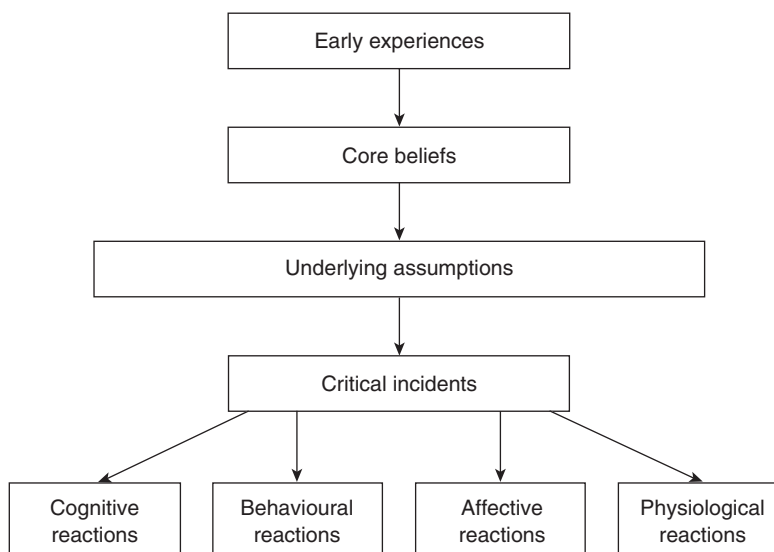
The target model illustrates several key points. The outer ring of the target points to the form of mental activity that people have most access to. It represents the streams of consciousness that enter our minds in response to everyday events, including the negative automatic thoughts that become the focus of many CB interventions. There are exceptions to this as, for example, some people become aware of very strong and negative core beliefs with distressing



regularity. However, most people are more likely to be aware of, and find it easiest to tune into, the thoughts represented by the outer ring.

The middle ring represents a set of often less accessible and more general beliefs – referred to as underlying assumptions. These are tacitly held, apply to all situations and can be conveniently thought of as ‘rules for living’. They are associated with patterns of responses in the ways that people act towards themselves, other people and the world in general. For instance, a person who holds the assumption ‘unless I do things 100 per cent right, then I am a failure’ may show a pattern of perfectionist behaviour or avoiding challenges.

In the centre ring of the target are core beliefs – also sometimes referred to as schemas or schemata. As the least accessible level of thinking, core beliefs represent the fundamental views we hold about other people, the world and ourselves in general. These beliefs arise from our early life experiences – mostly from the first and enduring lessons that life has taught us.



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The target model also points to the relationships between these three levels of cognition. The interactions between them can be described using Beck's (1995) linear formulation model, shown above.

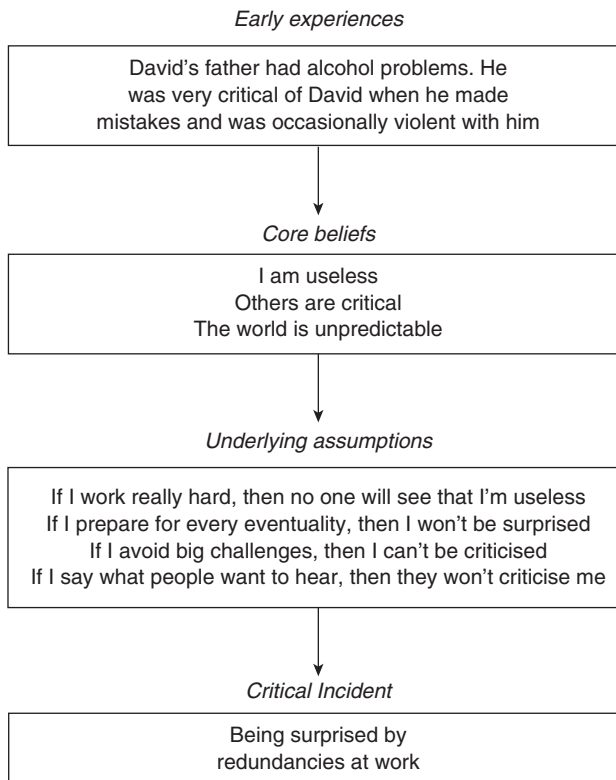
The diagram highlights interactions between the three levels of cognition described thus far. Beck describes how assumptions act as *compensatory* ways of dealing with life perceived via the lens of core beliefs, and are often expressed in 'if ... then ...' terms. For instance, a person who grows up believing that the world is a dangerous place may develop assumptions such as 'If I carefully assess situations for danger, *then* I will be safe.' Alternatively, another person with different life experiences might grow up believing that, while the world is dangerous, others will always be there to help. This person might develop assumptions such as 'If I have others around me, *then* I will be safe.' These two assumptions, logically, might result in different approaches to dealing with potentially dangerous situations.

The often compensatory nature of underlying assumptions in relation to core beliefs may be seen in individuals with core self and other beliefs such as 'I am vulnerable and others are abusive' that are compensated for by the assumption 'If I avoid getting close to people, I will not be abused.' Such assumptions often function as a way of protecting the person from the emotional distress of having core beliefs activated. The linear model shows how particular life events referred to as critical incidents can breach these defences to produce the cognitive, behavioural, affective and physiological reactions constituting mental health problems. Taking the earlier example, someone believing that the world is dangerous but others are helpful would probably find being alone in a dangerous situation very frightening. The assumption or rule that 'If I have others around me, then I will be safe' would effectively have been broken, leading to thoughts of danger and feelings of anxiety.

Continuing the earlier example of David's reactions to being made redundant, the linear model (see page 19) is initially helpful in two ways. First, it shows how some of David's core beliefs and assumptions were activated by the redundancy and also sheds light on the relationship with his practitioner. Second, it helps the practitioner to understand why David seemed reluctant to engage with the CB approach and why he avoids talking about his reluctance. The practitioner uses the formulation adapted from Beck's model to make links to David's early experiences. The resulting conceptualisation suggests calculated guesses about the significance of David's avoidant behaviour that can then be gently explored with him. The practitioner takes care to avoid blaming David for his behaviour. Indeed, using the linear model, they are able to agree that his avoidance seems entirely sensible given the predictions he has been making. Once David feels more comfortable discussing these issues, he is gently supported to move on using CB strategies. Later, David's somewhat tempered drive to do a good job becomes an asset in solving his problems and helping him work towards his goals.

The collaborative nature of the CB approach

David's case formulation example above hopefully demonstrates the need for clients to assume an equal and central role in their own progress. People seeking



CB help are sometimes surprised to find this out. Whether this is a daunting or exciting prospect, the collaborative nature of the approach will necessitate early discussion and preparation for the role. The relationship between therapist and client that lies at the heart of the approach implies a sharing of information and skills.

Enhancing client motivation

Inseparable from considerations concerning the quality of the therapeutic alliance and collaborative case formulation, it is important to highlight the important role for practitioners in enhancing client's motivation for change. Clients need to be helped to:

- be ready for change (Prochaska, 1999)
- achieve the hope that change is possible (Snyder et al., 1999)
- become change-focused – practitioner and client work together to create a context in which new or different perspectives, behaviour or experiences are welcomed and explored (Hubble et al., 1999a)
- potentiate change for the future – the practitioner helps the client see that any changes are a consequence of their own efforts (Hubble et al., 1999a)

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- build on the client's competence – the practitioner helps the client identify and build on their own strengths and resources (Hubble et al., 1999a)
- tap into the client's outside world – the client is encouraged to identify the factors, people and resources in their own life that will be helpful in the change process (Hubble et al., 1999a)
- have a healing ritual – the practitioner should demonstrate that they believe in the CB approach (Hubble et al., 1999a)
- have a possibility focus – practitioners should encourage clients to believe in the possibility of change in interventions that are oriented towards the future (Hubble et al., 1999a)
- work in a structured and focused way – one of the best predictors of negative outcome in any form of psychotherapeutic intervention is a lack of focus and structure (Hubble et al., 1999a)
- experience the practitioner as flexible – practitioners should avoid 'hiding behind' models or techniques (Hubble et al., 1999a).

Several important interrelated issues emerge from this list. First, the onus is on practitioners to work to establish trust and confidence – not just in relation to the CB approach and specific techniques, but also in the relationship with their client. Frequently, people in receipt of CB help who may have dropped out because of, usually understandable, problems with engagement have received blanket labels, such as 'resistant' or 'poorly motivated'.

Second, it is important for practitioners to act as 'hopefulness role models' for people needing help. To achieve the client's trust and confidence – in addition to the requirement to demonstrate consistent respect, courtesy, warmth and friendliness – practitioners should display optimism that service users *can* work towards achieving their goals.

Third, service users should be encouraged to consider any progress made while engaging in a CB intervention as the result of their own efforts, rather than, for example, the specialness of practitioners.

Fourth, the problems and goals described by people seeking help should generally be taken at face value. In large part because of non-evidence-based aspects of mental health curricula (see Chapter 15), it is often the case that the problems clients describe are considered by practitioners to be indicative of deeper, unexpressed problems and their goals are thus trivialised or disregarded.

Fifth, people seeking help should be given accessible information about their difficulties. Guided engagement with different types of media – written texts, Internet sites, video and audio material, for example – on different types of specific problem areas, usually helps individuals feel that they are not unique or weird because of the emotional distress they experience. However, caution should be exercised in this area: it follows from what has been said so far that information should *in and of itself* inspire hope and optimism in readers. It would thus be unhelpful to give a (say, psychoanalytical) reading that either mystifies or suggests that the person's subjectively experienced problems are not their *real* problems and that there are deeper problems at play.

Some useful websites and sources of helpful guided reading are listed at the end of the chapter.

SUMMARY

- The therapeutic alliance has long been considered crucial to the success of CB interventions.
- There are clear tasks and skills that need to be developed in the maintenance of a good therapeutic alliance.
- The historical development of the case formulation concept in CB work is associated with key assumptions.
- In practice, case formulation maps out the relationship between thought, emotion, behaviour, physical reactions and environment.
- Models of case formulation used in the CB approach range from simple to complicated.
- There are key issues to be considered in relation to enhancing client motivation for the approach.

Activities

- Consider the attention paid to the therapeutic alliance in your own work organisation. How could the situation be improved using the information from this chapter?
- Reviewing the case notes of clients in your organisation, explore the extent to which case formulation is used. Are records ever kept in case formulation diagrammatic form? If not, discuss with your colleagues whether or not doing so might enhance record-keeping.
- Explore with clients the factors that they think keep them motivated within the mental health system. Compare and contrast their responses with the motivation discussion in this chapter.

Useful websites

www.octc.co.uk

The website of the Oxford Cognitive Therapy Centre. Several useful self-help books have been prepared by members of the centre for specific problems, such as social anxiety and low self-esteem.

www.babcp.com

The website of the British Association for Behavioural and Cognitive Psychotherapies. A comprehensive array of informative leaflets is available from this website, both for specific disorders and to explain the CB approach.

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www.padesky.com

This excellent website contains a comprehensive list of the latest recommended textbooks for those interested in the CB approach, as well as audio and video resources for its application.

Further reading

Leahy, R.L., 2001, *Overcoming Resistance in Cognitive Therapy*. New York: Guilford Press.

In a considerably detailed way, Leahy provided a comprehensive overview of forms of, and ways to overcome, resistance in CB work. This emphasises the importance of the practitioner addressing their own distorted thinking about their relationship with the client.

Hubble, M.A., Duncan, B.L., and Miller, S.D., 1999, *The Heart & Soul of Change: What Works in Therapy*. Washington, DC: American Psychological Association.

This highly important text brings together the evidence for the common factors at play in the success of psychotherapeutic and counselling interventions.

Greenberger, D., and Padesky, C.A., 1995, *Mind Over Mood: Change How You Feel by Changing the Way You Think*. New York: Guilford Press.

This excellent self-help workbook is recommended for practitioners. It will enable them to work through and gain experience of case formulation and interventions, using their own difficulties as a reference point.