

The Case Formulation Approach to Cognitive Behavior Therapy

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Icelandic Association for Cognitive and Behavioural Therapies
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Handouts are available at . . .

- <https://oaklandcbt.com/talks-and-workshops>



The Case Formulation Approach to Cognitive Behavior Therapy Day 1

- Mr. "It might be cancer" 
- Why do case formulation-guided CBT?
- Empirical support
- Developing formulations and using them to guide intervention
 - Case-level formulation 
 - Disorder-level formulation
 - Symptom/behavior-level formulation  



The Case Formulation Approach to Cognitive Behavior Therapy Day 2

- Transdiagnostic mechanisms 
- Steps to develop a case formulation 
- Setting treatment goals
- Solving problems 
- Progress monitoring  
- The therapeutic relationship 

Action Items







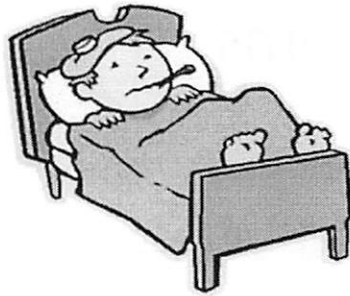
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The Case Formulation Approach to Cognitive Behavior Therapy

Day 1

- **Mr. "It might be cancer"** 
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- Empirical support
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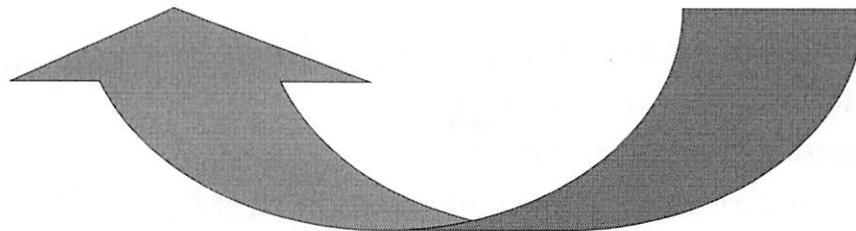


Overcoming treatment failure: Mr. “It might be cancer”

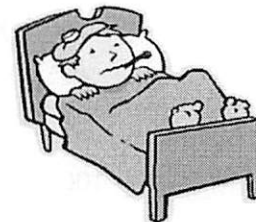
Persons, J. B., & Mikami, A. Y. (2002). Strategies for handling treatment failure successfully. *Psychotherapy*.

A Case Formulation-driven Approach to Cognitive-behavior Therapy

Assessment → Formulation → Intervention

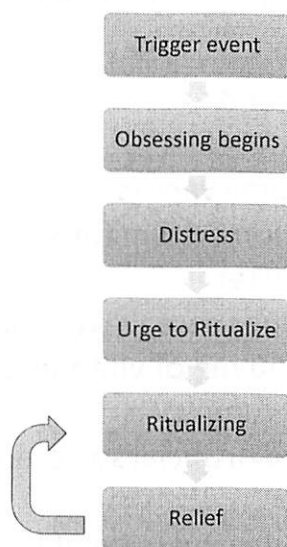


Mr. "It might be cancer"



- Mid 40s married white male business executive
- Recent removal of tiny bladder cancer; his doctor pronounced him cured
- Repeated episodes of noting a spot on body, experiencing a jolt of fear and the thought "it might be cancer," and asking for repeated reassurance from his wife that the spot was unchanged, etc.
- Met criteria for hypochondriasis (now illness anxiety disorder)

Initial Formulation and Treatment Plan (E/RP for OCD)



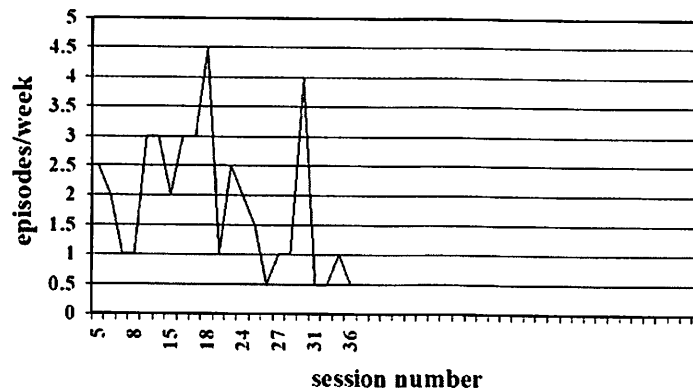
Exposure Hierarchy – Fear of Cancer

- 100+ asking all questions of M.D.
- 100- reading about bladder cancer and imagining dying of cancer
- 80 – reading about colon cancer
- 60 – reading about breast cancer
- 30 – reading about skin cancer
- 25 – looking at urine sample container
- 10 – saying aloud: “I was diagnosed with bladder cancer and the cancer was surgically removed.”

Health-Related Avoidance and Safety Behaviors

- Weigh myself daily
- Changed shampoo brand
- Rinse shampoo quickly
- I don't breathe hairspray vapors
- Installed water filtration system for showers
- I drink only bottled water
- I eat the same high fiber cereal every day
- I take vitamins and 250 mg of vitamin C daily
- I avoid breathing bus fumes
- I avoid fatty foods and artificial sweeteners
- I don't drink caffeine
- I try to eat a lot of fruits and vegetables

Hypochondriacal episodes during interventions focusing on hypochondriasis

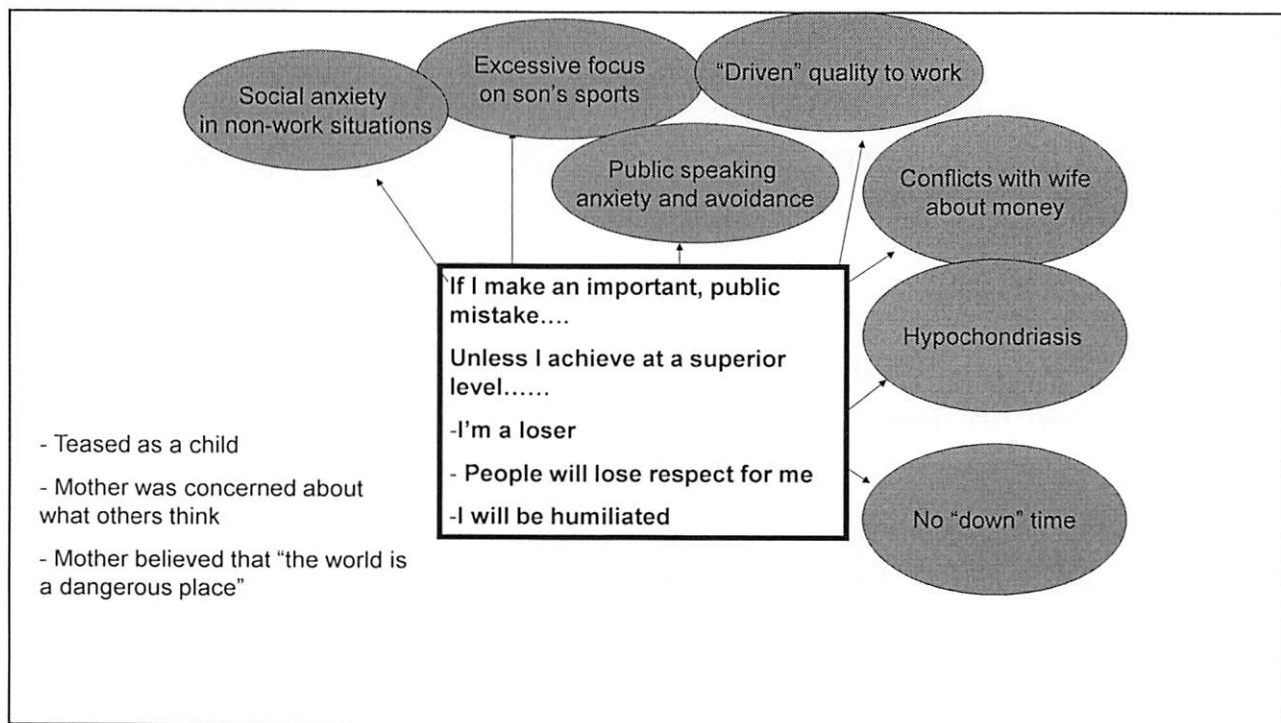


Collecting additional assessment data to try to obtain a new formulation and intervention plan

- Thought Record identified a new core fear
- Comprehensive problem list and diagnostic assessment identified an additional DSM disorder
- Information about origins of the problem supported the new formulation

Thought Record

Date	Situation	Behavior(s)	Emotions	Thoughts	Coping Responses
	Colleague says, "Oh you're sick again."			It could be cancer. ↓ I'll miss work. ↓ I'll drop a ball. ↓ I'll lose my job. ↓ I'll be humiliated.	



Additional DSM Diagnosis

- Social Anxiety Disorder

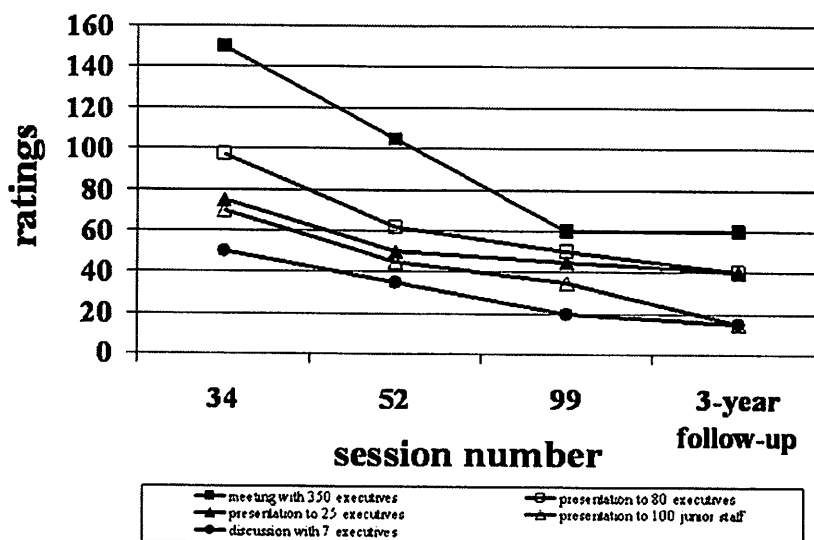
Revised Formulation and Treatment Plan

- Revised formulation: The fear underpinning symptoms of hypochondriasis was of humiliation, not cancer
- Revised treatment plan targeted fear of humiliation

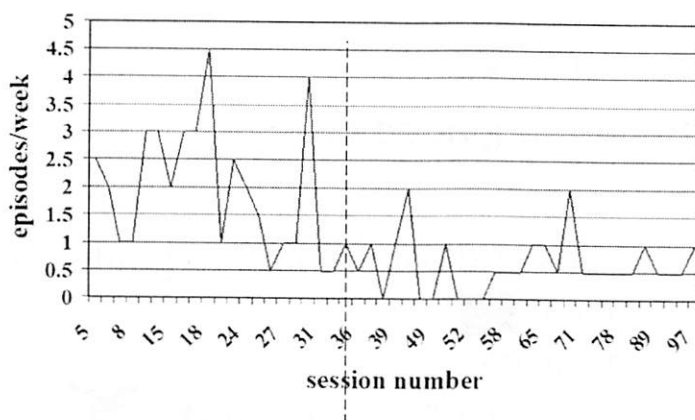
Ratings at several points in treatment of anxiety in public speaking situations

Feared Item	9/9/1992	2/10/1993	9/23/1994	3/19/1998
Annual sales meeting (350 executives)	150	NR	60	60
Award presentation at annual dinner (250 people)	100	75	60	60
Formal presentation to the management people (80 people, 30 senior executives)	97	62	50	40
Formal presentation to the financial network (25 people)	80	55	50	40
Formal presentation to the executive staff (25 senior executives)	75	50	45	40
Presentation to the executive committee	75	NR	40	20
Presentation to my department (100 people)	70	45	35	15
Presentation to a single department (10-45 people)	50	35	20	15
Discussion with the executive committee (7 senior executives)	50	35	20	15
1 to 1 with chairman	35	NR	20	0
Presentation to a small group within my department (5-6 people)	30	15	15	0
Discussion with a large group within my department	20	15	10	0
Staff meeting with my department	20	NR	0	0

Table 2
Self-report anxiety ratings of public speaking hierarchy items at four time points



Hypochondriacal episodes during interventions focusing on hypochondriasis and on public speaking







Overview of the “It could be cancer” case

- Initial poor outcome led to additional assessment, which led to . . .
- Revised diagnosis and formulation, which led to . . .
- New treatment targets and interventions, which led to . . .
- Ultimate good treatment outcome.



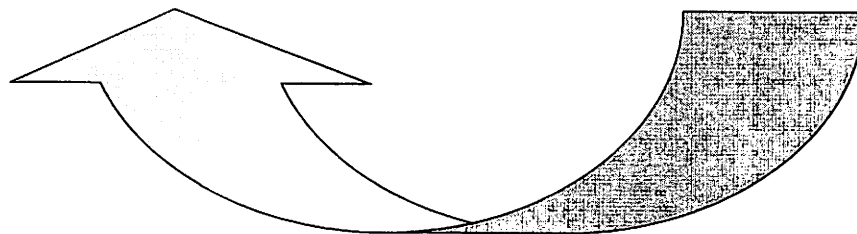


The Case Formulation Approach to Cognitive Behavior Therapy Day 1

- Mr. “It might be cancer” 
- **Why do case formulation-guided CBT?**
- Empirical support
- Developing formulations and using them to guide intervention
 - Case-level formulation 
 - Disorder-level formulation
 - Symptom/behavior-level formulation  

A Case Formulation-driven Approach to Cognitive-behavior Therapy

Assessment  Formulation  Intervention



case formulation-driven CBT helps the therapist solve these problems

Patients have multiple disorders and problems

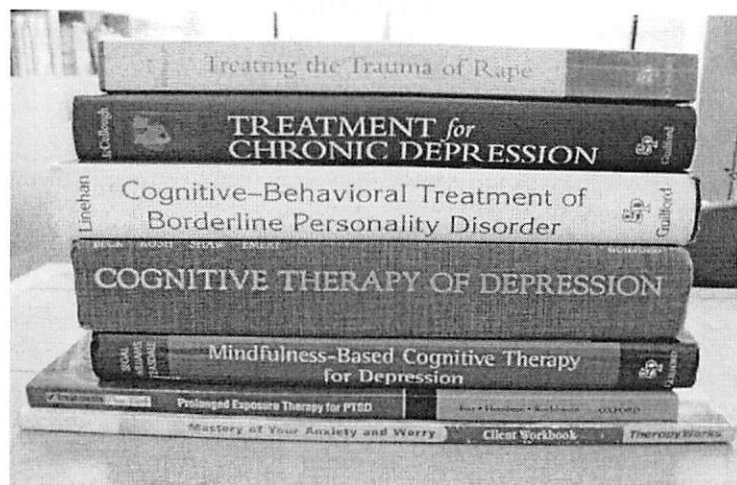
No ESTs for many disorders

Problem behaviors impede treatment

Nonresponse is common

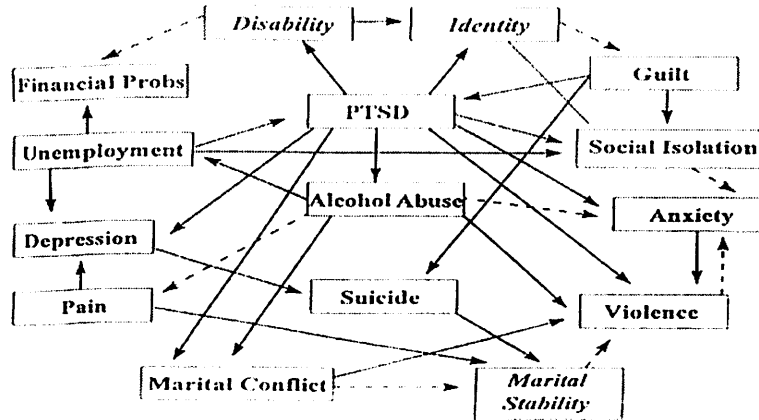
Patients have idiographic goals

Protocols for empirically-supported treatments (ESTs) generally target a single disorder



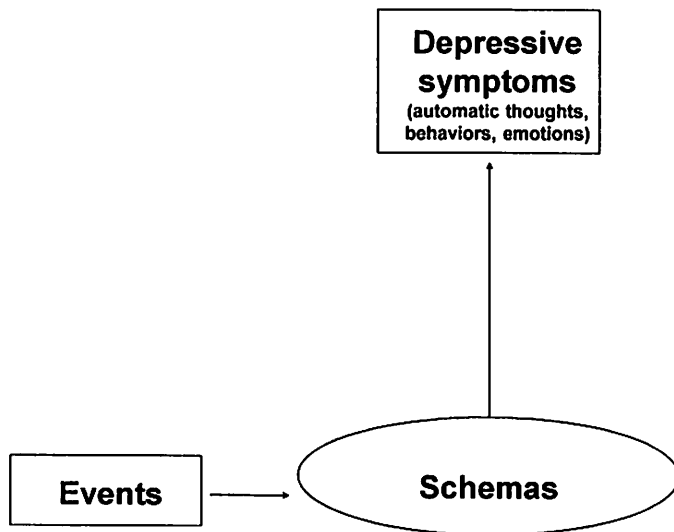
Most clients have multiple disorders and problems

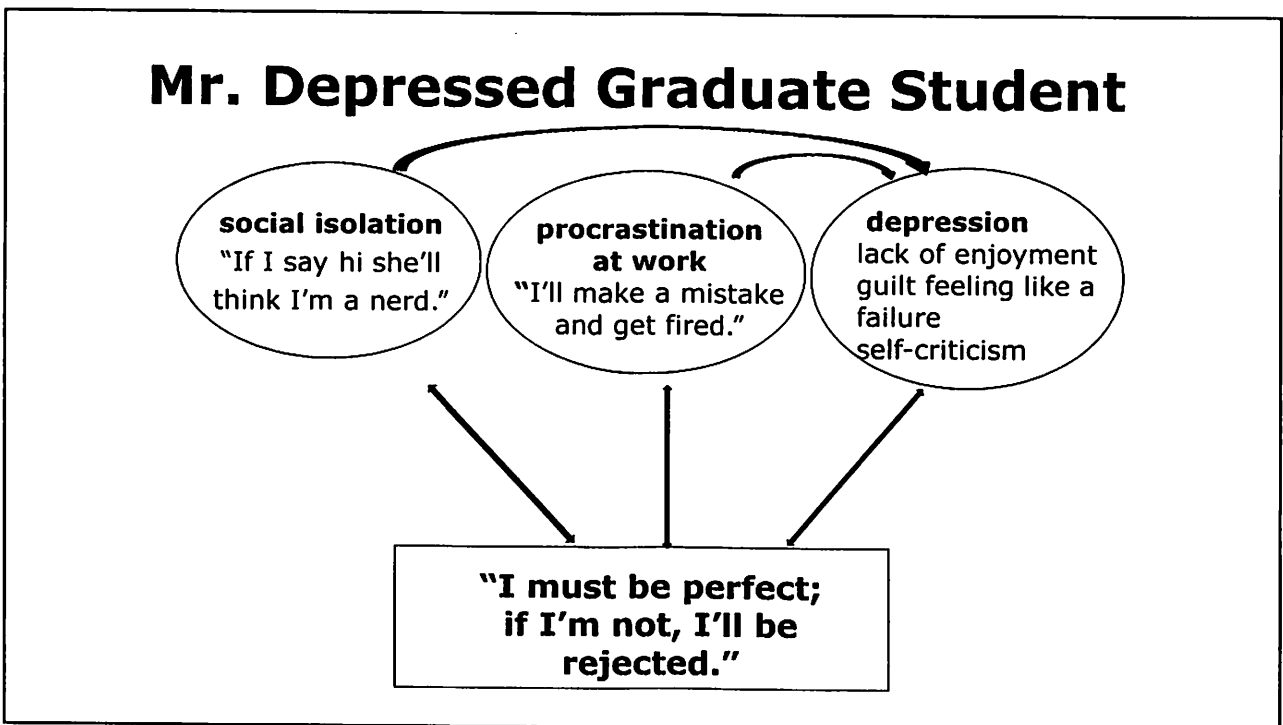
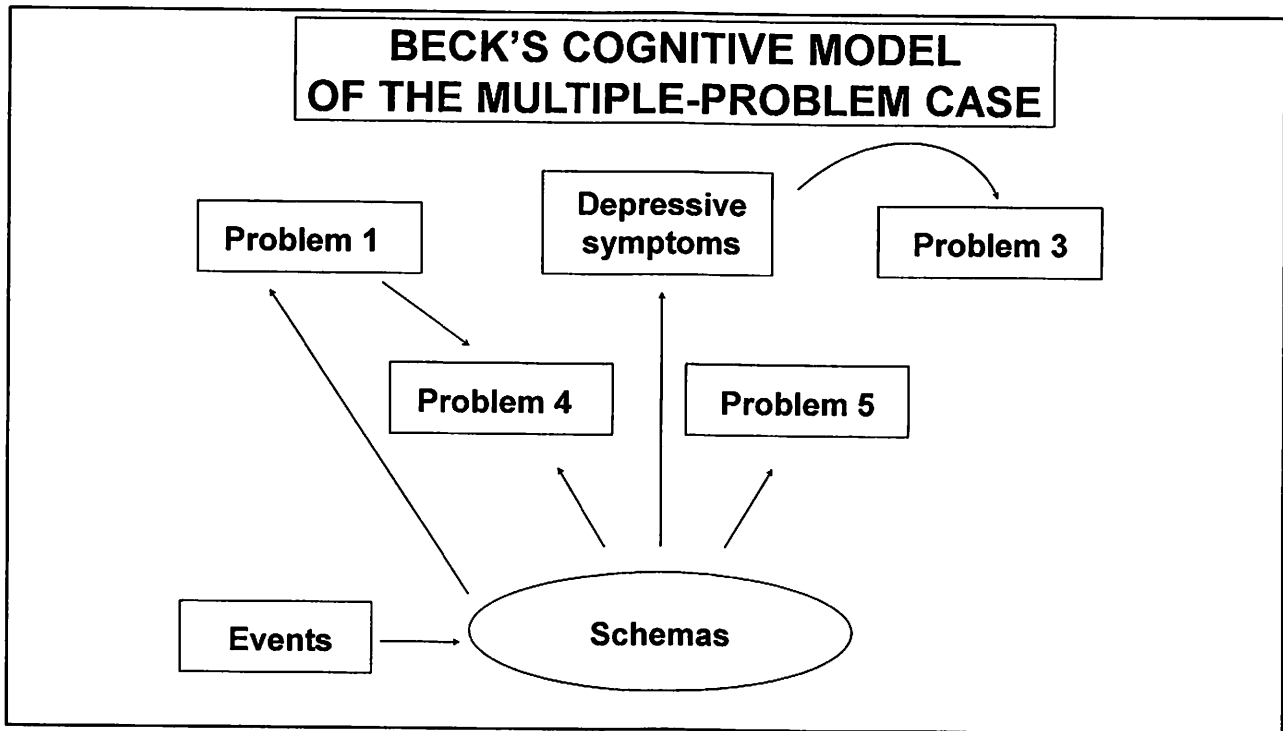
Initial Schematic of the Interrelations Among the Identified Problems For a Complex Case of PTSD



Beck, M. D., Kopp, E. S., & Klein, D. S. (1988). Cognitive-behavioral treatment for complex and chronic post-traumatic stress disorder. In E. M. J. Welfel & A. A. Hartman (Eds.), *Complex cases: The cognitive-behavioral approach* (pp. 194-216). Wiley & Sons, New York.

BECK'S COGNITIVE MODEL OF DEPRESSION





**case formulation-driven CBT helps
the therapist solve these problems**

Patients have multiple disorders and problems

No ESTs for many disorders

Problem behaviors impede treatment

Nonresponse is common

Patients have idiographic goals

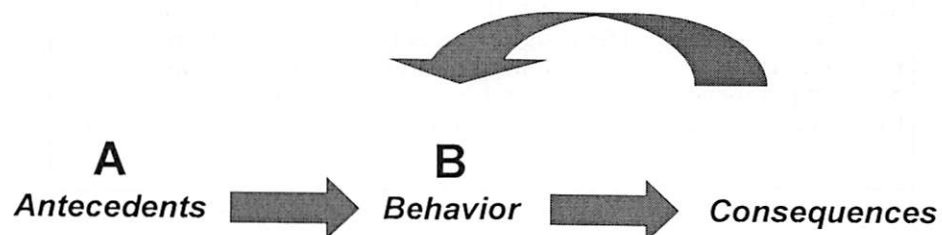
**No empirically-supported treatment is
available for many disorders and problems**

- Most personality disorders
- Autism spectrum disorders
- Somatization disorders
- Dissociative disorders
- “I want to get married and have a family.”

Case Formulation-driven CBT can guide treatment when no EST exists

- Steve, a mid 20's young man who had psychogenic vomiting and intellectual disability

Formulation of Steve's case was based on a transdiagnostic model:
OPERANT CONDITIONING



Functional Analysis

Antecedents (A)	Behaviors (B) (actions, thoughts, or emotions)	Consequences (C)

The A-B-C's of Change

(A) Antecedents	(B) Behavior	(C) Consequences
Change behavior by adding antecedents that lead to wanted behavior, and removing antecedents that lead to unwanted behavior.	Change behaviors (actions, thoughts, or feelings) by practicing substituting desired behaviors for undesired behaviors.	Change the events that follow your behavior to reinforce desired behaviors and not reinforce undesired behaviors.

Adapted from: David L. Watson & Roland G. Tharp (2002). Self-Directed Behavior: Self-Modification for Personal Adjustment. Belmont, CA: Wadsworth/Thomson Learning.

Functional Analysis of Steve's Vomiting Behavior

Antecedents (A)	Behaviors (B)	Consequences (C)
Boredom Nothing to do No meaningful relationships	Vomiting	Father cleans up vomit, takes patient to hospital and stays there with him for hours. TV, couch, pampering at home.

What Interventions Could be Used to Treat Steve's Vomiting Behavior?

Antecedents (A)	Behaviors (B)	Consequences (C)

case formulation-driven CBT helps the therapist solve these problems

Patients have multiple disorders and problems

No ESTs for many disorders

Problem behaviors impede treatment

Nonresponse is common

Patients have idiographic goals

Use the Conceptualization to Identify a Therapeutic Response to Clinically Relevant Behavior

Will you call my doctor and ask him to renew my Xanax prescription?

?



Client

Therapist

Adapted from Kohlenberg, R. J., & Tsai, M. (1991). *Functional analytic psychotherapy*.

case formulation-driven CBT helps the therapist solve these problems

Patients have multiple disorders and problems

No ESTs for many disorders

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Large Proportions of Depressed Patients Do Not Respond to ESTs

Driessen et al., 2013 (< 50% reduction in HAM-D)	CBT 37% Psychodynamic 42%
Luty et al., 2007 (< 60% change in Montgomery-Asberg Depression Rating Scale)	Interpersonal Therapy 59% CBT 49%
DeRubeis et al., 2005 16-wk HAM-D score of 12 or lower & either 14-wk score of 14 or lower or a 10- and 12-wk score of 12 or lower	42% CBT 42% Antidepressant Medication

Most Change in CBT for Depression Happens Early in Treatment

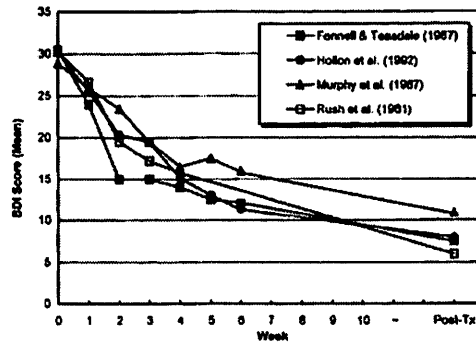


Figure 1. Temporal change in BDI scores in CBT for depression

Ilardi & Craighead, 1994, *CPSP*, 138-156.



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2019, Vol. 87, No. 6, 510–520
<https://doi.org/10.1037/a0050499>

Estimating Outcome Probabilities From Early Symptom Changes in Cognitive Therapy for Recurrent Depression

Jeffrey R. Vittengl
Truman State University

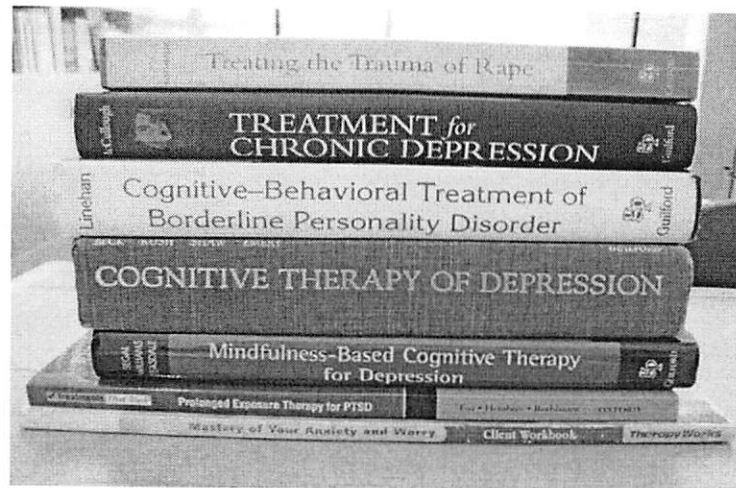
Lee Anna Clark
University of Notre Dame

Michael E. Thase
University of Pennsylvania

Robin B. Jarrett
The University of Texas Southwestern Medical Center

Patients with no symptom improvement by CT Session 9 (Week 5) had $\leq 10\%$ probability of remission and $>75\%$ of nonresponse.

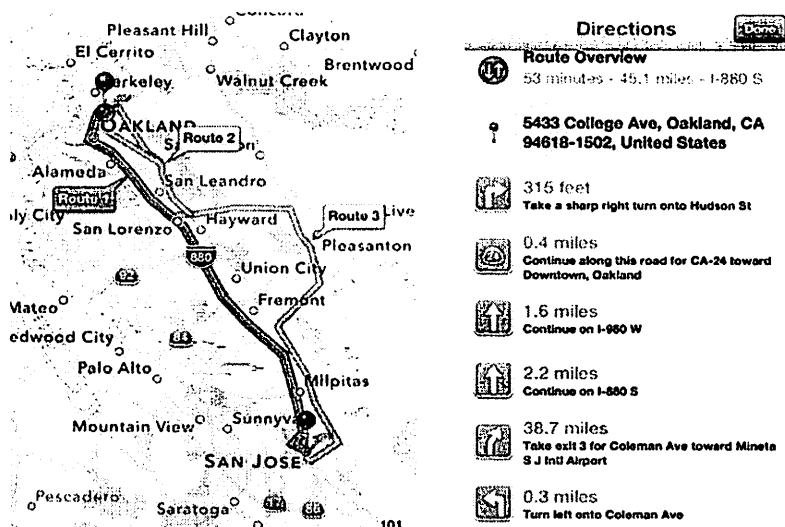
When the patient does not respond to the empirically-supported protocol, the protocol does not tell us what to do.



The case formulation approach offers the therapist a way to address treatment failure

- Collect more assessment data
- Consider whether a different formulation might lead to different interventions that might lead to a better outcome

A protocol is like a list of directions. A formulation is like a map.
If one route is blocked, it helps you find an alternate route.



case formulation-driven CBT helps the therapist solve these problems

Patients have multiple disorders and problems

No ESTs for many disorders

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The mother who wanted help using public bathrooms during her child's hospital stay



case formulation-driven CBT helps the therapist solve these problems

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Patients have idiographic goals

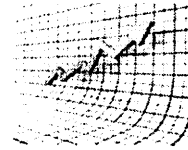
Risks of doing Case Formulation-driven Treatment (vs Following the Protocol)



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Empirical Foundations of case formulation-driven CBT



- EST-based formulations and interventions

Evidence-based Cognitive Conceptualization of Panic

Situation: Sitting in class thinking about final exam

TRIGGER- I have a little difficulty breathing

AUTOMATIC THOUGHTS- Something is wrong. What if I panic?

EMOTION- Fear

SOMATIC SENSATIONS- Rapid breathing, muscle tension, palpitations

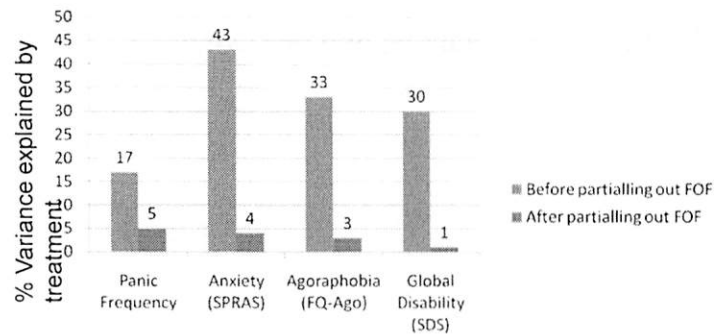
FOCUS ON SENSATIONS- How am I breathing? Is it getting worse?

INTENSIFICATION OF SENSATIONS

CATASTROPHIC INTERPRETATIONS- I'm suffocating! I might die!

PANIC

Change in Fear of Fear Accounts for Most of the Change Produced by CBT for Panic



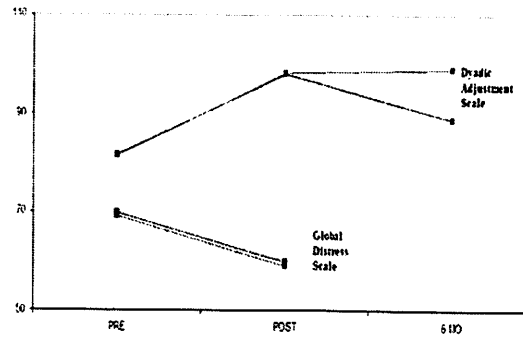
Smits et al., *JCCP*, 2004

Empirical Foundations of case formulation-driven CBT



- EST-based formulations and interventions
- A handful of RCTs show formulation-driven treatment is usually equal to and occasionally superior to standardized treatment

Standardized vs Flexible Marital Therapy Jacobson et al (1989)



Modular treatment was more effective than standard protocol or TAU for depression, anxiety, and conduct problems in youth

(Weisz et al., 2012, Arch Gen Psychiatry)

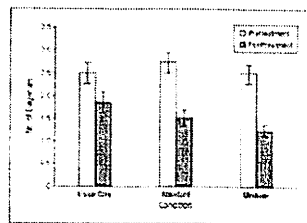
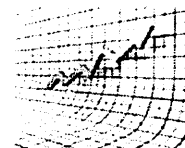


Figure 2. Diagnostic change from pre-treatment to post-treatment by study condition: standard marital treatment (59 youth [84% of the sample]), cognitive behavioral therapy for depression, cognitive behavioral therapy for anxiety, and behavioral parent training for conduct problems; modular treatment (62 youth [86%], integrating the procedures of the 3 separate treatments) and usual care (53 youth [79%]).

Empirical Foundations of case formulation-driven CBT



- EST-based formulations and interventions
- A handful of RCTs show formulation-driven treatment is usually equal to and occasionally superior to standardized treatment
- Uncontrolled trials show formulation-driven treatment produces outcomes similar to ESTs



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Behaviour Research and Therapy 44 (2006) 1041–1051

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Naturalistic outcome of case formulation-driven cognitive-behavior therapy for anxious depressed outpatients[☆]

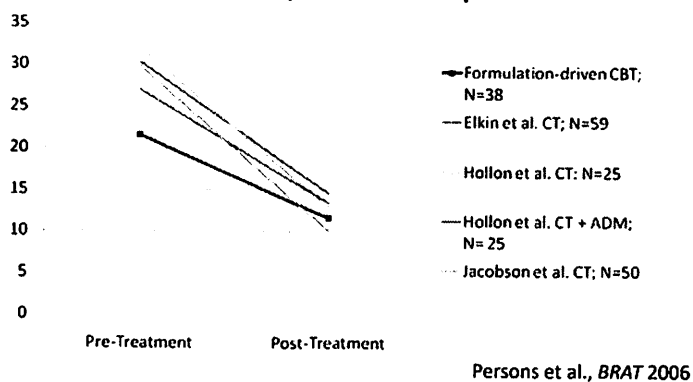
Jacqueline B. Persons^{a,*}, Nicole A. Roberts^{b,1}, Christine A. Zalecki^b,
Whitney A.G. Brechwald^b

^a*Psychology Department, San Francisco Bay Area Center for Cognitive Therapy, University of California, 5435 College Avenue, Oakland, CA 94618, Berkeley, USA*

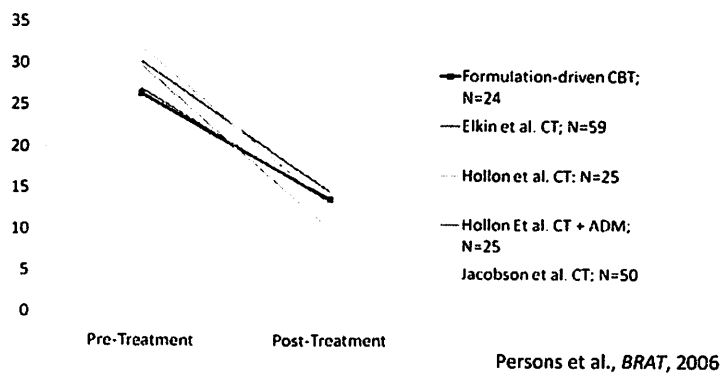
^b*Psychology Department, University of California, Berkeley, USA*

Received 7 January 2005; received in revised form 15 July 2005; accepted 2 August 2005

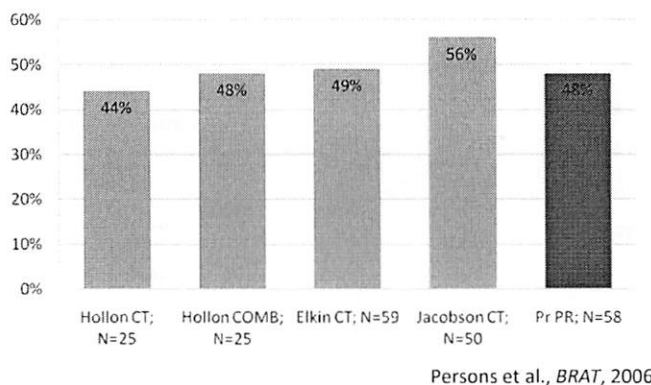
Pre- and Post-treatment BDI in Formulation-driven and Standardized CBT for Anxious Depressed Outpatients



Pre- and Post-treatment BDI in Formulation-driven and Standardized CBT When Initial BDI ≥ 20



Percent of Patients Who End Standardized and Formulation-driven CBT with BDI <10

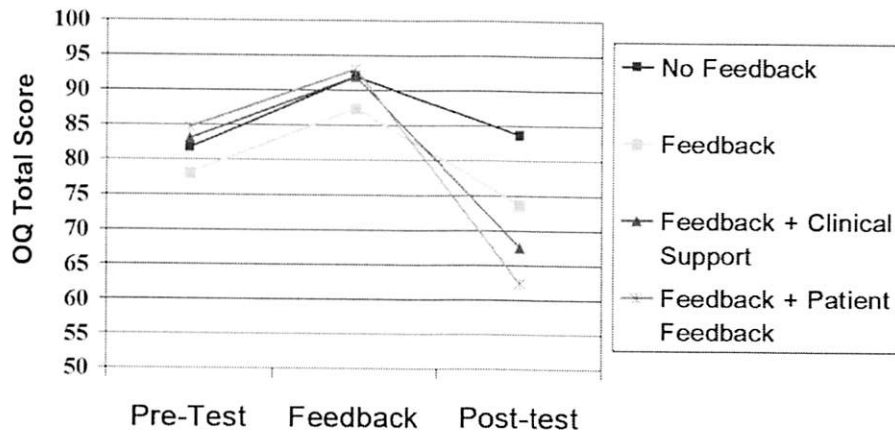


Empirical Foundations of case formulation-driven CBT



- EST-based formulations and interventions
- A handful of RCTs show formulation-driven treatment is usually equal to and occasionally superior to standardized treatment
- Uncontrolled trials show formulation-driven treatment produces outcomes similar to ESTs
- Progress monitoring improves outcomes

Giving Therapists Feedback about Patients' Progress Improves Outcomes of Patients Who Have Initial Poor Outcome



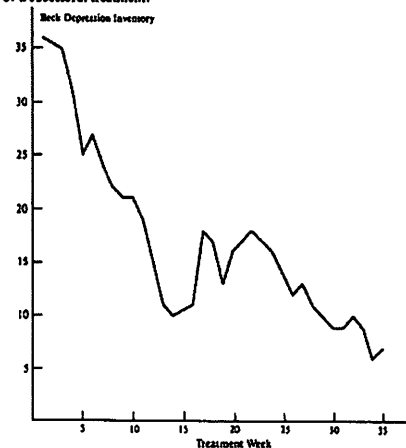
Lambert et al. J Clin Psychol, 2005, 61:165-174

The most important data are . . .







. . . progress monitoring data collected from every patient during treatment.

Figure 2.1 Changes in Beck Depression Inventory score over the course of a successful treatment.



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Definition of Case Formulation

A case formulation is a hypothesis about the psychological mechanisms (e.g., schemas, contingencies) that cause and maintain a patient's symptoms, problems, and disorders.

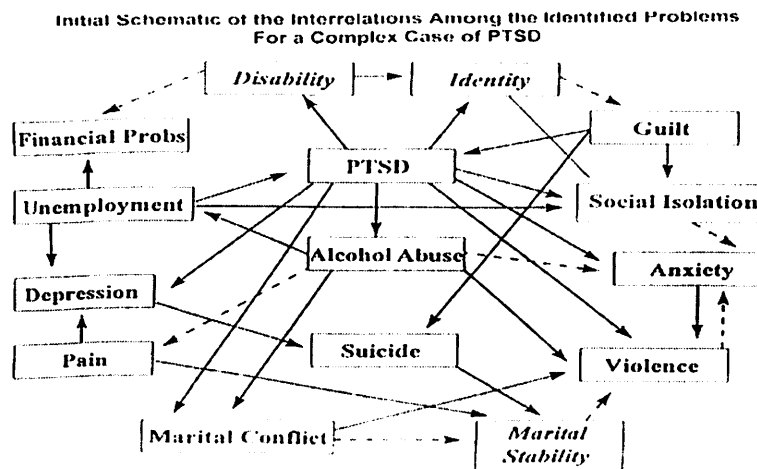
The function of the formulation . . .

- . . is to help the therapist guide intervention and solve problems.
- One of the main ways it does this is by identifying the treatment targets
- The *treatment utility* of the formulation is more important than its accuracy.

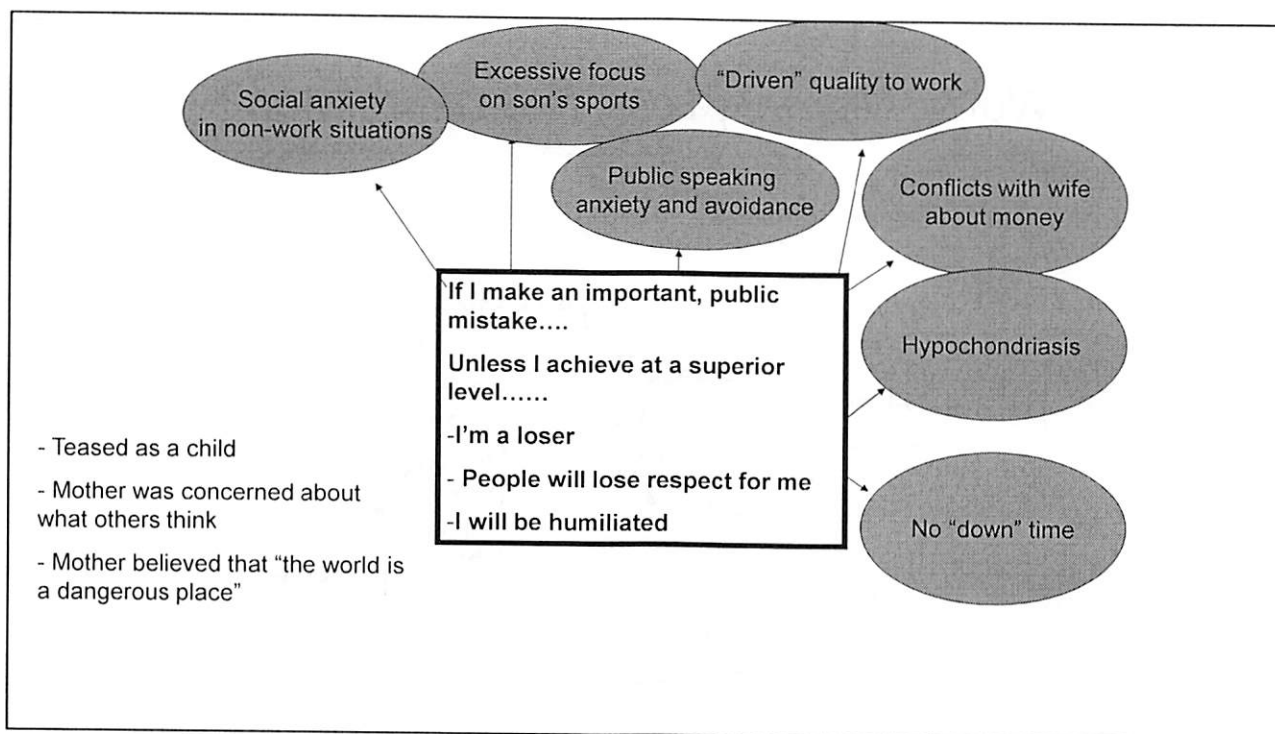
Three Levels of Formulation

- Case
- Disorder/Problem
- Symptom/Behavior

**A case consists of disorders and problems;
most disorders and problems consist of symptoms**



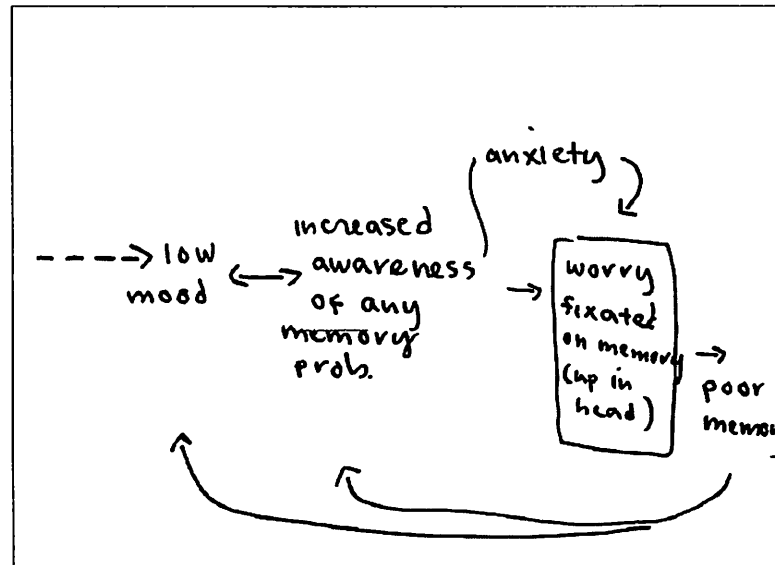
©2011
Kupst, M.D., Page 13 of 34, June 13, 2019. Reproductive behavior and mental health: implications of post-traumatic stress disorder. In Kupst, M. & Weiss, A. A. (Eds.), (2011). *Living Complex Cases: The Cognitive Behavioral Approach*. pp. 104-119. Wiley & Sons, New York.



Thought Record

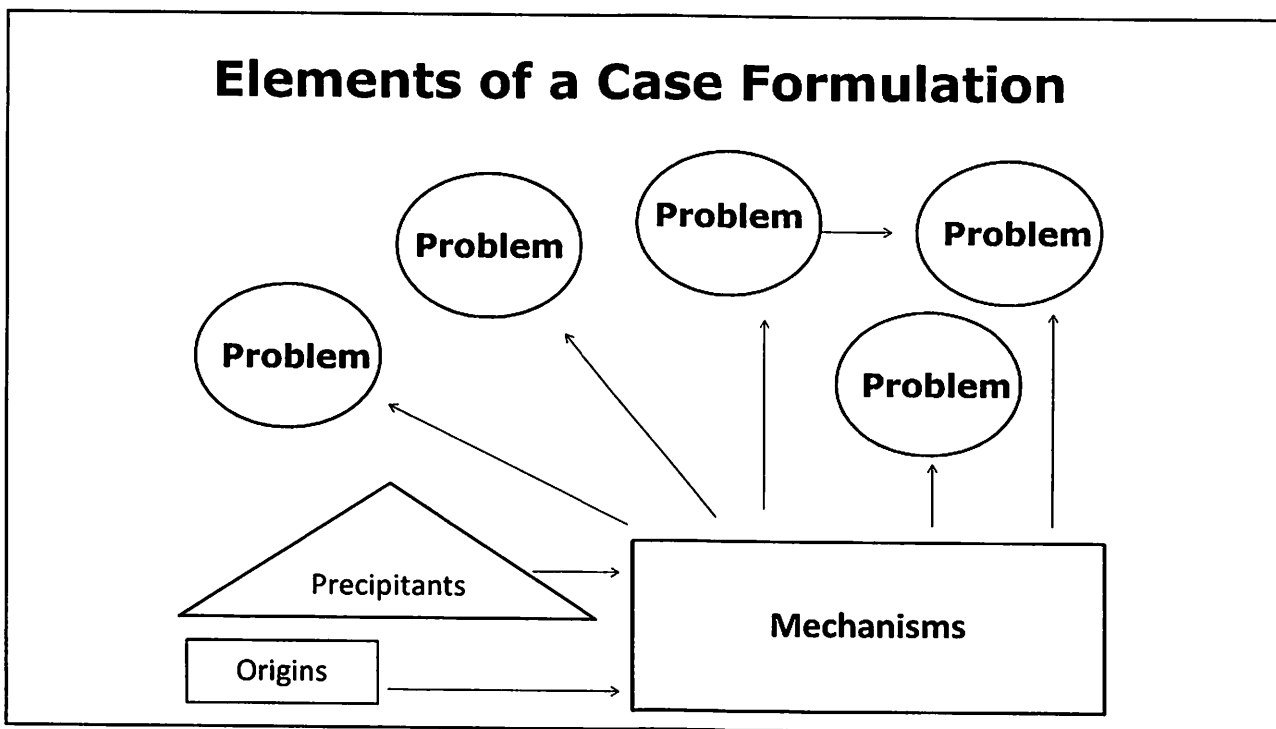
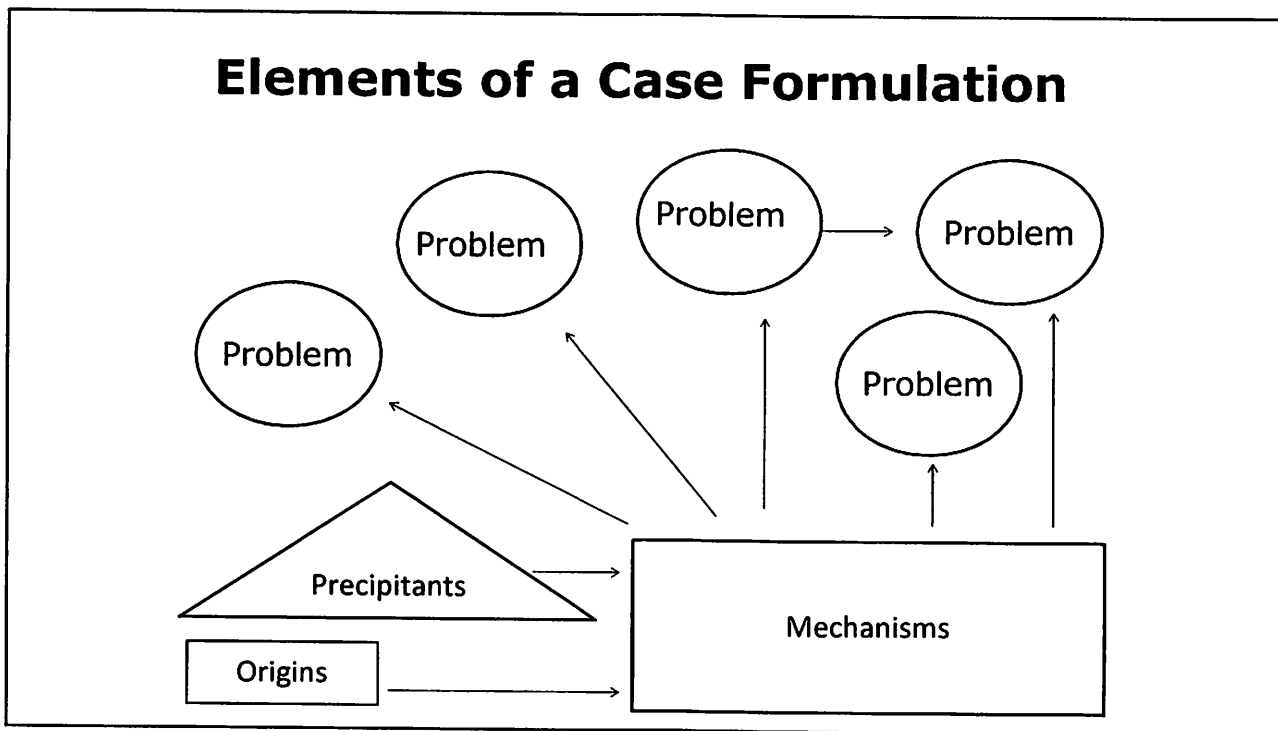
Date	Situation	Behavior(s)	Emotions	Thoughts	Coping Responses
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Worry, Memory Loss, and Depression



Three Levels of Formulation

- **Case**
- Disorder/Problem
- Symptom/Behavior



A problem is

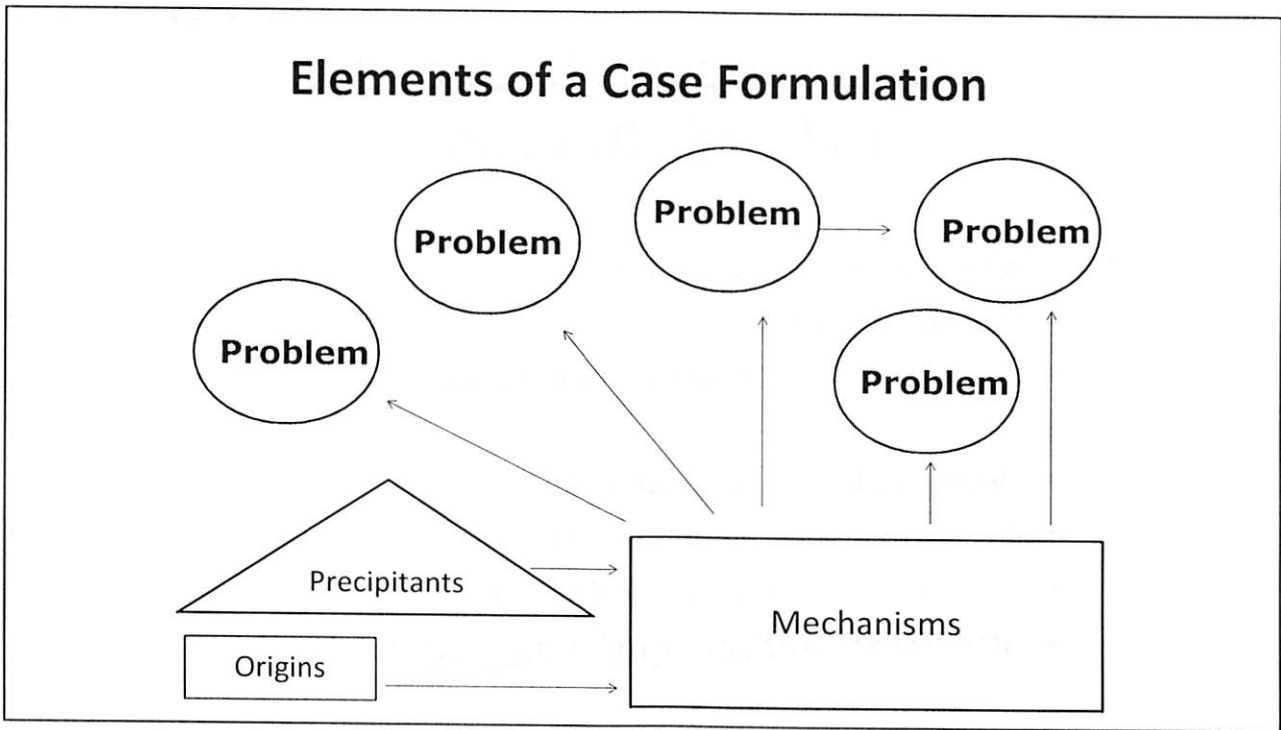
... a symptom or disorder or difficulty that is observable/behavioral. E.g., suicidal rumination, OCD, marital fighting and other difficulties, substance abuse, panic attacks.

A mechanism is

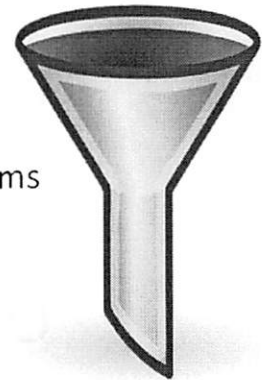
... a psychological (or biological) construct (e.g., maladaptive schemas, problematic contingencies, perfectionism, intolerance of uncertainty) that causes and/or maintains the person's problems



Obtaining a Comprehensive Problem List



Domains Assessed to Create a Comprehensive Problem List



- Psychological/psychiatric disorders and symptoms
- Medical disorders and symptoms
- Interpersonal
- Work
- Finances
- Housing
- Legal
- Leisure
- Healthcare difficulties

Intake Measures Used at the Oakland CBT Center

- Adult Intake Questionnaire
- Diagnostic Screen
- Depression Anxiety Stress Scales (DASS)
- PHQ-9
- Obsessive Beliefs Questionnaire
- A scale assessing social support
- Perseverative Thinking Questionnaire
- <https://oaklandcbt.com/intake-forms>

Guidelines for Developing a Problem List

- Develop a comprehensive list.
- Name each problem in one or two words. "Work dissatisfaction."
- Describe emotion, behavioral, and cognitive components. "Feels worthless, avoids work and thinks, 'I'm going to fail at that project.'"
- Strive for a mutually agreed-upon Problem List.

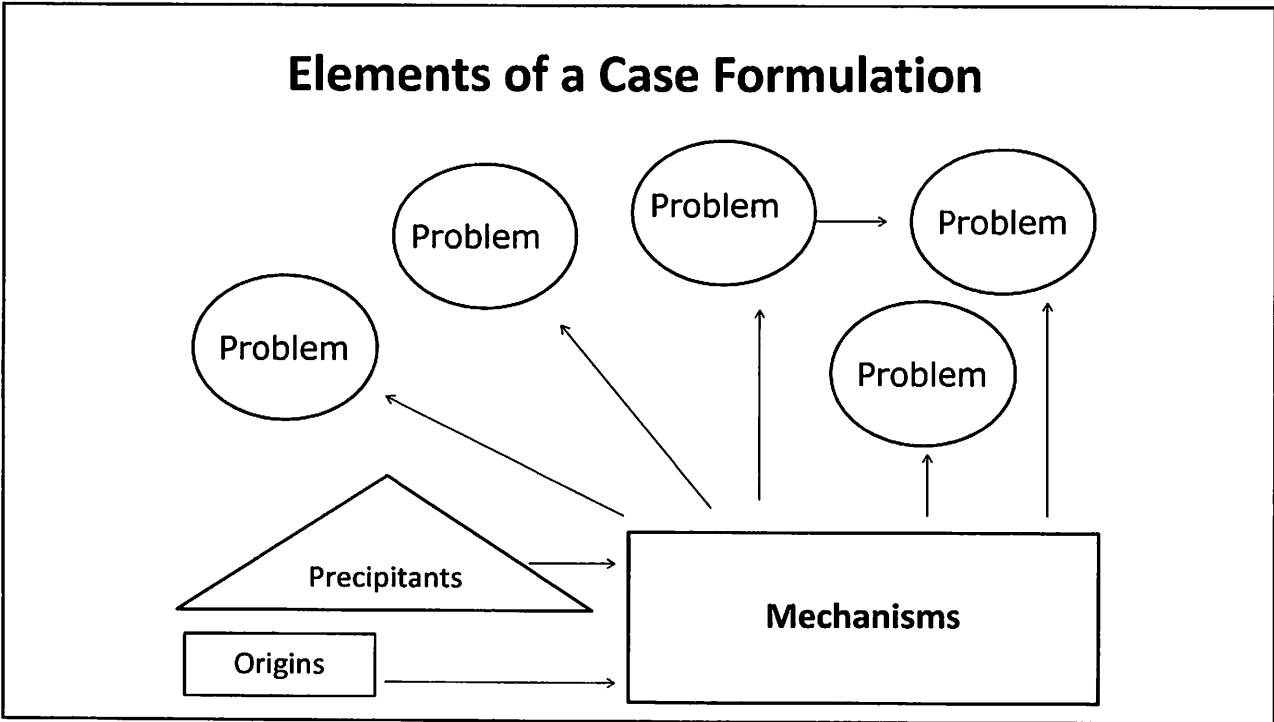
Priority Order of Problems

1. Suicidal and self-harming behaviors
2. Therapy-interfering behaviors
3. Quality-of-life interfering behaviors
4. Other problems

Quality-of-life-interfering Behaviors

- Severe substance abuse
- High-risk sexual behavior
- Criminal behaviors that may lead to jail
- Serious dysfunctional interpersonal behaviors (choosing abusive partners, ending relationships prematurely)
- Employment- or school-related dysfunctional behaviors (quitting jobs or school; inability to look for or find a job)
- Illness-related dysfunctional behaviors (inability to get proper medical care; not taking medications)
- Housing-related dysfunctional behaviors (living in shelters, cars, or overcrowded housing)
- Mental health-related dysfunctional behaviors (going into psychiatric hospitals)
- Mental disorder-related dysfunctional patterns (behaviors that meet criteria for other severe mental disorders)

Adapted from Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*.



A strategy for developing a case-level formulation

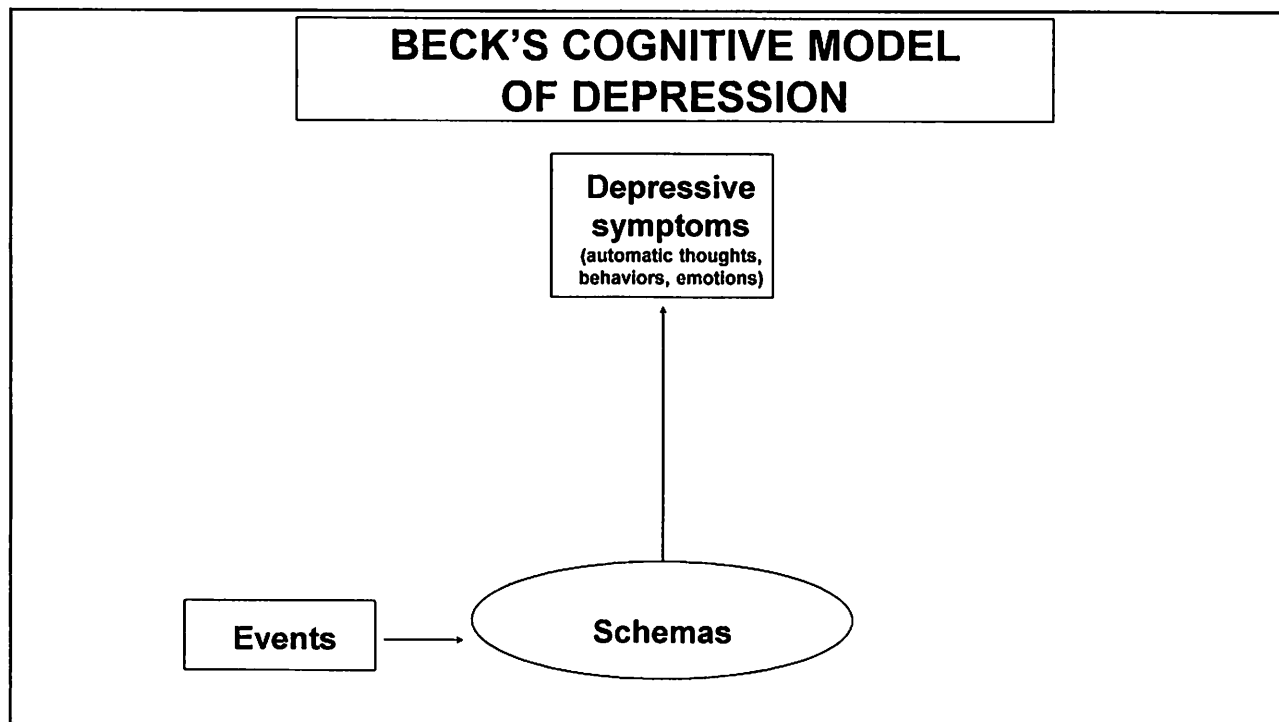
Extend a symptom or disorder formulation to account for all of the patient's problems and disorders

Functional Analysis of Steve's Vomiting Behavior

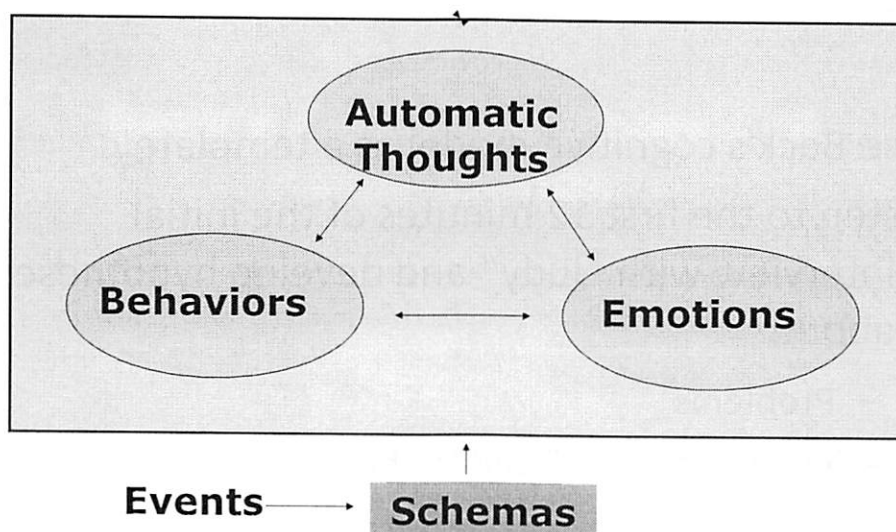
Antecedents (A)	Behaviors (B)	Consequences (C)
Boredom Nothing to do No meaningful relationships	Vomiting	Stimulation, activity Special treatment (TV, couch) Attention from father

A strategy for developing a case formulation based on Beck's cognitive model

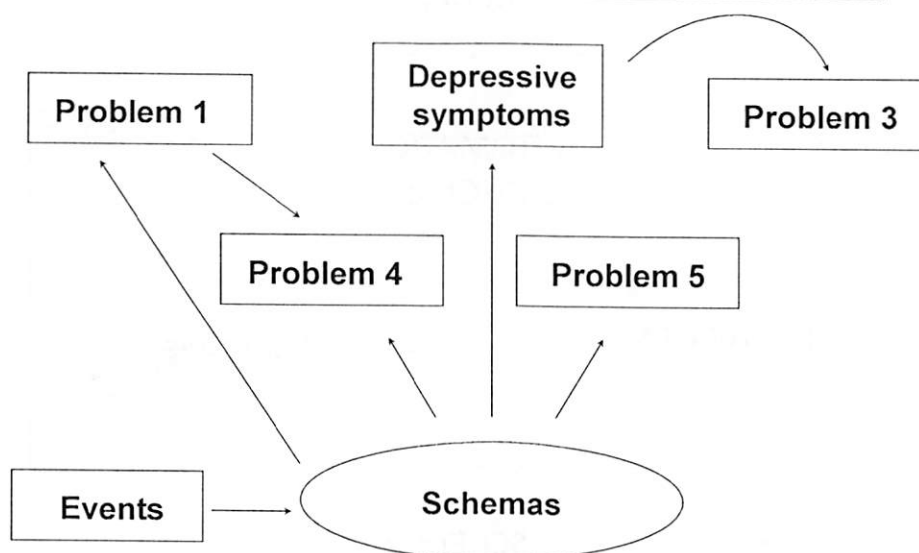
Extend Beck's formulation of depressive disorder to account for all of the patient's problems and disorders



Beck's Cognitive Theory of Depression



BECK'S COGNITIVE MODEL OF THE MULTIPLE-PROBLEM CASE





Audiotape EXERCISE

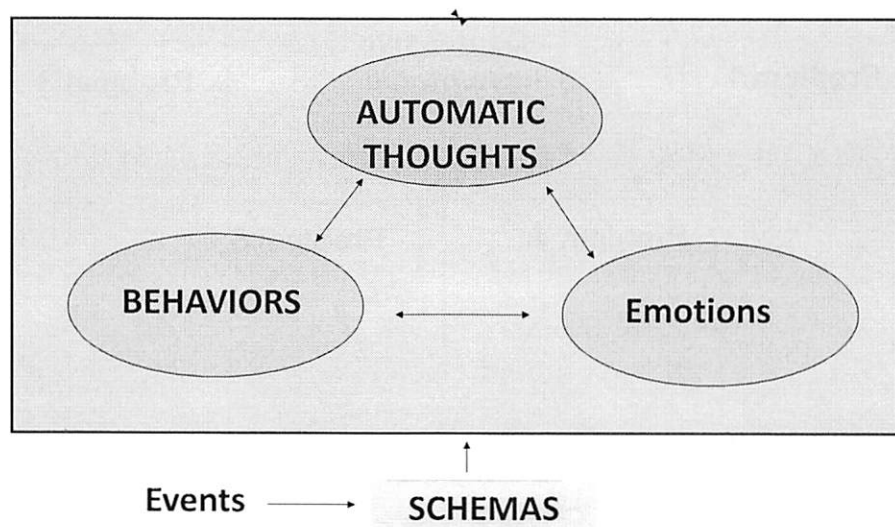


Use Beck's cognitive model as a template

Listen to the first 12 minutes of the initial interview with "Judy" and develop hypotheses about:

- Problems
- Schemas of "Self" and "Others"

TREATMENT TARGETS Identified by Beck's Cognitive Theory



Interventions in Beck's Cognitive Therapy

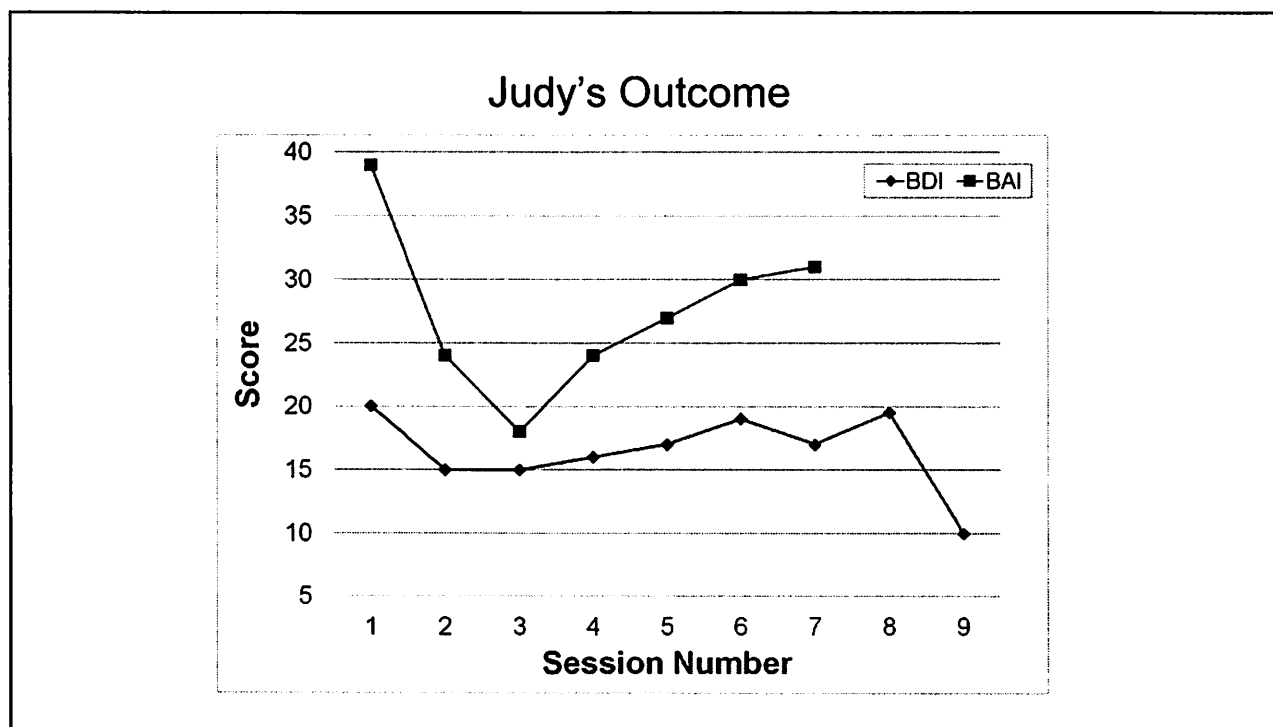
- Behavioral activity scheduling
- Cognitive restructuring
- Behavioral experiments
- Positive data log
- Continuum method
-

Exercise



Using the Formulation to Guide Treatment for Judy

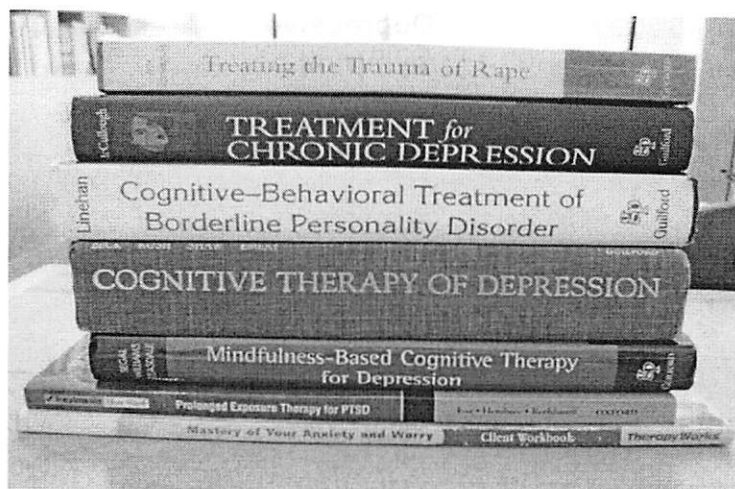
- Work with your neighbor
- Examine the formulation we developed
- List interventions you might use to treat Judy
- Speculate about obstacles to treatment that the formulation suggests



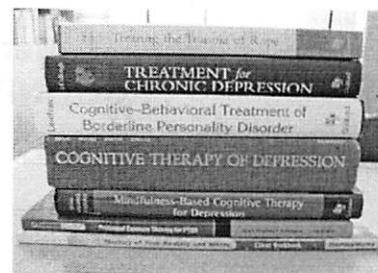
Three Levels of Formulation

- Case
- **Disorder/Problem**
- Symptom/Behavior

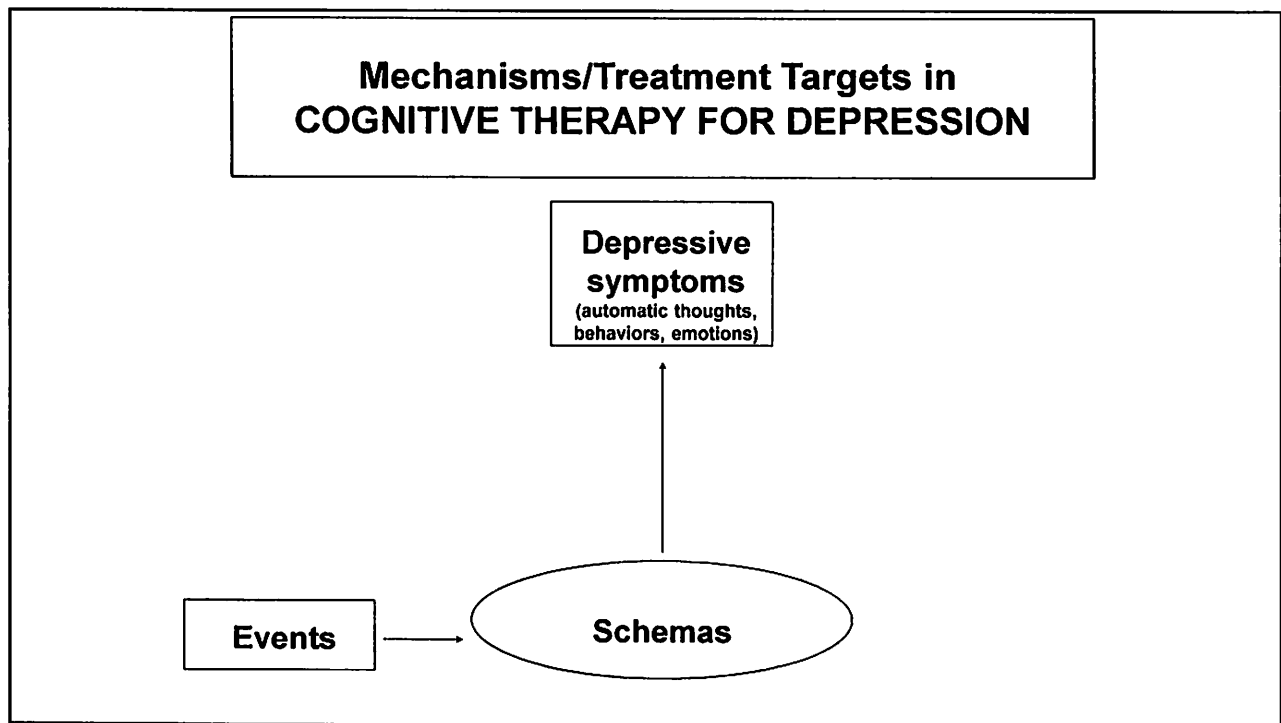
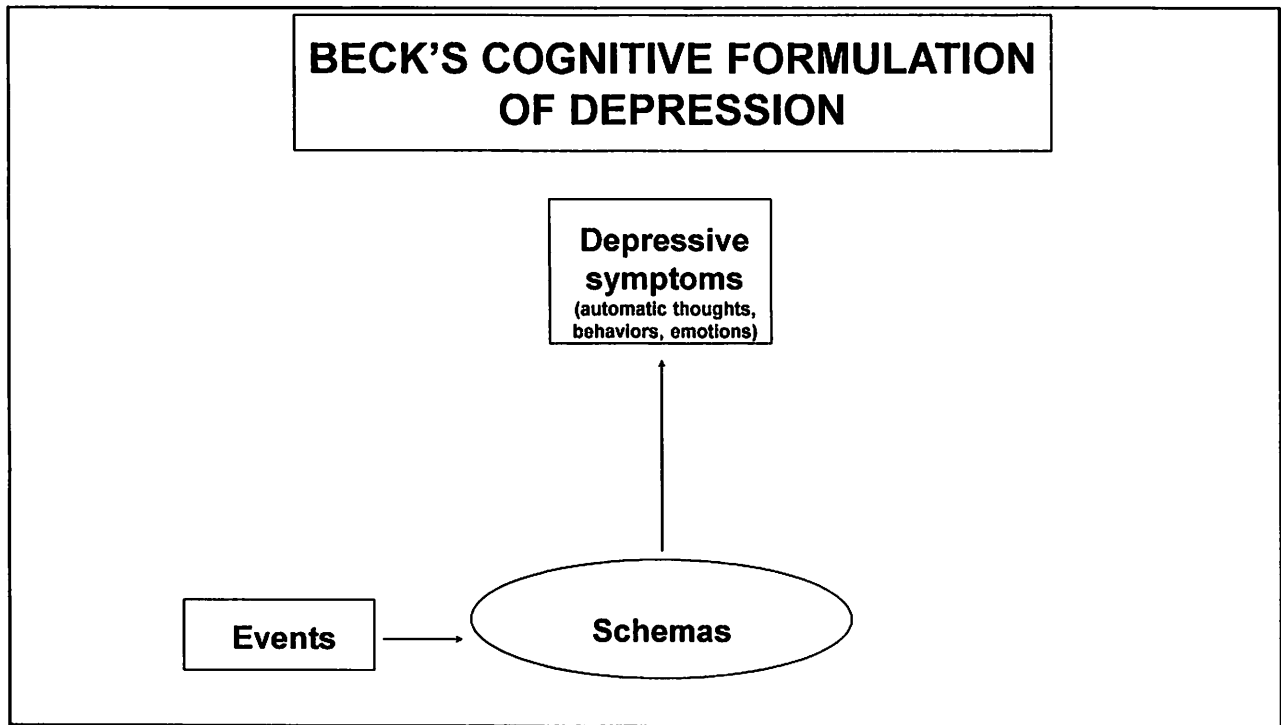
To develop a disorder formulation, start with the Empirically-supported Treatments (ESTs)

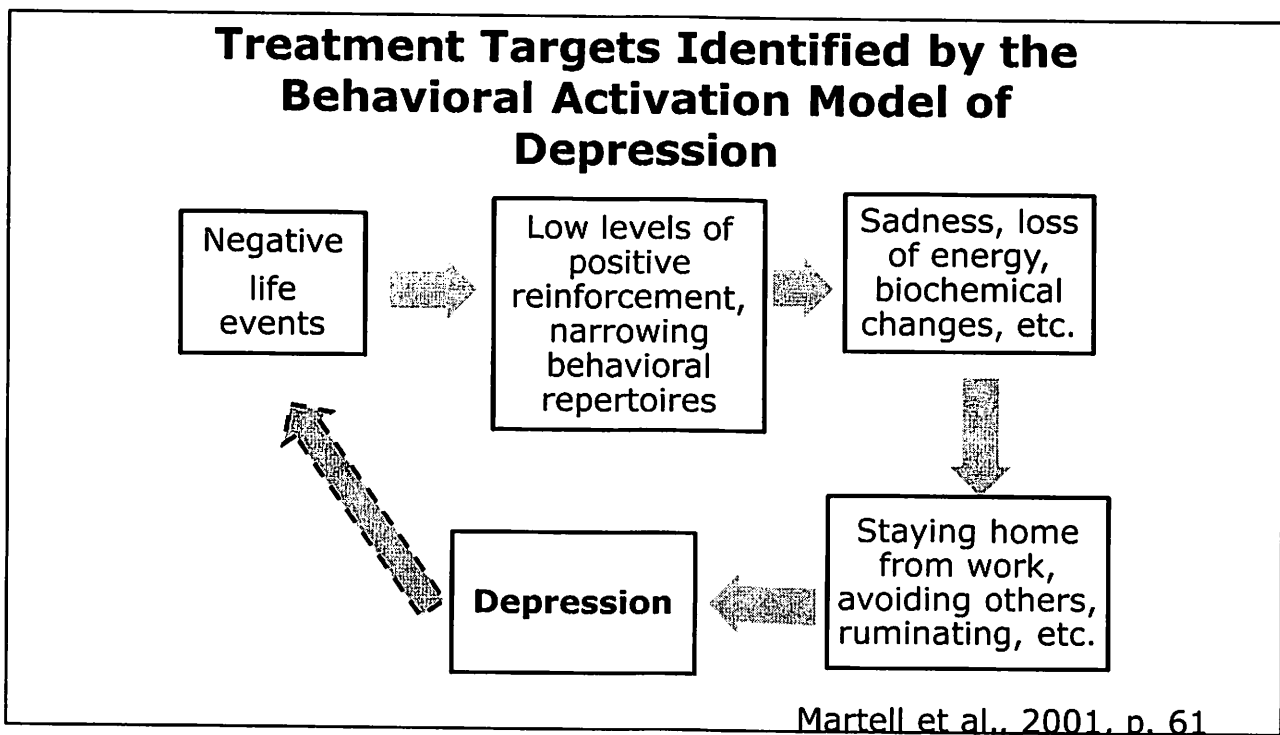
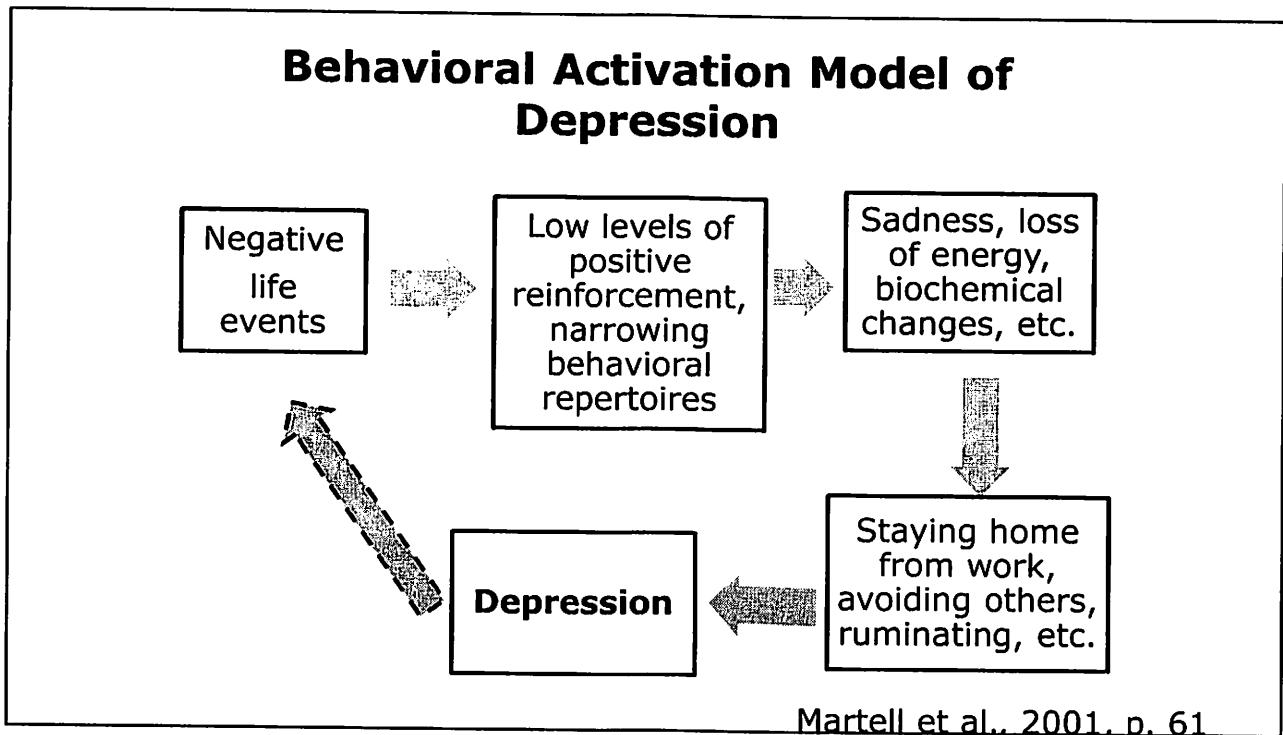


To Develop a Disorder Formulation,
Start with the ESTs



- Most ESTs treat a disorder.
- The EST is based on a formulation of the disorder.
- The formulation describes psychological mechanisms (e.g., schemas, contingencies, skill deficits) that cause and maintain the symptoms of the disorder.
- The EST protocol describes interventions that change the symptoms by changing the mechanisms.





Cognitive Formulation of Panic

Situation: Sitting in class thinking about final exam

TRIGGER- I have a little difficulty breathing

AUTOMATIC THOUGHTS- Something is wrong. What if I panic?

EMOTION- Fear

SOMATIC SENSATIONS- Rapid breathing, muscle tension, palpitations

FOCUS ON SENSATIONS- How am I breathing? Is it getting worse?

INTENSIFICATION OF SENSATIONS

CATASTROPHIC INTERPRETATIONS- I'm suffocating! I might die!

PANIC

Mechanisms/Treatment Targets in the Cognitive Formulation of Panic

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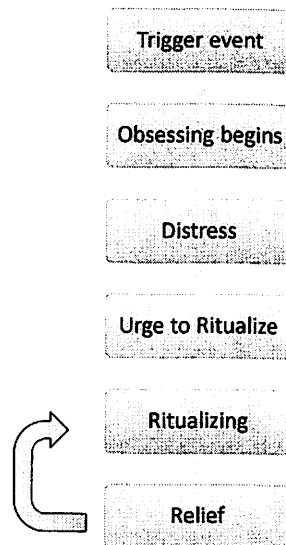
FOCUS ON SENSATIONS- How am I breathing? Is it getting worse?

INTENSIFICATION OF SENSATIONS

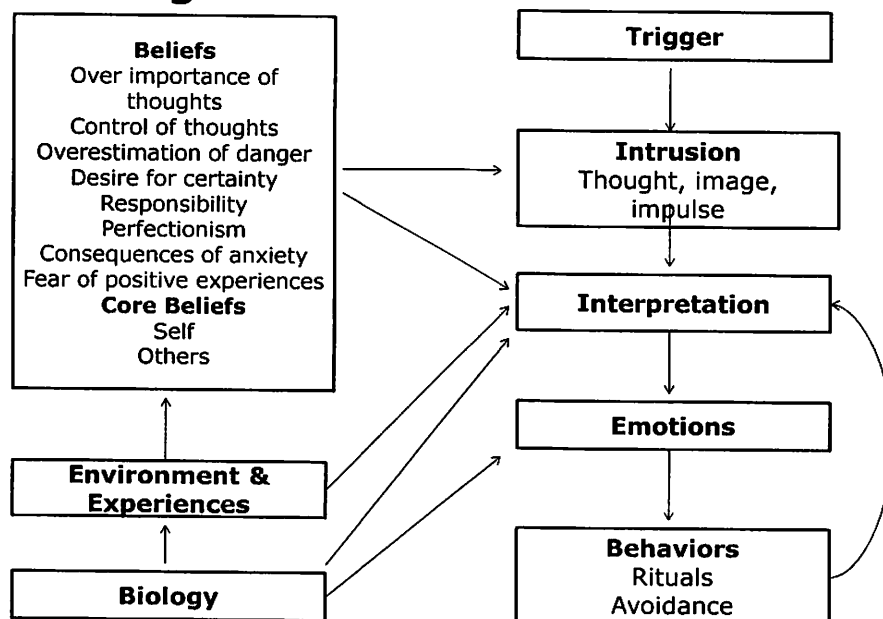
CATASTROPHIC INTERPRETATIONS- I'm suffocating! I might die!

PANIC

Behavioral Formulation of OCD

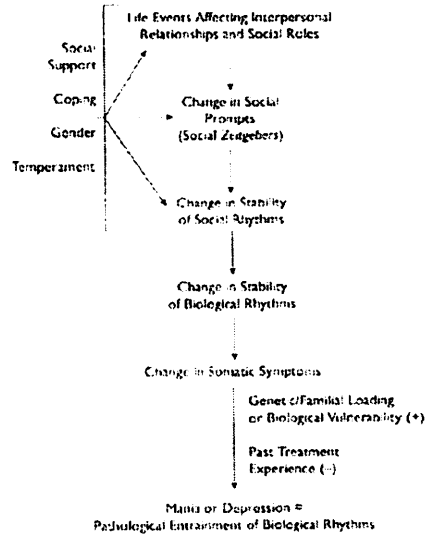


Cognitive Model of OCD



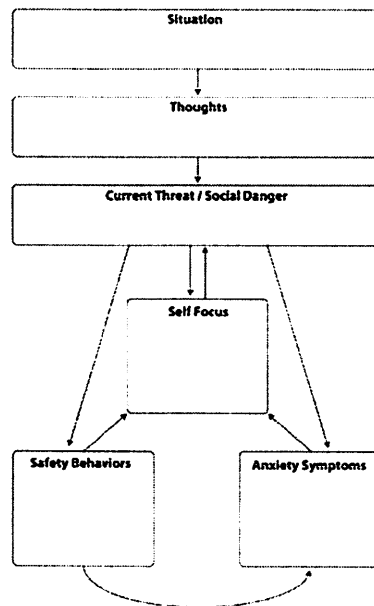
Adapted from Wilhelm & Steketee, 2006

Social Zeitgeber Theory underpinning Interpersonal and Social Rhythm Therapy for bipolar disorder



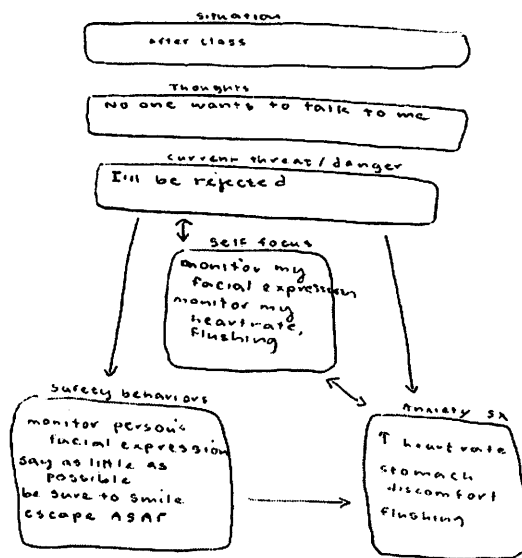
Frank, *Treating Bipolar Disorder*, 2005

Cognitive Model of Social Anxiety



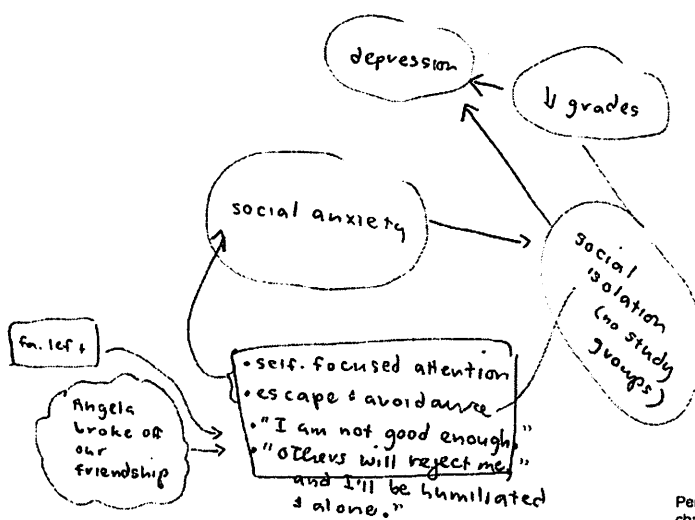
Psychology Tools
Clark & Wells, 1995

Formulation of Anne's Social Anxiety



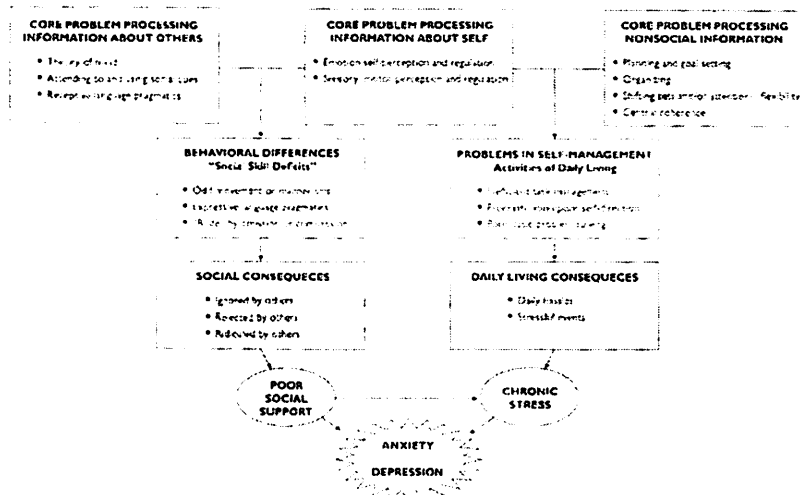
Persons & Talbot
chapter in Dmidjian, in
press.

Formulation of Anne's Case



Persons & Talbot
chapter in Dmidjian,
in press.

Formulation of Autism Spectrum Disorder



Gaus, *CBT for Adult Asperger Syndrome*, Guilford, 2007, p. 41

Three Levels of Formulation

- Case
- Disorder/Problem
- **Symptom/Behavior**

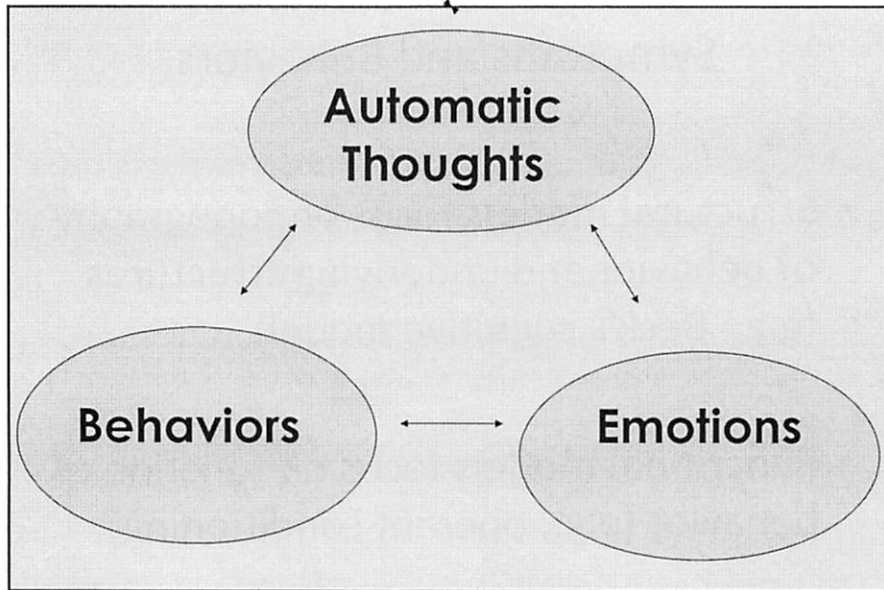
Two Models Can be Used to Formulate Symptoms and Behaviors

- **Structural models** focus on topography of behavior and underlying structures (e.g., Beck's cognitive model)
- **Functional models** focus on function of behavior (e.g., operant conditioning)

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Beck's Cognitive Model of Symptoms



Thought Record

Date	Situation (Event, memory, plan, etc.)	Behaviors	Emotions	Thoughts	Coping Responses
		Urges to commit suicide, suicidal behavior			

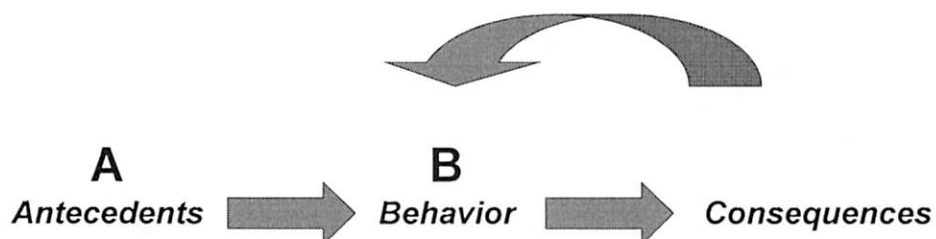
Thought Record

Date	Situation (Event, memory, plan, etc.)	Behaviors	Emotions	Thoughts	Coping Responses
	Severe and/or unremitting depression/pain/ distress	Urges to commit suicide, suicidal behavior	hopeless ness	This pain will never end.	Anti- hopelessness interventions; behavioral experiment to test belief, "I will never enjoy anything again."

Two Models Can be Used to Formulate Symptoms and Behaviors

- **Structural models** focus on topography of behavior and underlying structures (e.g., Beck's cognitive model)
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OPERANT CONDITIONING MODEL OF BEHAVIOR



Formulating Suicidal Behavior Using Operant Conditioning

Antecedents (A)	Behaviors (B) (actions, thoughts, or emotions)	Consequences (C)
Overwhelming problems	Suicidal behavior	Hospitalization (escape from problems)

Treating Suicidal Behavior Using Operant Conditioning

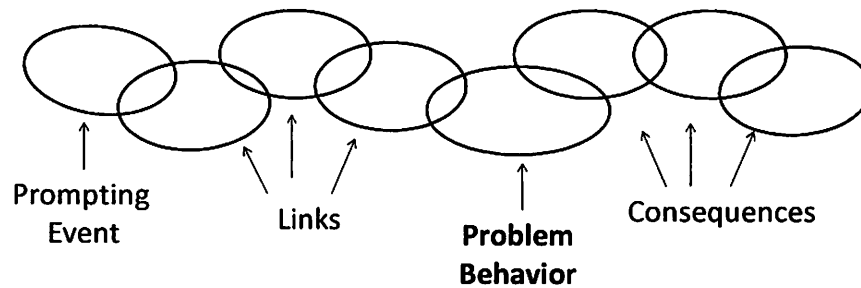
Antecedents (A)	Behaviors (B) (actions, thoughts, or emotions)	Consequences (C)
Reduce/help the person solve the problems	Teach adaptive problem-solving and help-requesting skills	Prevent hospitalization, respond immediately to adaptive requests for help

Using behavioral chain and solution analysis to develop a formulation and get intervention ideas for a problem behavior



Chain Analysis of Problem Behavior

Vulnerabilities: _____



Behavioral Chain and Solution Analysis

Work with the patient to . . .

1. Identify a problem behavior (B) that occurred at a particular time
2. Identify antecedents (As) and consequences (Cs) of the B
3. Identify alternate As that do not lead to B
4. Obtain a commitment to do the alternate As

Linehan, 1993. *CBT for Borderline Personality Disorder*

Chain Analysis

Describe the problem behavior in detail blowing up at son over eating bowl of cereal -

What things in myself or my environment made me vulnerable? had jst spent 1/2 hr. arguing with ex-wife I did not have lunch (5 pm)

What event (in the environment) started the chain? walked out of bathroom to find entire bowl eaten

What happened next? (events in the environment; my behavior, thoughts, emotions, body sensations)

- 1" "I can't believe my eyes."
- 2" blamed self for not hiding bowl better
- 3" _____
- 4" betrayal of trust: "He can't be trusted."
- 5" _____
- 6" "All my efforts are for naught."
- 7" "I want to make him feel bad."
- 8" _____
- 9" _____
- 10" _____

What happened after the problem behavior? (events; my behaviors, thoughts, emotions, body sensations)

- 11" guilty; disappointed in self
- 12" "I have no control."

Adapted from Mowrer, et al. (1999). *COGNITIVE AND BEHAVIORAL PRACTICE*, 23-41.
© 2009 San Francisco Bay Area Center for Cognitive Therapy (SEEDS College, Hayward, CA, 94618)
(510) 422-4355 (ext) • (510) 380-7488 (fax) • www.charts.com (website)



The Case Formulation Approach to Cognitive Behavior Therapy Day 2

- Transdiagnostic mechanisms
- Steps to develop a case formulation
- Setting treatment goals
- Solving problems
- Progress monitoring
- The therapeutic relationship



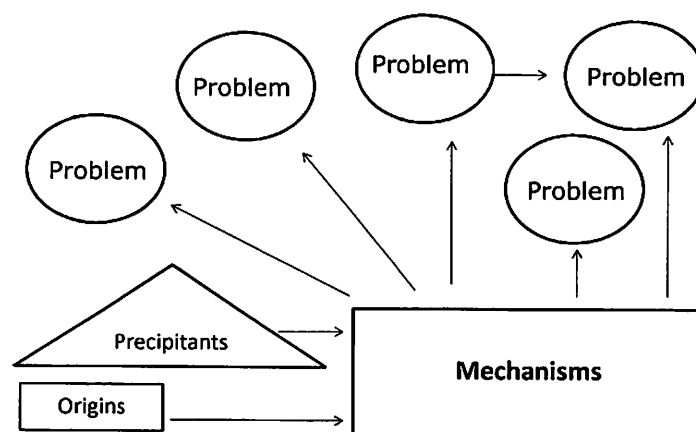
The Case Formulation Approach to Cognitive Behavior Therapy Day 2

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A mechanism is

... a psychological construct that causes and/or maintains the person's problems

Elements of a Case Formulation



Examples of cognitive behavioral mechanisms

- Schemas about self, others, world, future
- Problematic contingencies
- Perfectionism
- Intolerance of uncertainty
- Anxiety sensitivity (catastrophic misinterpretation of benign sensations)

Transdiagnostic mechanisms

- **Perfectionism**
- Intolerance of uncertainty
- Anxiety sensitivity (catastrophic misinterpretation of benign sensations)

Transdiagnostic mechanisms

- Perfectionism
- **Intolerance of uncertainty**
- Anxiety sensitivity (catastrophic misinterpretation of benign sensations)

Transdiagnostic mechanisms

- Perfectionism
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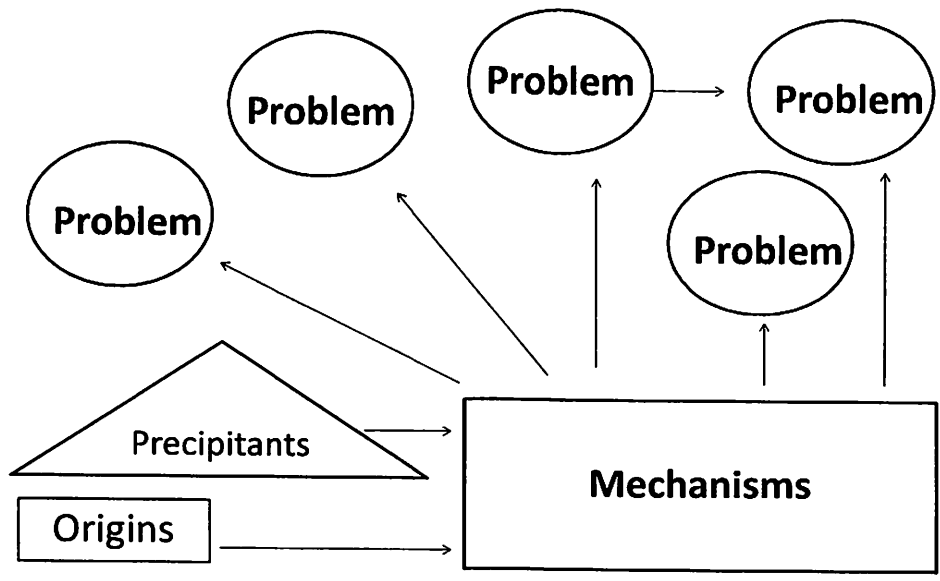


The Case Formulation Approach to Cognitive Behavior Therapy

Day 2

- Transdiagnostic mechanisms
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Elements of a Case Formulation



Guidelines for Developing a Problem List

- Develop a comprehensive list.
- Name each problem in one or two words. "Work dissatisfaction."
- Describe emotion, behavioral, and cognitive components. "Feels worthless, avoids work, thinks, 'I'm going to fail at that project.'"
- Strive for a mutually agreed-upon Problem List.

Draft a Problem List for your Complex Case

- Use the "bubbles" diagram
- Write problems in the "bubbles" at the top, and mechanisms in the bottom box.
- As I walk through each domain on the next slide, write in the bubbles any problems your patient has in any of these domains
- If you identify domains that need further assessment, you might note those with a ?

Domains Assessed to Create a Comprehensive Problem List

- Psychological/psychiatric disorders and symptoms
- Medical disorders, symptoms, treatment
- Interpersonal
- Work
- Finances
- Housing
- Legal
- Leisure
- Ethnicity/culture
- Mental health treatment

Intake Measures Used at the Oakland CBT Center

- Adult Intake Questionnaire
- Diagnostic Screen
- Depression Anxiety Stress Scales (DASS)
- PHQ-9
- Obsessive Beliefs Questionnaire
- A scale assessing social support
- Perseverative Thinking Questionnaire
- <https://oaklandcbt.com/intake-forms>

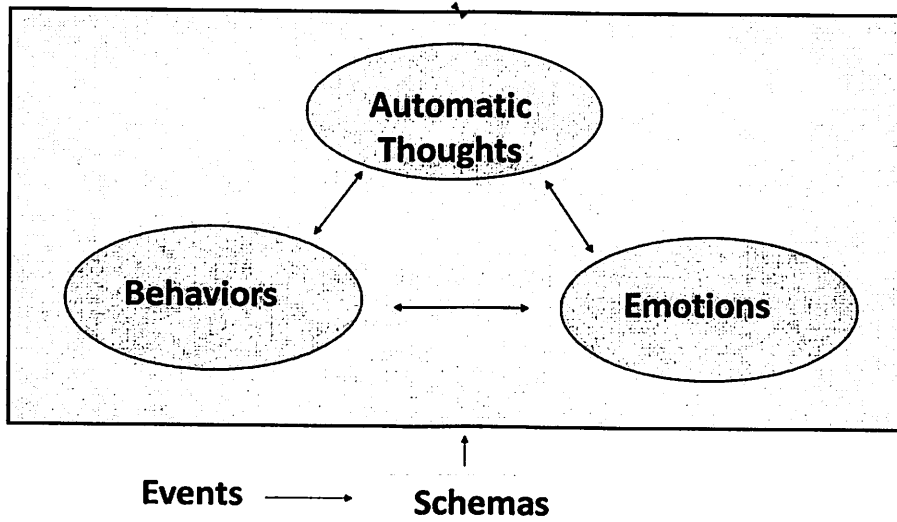
Strategies for developing mechanism hypotheses

- Use standardized assessment scales
- Identify disorder formulations that might be modifiable to fit your case (Judy)
- Start with a symptom formulation (Steve the vomiting case)
- Identify transdiagnostic mechanisms that might account for your patient's symptoms and problems
- Look for common elements/themes in problems
- Identify relationships among problems

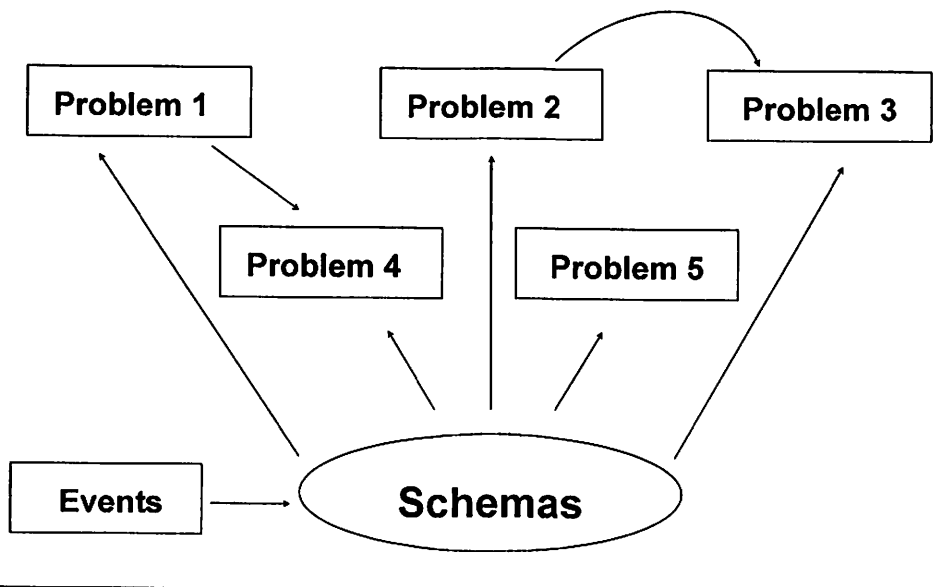
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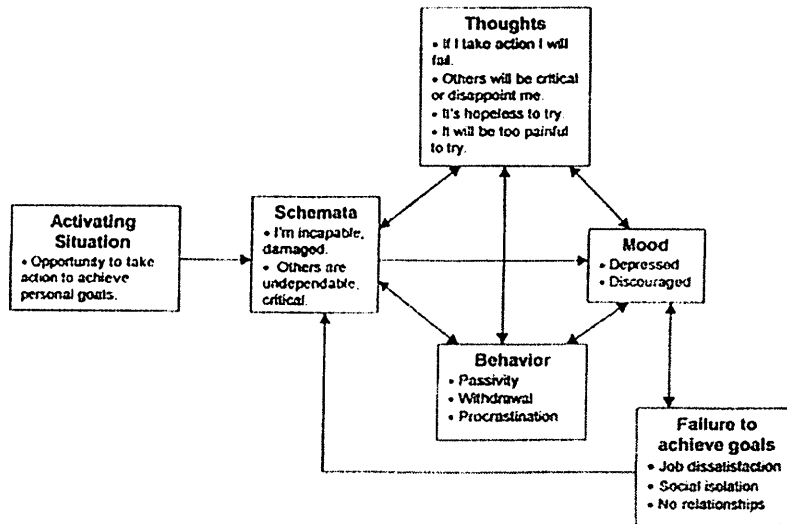
Beck's Cognitive Theory of Depression



APPLYING BECK'S COGNITIVE MODEL TO THE MULTIPLE-PROBLEM CASE

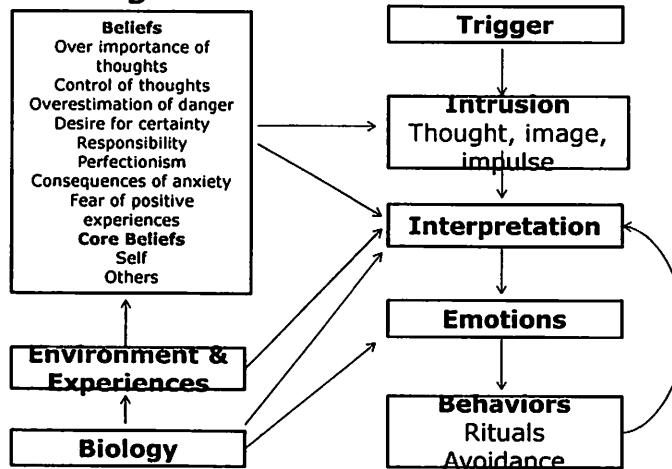


Formulation of Pat's Case

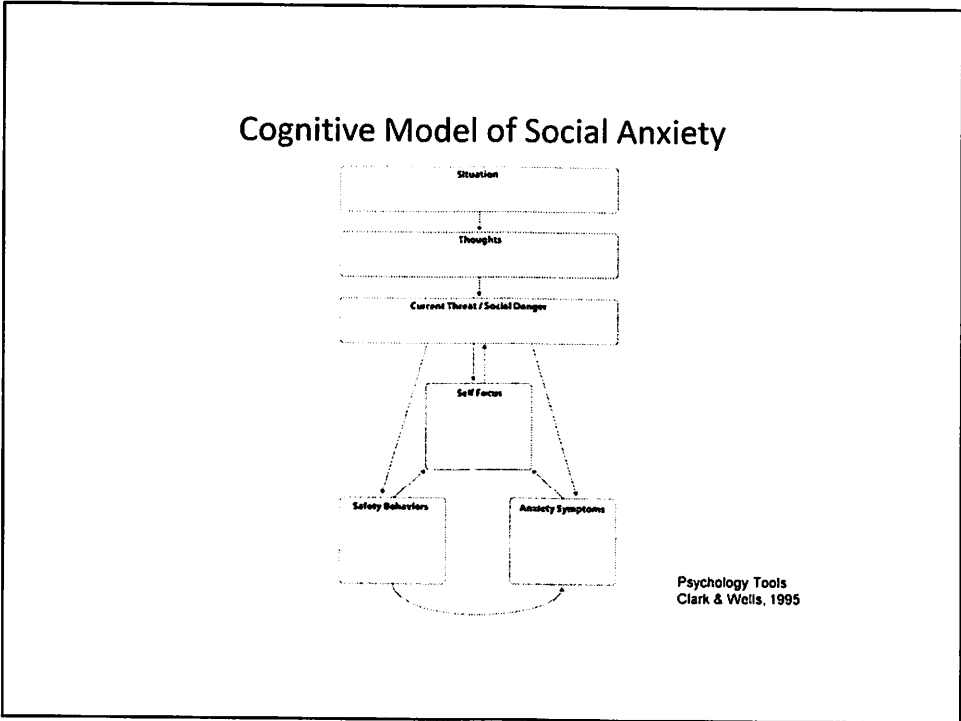
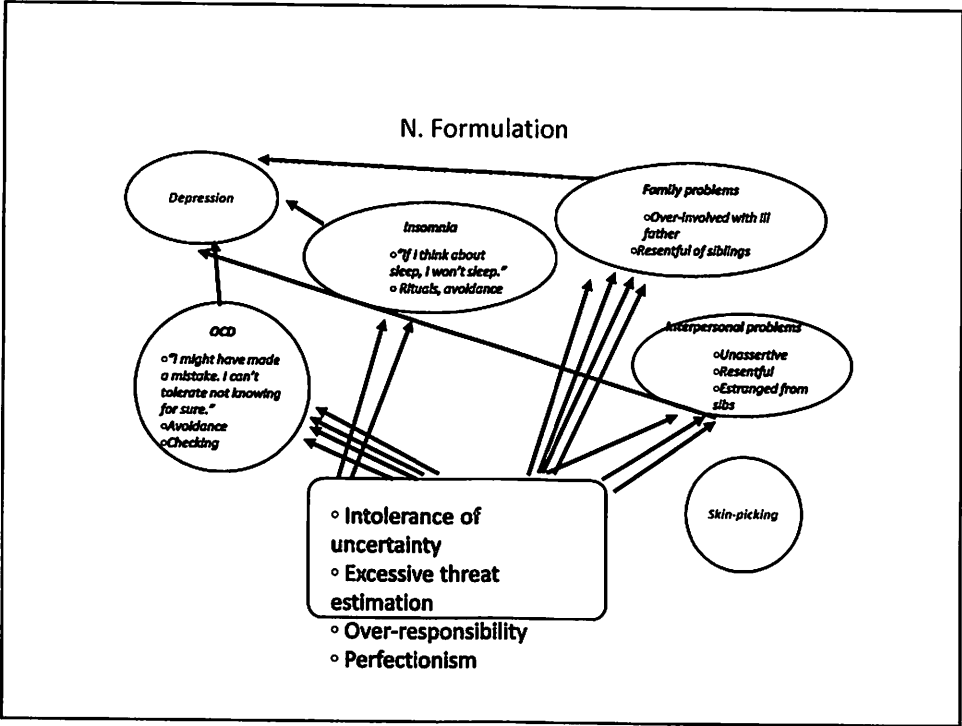


From Persons, J.B. & Davidson J.(2001). Cognitive-behavioral Case Formulation. In (Dobson, K. ed.) *Handbook of Cognitive-behavioral Therapies*, New York: Guilford

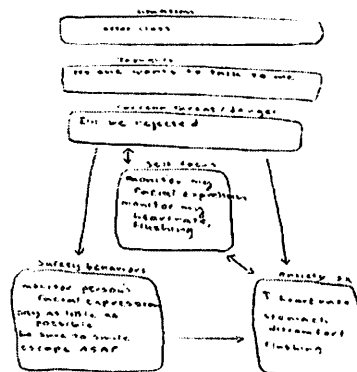
Cognitive Model of OCD



Adapted from Wilhelm & Steketee, 2006

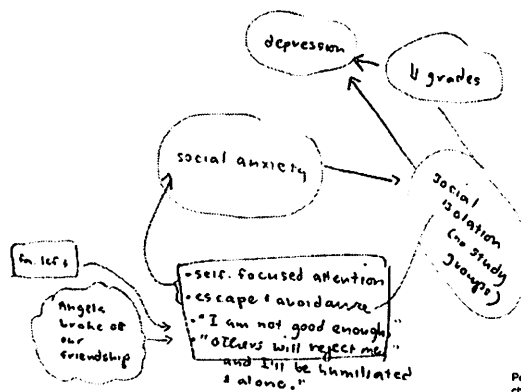


Formulation of Miss Social Anxiety's Social Anxiety



Persons & Talbot chapter in Dimidjian, *Evidence-Based Practice in Action*, Guilford, 2019

Formulation of Anne's Case



Persons & Talbot
chapter in
Dimidjian, in press

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Strategies for developing mechanism hypotheses

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Might any of these mechanisms cause your patient's symptoms?

- Perfectionism
- Intolerance of uncertainty
- Excessive threat estimation
- Inflated responsibility
- Low perceived control
- Anxiety sensitivity (catastrophic misinterpretation of benign sensations)

More mechanisms to consider. . . .

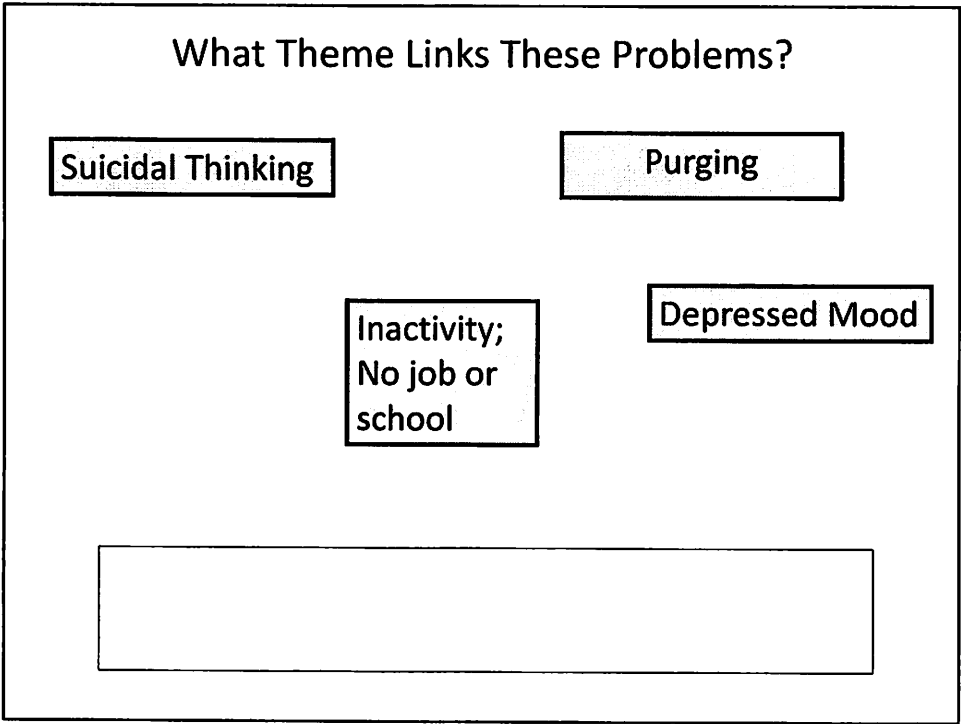
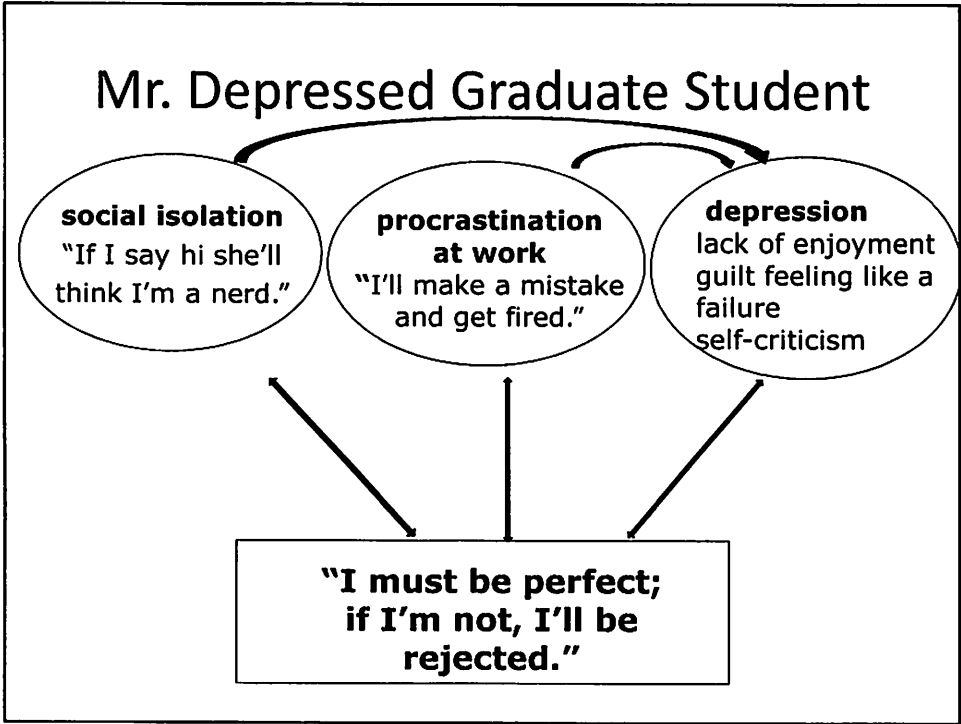
- Repetitive negative thinking (worry, rumination)
- Emotion regulation difficulties
- Poor problem orientation
- Low distress tolerance
- Fear of negative evaluation
- Self criticism

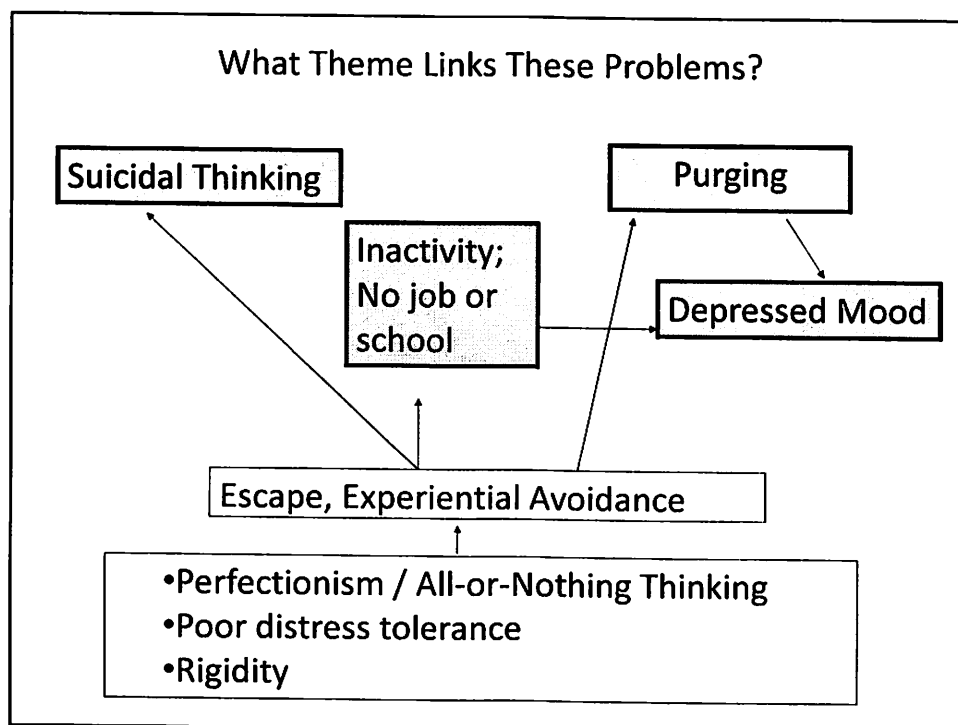
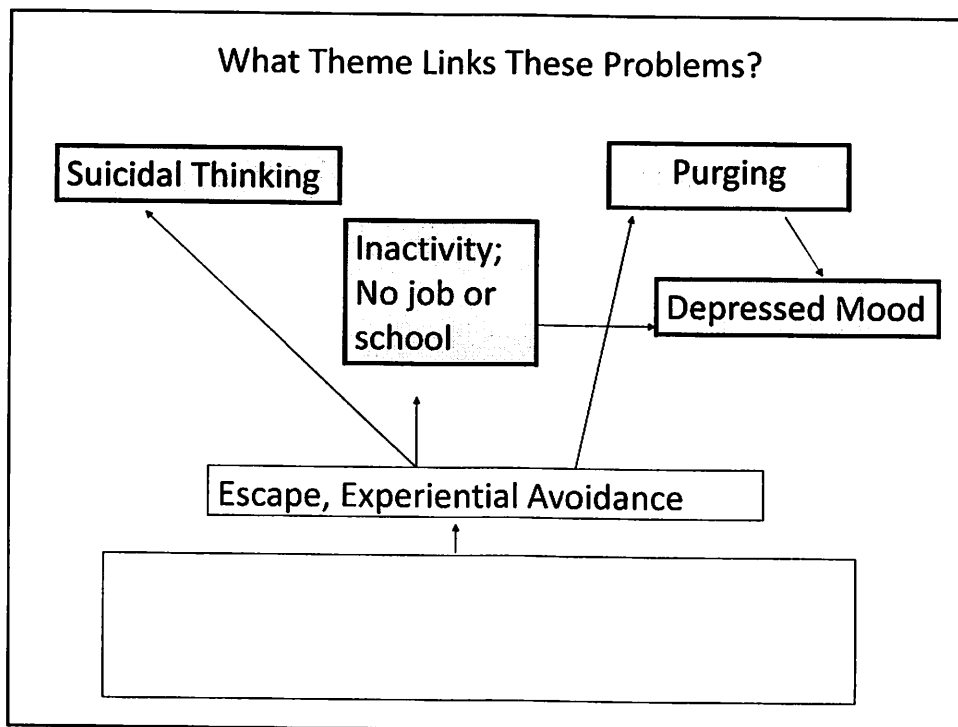
More mechanisms to consider . . .

- Avoidance, including experiential avoidance
- Compulsions and other safety behaviors
- Thought/emotion suppression
- Cognitive misappraisal
- Attentional focus
- Executive functioning deficits

Strategies for developing mechanism hypotheses

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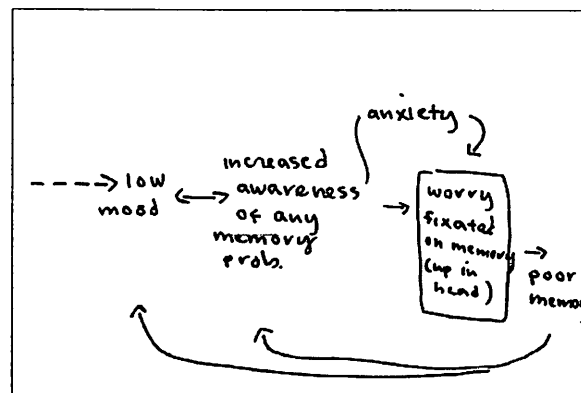




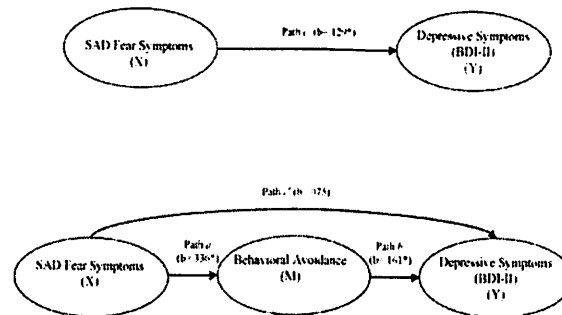
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- Look for common elements/themes in problems
- **Identify relationships among problems**

Worry, Memory Loss, and Depression



Behavioral avoidance as a mediator between social anxiety fear and depressive symptoms
(Moitra et al., 2008)



The Case Formulation
Approach to
Cognitive Behavior Therapy
Day 2

- Transdiagnostic mechanisms 
- Steps to develop a case formulation 
- **Setting treatment goals**
- Solving problems
- Progress monitoring  
- The therapeutic relationship 



Setting SMART Goals

- Mnemonic acronym for criteria to guide goal-setting
- Developed in business, adopted by health professionals

SMART criteria



- **S - Specific**
- **M - Motivating**
- **A - Agreed-upon**
- **R - Realistic**
- **T - Trackable**

Specific

- Score a 40 on the Cognitive Therapy Rating Scale review of one of my therapy sessions.
- Practice using 3 different cognitive behavior therapy skills on myself and write down one or two things I learn from doing this.
- Learn to use one scale for monitoring my patient's progress in therapy and practice using it with my patient.

Notice all the goals on the previous slide set an explicit criterion to define when the goal has been accomplished

Less specific goals that do not set an explicit achievement criterion include:

- Feel less depressed
- Get lower scores on the Depression Scale of the DASS
- Score within the normal range on the Depression Scale of the DASS

Making goals **specific**

- Begin dating
- **Go out on a date with one new person every month**
- Feel less anxious in social situations
- **Feel anxiety 3 or less on a 10 point scale when I am in a social situation with more than one person**

Motivating

Agreed-upon

Priority Order of Problems

- 1. Suicidal and self-harming behaviors**
- 2. Therapy-interfering behaviors**
- 3. Quality-of-life interfering behaviors**
- 4. Other problems**

Quality-of-life-interfering Behaviors

- Severe substance abuse
- High-risk sexual behavior
- Criminal behaviors that may lead to jail
- Serious dysfunctional interpersonal behaviors (choosing abusive partners, ending relationships prematurely)
- Employment- or school-related dysfunctional behaviors (quitting jobs or school; inability to look for or find a job)
- Illness-related dysfunctional behaviors (inability to get proper medical care; not taking medications)
- Housing-related dysfunctional behaviors (living in shelters, cars, or overcrowded housing)
- Mental health-related dysfunctional behaviors (going into psychiatric hospitals)
- Mental disorder-related dysfunctional patterns (behaviors that meet criteria for other severe mental disorders)

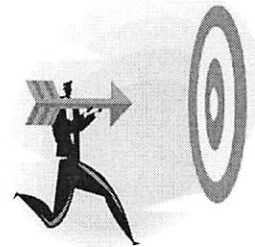
Adapted from Linehan, M. M. (1993). Cognitive-behavioral treatment of borderline personality disorder.

Realistic

What is realistic depends on what the person is currently doing



**To keep the goals realistic,
set performance goals, not
outcome goals**



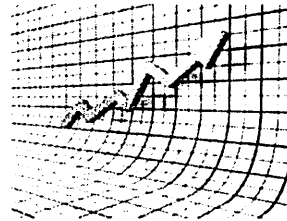
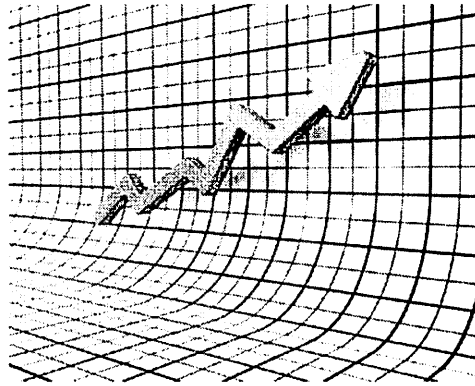
Performance goals

- Contact 3 potential employers/week
- Call 3 radio stations to ask them to post an ad spot

Outcome goals

- Lose 5 pounds
- Get a job
- Get a boyfriend
- Go to a movie on Saturday with Susan

Trackable



Monitoring is . . .

- more difficult than it seems
- powerful



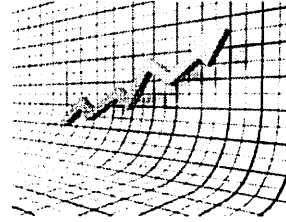
Monitoring is . . .

- more difficult than it seems
- powerful

Monitoring

- More difficult than it seems:
the video of the passing balls





Monitoring is . . .

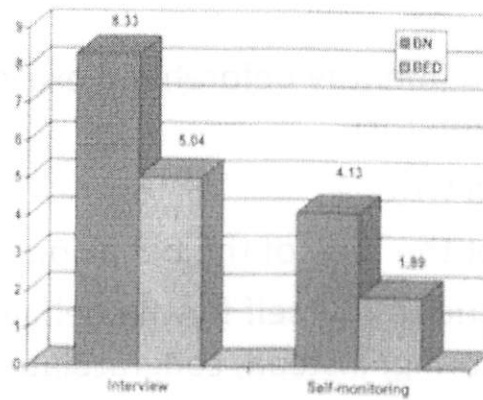
- more difficult than it seems
- powerful

Progress monitoring promotes goal attainment

- In 138 studies of goals like sticking to a diet, increasing exercise, adhering to diabetes treatment, taking medications as prescribed . . .
- . . . participants were more likely to accomplish their goal if they monitored their behavior
- Monitoring was most effective if done in writing and shared with others

• Harkin et al., 2015, *Psychological Bulletin*

Binge eating decreased by half in participants with bulimia and binge eating disorder who monitored their eating



Adapted from Latner & Wilson, 2002.

Progress monitoring has larger effects on goal attainment when . . .

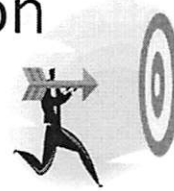
- ✓ Information is physically recorded (in writing or on smartphone or other log)
- ✓ Outcomes are reported to another person

• Harkin et al., 2015, *Psychological Bulletin*

To make the monitoring task easier and the results more accurate

- Use a form (identify beforehand exactly what you will monitor)
- Monitor in writing
- Monitor at the time of the behavior, not later
- Do not criticize yourself for the behavior you are monitoring; instead, congratulate yourself for monitoring

One more consideration



Whenever possible, set a goal of increasing a desired behavior (vs decreasing an undesired one)

Set a goal of increasing a desired behavior (vs decreasing an undesired one)




- “I’m going to walk down the street and look for job notices.”

NOT

- I’m going to stop watching so much TV.



The Case Formulation Approach to Cognitive Behavior Therapy Day 2

- Transdiagnostic mechanisms 
- Steps to develop a case formulation 
- Setting treatment goals
- **Solving problems**
- Progress monitoring  
- The therapeutic relationship 

case formulation-driven CBT helps the therapist solve these problems

- ✓ Multiple disorders and problems
- ✓ No ESTs for many disorders
- ✓ **Problem behaviors impede treatment**
- ✓ Nonresponse is common

To address problem behavior. . .

- Use the formulation to help you identify clinically-relevant behavior
- Develop a formulation of the problem behavior and use it to guide intervention

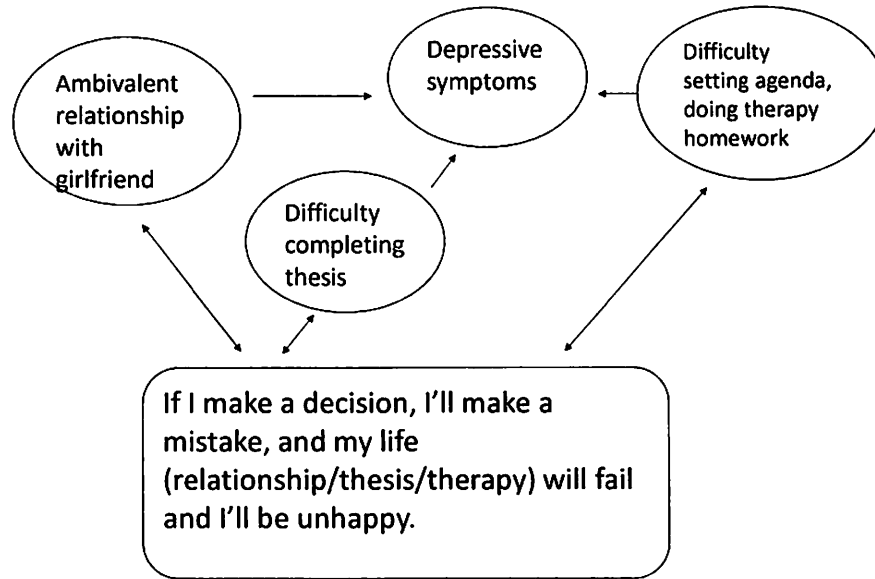
Robert: The patient who could not set an agenda for the therapy session



Thought Record

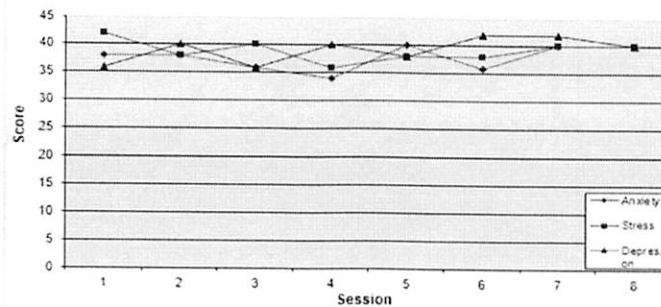
Date	Situation	Behavior	Emotions	Thoughts	Coping Responses
	Jackie asks for my agenda for the therapy session	Ask Jackie to propose agenda topics	Anxious Apprehensive	I'll pick the wrong topic. Then the session won't help me. Therapy probably won't help me; I should try medications instead.	

Formulation of Robert's case



When the patient's symptoms interfere with treatment:
Ms. ADHD

DASS data show that Ms. ADHD does not improve at all during 8 sessions of treatment

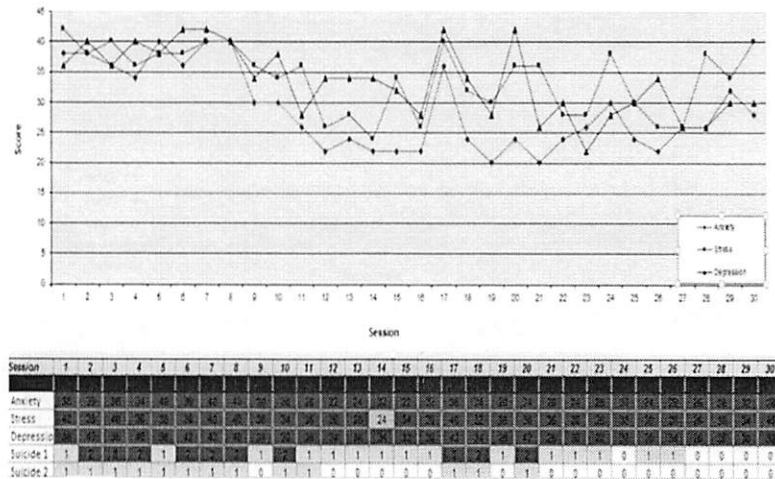


Session	1	2	3	4	5	6	7	8
Anxiety	38	38	36	34	40	38	40	40
Stress	42	40	40	38	40	38	40	40
Depression	35	40	39	40	35	41	40	40
Suicide 1	1	2	2	2	1	2	2	2
Suicide 2	1	1	1	1	1	1	1	1

Several symptoms of ADHD interfered with treatment

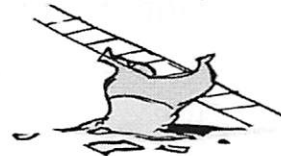
- Patient was not taking her ADHD medications reliably because she forgot to do it
- Patient was not taking her antidepressant because she forgot to ask her psychiatrist to renew the prescription
- Patient arrived late to therapy sessions because she did not allow sufficient travel time

Aggressive focus on symptoms that interfered with treatment was helpful



case formulation-driven CBT helps the therapist solve these problems

- ✓ Multiple disorders and problems
- ✓ No ESTs for many disorders
- ✓ Problem behaviors impede treatment
- ✓ **Nonresponse is common**



The case of Cousin Rose

Thought Record

Date	Situation	Behavior	Emotions	Thoughts	Coping Responses
	I promised to visit Rose but don't want to do it.	Postpone the trip	Depressed, fatigued	It's too demanding a trip. I just can't do it when I feel like this. I'll do it later when I feel better.	

Thought Record

Date	Situation	Behavior	Emotions	Thoughts	Coping Responses
	I promised to visit Rose but don't want to do it	Postpone the trip	Depressed, fatigued	<p>It's too demanding a trip.</p> <p>I just can't do it when I feel like this.</p> <p>I'll do it later when I feel better.</p>	<p>I can't wait until I FEEL like doing things – I need to DO them first. Later I'll FEEL like doing them.</p> <p>ACTION PLAN: I'll push myself to make the visit.</p>

Result

- The patient failed to do her homework. She did not make the visit to cousin Rose.
- Sometimes homework compliance is a signal that the formulation is incorrect.
- The therapist assessed further.

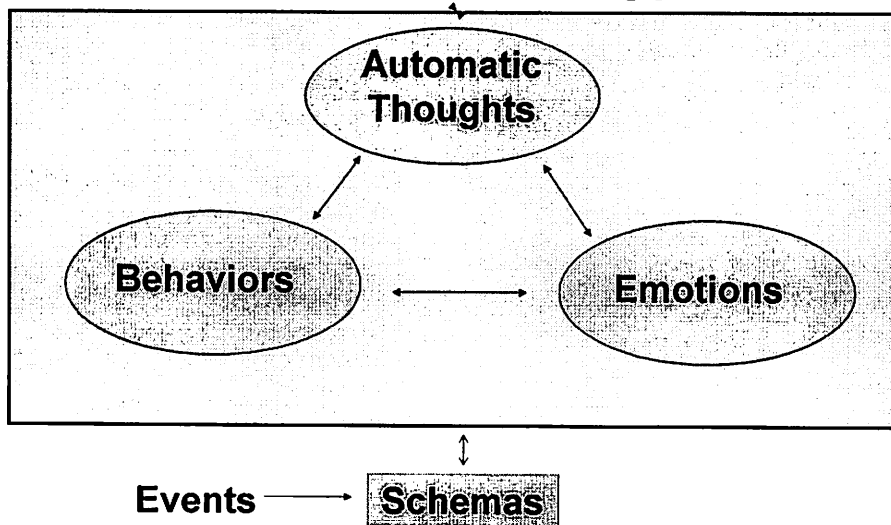
Thought Record					
Date	Situation	Behavior	Emotions	Thoughts	Coping Responses
	I have promised to visit Rose but don't want to do it	Postpone the trip	Depressed, fatigued, guilty, resentful	<p>It's too demanding a trip.</p> <p>I SHOULD visit her – she's sick.</p> <p>I'm ALWAYS doing things for her but she never does anything for me.</p> <p>If I don't make the trip, I'm a bad person.</p>	

Thought Record					
Date	Situation	Behavior	Emotions	Thoughts	Coping Responses
	I have promised to visit Rose but don't want to do it	Procrastinate on making the trip	Depressed, fatigued, guilty, resentful	<p>It's too demanding a trip.</p> <p>I SHOULD visit her – she's sick.</p> <p>I'm ALWAYS doing things for her; she never does anything for me.</p> <p>If Rose needs something and I don't do it, I'm a bad person.</p>	<p>It feels demanding because I don't want to do it.</p> <p>It's reasonable that I don't want to do it; she's not nice to me.</p> <p>I'm not bad if I don't visit.</p> <p>ACTION PLAN: I'll call her instead of visiting.</p>

Result

- **Success!**
- **The patient called cousin Rose to say she could not visit.**

Beck's Cognitive Theory of Psychopathology



Schema Hypothesis #1

“I am a weak and helpless person and I can’t do anything on my own.”

Schema Hypothesis #2

“My needs don’t count; if someone needs me to do something, I should do it. If I don’t, I’m bad.”

Conclusion

- **Interventions guided by one schema hypothesis were not successful (patient did not do the homework).**
- **When the therapist identified additional automatic thoughts and an alternate schema hypothesis and used those to guide interventions, the patient did the homework.**

Overcoming Treatment Failure

**Mr. "I might make the wrong
choice"**

Persons, J. B. (1990). Disputing irrational thoughts can be avoidance behavior: A case report. *the Behavior Therapist*, 13, 132-133.

Jim

- 24 year old white single male
- just beginning graduate school
- attending a medium-rank university (not accepted to a top school)
- his father was chronically depressed and miserable at work

Symptoms

- **Anxiety:** anxious feelings, worry, fears of bad things happening, muscle tension, difficulty concentrating, fatigue
- **Depression:** sad and blue, feeling inadequate, self-critical thoughts, not enjoying things, insomnia

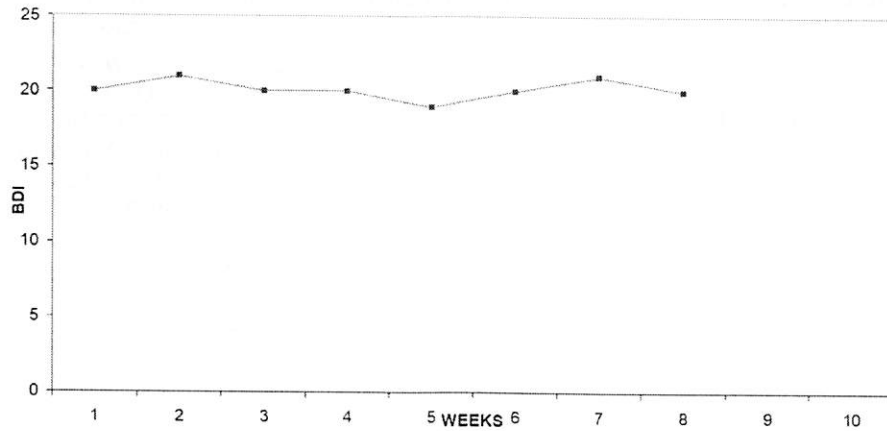
Initial Formulation and Treatment Plan . . .

were based on Beck's cognitive model
and emphasized restructuring of
negative automatic thoughts

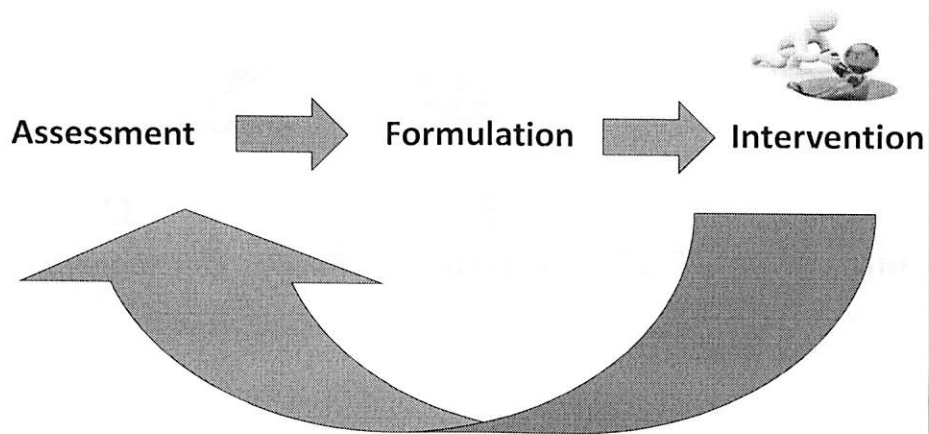
Thought Record

Date	Situation	Behavior	Emotion	Thoughts	Coping Responses
	IN CLASS, FEELING BORED		ANXIETY DEP- RESSION	MAYBE I CHOSE THE WRONG SCHOOL. I CAN'T BE HAPPY HERE. MAYBE I SHOULD WITHDRAW AND APPLY AGAIN NEXT YEAR.	I CAN REVIEW MY DECISION IN A SYSTEMATIC WAY. ACTION PLAN: LIST ADVANTAGES & DISADV OF STAYING HERE VS LEAVING.

Jim's Progress in Treatment



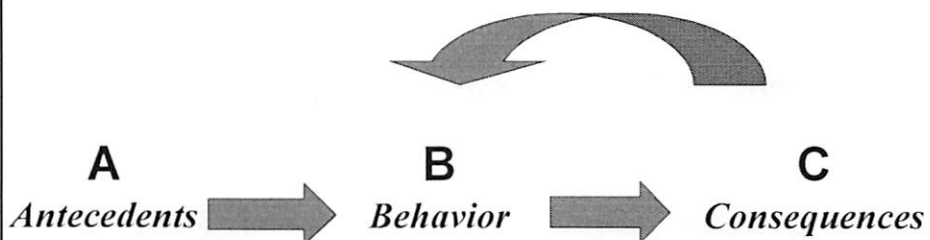
Jackie's Response to Jim's Lack of Progress: Consultation to get new formulation and intervention ideas



Thought Record

Date	Situation	Behavior	Emotion	Thoughts	Coping Responses
	AT A PARTY	LEAVE THE PARTY	ANXIETY	<p>I FEEL ANXIOUS.</p> <p>I DON'T FIT IN HERE.</p> <p>I CAN'T ENJOY THIS IF I FEEL ANXIOUS.</p> <p>I NEED TO LEAVE.</p>	<p>I CAN GO HOME TO DO A THOUGHT RECORD AND I WILL FEEL BETTER.</p>

Reformulation based on the Operant Model



Functional Analysis of Jim's Behavior

Antecedents (A)	Behaviors (B)	Consequences (C)
Party where he did not know anyone and felt anxious	Obsess about his future Leave the party and go home to do a Thought Record	Reduction of anxiety (in the short run) Disengagement from his graduate program Depression Loss of confidence

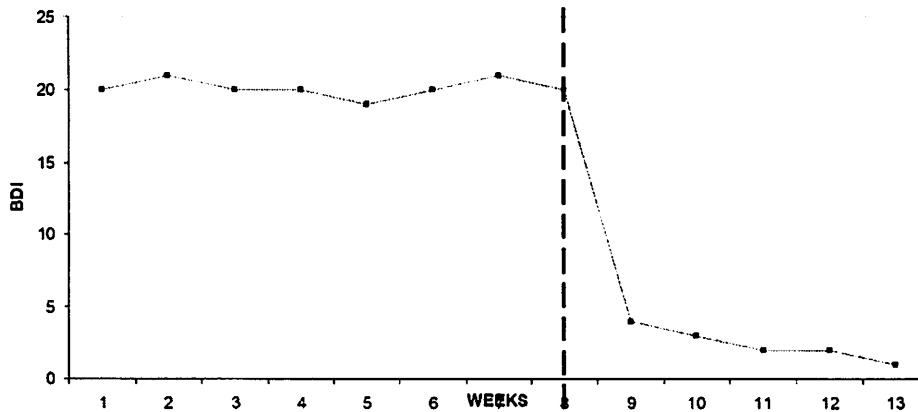
Working with the Patient to get a New Formulation and Treatment Plan



New Treatment Plan Based on the Functional Analysis of Jim's Behavior

Antecedents (A)	Behaviors (B)	Consequences (C)
<p>Classes</p> <p>Homework assignments</p> <p>Social events (all events at graduate school)</p>	<p>Engage and participate.</p> <p>Normalize anxiety and tolerate it.</p> <p>Stop obsessing about the future and about leaving.</p>	<p>?</p>

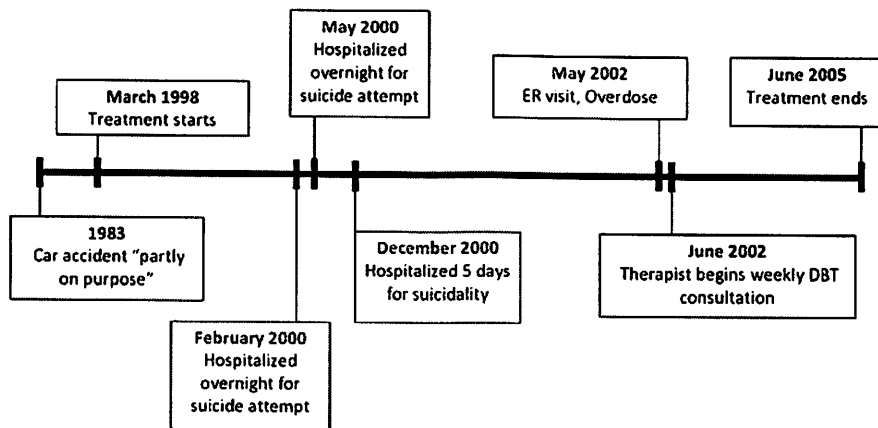
Jim's Response to the Change in Treatment



Conclusions

- Initial poor outcome led to additional assessment, which led to . . .
- Revised formulation, which led to . . .
- New treatment targets and interventions, which led to . . .
- Ultimate good treatment outcome.

Norma's suicidality increased after she began treatment with standard CBT and stopped after the therapist began using DBT



Red dates: Suicide Attempt

"CAN'T DECIDE" CASE: USING DATA TO REVISE FORMULATION AND IMPROVE OUTCOME

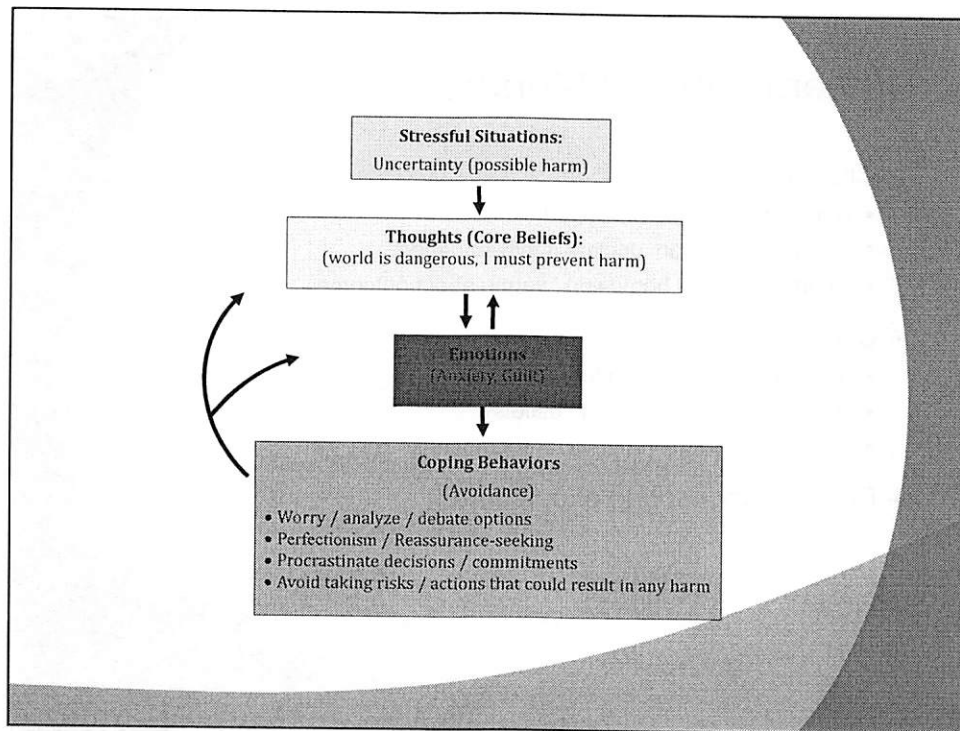
Victoria Lemle Beckner, Ph.D.

Assistant Clinical Professor, UCSF Dept of Psychiatry
San Francisco Group for Evidence-Based Psychotherapy

ABCT Panel: Testing Case-Formulation Hypotheses in Clinical
Practice
San Francisco, November 2012

Case Background

- ◎ Presenting Problem: GAD
 - Chronic worry, chronic low-level anxiety
 - Imagines worst case scenario to be prepared
 - "Overthinks" everything (analyzes, plans, debates options)
 - Has trouble making decisions, feels paralyzed in life
 - Stuck in unfulfilling job; ambivalent about boyfriend
- ◎ Baseline Scores
 - Outcome Measures
 - Beck Depression Inventory = 16 (mild - moderate)
 - Burns Anxiety Inventory = 22 (moderate)
 - Penn State Worry Questionnaire = 67 (high)
 - Mechanism Measure: Obsessive Belief Questionnaire (OBQ):
 - Expectation of Harm, Responsibility to Prevent Harm = 53 (moderately elevated)
 - Perfectionism and Intolerance of Uncertainty = 58 (moderately elevated)
 - Importance and Control of Thoughts = 50 (highly elevated)

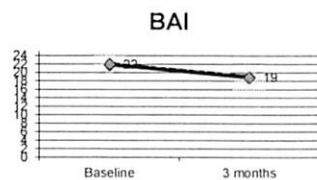


Treatment

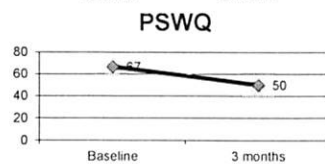
- ◎ Psychoeducation (model)
 - Intolerance of uncertainty (possible harm)
 - Worry, rumination, analyzing = attempts to increase certainty and avoid decision / action that could result in possible harm
 - How avoidance maintains problem
- ◎ Exposure
 - Anxiety tolerance (in-session exposures, mindfulness)
 - Imaginal exposure to harmful scenarios (worst-case)
 - Behavioral exposures focused on tolerating uncertainty, not being perfect ("mistake" exposures, "ruffling feathers" exposures)
- ◎ Problem-solving
 - Problem-solving for what you can control
 - Acceptance / mindfulness for what you can't control
- ◎ Assertiveness training

Outcome After 3 Months...

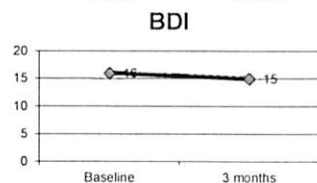
- ◎ Client observations:
 - Good insight, positive rapport
 - Passive in session, unclear if fully engaged
 - Inconsistent with homework, vague about outcome
- ◎ Client report:
 - Really understands model
 - Has changed her thinking / beliefs
 - Not much change in her life and emotions
- ◎ Progress monitoring of outcome....



Anxiety: Still mild-mod

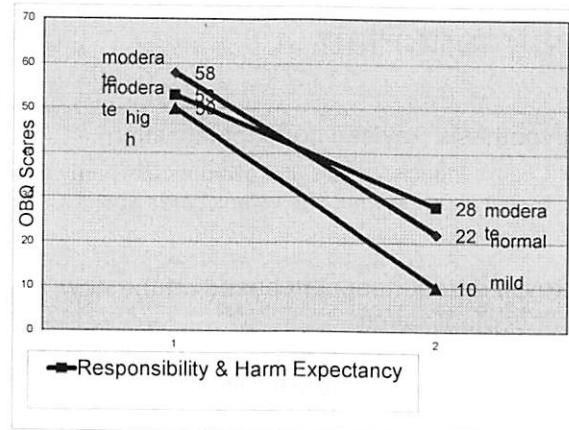


Worry: Dropped below GAD mean, but still mod-high



Depression: No change

OBQ: Baseline & 3 Months



What's Going On Here?

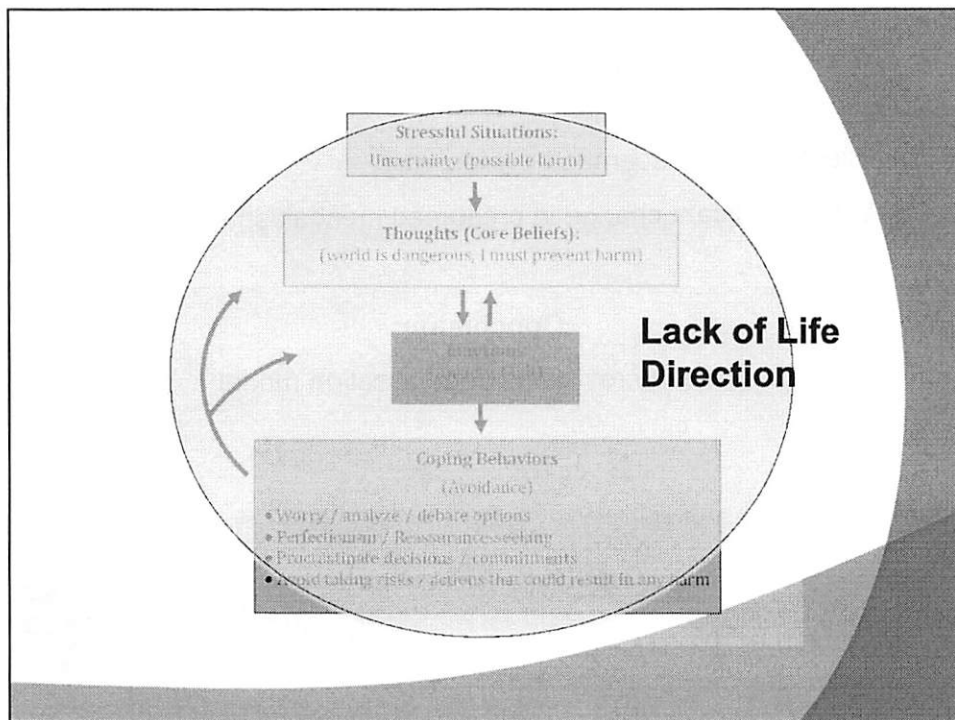
- ◉ Client does not seem to be improving
- ◉ Yet... significant change in presumed mechanisms!!

Conclusion:

Need to revisit conceptualization model

Revising Conceptualization and Treatment Plan

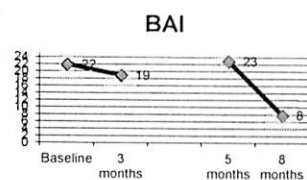
- ⦿ Hypothesis (revised conceptualization):
 - Client's indecisiveness and avoidance is partly driven by *not knowing what she values/cares about*
- ⦿ Revised treatment plan based on the new conceptualization:
 - Focus treatment on highlighting values – what she wants to move *toward* in her life



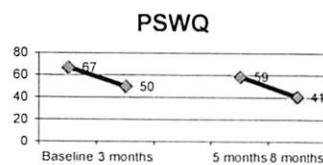
Revised Treatment

NOTE: Client left therapy for 7 wks, then returned

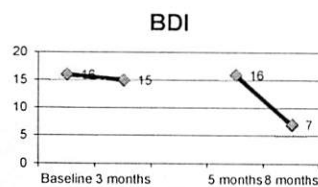
- ⊙ Explored / elaborated on client's values
 - Cultural identity (Muslim values, centrality of family)
 - Importance of helping others
- ⊙ Reframed behavioral experiments and exposures
 - As movement toward meaningful goals
 - As expressions of how she wanted to be / live
- ⊙ Client became more engaged / compliant
 - Began to experience positive reinforcement
- ⊙ Termination



Anxiety: Dropped to
borderline



Worry: Dropped to
moderate



Depression: Dropped to
normal range

Outcome: 6 Months

- ⦿ Quit job to look for better fit w/values
- ⦿ Made changes in current long-term relationship
 - Practiced gratitude, extending herself, being more present in the moment
 - Ultimately decided to leave relationship
- ⦿ Improved relationship with mother
- ⦿ Increased sense of purpose, decisiveness, feeling engaged in life

Contact Info

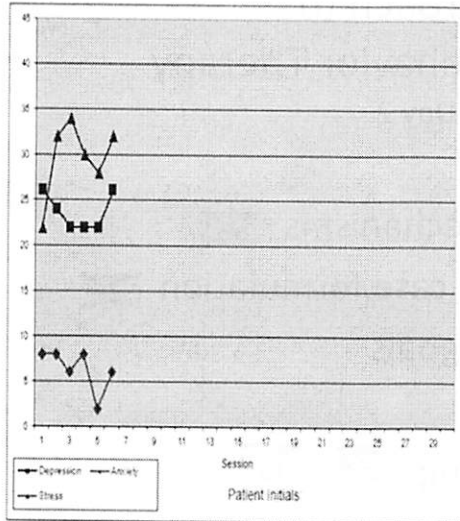
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Website: www.sfpsychology.com

Assistant Professor, UCSF Dept of Psychiatry

Lead Author: *Conquering Post-Traumatic Stress Disorder*
(self-help book for survivors of trauma)

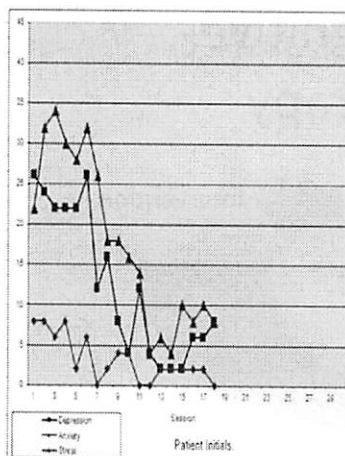
Before we targeted rumination



Session	1	2	3	4	5	6
Date	#####	#####	#####	#####	#####	#####
d1	1	2	3	2	3	2
d2	2	0	1	0	0	0
d3	3	3	2	2	2	2
d4	0	0	0	0	0	0
d5	3	2	2	2	2	3
d6	2	3	3	3	3	3
d7	0	1	0	0	0	0
d8	0	2	0	1	0	1
d9	2	3	1	3	1	0
d10	1	2	2	2	2	2
d11	3	3	0	3	2	3
d12	1	2	2	2	2	3
d13	3	2	2	2	2	3
d14	2	3	3	3	3	3
d15	0	0	1	1	0	3
d16	2	1	1	2	3	2
d17	1	1	1	1	0	1
d18	2	1	3	1	1	1
d19	0	0	0	0	0	0
d20	0	0	0	0	0	0
d21	0	1	1	0	0	0
d22	0	0	0	0	0	0
d23	0	0	0	0	0	0

Depression	26	24	22	22	22	26
Anxiety	8	8	6	8	2	6
Stress	22	32	34	30	29	32

After we targeted rumination



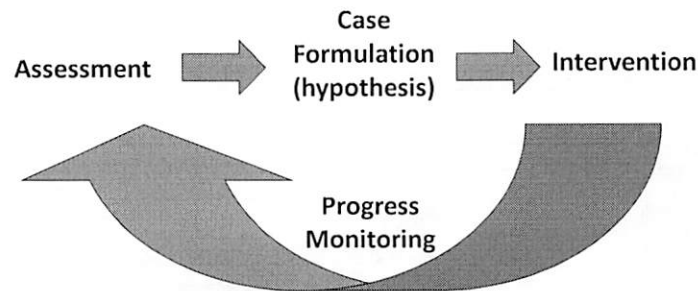
Session	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29				
Date	10/6/14	10/13/14	10/20/14	10/27/14	11/3/14	11/10/14	11/17/14	11/24/14	12/1/14	12/8/14	12/15/14	12/22/14	12/29/14	1/5/15	1/12/15	1/19/15	1/26/15	2/2/15	2/9/15	2/16/15	2/23/15	3/2/15	3/9/15	3/16/15	3/23/15	3/30/15	4/6/15	4/13/15	4/20/15				
d1	1	2	3	2	3	2	2	2	1	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
d2	2	0	1	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
d3	3	3	2	2	2	2	1	1	1	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
d4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
d5	3	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2		
d6	2	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	
d7	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
d8	0	2	0	1	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
d9	2	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3	
d10	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	
d11	3	3	0	3	3	3	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	
d12	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	
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d16	2	1	1	2	1	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
d17	1	1	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
d18	2	1	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3	1	3
d19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
d20	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
d21	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
d22	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
d23	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Depression	26	24	22	22	22	26	12	16	5	4	12	4	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2		
Anxiety	8	8	6	8	2	6	-	2	4	4	-	-	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2		
Stress	22	32	34	30	28	32	26	16	16	16	14	4	6	4	10	8	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Suicide 1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
Suicide 2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		



The Case Formulation Approach to Cognitive Behavior Therapy Day 2

- Transdiagnostic mechanisms
- Steps to develop a case formulation
- Setting treatment goals
- Solving problems
- **Progress monitoring**
- The therapeutic relationship

The Case Formulation Approach to Cognitive- behavior Therapy



Progress Monitoring Defined



An outcome scale and/or a process scale are completed

- in writing or online
- before every therapy session
- reviewed in session and used to guide treatment

Outcome and Process

- **Outcome**
 - Symptoms (e.g., DASS, PHQ-9)
 - Behaviors (e.g., binges or panic attacks or late arrival at work)
- **Process includes . . .**
 - Psychological mechanisms (e.g., perfectionism, self-criticism, intolerance of uncertainty)
 - The therapeutic alliance
 - What the client reports s/he is learning
 - Compliance

Tools to Monitor Outcome

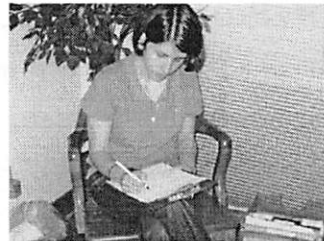


Provided in the handouts:

- Patient Health Questionnaire-9 (PHQ-9)
- Daily Log
- MOOD Chart

Additional tools, including the Depression Anxiety Stress Subscales (DASS) and Excel scoring tool, are at <https://oaklandcbt.com/forms-and-tools-for-clinicians>

Completing a standardized scale in the waiting room before the session



Tools to Monitor Process



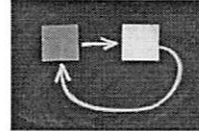
- Session Assignment and Feedback Form (SAFF)
- Mechanism measures like the OBQ-44, Perseverative Thinking Questionnaire
- Available at <https://oaklandcbt.com/forms-and-tools-for-clinicians>

Monitoring Therapy Process at Every Session: Session Assignment and Feedback Form (SAFF)



Persons, J. B., Hong, J., Beckner, V. L., Owen, D. J., & Eidelman, P. (2012, November). *Monitoring therapy process at every session: Development of a new tool and clinical examples of its utility.* Association for Behavioral and Cognitive Therapies, National Harbor, MD.

The SAFF Gives Feedback about Therapy Process



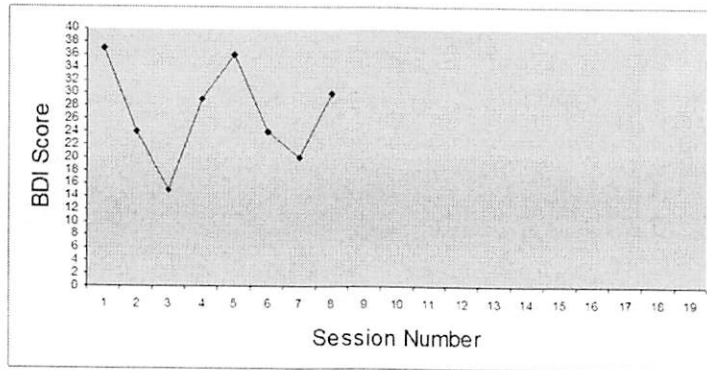
- Skills and concepts patient is learning
- Homework compliance
- Perceived helpfulness of homework
- Strength of the alliance
- Patient perception of session helpfulness
- Patient perception of progress

How to Use the SAFF

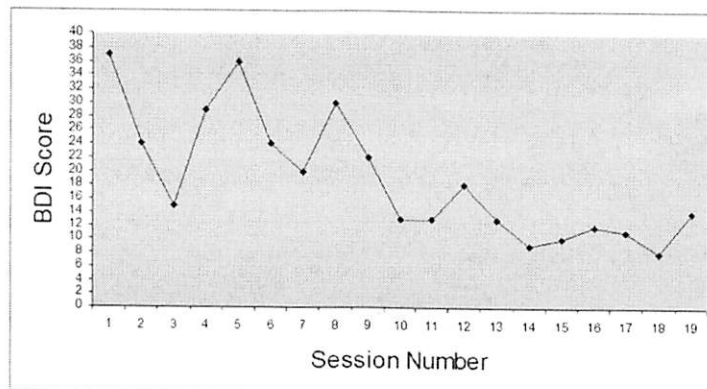
- Ask patient to complete SAFF and bring to next session
- At the beginning of the next session:
 - copy SAFF and return original to the patient
 - review SAFF with patient
 - use SAFF data to set agenda and guide decision-making
- Collect in tandem with an outcome measure



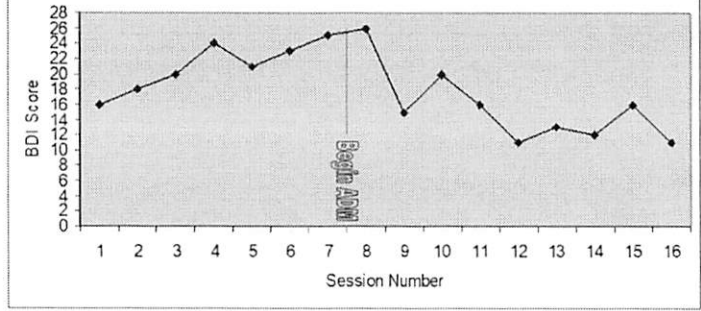
Using Outcome Monitoring to Help the Therapist Stay on Track (regulate her emotions)



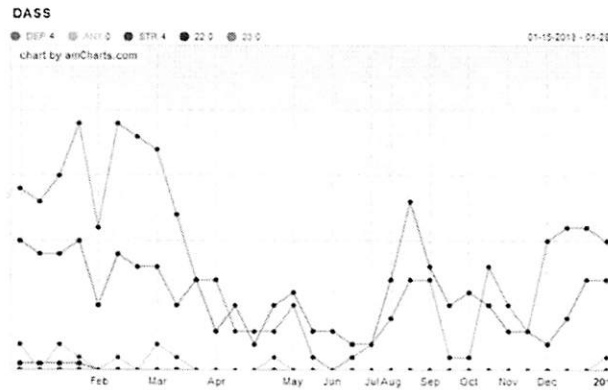
Using Outcome Monitoring to Help the Therapist Stay on Track

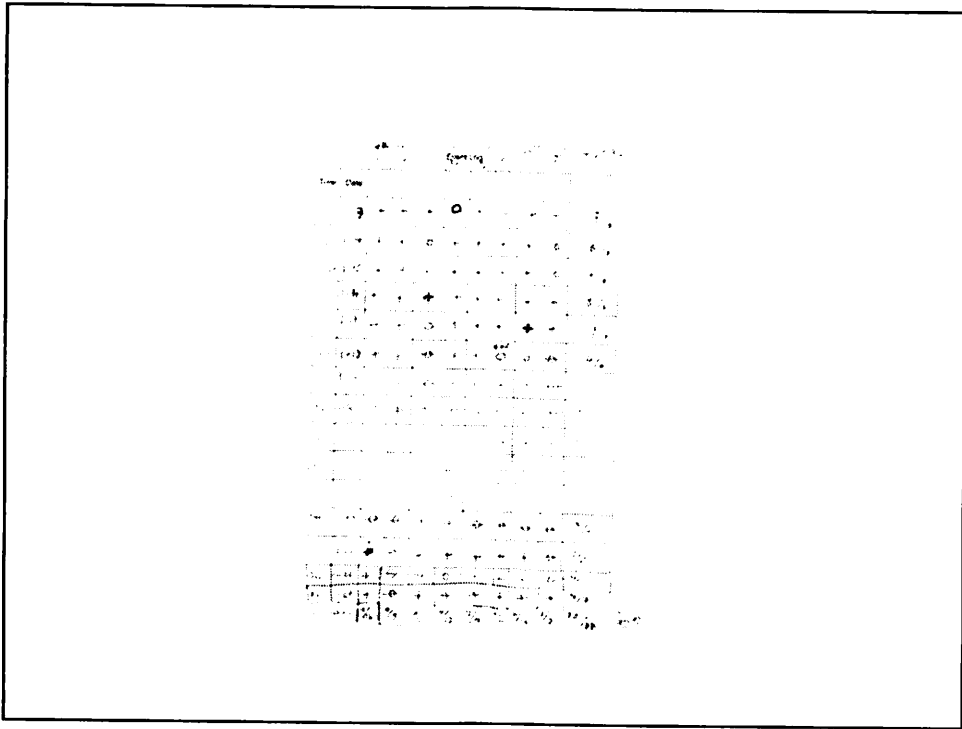


Using Outcome Monitoring to Identify a Response to Medication

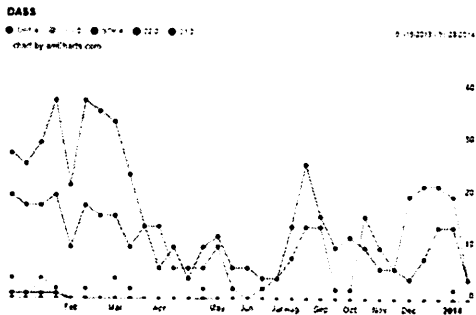


Outcome Monitoring Data "Mr. I am not doing enough"

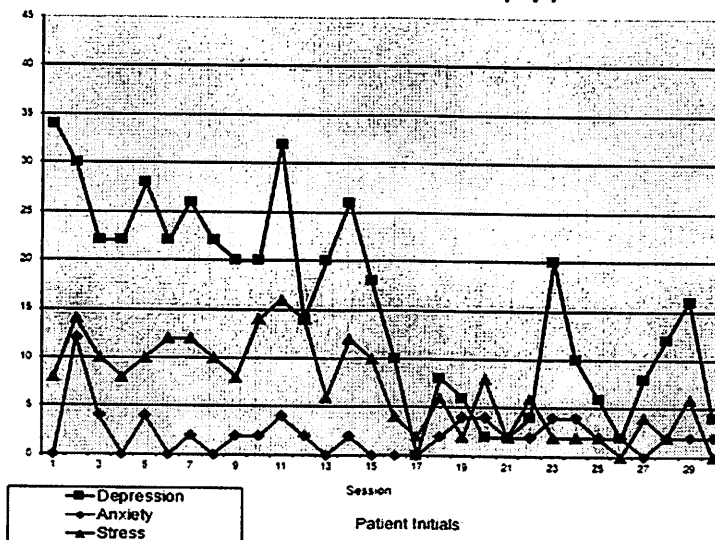




Outcome Monitoring Data "Mr. I am not doing enough"






Entire treatment (after resuming pharmacotherapy)



The Case Formulation Approach to Cognitive Behavior Therapy

Day 2

- Transdiagnostic mechanisms 
- Steps to develop a case formulation 
- Setting treatment goals
- Solving problems
- Progress monitoring  
- The therapeutic relationship 



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THANK YOU!

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