Using the Case Formulation and Progress Monitoring Data to Guide CBT

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Oakland Cognitive Behavior Therapy Center, Oakland, CA
and
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World Congress of Behavioural and Cognitive Therapies

Berlin July 17, 2019, 9:00 a.m. – 17:00 p.m.

9:00 a.m. Introductions and Plan for the Day

9:30 Why do Case Formulation-guided CBT?

10:00 Empirical Foundations

10:15 Formulation and Intervention

Formulation at the level of the symptom

- **10:45 – 11:15 COFFEE BREAK**

11:15 Formulation and Intervention

Formulation at the level of the disorder and the case

12:00 Audiotape exercise: Develop an initial formulation of the case of Judy and use it to guide treatment based on an audiotape of the first 12 minutes of the initial interview

13:00 – 14:00 LUNCH BREAK

14:00 Progress Monitoring

15:15 -15:45 COFFEE BREAK

15:45 Using the formulation and progress monitoring to guide treatment

16:30 Finishing up: Review of goals and action plans

Using the Case Formulation and Progress Monitoring to Guide Cognitive-behavior Therapy

Jacqueline B. Persons, Ph.D.
oakland cognitive behavior therapy center

WCBCT, Berlin, July 17, 2019

Handouts are available at . . .

- **https://oaklandcbt.com/talks-and-workshops**

- Why do case formulation-guided CBT?
- Empirical foundations
- Formulation and intervention
- Progress monitoring
- Using the formulation and progress monitoring to guide treatment

EXERCISE

With your neighbor:

Reflect on the Agenda.

Write down your learning goals for the workshop today. (2 min)

Goals for the Workshop Today

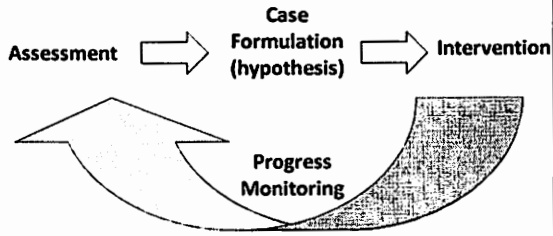
- _____
- _____
- _____

Action Items

- _____
- _____
- _____
- _____

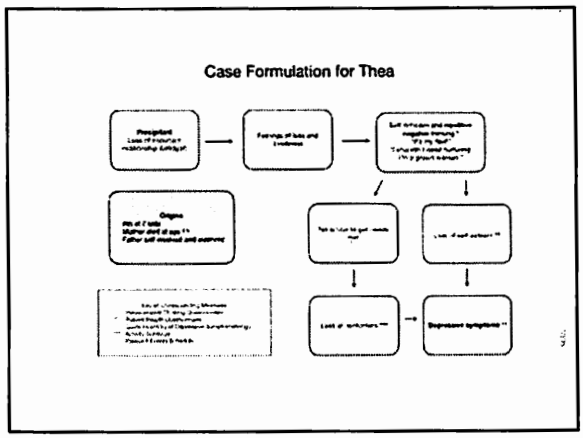
- **Why do case formulation-guided CBT?**
- Empirical foundations
- Formulation and intervention
- Progress monitoring
- Using the formulation and progress monitoring to guide treatment

A Case Formulation-driven Approach to Cognitive-behavior Therapy



Definition of Formulation

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



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

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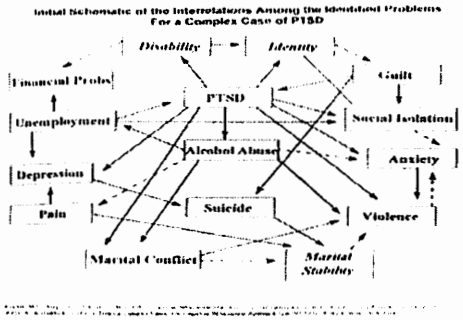
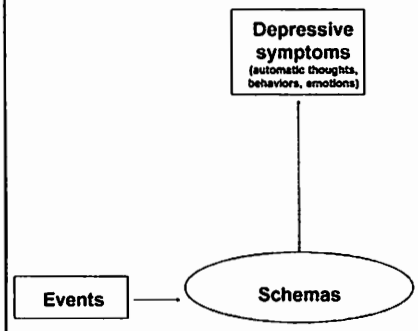
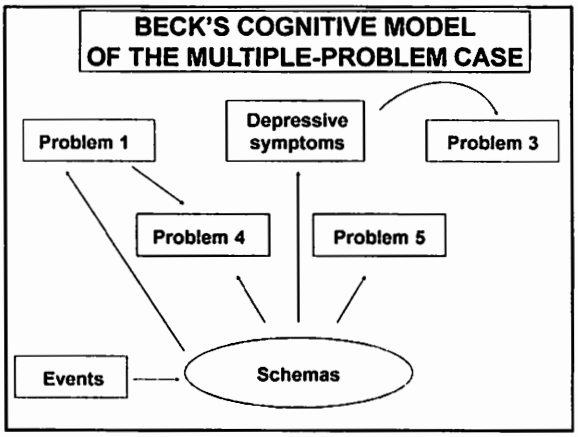
Most clients have multiple disorders and problems

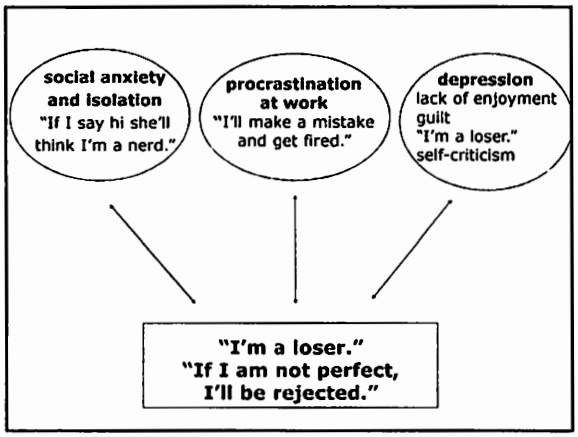


BECK'S COGNITIVE MODEL OF DEPRESSION



BECK'S COGNITIVE MODEL OF THE MULTIPLE-PROBLEM CASE





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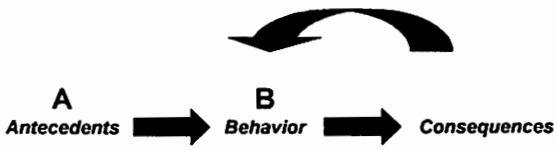
No empirically-supported treatment is available for many disorders and problems

- **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 young man who had psychogenic vomiting and mental retardation

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.

Treatment of Steve's Vomiting Behavior Based on the Functional Analysis

Antecedents (A)	Behaviors (B)	Consequences (C)
Day treatment program	Vomiting	Clean up own vomit. Father takes to hospital, then leaves. No pampering at home after vomiting.

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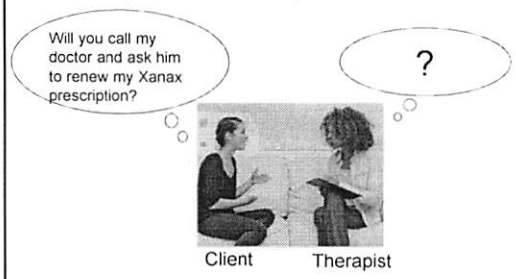
Thought Record

Date	Situation	Behavior	Emotions	Thoughts	Coping Responses
	Difficulty setting therapy session agenda		Anxious Appre-hensive	I'll pick the wrong topic. The session won't help me. Therapy probably won't help me; I should try medications	

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



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

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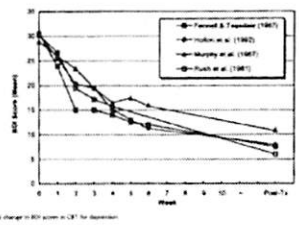
Large Proportions of Depressed Patients Do Not Respond to ESTs

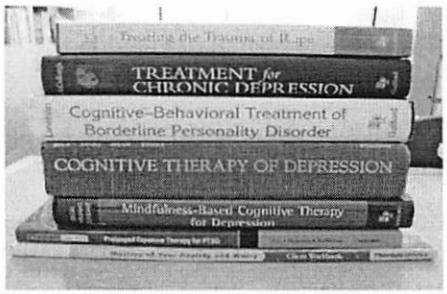
Driessen et al., 2013 (< 50% reduction in HAM-D)	CBT 37% Psychodynamic 42%
Luty et al., 2007 < 60% change in Montgomery-Asberg Depression Rating Scale)	Interpersonal Therapy 59% CBT 49%
DeRubeis et al., 2005 16-wk HAM-D score of 12 or lower & either 14-wk score of 14 or lower or a 10- and 12-wk score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

Most Change CBT for Depression Happens Early in Treatment



Ilardi & Craighead, 1994, *Clin Psychol Sci Prac* 1:138-156.

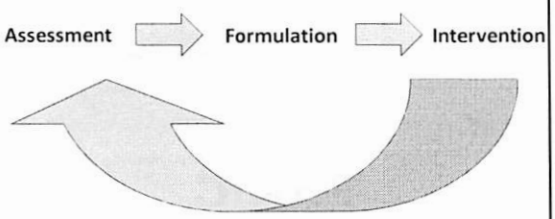
When the patient does not respond to the empirically-supported protocol, it is difficult to know what to do next.



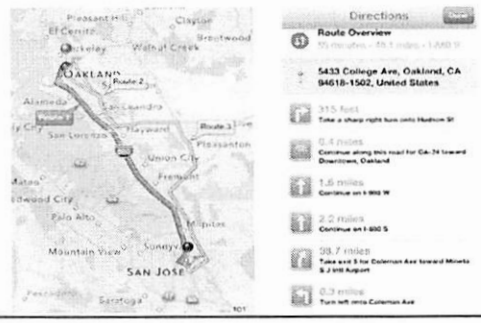
The case formulation approach offers the therapist a way to address treatment failure

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

A Case Formulation-driven Approach to Cognitive-behavior Therapy



A protocol is like a list of directions, whereas a formulation is like a map (if one route is blocked, the map helps you find others)



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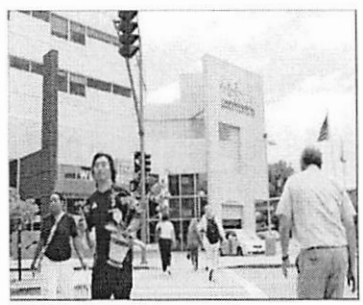
✓ Idiographic Goals: The mother who wanted help using public bathrooms during her child's hospital stay



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- **Empirical foundations**
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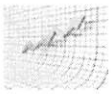
- Progress monitoring
- Using the formulation and progress monitoring to guide treatment

Empirical Foundations of case formulation-driven CBT



- EST-based formulations and interventions

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

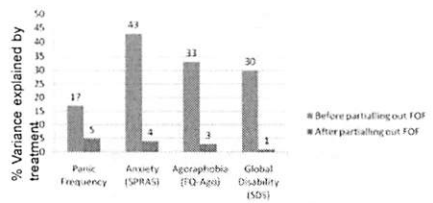
FOCUS ON SENSATIONS- How am I breathing? Is it getting worse?

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

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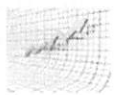
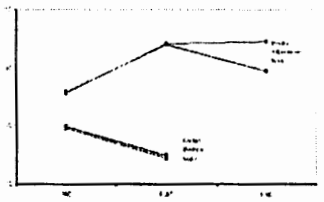


- EST-based formulations and interventions
- A handful of RCTs show formulation-driven treatment is usually equal to and occasionally superior to standardized treatment

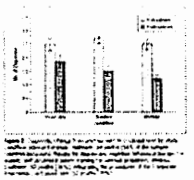
Standardized vs Flexible Marital Therapy

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



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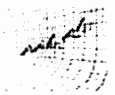

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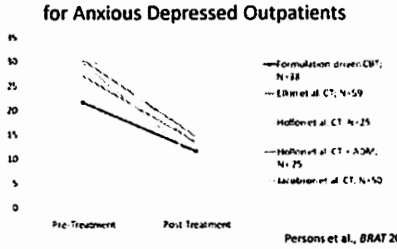
- A handful of RCTs show formulation-driven treatment is usually equal to and occasionally superior to standardized treatment
- Uncontrolled trials show formulation-driven treatment produces outcomes similar to ESTs

Naturalistic case formulation-driven CBT for anxious depressed outpatients produces outcomes similar to those of RCTs for depression

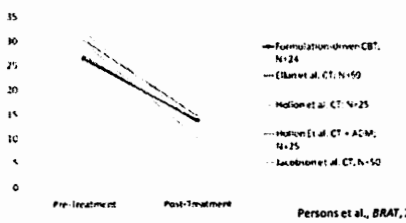
Persons, Roberts, Zalecki, & Brechwald, 2006, *Behaviour Research and Therapy*

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



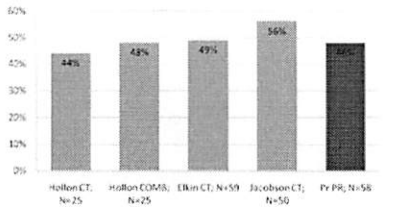
Persons et al., *BRAT* 2006

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



Persons et al., *BRAT*, 2006

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



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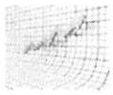


- EST-based formulations and interventions
- A handful of RCTs show formulation-driven treatment is usually equal to and occasionally superior to standardized treatment
- Uncontrolled trials show formulation-driven treatment produces outcomes similar to ESTs
- Many single case studies of self-injurious behavior and similar problems show that formulation-driven treatment is superior to standardized treatment
- Progress monitoring improves outcomes

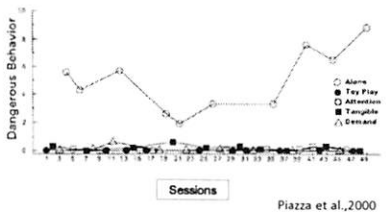
An evaluation of the effects of matched stimuli on behaviors maintained by automatic reinforcement

Piazza, Adelinis, Hanley, Goh, & Della, 2000, *Journal of Applied Behavior Analysis*

Betsy

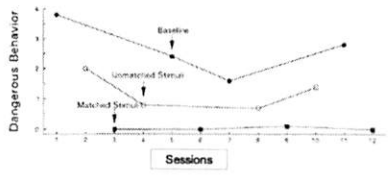
- 6 year old girl diagnosed with ADHD and severe mental retardation
- Hospitalized for treatment of dangerous behavior (e. g., climbing on furniture and jumping out of windows)

Functional analysis suggested that Betsy's behavior was automatically reinforced (via intrinsically rewarding kinesthetic sensations)

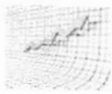


Piazza et al.,2000

Betsy showed less dangerous behavior when stimuli provided kinesthetic stimulation similar to the dangerous behavior (Matched) than when they did not (Unmatched) and in the Baseline condition



Empirical Foundations of case formulation-driven CBT



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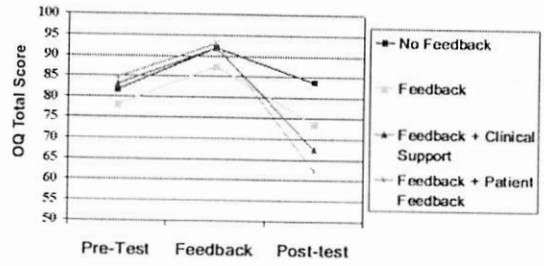
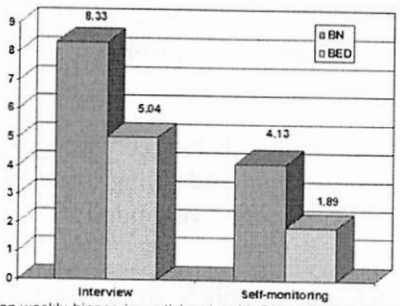
Giving Therapists Feedback about Patients' Progress Improves Outcomes of Patients Who Have Initial Poor Outcome



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

Self-monitoring reduces frequency of binge eating



Mean weekly binges in participants with BN or BED reported during interviews and subsequent self-monitoring.
Latner, J. D., & Wilson, G. T., *Behavior Therapy*, 2002.

The most important data are . . .

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

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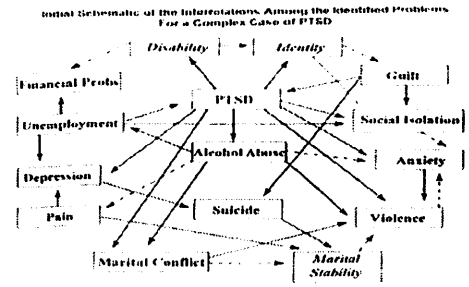
Three Levels of Formulation

- Symptom
- Disorder/Problem
- Case

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



Three Levels of Formulation

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

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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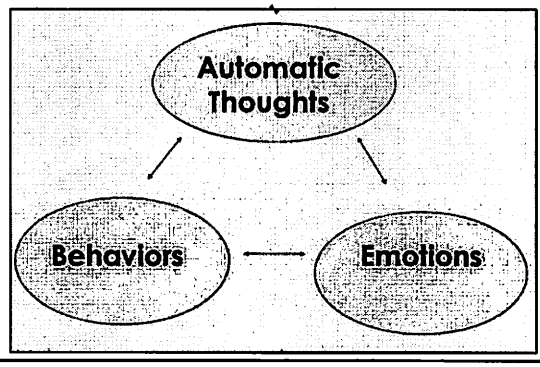
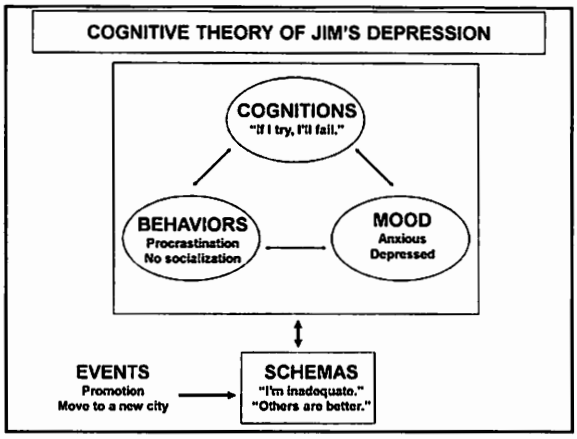
Beck's Cognitive Model of Symptoms





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	hopelessness	This pain will never end.	Anti-hopelessness interventions; behavioral experiment to test belief, "I will never enjoy anything again."

Thought Record

DATE	SITUATION (Event, memory, attempt to do something, etc.)	BEHAVIOR(S)	EMOTIONS	THOUGHTS	COPING RESPONSES

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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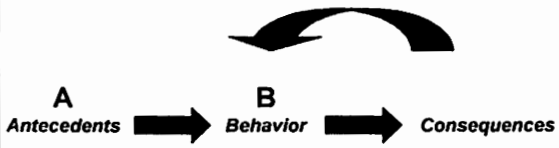
OPERANT CONDITIONING MODEL OF BEHAVIOR



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

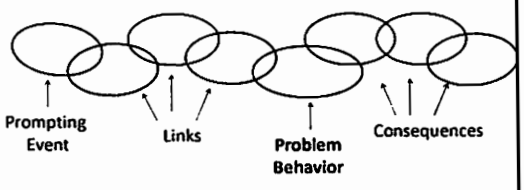
Antecedents (A)	Behaviors (B) (actions, thoughts, or emotions)	Consequences (C)
Reduce/help the person solve the problems	Teach adaptive problem-solving and help-requesting skills	Prevent hospitalization, respond immediately to adaptive requests for help

Another clinical application of operant conditioning

Behavioral chain and solution analysis

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*

A – B- C Log

Time	Date	A	B	C

Chain Analysis

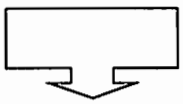
Describe the problem behavior in detail _____

What things in myself or my environment made me vulnerable?

_____

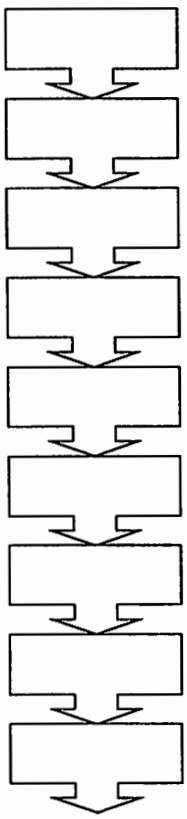
_____

What event (in the environment) started the chain?



_____

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



1st _____

2nd _____

3rd _____

4th _____

5th _____

6th _____

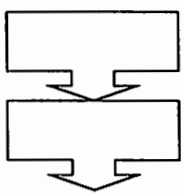
7th _____

8th _____

9th _____

10th _____

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



11th _____

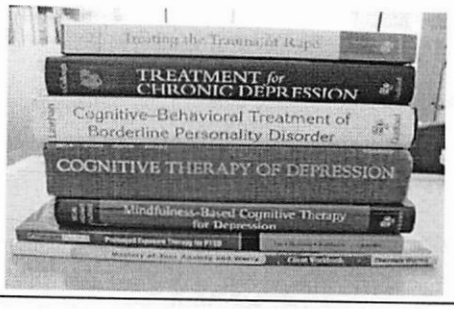
12th _____

Adapted from Mansueto et al. (1999). Cognitive and Behavioral Practice, 23-43.

Three Levels of Formulation

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

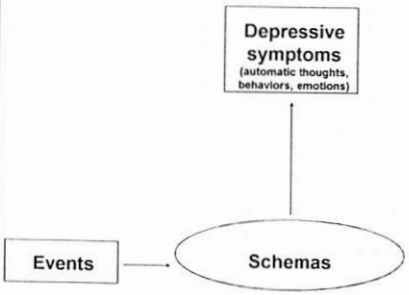
To develop a disorder formulation, start with the Empirically-supported Treatments (ESTs)



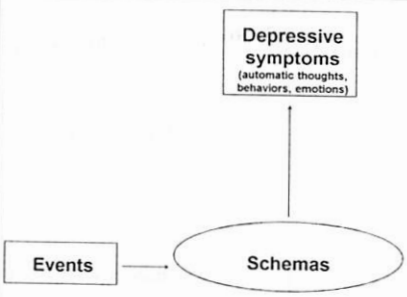
To Develop a Disorder Formulation, Start with the ESTs

- 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.

BECK'S COGNITIVE FORMULATION OF DEPRESSION



Mechanisms/Treatment Targets in COGNITIVE THERAPY FOR DEPRESSION



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

Situation: Sitting in class thinking about final exam

TRIGGER- I have a little difficulty breathing

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EMOTION- Fear

SOMATIC SENSATIONS- Rapid breathing, muscle tension, palpitations

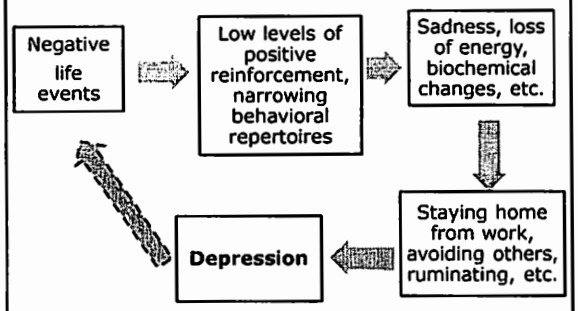
FOCUS ON SENSATIONS- How am I breathing? Is it getting worse?

INTENSIFICATION OF SENSATIONS

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

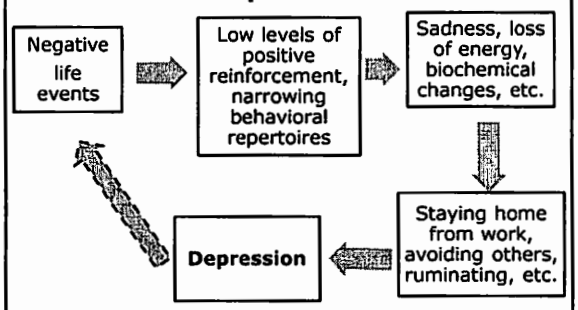
PANIC

Behavioral Activation Model of Depression



Martell et al., 2001

Treatment Targets Identified by the Behavioral Activation Model of Depression

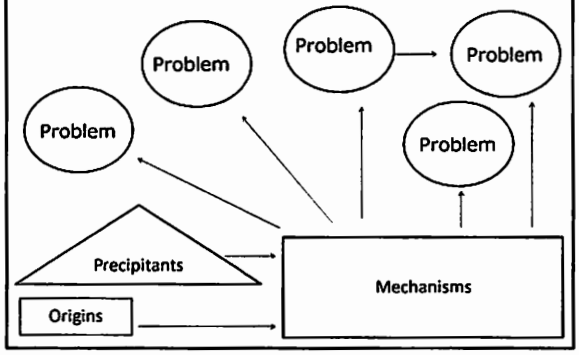


Martell et al., 2001

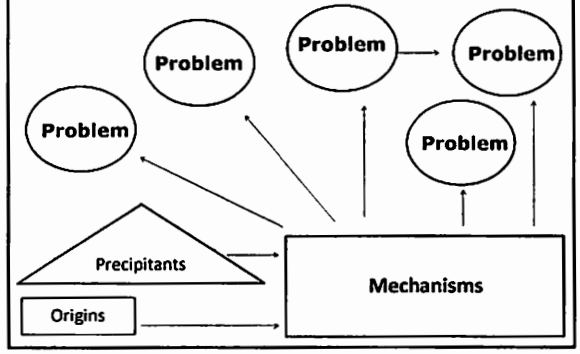
Three Levels of Formulation

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

Elements of a Case Formulation



Elements of a Case Formulation



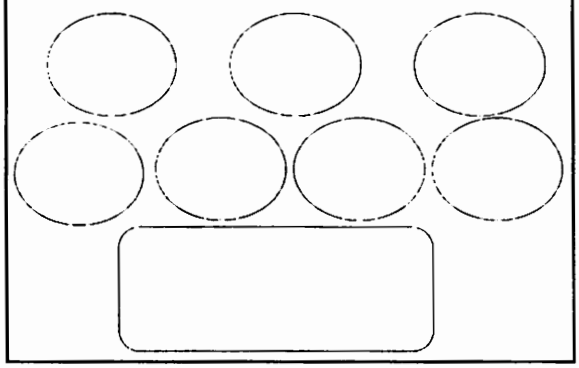
A problem is

. . . 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

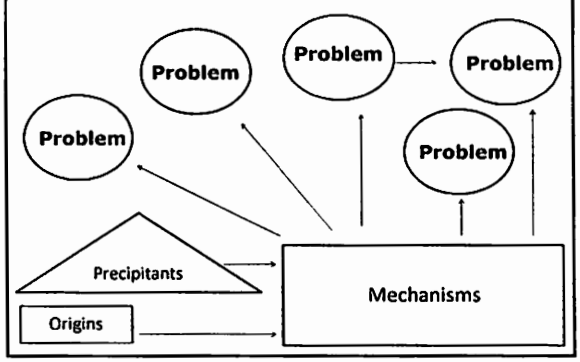
. . . a biological or psychological construct (e.g., maladaptive schemas, problematic contingencies, perfectionism, intolerance of uncertainty) that causes and/or maintains the person's problems

The Case Formulation



Obtaining a Comprehensive Problem List

Elements of a Case Formulation



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

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)

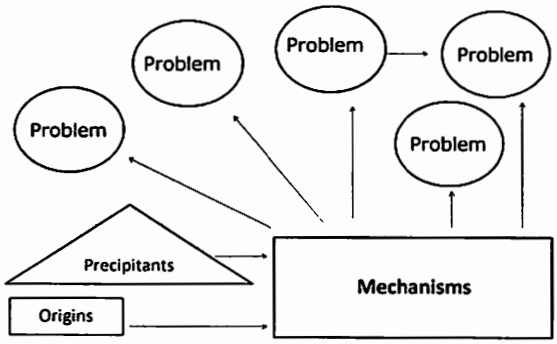
Adapted from Linehan, M M (1993) *Cognitive-behavioral treatment of borderline personality disorder*

Intake Measures Used at the Oakland CBT Center

- Adult Intake Questionnaire
- Diagnostic Screen
- Depression Anxiety Stress Scales (DASS)
- PHQ9
- Functioning and Satisfaction Inventory (FSI)
- Obsessive Beliefs Questionnaire
- A scale assessing social support
- Perseverative Thinking Questionnaire
- https://oaklandcbt.com/intake-forms

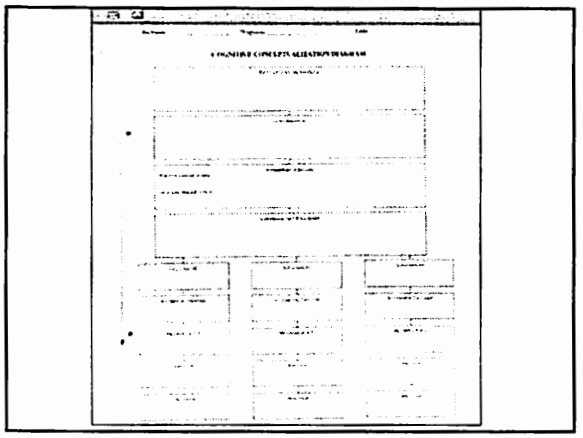
Developing a Mechanism Hypothesis

Elements of a Case Formulation



Tools to Help Develop Mechanism Hypotheses

- Thought Records
- Behavioral Chain analysis form
- Beck's Cognitive Conceptualization Diagram
- Behavioral Chain analysis form
- Standardized tools (e. g., Obsessive Beliefs Questionnaire, Perseverative Thinking Questionnaire); available at https://oaklandcbt.com/forms-and-tools-for-clinicians



A strategy for developing a case-level formulation

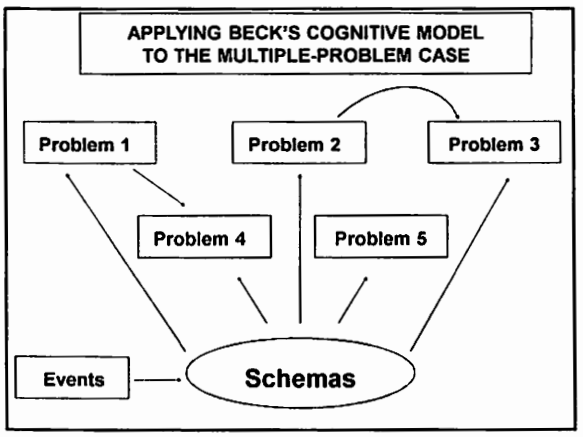
Extend a symptom or disorder formulation to account for all of the patient's problems and disorders

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



Audiotape Exercise

Develop an initial formulation of the case of Judy using Beck's cognitive model

EXERCISE

Use Beck's cognitive model.

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

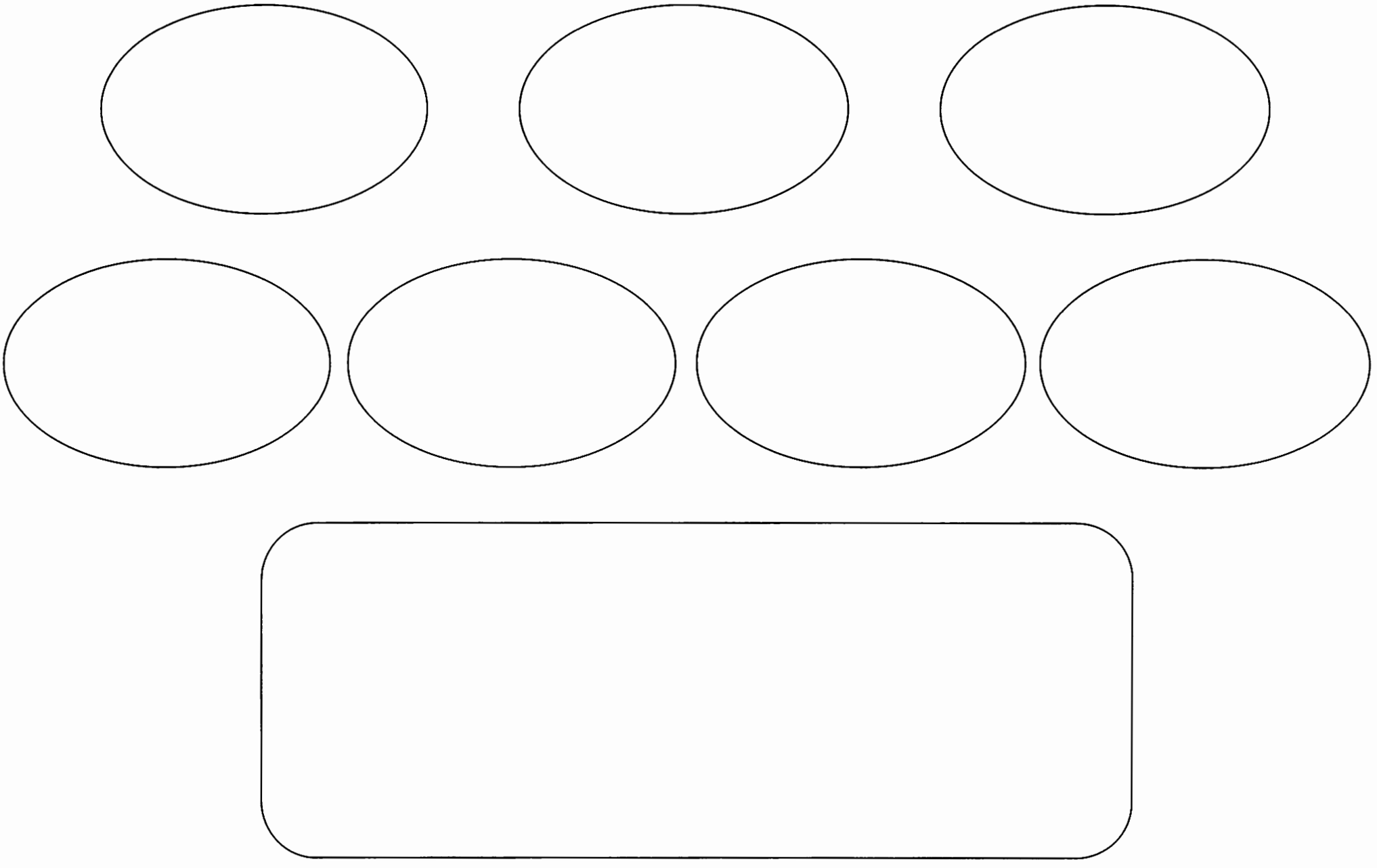
- Problems
- Schemas of "Self" and "Others"

Exercise

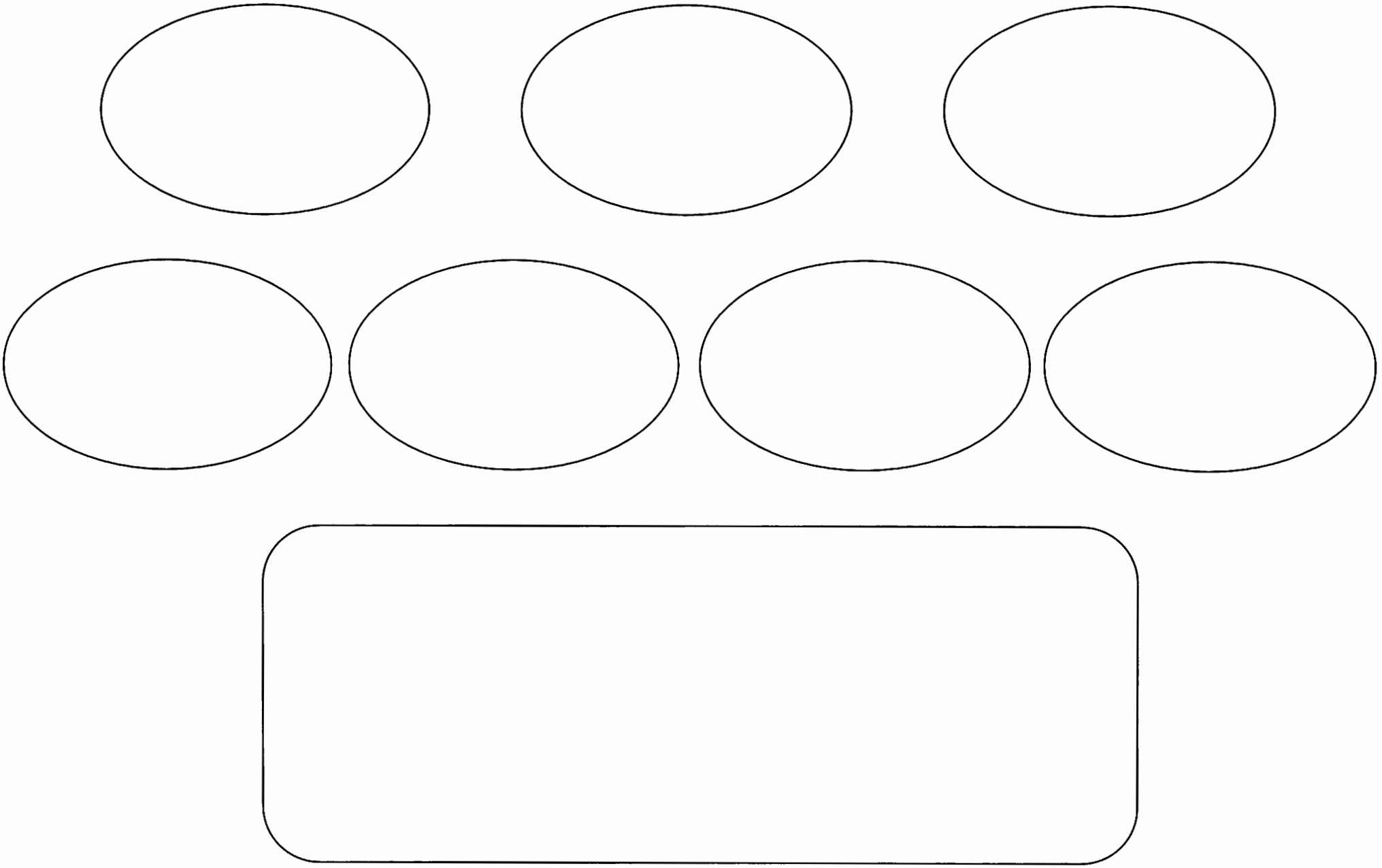
Develop a Formulation of the Case of Judy

- Work with your neighbor
- Identify as many problems as you can
- Propose hypotheses about schemas of Self and Others

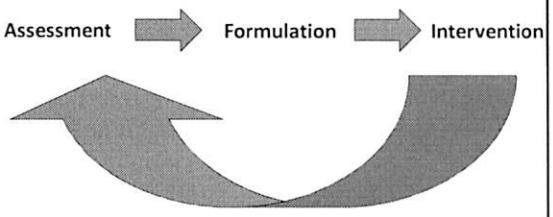
Case Formulation for _____



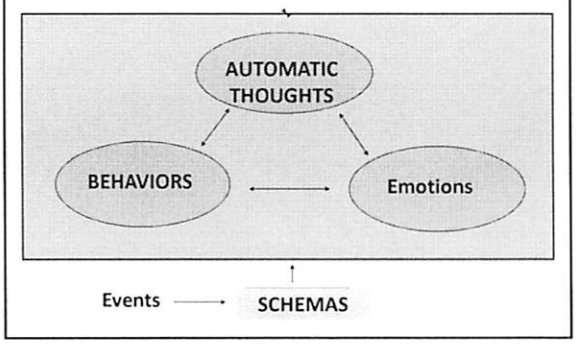
Case Formulation for _____



Using the Case Formulation to Guide Intervention



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
- . . . .

ACTIVITY SCHEDULE

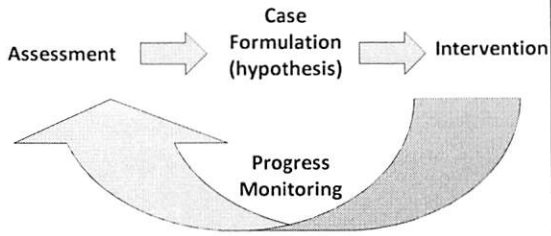
	MONDAY DATE:	TUESDAY DATE:	WEDNESDAY DATE:	THURSDAY DATE:	FRIDAY DATE:	SATURDAY DATE:	SUNDAY DATE:
7-8							
8-9							
9-10							
10-11							
11-12							
12-1							
1-2							
2-3							
3-4							
4-5							
5-6							
6-7							
Evening							

Thought Record

DATE	SITUATION (Event, memory, attempt to do something, etc.)	BEHAVIOR(S)	EMOTIONS	THOUGHTS	COPING RESPONSES

- Why do case formulation-guided CBT?
- Empirical foundations
- Formulation and intervention
- **Progress monitoring**
- Using the formulation and progress monitoring to guide treatment

A Case Formulation-driven Approach to Cognitive-behavior Therapy



Dr. Beck's account of the development of cognitive therapy

Outcome and Process

- **Outcome**
  - Symptoms (e.g., DASS, PHQ9)
  - 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

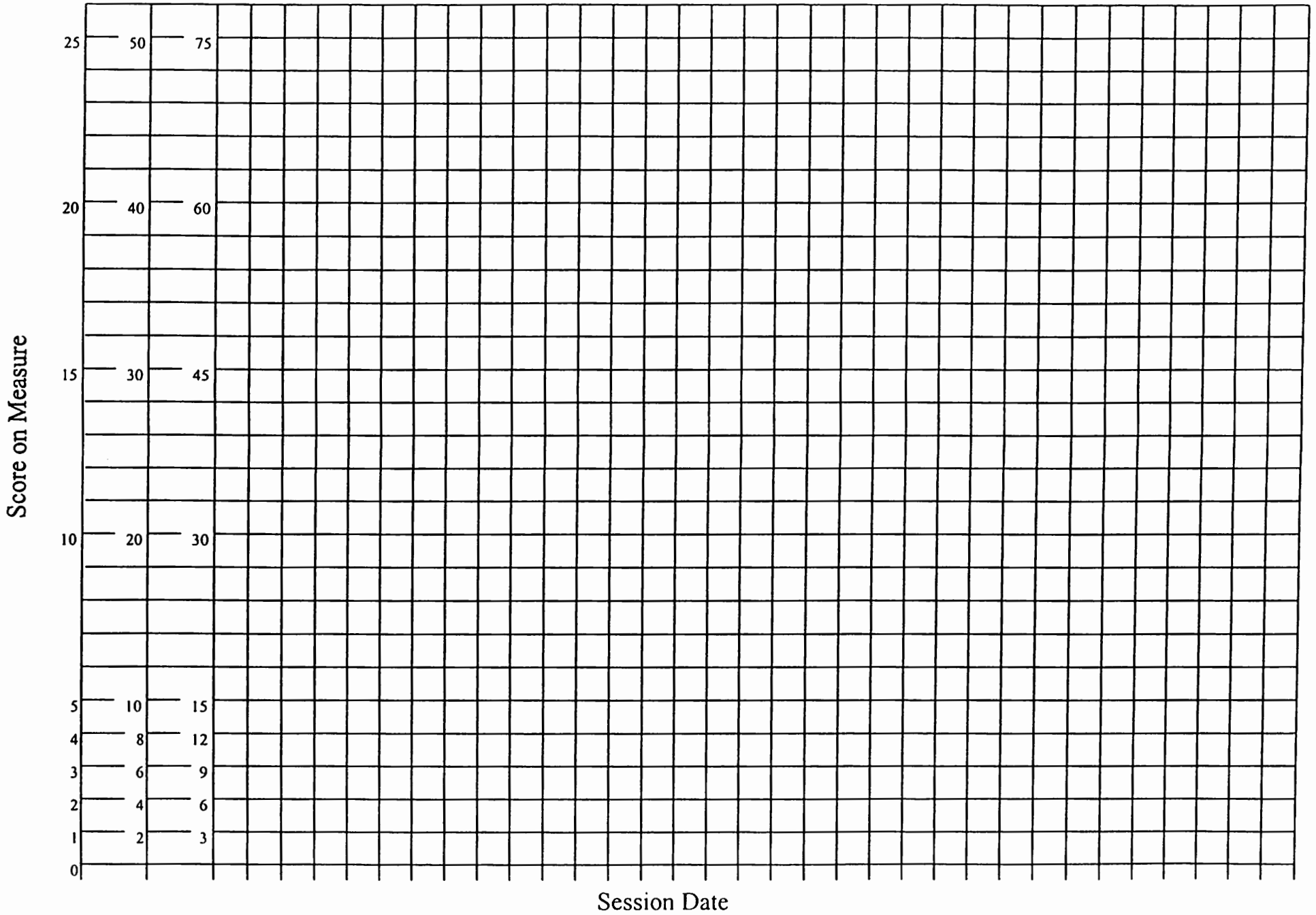
Progress Monitoring Defined

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

Completing a standardized scale in the waiting room before the session

Progress Plot for _____



Your Progress Monitoring

- Were you were trained to do this?
- Do you do this in:
  - Every session
  - Half of sessions
  - Less than half of sessions
  - Not at all

Tools to Monitor Outcome

Provided in the handouts:

- Patient Health Questionnaire-9 (PHQ
- 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

PATIENT HEALTH QUESTIONNAIRE PHQ-9 FOR DEPRESSION

USING PHQ-9 DIAGNOSIS AND SCORE FOR INITIAL TREATMENT SELECTION

A depression diagnosis that warrants treatment or treatment change, needs at least one of the first two questions endorsed as positive (*little pleasure, feeling depressed)* indicating the symptom has been present more than half the time in the past two weeks.

In addition, the tenth question about difficulty at work or home or getting along with others should be answered at least "somewhat difficult."

When a depression diagnosis has been made, patient preferences should be considered, especially when choosing between treatment recommendations of antidepressant treatment and psychotherapy.

PHQ-9 Score	Provisional Diagnosis	Treatment Recommendation
5-9	Minimal symptoms*	Support, educate to call if worse; return in 1 month.
10-14	Minor depression ††	Support, watchful waiting
	Dysthymia*	Antidepressant or psychotherapy
	Major depression, *mild*	Antidepressant or psychotherapy
15-19	Major depression, *moderately severe*	Antidepressant or psychotherapy
≥ 20	Major depression, *severe*	Antidepressant and psychotherapy (especially if not improved on monotherapy)

* If symptoms present ≥ two years, then probable chronic depression which warrants antidepressant or psychotherapy (ask, *"In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?"*).

†† If symptoms present ≥ one month or severe functional impairment, consider active treatment.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

MONTH:

MOOD CHART

NAME:

Day of the Month	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	30	31
Med:																															
Med:																															
Med:																															
NOTES																															
Elevation / MOOD / Depression: Severe																															
Mod																															
Mild																															
NL																															
Mild																															
Mod																															
Severe																															
SLEEP (Hrs) 0																															
2																															
4																															
6																															
8																															
10																															
12																															
14																															
ENERGY or ACTIVITY: High																															
NL																															
Low																															
_____ High																															
NL																															
Low																															
Day of the Month	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	30	31

Session Assignment and Feedback Form (SAFF)

Today's Date _____ Next Session _____

Assignments	M	Tu	W	Th	F	Sa	S

Please complete during or immediately after the session

What are 1 or 2 things you want to remember from the session?

_____

_____

_____

_____

_____

In the session	Not at all	A little	Moderately	Quite a bit	Very much	Extremely
1. I felt uncomfortable with my therapist.	0	1	2	3	4	5
2. My therapist and I were in total agreement about how we worked on my problems.	0	1	2	3	4	5
3. I felt confident that I made progress toward my therapy goals.	0	1	2	3	4	5
4. I felt certain that my therapist and I were in complete agreement about my therapy goals.	0	1	2	3	4	5

Please complete just before the next session

	I didn't do any	Not at all	A little	Moderately	Quite a bit	Very much	Completely
How helpful were any of the assignments you did?		0	1	2	3	4	5

What skills did you use during the last week?

- ☐ Mindfulness
- ☐ Self-care
- ☐ Focus on the CB model of your problems
- ☐ Self-monitoring
- ☐ Activity scheduling
- ☐ Problem-solving
- ☐ Opposite action
- ☐ Access social support
- ☐ Test/change thoughts/beliefs
- ☐ Interpersonal effectiveness
- ☐ Acceptance
- ☐ Focus on goals and values
- ☐ Focus on positives
- ☐ Other: _____
- ☐ None

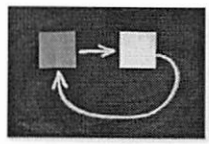
	Not at all	A little	Moderately	Quite a bit	Very much	Completely
Are you confident you can use these skills when you need them?	0	1	2	3	4	5

What do you want to discuss next session?

_____

_____

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

Assessment Tools Useful for Developing Formulation (Mechanism) Hypotheses

Collections of Measures

Antony, M. M., Orsillo, S. M., & Roemer, L. (2001). *Practitioner's guide to empirically based measures of anxiety.* New York, NY: Kluwer Academic/Plenum Publishers.

Fischer, J., & Corcoran, K. (2007). *Measures for clinical practice and research: A sourcebook* (Vol. 1 (Couples, Families, Children). Oxford: Oxford University Press.

Fischer, J., & Corcoran, K. (2007). *Measures for clinical practice and research: A sourcebook* (Vol. 2 (Adults). Oxford: Oxford University Press.

Nezu, A. M., Ronan, G. F., Meadows, E. A., & McClure, K. S. (2000). *Practitioner's guide to empirically based measures of depression.* New York, NY: Kluwer Academic/Plenum Publishers.

Mechanism Assessment Tools

Bieling, P. J., Beck, A. T., & Brown, G. K. (2000). The Sociotropy Autonomy Scale: Structure and implications. *Cognitive Therapy and Research, 24,* 763-780. (reprinted in Nezu et al., above)

Frost, R. O., Martin, P., Lahart, C., & Rosenblate, R. (1990). The dimensions of perfectionism. *Cognitive Therapy and Research, 14*, 449-468. (reprinted in Antony et al., above)

MacPhillany, D. J., & Lewinsohn, P. M. (1982). The Pleasant Events Schedule: Studies on reliability, validity, and scale intercorrelation. *Journal of Consulting and Clinical Psychology, 50*, 363-380. (reprinted in Nezu et al., above)

Obsessive Compulsive Cognitions Working Group (2005). Psychometric validation of the obsessive belief questionnaire and interpretation of intrusions inventory – Part 2: Factor analyses and testing of a brief version. *Behaviour Research and Therapy, 43,* 1527-1542. (OBQ44 and an excel scoring document are posted at https://oaklandcbt.com/forms-and-tools-for-clinicians)

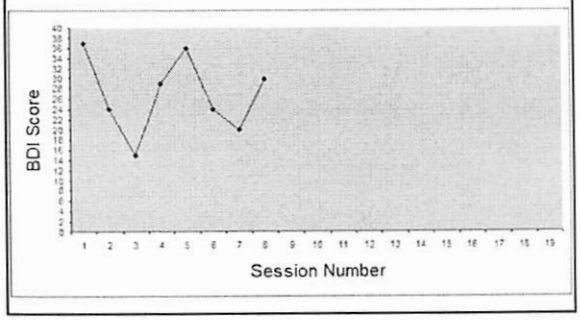
Taylor, S. & Cox, B. J. (1998). An expanded Anxiety Sensitivity Index: Evidence for a hierarchic structure in a clinical sample. *Journal of Anxiety Disorders, 12,* 463-483. (ASI and ASI-revised are reprinted in Antony et al. above)

Freeston, M. H., Rheaume, J., Letarte, H., Dugas, J. J., & Ladouceur, R. (1994). Why do people worry? *Personality and Individual Differences, 17*, 791-802. (Paper about Intolerance of Uncertainty Scale, which is reprinted in Antony et al., above)

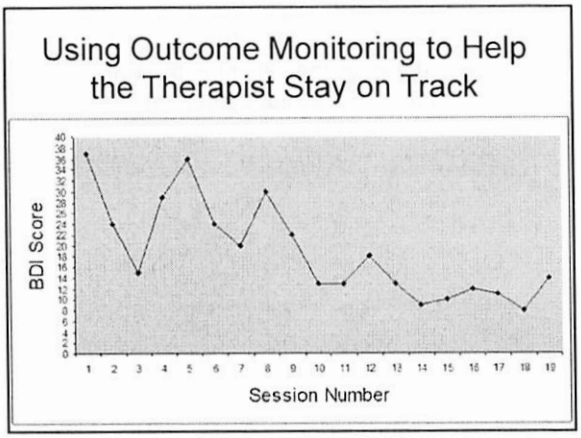
Young Schema Questionnaire (YSQ). A paper-and-pencil self-report tool that assesses the 18 maladaptive schemas described by Jeffrey Young's Schema Theory. Available at: www.schematherapy.com

Progress Monitoring Examples

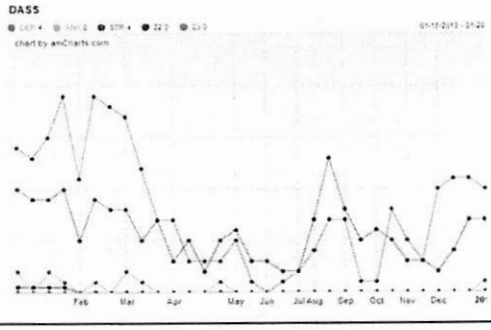
Using Outcome Monitoring to Help the Therapist Stay on Track (regulate her emotions)

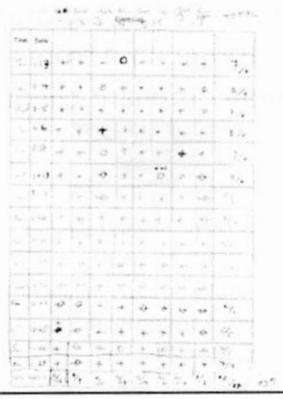


Using Outcome Monitoring to Help the Therapist Stay on Track

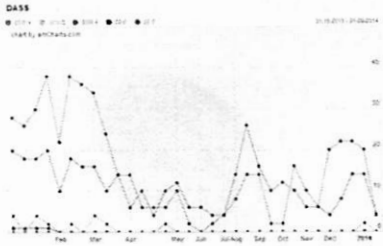


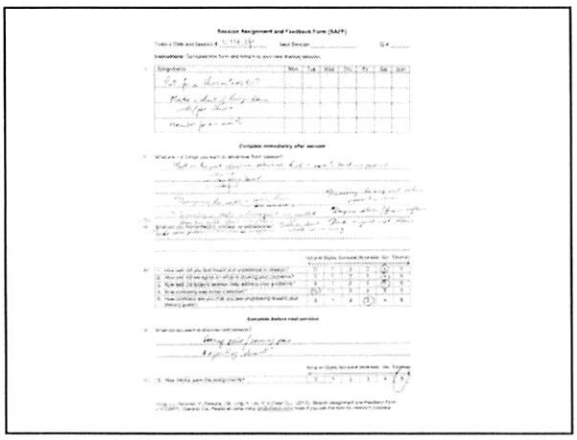
Outcome Monitoring Data "Mr. I am not doing enough"



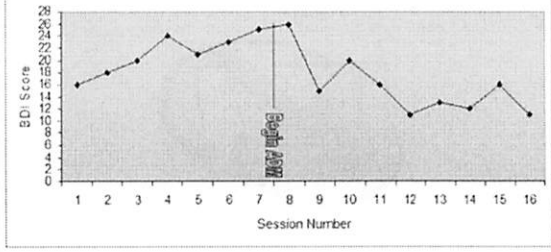


Outcome Monitoring Data "Mr. I am not doing enough"

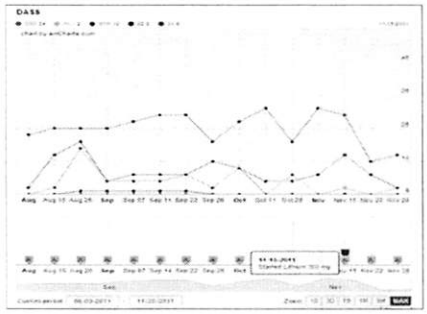




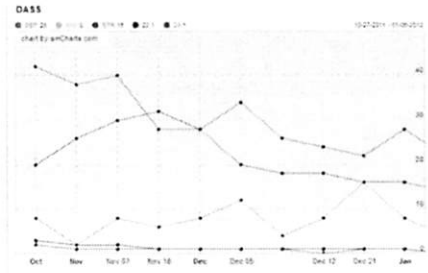
Using Outcome Monitoring to Identify a Response to Medication



Progress plot identifying change in treatment that is tied to big symptom change



As depression improves, stress and anxiety can worsen as the patient approaches previously-avoided situations



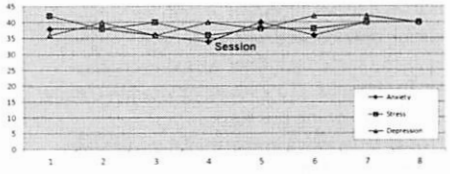
VIDEO DEMONSTRATIONS: Obtaining progress monitoring data from the noncompliant client

EXERCISE: Obtaining progress monitoring data from your noncompliant client

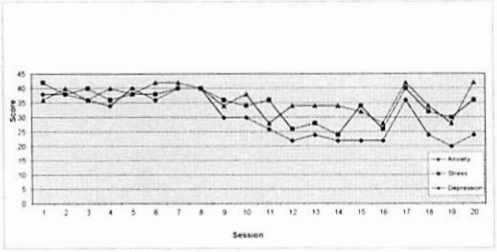
- Pair up. One be client, one be therapist
- Use the PHQ9 in your handouts
- Client did not do the measure before the session
- Therapist asks the client to do the measure at the beginning of the session

- Why do case formulation-guided CBT?
- Empirical foundations
- Formulation and intervention
- Progress monitoring
- **Using the formulation and progress monitoring to guide treatment**

Weekly scores on the DASS show that Ms. ADHD is not making progress in treatment



Intensive Focus on Attendance and Medication Compliance Led to Improvement for Ms. ADHD

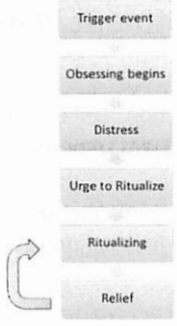


Using the formulation and progress monitoring data to overcome treatment failure

Mr. "I might have cancer"

Persons, J. B., & Mikami, A. Y. (2002) *Psychotherapy*.

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

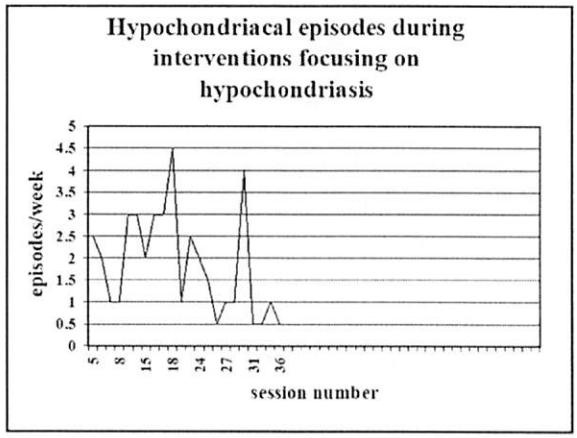


Exposure Hierarchy – Fear of Cancer

100 +	asking all questions of M.D.
100 -	reading about bladder cancer - "80%" statistic
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 Rituals

- 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

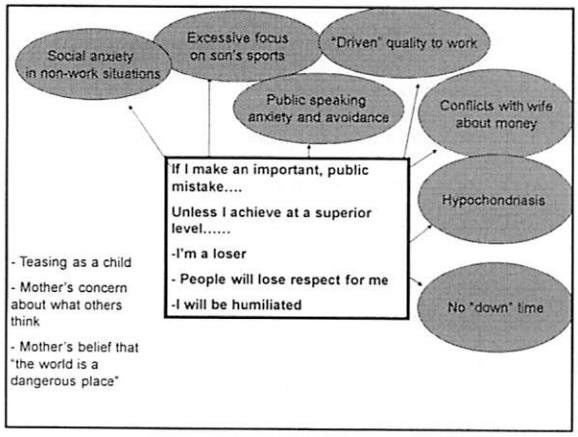


Collecting Additional Assessment Data to Revise the Formulation

- 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 core fear hypothesis

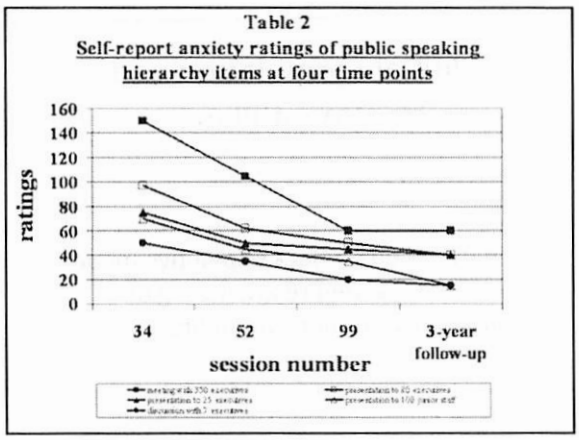
Thought Record

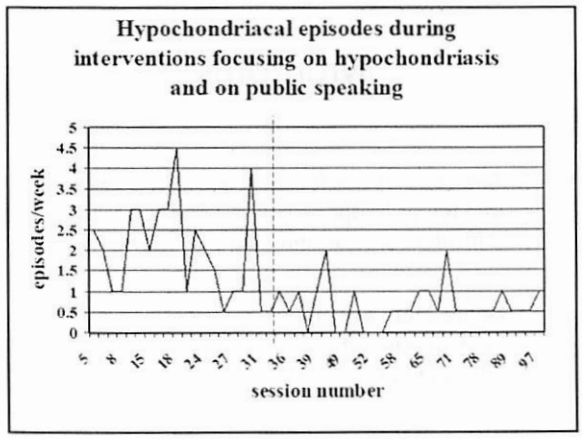
Date	Situation	Behavior(s)	Emotions	Thoughts	Coping Responses
	Colleague says, "Oh you're sick again."			It could be cancer. ⇩ I'll miss work. ⇩ I'll drop a ball. ⇩ I'll lose my job. ⇩ I'll be humiliated.	



Revised Formulation and Treatment Plan

- Revised formulation: The fear underpinning hypochondriasis was of humiliation, not cancer
- Revised treatment plan targeted fear of humiliation and focused on public speaking situations





Conclusions

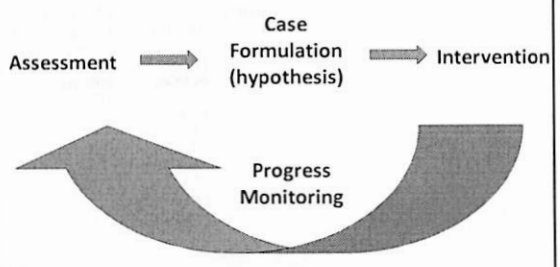
- Initial poor outcome led to additional assessment, which led to . . .
- Revised diagnosis and formulation, which led to . . .
- New treatment targets and interventions, which led to . . .
- Ultimate good treatment outcome.

Using the Formulation and Progress Monitoring to Overcome Treatment Failure

Mr. "I might be making the wrong choice"

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

A Case Formulation-driven Approach to Cognitive-behavior Therapy



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

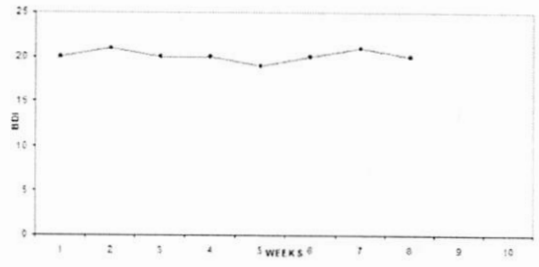
Initial Formulation and Treatment Plan . . .

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 Responses to Jim's Lack of Progress: Consultation to get a new formulation and intervention ideas

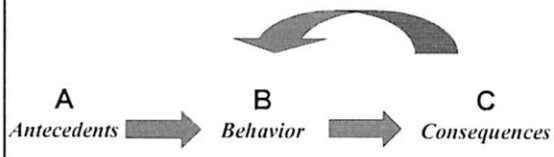
Assessment → Case Formulation (hypothesis) → Intervention

Progress Monitoring

Thought Record

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

Reformulation based on the Operant Model



Functional Analysis of Jim's Behavior

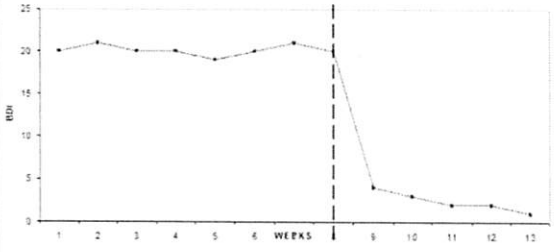
Antecedents (A)	Behaviors (B)	Consequences (C)
Party where he did not know anyone and felt anxious	Leave the party and go home to do a Thought Record	Reduction of anxiety in the short run Disengagement, depression, loss of confidence in the long run

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)
Classes Homework assignments Social events (all events at graduate school)	Engage and participate. Normalize anxiety and tolerate it. Stop obsessing about leaving.	?

Jim's Response to the Change in Treatment



- Why do case formulation-guided CBT?
- Empirical foundations
- Formulation and intervention
- Progress monitoring
- Using the formulation and progress monitoring to guide treatment

EXERCISE

With your neighbor:

1. **Review the goals you set for yourself. Did you meet them? (2 min)**
2. **Review your list of action items. (2 min)**

THANK YOU!

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www.oaklandcbt.com

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