CHAPTER 6

Cognitive-Behavioral Case Formulation

Jacqueline B. Persons
Joan Davidson

Hazel came to her therapy session feeling depressed and discouraged. She had failed to follow through with her plan to visit her cousin Rose on Sunday. In the previous session her therapist had worked with her on a Thought Record that focused on the upcoming visit and elicited these thoughts about the trip: “I feel too depressed, I have no energy,” I can’t make the visit when I feel like this,” and “I’ll do it later when I feel better.” The therapist’s formulation was that Hazel had a schema of herself as weak, fragile, and helpless, and that this belief was the root of many of her symptoms of depression, especially her passivity and behavioral inactivity. The therapist had worked collaboratively with Hazel to develop this formulation, and had shown Hazel how that view of herself produced the thoughts she had in the situation involving the trip to visit her cousin. Guided by this formulation, Hazel and her therapist had worked to develop some responses to Hazel’s automatic thoughts using the anti-do-nothingism intervention that Dr. Burns describes in Feeling Good (Burns, 1999). These were responses like, “I can do this even though I feel lousy,” “I’ll feel better after I do it,” and “I can’t wait until I feel better; I need to take action first.”

However, this line of intervention failed. Hazel came to the next session feeling more depressed than before (her Beck Depression Inventory [BDI] score was 6 points higher) and reporting that she had not been able to push herself to make the visit. This setback led Hazel’s therapist to take another look at her conceptualization of the
situation involving the trip. The therapist collected more assessment data to get a clearer picture of what was going on and with some probing, elicited from Hazel some feelings and thoughts about the trip that the therapist previously had not known about. Hazel felt resentful and guilty about the trip, and had the thoughts, “I don’t want to visit her, but Rose is ill and really needs me, so I should go” and “If I don’t make this trip, I’m a bad cousin.” This information suggested that in addition to self-schemas of being weak and helpless, Hazel also held what Young, Klosko, and Weishaar (2003) call the “subjugation” schema, that is, the view that she is unimportant, and that her role in life is to meet others’ needs.

Guided by this new formulation hypothesis, Hazel and the therapist agreed to shift their tack. Instead of working to help Hazel overcome her do-nothing thoughts and push ahead to make the trip, the therapist worked to help Hazel identify and overcome her subjugation beliefs and guilt, pay better attention to her needs, and speak up assertively to let her cousin know that she would not be able to visit but would check in by phone. This intervention was successful. Hazel was able to call her cousin and cancel her visit. She came to her next session feeling less depressed and more energized than she had in some time.

This vignette illustrates the role of the cognitive-behavioral (CB) formulation in treatment. The formulation is a hypothesis about the factors that cause and maintain the patient’s problems, and it guides assessment and intervention.

This chapter begins with a description of the hypothesis-testing approach to clinical work, of which the case formulation is a part. We discuss the role of the case formulation in treatment and review evidence that the formulation contributes to the effectiveness of treatment. We also describe the elements of the CB case formulation and present a case to illustrate the process of developing a formulation and using it to guide treatment.

We describe our own approach to CB case formulation (see also Persons 2008). Others include functional analysis (Haynes & O’Brien, 2000) and the methods described by Judy Beck (1995) and others (Koerner, 2006; Kuyken, Padesky, & Dudley, 2009; Nezu, Nezu, & Lombardo, 2004; Tarrier, 2006).

**CASE FORMULATION AS PART OF A HYPOTHESIS-TESTING MODE OF CLINICAL WORK**

The case formulation is an element of a hypothesis-testing empirical mode of clinical work that is described in Figure 6.1. The therapist begins the process by carrying out an assessment to collect information that is used to develop an initial formulation of the case. The case formulation is a hypothesis about the psychological mechanisms and other factors that cause and maintain a par-

ticular patient's disorders and problems. The formulation is used to develop a treatment plan and to assist in obtaining the patient's informed consent to it. After obtaining informed consent, the therapist moves forward with treatment. At every step in the treatment process, as the backward arrow in Figure 6.1 indicates, the therapist returns repeatedly to the assessment phase; that is, the therapist collects data to monitor the process and progress of the therapy and uses those data to test the hypotheses (formulations) that underpin the intervention plan and to revise them as needed.

Thus, the four elements of case formulation-driven cognitive-behavioral therapy (CBT) are (1) assessment to obtain a diagnosis and case formulation; (2) treatment planning and obtaining the patient's informed consent to the treatment plan; (3) treatment; and (4) continuous monitoring and hypothesis testing. We discuss each element in turn.

Assessment to Obtain a Diagnosis and Initial Case Formulation

Before treatment begins, the therapist collects assessment data to develop a diagnosis and an initial case formulation. To get this information, the therapist uses interviews, self-report data from the patient, and other sources, including reports from family members and other clinicians.

Many clinicians are reluctant to conduct a diagnostic assessment. They do not want to impede the patient from "telling his or her story"; they fear that the patient will have a negative reaction, or they argue that diagnostic classification and CB theories and therapies are difficult to reconcile conceptually (Follette, 1996). Despite the validity of these concerns, diagnosis yields information that is helpful—if not essential—in treatment. For example, the distinction between unipolar and bipolar mood disorders has important impli-
cations for both psychotherapy and pharmacotherapy. Furthermore, the psychopathology, epidemiology, and treatment efficacy literatures are organized by diagnosis, and the effective clinician draws on these literatures. In fact, one of the main methods to develop a case conceptualization and treatment plan is for the therapist to rely on evidence-based formulations and treatment protocols, which usually target disorders. Diagnosis can provide the therapist with some immediate formulation hypotheses. For example, a diagnosis of panic disorder suggests the formulation that panic symptoms result from catastrophic interpretations of benign somatic sensations (Clark, 1986).

A case formulation is important, because interventions flow from it, as Hazel’s case at the beginning of this chapter illustrates. The formulation also provides a way to tie all of the patient’s symptoms and problems into a coherent whole. As described later in more detail, a complete case formulation describes all of the patient’s symptoms, disorders, and problems, and proposes hypotheses about the mechanisms causing the disorders and problems, the precipitants of the disorders and problems, and the origins of the mechanisms.

Whenever possible, the case formulation is based on an empirically supported “nomothetic,” or general formulation. The therapist’s task is to translate from nomothetic knowledge to idiographic practice, where an “idiographic” formulation and treatment plan describe the causes of symptoms or disorders and the plan for treating them in a particular individual. Hazel, the patient described in the vignette at the beginning of the chapter, met criteria for major depressive disorder; therefore, her therapist based the formulation of her case on Beck’s cognitive model of depression (Beck, Rush, Shaw, & Emery, 1979), because it offers an evidence-based formulation and treatment for depression. Hazel’s therapist individualized Beck’s nomothetic formulation by proposing schema hypotheses that were unique to Hazel’s case, and that accounted for her particular symptoms and problems.

Treatment Planning and Obtaining Informed Consent for Treatment

The treatment plan follows from the case formulation. In case formulation-driven CBT, the heart of the treatment plan is not the interventions, but what we call the “mechanism change goals of treatment.” These are changes in the psychological mechanisms that the treatment is designed to achieve, and they are based directly on the mechanism hypotheses of the case formulation. So, for example, the formulation that depressive symptoms result from a dearth of positive reinforcement leads to a treatment plan in which the therapist proposes to treat the patient’s symptoms by increasing the amount of positive reinforcement the individual receives (Lewinsohn & Gotlib, 1995).

Before beginning treatment, the therapist obtains the patient’s informed consent to proceed with the proposed treatment. During the consent process, the therapist develops a diagnosis and formulation of the patient’s condition
and provides this information to the patient; describes available treatment options; recommends a treatment, describes it, and provides a rationale for the recommendation; and obtains the patient’s agreement to proceed with the recommended treatment plan or a compromise treatment plan. Informed consent is particularly important in case formulation–driven CBT, because the therapist often adapts the empirically supported treatment (EST) to meet the unique needs of the patient at hand or even develops an experimental treatment when no EST is available.

**Treatment**

Therapists who use a case formulation–driven approach to treatment do not rely on a protocol. Instead, they rely on the formulation as a guide to the treatment and select appropriate interventions from the protocol tied to the formulation (e.g., in Hazel’s case, from (Beck et al., 1979), from other evidence-based protocols for the patient’s disorder and for other disorders, and from the therapist’s and patient’s experience of what has been helpful in the past. Treatment in case formulation–driven CBT follows a sort of technical eclecticism, where the unifying coherence is provided by the formulation of the case.

**Monitoring and Hypothesis Testing**

As treatment proceeds, patient and therapist collect data at every therapy session to test the formulation and monitor the process and outcome of therapy. These data allow patient and therapist to answer questions such as the following: Are the symptoms remitting? Are the mechanisms changing as expected? Do the mechanisms (e.g., cognitive distortions) and symptoms (e.g., hopelessness) relate to each other as expected? Does the patient accept and adhere to the interventions and recommendations? Do any problems in the therapeutic relationship interfere with treatment? If the process or outcome of therapy is poor, then the therapist works with the patient to collect more data and to determine what is interfering with progress, and whether a different formulation might lead to a different intervention plan that produces better results.

It is important to monitor progress at every session. Monitoring helps the patient and the therapist determine when the patient has achieved his or her goals and is ready to terminate treatment. When monitoring indicates that treatment is failing, monitoring can identify the failure and alert patient and therapist to the need to initiate a problem-solving process in an attempt to turn the therapy around. Useful monitoring tools appear in Antony, Orsillo, and Roemer (2001), Fischer and Corcoran (2007), and Nezu, Ronan, Meadows, and McClure (2000). Colleagues Kelly Koerner, Cannon Thomas, Janie Hong and Jacqueline Persons have developed some software tools for this purpose; information about them is posted at www.practiceground.org.
Cognitive-Behavioral Case Formulation

USING THE FORMULATION IN TREATMENT

Levels of Formulation and Intervention

Formulations are developed at three levels of analysis, and formulations at the various levels guide different aspects of treatment. The three levels are symptom, disorder, and case. These three levels are nested. A “disorder” comprises a set of symptoms, and a “case” comprises one or more disorders and problems. As a result, a case-level formulation generally consists of an extrapolation or extension of one or more disorder- and symptom-level formulations.

The case-level formulation guides the process of treatment planning, especially the process of setting goals and making decisions about which problems to tackle first; it also often frequently guides agenda setting in the therapy session and selection of treatment targets. Most intervention happens at the level of the symptom and is guided by a symptom-level formulation. However, the interventions used to treat a symptom do not just depend on the symptom-level formulation. For example, Hazel’s therapist’s symptom-level formulation (behavioral passivity) was informed by schema hypotheses drawn from the formulations at the level of the disorder, in this case, the schema hypotheses that are central to Beck’s formulation of depression. That is, the original formulation of Hazel’s core schema as “I’m helpless” guided the therapist to address Hazel’s passivity by targeting these thoughts. The schema hypothesis “I’m unimportant; my role is to care for others” helped the therapist treat Hazel’s passivity by targeting her failure to identify and validate her own wishes and to speak up assertively to get them met.

Ways the Formulation Helps in Treatment

The formulation helps treatment in many ways. A key role of the formulation is to guide intervention. As the case of Hazel illustrates, different formulations of a problem lead to different interventions. The formulation can also strengthen the alliance and help the patient adhere to the treatment plan, even if it entails a fair amount of distress and hard work, as CBT often does. The case of Steve, described later in this chapter, illustrates the way the therapist’s sharing of the formulation enables Steve to play an active, leadership role in his treatment. A detailed discussion of how the formulation helps the therapist overcome failure, with a case example, is provided in (Persons & Mikami, 2002).

Treatment Utility of the Cognitive-Behavioral Case Formulation

CB therapists adopt a functional view of the case formulation. The key question of interest to the CBT therapist is not “Is the formulation accurate?” or “Does the formulation account for every piece of information I have about the patient?” but “Does the formulation add to the effectiveness of treatment?”
and provides this information to the patient; describes available treatment options; recommends a treatment, describes it, and provides a rationale for the recommendation; and obtains the patient’s agreement to proceed with the recommended treatment plan or a compromise treatment plan. Informed consent is particularly important in case formulation-driven CBT, because the therapist often adapts the empirically supported treatment (EST) to meet the unique needs of the patient at hand or even develops an experimental treatment when no EST is available.

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The function of the CB formulation is to guide intervention in a way that improves outcome (Hayes, Nelson, & Jarrett, 1987).

A small literature addresses the question of whether use of a formulation leads to better treatment outcome. A handful of randomized trials that compare the outcomes of case formulation–driven and standardized CBT show that formulation-driven treatment produces outcomes that are equal to (Jacobson et al., 1989; Schulte, Kunzel, Pepping, & Schulte-Bahrenberg, 1992) or a bit better than standardized treatment (Schneider & Byrne, 1987). Uncontrolled trials show that treatment of depressed (Persons, Bostrom, & Bertagnolli, 1999; Persons, Burns, & Perloff, 1988) and depressed anxious patients (Persons, Roberts, Zalecki, & Brechwald, 2006) guided by a CB case formulation and weekly progress monitoring has outcomes similar to those of patients receiving CBT or CBT plus pharmacotherapy in the randomized controlled trials. Another uncontrolled trial (Ghaderi, 2006) showed that patients with bulimia nervosa who received individualized treatment guided by a functional analysis had better outcomes than patients who received standardized treatment on some (abstinence from bulimic episodes, eating concerns, and body shape dissatisfaction) but not other (self-esteem, perceived social support from friends, and depression) outcome measures. Reviews by Nelson-Gray (2003) and Haynes, Leisen, and Blaine (1997) have reported that functional analysis has good treatment utility in individuals with severe behavioral problems, such as self-injurious behavior. Overall, the treatment utility of case formulation, especially for the types of outpatients seen in routine clinical practice, has rarely been studied. Thus, the strongest empirical support for the treatment utility of a CB case formulation currently comes from the method's reliance on evidence-based nomothetic formulations that are used as templates for the idiographic case formulation, and from the idiographic data that the therapist collects to monitor each patient's progress.

THE ELEMENTS OF THE CASE-LEVEL FORMULATION

The case formulation describes all of the patient’s disorders and problems, and proposes hypotheses about the mechanisms causing the disorders and problems, the precipitants of the disorders and problems, and the origins of the mechanisms, and ties all the elements together into a coherent whole.

Disorders and Problems

The case formulation accounts for all of the disorders and problems a patient is experiencing. To obtain a comprehensive problem list, the therapist assesses the following domains: psychiatric symptoms, interpersonal, occupational, school, medical, financial, housing, legal, leisure, and difficulties with mental health or medical treatment. A comprehensive list is critical for three reasons
First, the importance of any symptom, problem, or diagnosis depends on the patient’s other problems and diagnoses. For example, a symptom of derealization has different implications for a person with panic disorder than for a person who abuses substances or has a dissociative disorder. To understand the case fully, the therapist must know all of the problems. Second, the therapist who simply focuses on the obvious problems or those on which the patient wishes to focus may miss important problems. Patients frequently wish to ignore problems such as substance abuse, self-harming behaviors, or others that can interfere with the successful treatment of the problems on which the patient does want to focus. Third, a comprehensive problem list often reveals common elements or themes that cut across problems. Awareness of these themes can help to generate initial mechanism hypotheses.

The problem list overlaps considerably with Axes I, II, III, and IV of a DSM diagnosis. However, in the Problem List the therapist begins to translate diagnostic information into terms that facilitate conceptualization and intervention from a CB point of view. One way that the Problem List facilitates CB treatment planning is by giving higher priority to problems in functioning than does the DSM, which places those problems down the list on Axis IV. Also, the Problem List details the symptoms of the particular Axis I and II psychiatric disorders the patient is experiencing, and symptoms can often be described in terms of the cognitions and behaviors that are the currency of CBT.

Mechanisms

The heart of the case-level formulation is a description of psychological mechanisms that cause and maintain the patient’s problems and symptoms. The formulation might also include biological mechanisms (e.g., low thyroid can contribute to depressive symptoms), but we focus here on primarily psychological mechanisms.

To develop a mechanism hypothesis, the therapist can, as already discussed, rely on a nomothetic disorder formulation that underpins an EST, such as the formulation of obsessive-compulsive disorder that underpins exposure and response prevention (ERP) or the formulation of depression that underpins behavioral activation therapy (BA; Martell, Addis, & Jacobson, 2001). A second strategy is to base the case formulation on a more general psychological theory (e.g., the theory of operant conditioning). The case example presented later in this chapter uses both strategies.

Precipitants

The CB formulation is typically a “diathesis–stress” hypothesis; that is, it describes how vulnerability factors or mechanisms (“diatheses”) interact with “stressors” to cause and/or maintain symptoms and problems. Stressors can
be external events (e.g., death of a parent) or internal factors (e.g., an endocrine disorder). Thus, many CB formulations are biopsychosocial formulations and include a description of the events that triggered the mechanisms to produce the symptoms and problems.

**Origins of the Mechanisms**

It is useful to develop a hypothesis about how the patient acquired the mechanisms that cause the problems. An understanding of the likely origins of the problems in the patient’s history lends the formulation internal coherence and can also encourage the use of interventions that target symptoms that are tied to early learning events (Padesky, 1994; Young, 1999).

**Tying All the Elements Together**

The case formulation describes what origins led to the development of what mechanisms, which, activated by specific precipitants, cause the patient’s symptoms, disorders, and problems, and links all of these elements together into a coherent whole. It identifies treatment targets and the relationships among them that therapy will attempt to change. The elements of the case formulation for Hazel are identified with CAPITAL LETTERS.

As a result of being the oldest female in a large family, in which her mother was overwhelmed and expected Hazel to play a major caretaking role for her siblings (ORIGINS), Hazel learned the schemas “I’m unimportant,” “Others are more important,” and “My role in life is to meet the needs of others” (MECHANISMS). These schemas were activated by her husband’s illness and his need for a great deal of care from Hazel (PRECIPITANT). As a result of exhausting herself to care for him, Hazel began experiencing symptoms of depression (PROBLEM) and became socially isolated (PROBLEM), which exacerbated her depression. She also experienced worsening of chronic hypertension and diabetes (PROBLEMS), because her excessive attention to her husband’s needs prevented her from attending to her own medical needs.

**DEVELOPING A FORMULATION FOR “STEVE” AND USING IT TO GUIDE HIS TREATMENT**

The case of “Steve,” who was treated by the second author (J. D.), illustrates the processes of development and use of a case formulation to guide treatment.

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1“Steve” gave permission for his case to be presented here. Identifying information was changed to protect his privacy.
Assessment to Develop a Diagnosis and Initial Case Formulation

Steve called to request a consultation appointment, stating that although he was managing well now, he had found CBT to be quite helpful to treat his depression in the past and wanted "a tune-up." As the therapist spoke with Steve on the telephone to evaluate whether a consultation was appropriate, she also listened for information pertaining to elements of the case-level formulation (origins, mechanisms, precipitants, problems) and other important aspects of Steve's status and history. Steve told the therapist that he had been in treatment for depression for 16 years and hospitalized twice. His most recent treatment had been about 5 years earlier. He had recently adopted a child (a possible precipitant). Steve was pleasant and engaging, and he sounded like a good candidate for CBT. His request for "booster" sessions sounded quite reasonable. However, Steve's brief account of his psychiatric history raised a red flag. His long-term treatment for depression and two hospitalizations indicated a severe level of past psychopathology that seemed discrepant with how cheerful and lighthearted he sounded on the phone.

The therapist offered to meet with Steve for one or more consultation sessions in which she would assess Steve's problems and symptoms, and offer her recommendations. Steve would evaluate whether the therapist's assessment findings and treatment recommendations made sense to him, and if individual CBT was indicated, Steve and the therapist would evaluate whether they were a good match to work together. Steve gave permission for the therapist to send him a packet of questionnaires to complete and bring to the initial consultation session. The intake packet comprised the revised Symptom Checklist–90 (SCL–90R; Derogatis, 2000), the BDI (Beck et al., 1979), the Burns Anxiety Inventory (Burns, 1997), the Functioning and Satisfaction Inventory (FSI; Davidson, Martinez, & Thomas, 2006), and an Adult Intake Questionnaire (reprinted in Persons, 2008) that asked questions about previous and concurrent treatment, substance use, trauma, family and social history, and legal and other potential problems. The intake packet also included a Treatment and Evaluation Agreement that outlined the limits of confidentiality, the therapist's business policies, and other information needed for informed consent. The therapist asked Steve to review the document and, if he was comfortable with it, to sign it and bring it to the first consultation session, or to raise any concerns and questions at the beginning of the initial meeting.

The primary goals in the initial interview were to work collaboratively with Steve to begin to develop a Problem List, some diagnostic hypotheses and initial formulation hypotheses, and a treatment plan. It was also important to begin to develop a good working alliance. The telephone conversation provided the start of a tentative Problem List (symptoms of depression) and a possible precipitant (recent adoption of a child).

When Steve arrived, the therapist asked his permission to take the first 5 minutes of the session to review the intake packet materials before starting the interview. The initial demographic piece of the Adult Intake Questionnaire
revealed that Steve was a gay man in his early 30s who worked as a senior project manager for a high-tech firm and lived with his partner and the child they had recently adopted.

Steve's BDI score was 21, which indicated a moderate level of depression. Symptoms included sadness, discouragement about the future, feeling like a failure, self-criticism, self-blame, lack of enjoyment, loss of interest in people, difficulty making decisions, difficulty getting started doing things, and fatigue. He reported suicidal thoughts but no suicidal intent or plan. Steve scored 12 on the Burns Anxiety Inventory, which indicated mild anxiety. Symptoms included anxious feelings, difficulty concentrating and racing thoughts, as well as tight, tense muscles, and feeling tired, weak, or easily exhausted. He denied worry, however. He endorsed SCL-90R items that were consistent with the other inventories. He gave the highest possible score to only one SCL-90R item: "Feeling that something bad is going to happen to you."

On the FSI (Davidson et al., 2006), Steve reported that he functioned "very well" at work and "somewhat well" in relationships with relatives and friends. He maintained good health care behaviors. Although he was happy with his standard of living, he was "very dissatisfied" with his home/neighborhood/community, and the therapist made a note to collect more information about this. Steve reported that he was functioning "a little poorly" in his relationship with his partner, although he felt very satisfied with the relationship.

The Adult Intake Questionnaire also provided information about Steve's symptoms and problems, and some history. Steve reported that he drank one alcoholic drink per week. He denied using recreational drugs and having current or serious past medical problems. Steve had been married to his high school girlfriend for 1 year before divorcing 15 years earlier. He had come out as a gay man 12 years earlier and for 5 years had lived with his male domestic partner. Steve denied a history of trauma or abuse. He reported that he had had two previous inpatient stays and had taken an antidepressant medication for the previous 5 years, and that it was helpful.

As the therapist moved into the interview, she found that Steve again presented as bright, articulate, and interpersonally skilled, and as warm, genuine, and psychologically minded. Steve described again his wish to get CBT to help him tune up how he managed some stressors. These stressors included the need to move to a new home within a good school district, as their child was reaching school age, and the fact that his partner had been recently diagnosed with cancer that was not immediately life threatening but that did require further testing and treatment. Steve reported that he wanted to be certain he could maintain good coping in the face of these stressors.

As the therapist worked with Steve to develop a Problem List, she was surprised to see that he did not describe symptoms of depression or show facial expressions, body postures, or other evidence of depressed mood. This presentation was inconsistent with his report on the BDI and the SCL-90R, where he had endorsed many symptoms of depression. The therapist noticed
the discrepancy but did not yet understand it, and knew that she needed to account for it in her formulation of Steve’s case.

Steve was an excellent historian, and it was easy for the therapist to collect a good family history. Steve reported that his upbringing had been greatly influenced by the extreme and intolerant religious group to which his parents belonged. They firmly believed and taught him that if he did not excel in school and church activities, and did not follow the path they had laid out for him (to be a missionary and leader in the church, and to marry and produce children who would continue the tradition), then he was unacceptable to God, his parents, and their religious community. In fact, he would be damned to hell and struck down dead if he participated in any of a number of forbidden activities, including masturbation and homosexual acts. Steve tried to follow the path that his parents planned for him. At first he had some success, excelling in school and Bible studies. However, this lifestyle became increasingly incompatible with his own goals, values, and interests. Steve began to realize that he was gay and wanted a career in business rather than to marry and work for the church. Matters came to a head when Steve was 18. He had realized he was gay and felt unworthy and damned to hell. He fell into an acute depressive episode, attempted suicide by hanging himself (but the support to which he tied the rope broke), and spent 1 month in a psychiatric inpatient unit. Reflecting on his hospitalization, Steve reported, “It felt great to be locked in and away from my family’s influence, with no religious counselors.” When Steve left the hospital and realized that, contrary to his expectation, he had not been “struck down dead,” he began to “rebuild” himself. He divorced, moved to another community, and went to college to study business. He sought therapy to help with this transition and in particular to help him come to terms with the fact that he was a homosexual.

Steve experienced a second episode of depression and suicidality at the age of 28, precipitated by beginning to live with and to establish a committed relationship with another gay man. He was again hospitalized for a month. After his discharge, Steve worked with a CB therapist and found CBT to be “extremely helpful.” He especially liked activity scheduling, Thought Records, and keeping Positive Data Logs (PDLs).

As the initial consultation session came to a close, Steve and the therapist agreed to meet again to complete the assessment and treatment planning process. Steve agreed to complete an activity schedule, BDI, and Burns Anxiety Inventory before the second session, and to draft a list of treatment goals.

During the second consultation session, the therapist reviewed the activity schedule and learned that Steve was indeed carrying lots of responsibility and functioning at a high level. She also collected diagnostic information. Based on all the information she gathered, her initial diagnostic hypotheses were that Steve met criteria for major depressive disorder, recurrent, moderate, and dysthymia, but not for a bipolar disorder or an anxiety disorder. The therapist summarized the Problem List she had developed with Steve (depression; concerns about coping with stressors, especially his partner’s illness;
and dissatisfaction with his neighborhood and school system). She shared her diagnostic hypotheses and advised Steve that he met criteria for both major depression and dysthymia. Steve concurred and emphasized that his goal was to continue functioning and to avoid another severe depressive episode.

The therapist reviewed Beck’s cognitive model of depression with Steve and based her initial formulation hypothesis on it. She chose this model because Steve had used it in his previous therapy, and it was the model with which the therapist was most familiar. She shared her initial schema hypotheses with Steve, namely, that Steve had the self-schema “I am unworthy/bad/unacceptable to God,” and a schema of others as rejecting and judgmental. These schemas appeared to have their origins in Steve’s fundamentalist religious upbringing, and, when triggered, to produce depressive symptoms. The stressors of his partner’s illness, the recent adoption of a child, and the need to move to a new community that would provide a good school for his child were likely precipitants to Steve’s current depression.

**Treatment Planning and Obtaining Informed Consent to Treatment**

Based on the diagnoses and formulation, Steve’s previous success in CBT, and his own wishes, the therapist proposed an initial treatment plan of weekly individual CBT sessions. The therapist and Steve agreed that they seemed like a good match to work together. As she proposed the treatment plan, Steve’s therapist informed him that she did not have a complete formulation of his problems and symptoms, and that she wanted to spend more time working with him to understand what was causing his symptoms and concerns and to clarify the details of what he needed in the therapy. Steve liked this proposal. The therapist also recommended that Steve continue his antidepressant medication, and he agreed. Steve and the therapist set initial treatment goals, including reduction of depressive symptoms and concern about losing his ability to function. The therapist explained that they would monitor Steve’s progress throughout the therapy, and that if progress stalled, then they would revisit the formulation and treatment plan. Steve was agreeable to this as well, and he agreed to complete a BDI and Burns Anxiety Inventory before every session to assess progress.

As the second session ended, Steve asked to set a homework plan to resume keeping a PDL, because it had been so helpful to him in the past. The PDL (Padesky, 1994; Tompkins, Persons, & Davidson, 2000) is a list of concrete and specific instances of data that support the healthy schema the patient is attempting to strengthen. The schema Steve chose to address was “I am worthy.” From what the therapist had learned about Steve’s family history, precipitants to major depressive episodes, and his previous success using a PDL, this homework plan seemed to make good sense. The therapist had some concern that addressing this schema from the get-go as a homework assignment might be premature, because she did not know Steve very well yet, and schema change interventions were usually used later in treatment, not at
the beginning, but given Steve’s eagerness to use the PDL and his report about how helpful the intervention had been to him in the past, she agreed to the plan.

**Treatment, Progress Monitoring, and Hypothesis Testing**

The next three sessions fleshed out Steve’s case formulation and focused the treatment more precisely. Something striking happened in the third session. Steve had completed his PDL and brought an impressive list of data that supported the new schema of himself as worthy. Steve’s therapist was struck by how impressive his data were. Most patients who use the PDL to strengthen a schema have a lot of difficulty generating material for the log and come in with just a handful of items. But Steve had listed numerous small and large accomplishments, and many instances of positive feedback he had received from work colleagues and supervisors, community leaders, and social service agencies that had helped him foster and adopt a child. He had extensive concrete evidence of his worthiness. When the therapist pointed this out, Steve agreed. He reported that he was acutely aware of a huge “mismatch” between the view of himself as worthy and what he called “a core belief that’s always present” that he was not worthy and was in fact a failure and a bad person who was damned to hell. The view of himself as a failure was based on what he had learned at home from his parents and at church. By his parents’ standards, Steve reported, he was a failure. He was a gay man who had left the church, and he literally deserved to be struck dead or go to hell.

As he talked about the mismatch of his old belief about himself and the new one, Steve became increasingly distressed and began to sob. The therapist waited for Steve to regain his composure, and when she saw that he was having difficulty doing so, she used grounding techniques described in posttraumatic stress disorder (PTSD) treatment protocols to help Steve calm himself. She asked Steve to look directly at her so he could focus on what she was saying, and she instructed him to take slower breaths, then to look around the room and name items and colors one at a time. After about 10 minutes, Steve regained control. As they talked about what had happened, Steve told the therapist that experiencing such intense sadness and distress was quite frightening to him. He reported that he had not realized how strongly he held the belief that he was unworthy and bad. He was terrified of losing control and feared that he would “fall apart” if he acknowledged the mismatch between the old “unworthy” belief and the new one that he was worthy. Steve’s fears were strengthened by his observation that he had become depressed and suicidal, and spent a month in a psychiatric unit each time he confronted the mismatch between these beliefs. In fact, what had just happened in the session was the very thing Steve had feared and avoided. He had avoided confronting the mismatch between his conflicting views of himself for fear that he would lose control. The PDL forced him to confront the mismatch, thus activating emotions that felt overwhelming to him.
The fear of emotional dysregulation explained the discrepancy the therapist had noted between Steve’s cheerful demeanor and the numerous symptoms he endorsed on the self-report scales of depression. Steve had minimized his depressive symptoms (and had stayed busy, as the activity schedule indicated) to avoid acknowledging his distress, because he believed that if he felt or showed sadness, he was at risk of falling apart. The therapist discussed this issue with Steve, and they agreed to add the fear of intense emotions to the mechanisms part of the formulation. Thus, Steve’s emotional reaction in the third session provided data that led to a revised formulation of his case and helped to clarify his treatment goals. The therapist maintained her initial formulation of key schemas as described earlier, and added to the formulation Steve’s fears of confronting the mismatch between the old and new views of himself, and especially of experiencing the intense emotions that this confrontation elicited.

The new formulation proposed that Steve was raised in a home (ORIGINS) in which he was taught the belief, “If I deviate from God’s rules, I am unacceptable to God and unworthy” (MECHANISM). He also had a view of himself as fragile. In particular, he believed, “If I confront the conflict between my views of myself as unworthy and worthy, I will fall apart and be unable to function.” He also believed that others were judgmental, critical, rejecting, unforgiving; the world was confusing, full of contradictions; and the future was uncertain, frightening (“because my mental health is fragile”) (MECHANISM). As a result of these beliefs, Steve avoided acknowledging his old beliefs, the contradiction of the old and new beliefs, and any emotional distress, including his symptoms of depression (PROBLEM). Life stressors, including the adoption of child, the search for new home, and his partner’s cancer (PROBLEMS and PRECIPITANTS) activated his view of himself as fragile (MECHANISM). As a consequence, he began to feel inadequate and overwhelmed, and had symptoms of depression (PROBLEMS).

Based on this new information, Steve and the therapist agreed to add two additional treatment goals. First, Steve agreed that he wanted to decrease his fear of negative emotions and to overcome his belief that he would fall apart and become unable to function if he experienced negative emotions, especially sadness. Second, he agreed to add the goal of developing balanced schemas that “resolve the mismatch between my view of myself as unworthy/unacceptable and the new view of myself as worthy and acceptable.”

Over the course of the next two sessions, Steve and his therapist examined the core schemas of being of unworthy and “disgusting” to God, and the mismatch of the old and new schemas. The therapist continued to use grounding techniques from PTSD protocols to help Steve maintain and regain emotion regulation when, in the course of this work, he became distressed. In this way, Steve learned that he could experience negative emotions in therapy sessions and still regain his composure in the office and function well when he left the office. Overcoming the fear of dysregulation allowed Steve to carry
out homework assignments to address his mismatched beliefs about himself. He developed detailed lists of "old values" that he learned from his parents and of his new "core values." He decided to reconcile these two value systems rather than to embrace one and reject the other. Steve reported that this process felt "big," but that he felt hopeful about resolving the conflict between his beliefs.

An event occurred between these early treatment sessions that further informed the formulation and the treatment plan. As part of his work to reconcile his two value systems, Steve attended a nondenominational church service. The sermon included the words, "God loves you in all of your imperfections." These words represented a view of God as accepting, which represented values directly opposed to his parent's values. In just the way the PDL had, this event highlighted the mismatch of his two value systems and triggered Steve's fear of losing control. Steve felt so anxious that he fled the church, fearing that if he stayed, he would become emotionally overwhelmed and fall apart. This reaction was a piece of data supporting the formulation hypothesis that fear and avoidance of emotional dysregulation, and the tension between old and new values, were at the heart of Steve's difficulties.

Moreover, the level of fear he experienced and his escape behavior in church suggested to the therapist that Steve might benefit from an exposure-based treatment of the sort used to treat clinical fears and phobias (e.g., Foa, Hembree, & Rothbaum, 2007). The therapist proposed to Steve that an exposure-based treatment component would allow him systematically to face his fears of dysregulation and of the conflict between his belief systems. The therapist explained the anxiety disorders treatment model of graded exposures to feared situations, using a rating system of subjective units of distress (SUDS) levels to allow Steve to approach gradually and overcome feared situations (Foa et al., 2007). Steve reported that although he had not previously thought about his problems in terms of fears of emotional dysregulation and anxiety, this formulation felt right to him. He liked the systematic exposure-based treatment plan, and he agreed to develop a hierarchy of situations and words that activated emotional dysregulation.

The remainder of the therapy was straightforward. Steve and his therapist developed a short hierarchy of emotionally activating words and situations, and assigned SUDS levels (from 1 to 100, with 100 being the most anxiety provoking) to each item. Examples of hierarchy items included writing (SUDS = 60) and saying (SUDS = 70) the phrase "God loves me in all of my imperfections" and listening to a recording of the sermon that had caused him to flee the church (SUDS = 90). Steve first practiced writing and then verbally repeating the phrase in session, until his SUDS rating dropped below 20. He initiated a plan to repeat the phrase as often as he could throughout the day, including while in the shower, on breaks at work, and during free time at home. Steve was so motivated by how much better he felt after doing this for a week that he ordered a tape of the sermon and began listening to it as soon as it arrived
in the mail. His SUDS ratings quickly dropped below 20, which provided data that the case formulation and exposure-based treatment plan were on track. Steve learned that he could fully experience the negative emotions associated with the triggers on his hierarchy without becoming dysregulated, and he no longer needed the grounding techniques the therapist had taught him in the early sessions. Steve and his therapist were able to develop and discuss evidence supporting an integrated schema that allowed him to embrace his new values, while still being loved and accepted by God. He became comfortable with the belief: “I am imperfect and God still loves me. God loves me as I am.”

After the eighth session, Steve felt ready to take his son for an extended visit to his parents over the holidays. Steve’s willingness to undertake this visit was evidence of the progress he had made in treatment, because it indicated his willingness to engage in interactions with his family members that forced him to face conflicting value systems, negative emotions, and the potential for emotional dysregulation. When he returned from his trip home, Steve was pleased to report that he had been more assertive with his family than he had been in the past and had not avoided situations that were emotionally activating. He had experienced a range of emotions, including negative ones, when he interacted with his family and had felt good about his values, his parenting, and his accomplishments. He reported that it felt “so liberating” not to carry the burden of his old schema around with him. He stated that he felt ready to terminate treatment.

Steve’s therapist suggested that they review his progress toward his goals to evaluate whether termination made sense, and Steve agreed to that plan. They had most extensive data on his first goal, that of reducing Steve’s depressive symptoms. He had begun treatment with a BDI score of 21. By the third session, when he reviewed the PDL and became dysregulated, his score was 11. Steve reported feeling “shaky” at the end of this session (“crying means I’m not OK”), but also that it felt positive to “capture the core problem.” In sessions 4 and 5, as he confronted the mismatch between his schemas and experienced a great deal of emotional distress, his BDI scores increased to 15 and then 16. After working in and out of session to confront the ideas that were most frightening to him, Steve improved markedly. When he returned for his sixth session, his BDI score had dropped to 8, and it was 4 in his 10th and final session. With regard to his goal of reducing concern about his ability to handle stressors, Steve reported feeling confident that he now could handle moving to a new neighborhood and coping with his partner’s illness, because he was no longer fearful of “falling apart.” He and his partner had begun house hunting, which was something Steve had previously avoided. He had evidence (e.g., from his exposure sessions and his visit to his parents) of his ability to tolerate negative emotional states, and he had made significant progress toward reconciling his old and new value systems.

As they prepared for termination, the therapist and Steve reviewed what he had learned in treatment. Steve was delighted with what he had accom-
plished in such a brief therapy. Steve pointed out that when he had been severely depressed in the past, he was unable to face the conflict between his beliefs and the accompanying activation of affect. He was pleased that he had initiated this treatment while he was high functioning, and that he and the therapist had successfully identified the obstacle (fear of negative emotions and emotion dysregulation) to developing a positive and integrated self-schema.

The therapist expressed some concern that Steve might be ending treatment prematurely and be vulnerable to relapse. This concern was consistent with the formulation hypothesis that Steve’s fears of emotional dysregulation and of acknowledging symptoms or problems might cause him to perceive the need for therapy as an indicator of not being OK, which he previously had equated with catastrophic consequences. Steve was receptive to considering the points the therapist raised but insisted that he had done the necessary work and felt ready to end therapy. Also, Steve had achieved his treatment goals, and the data from the weekly BDI scores indicated that his depressive symptoms had remitted. Steve and the therapist agreed that he would contact her to arrange for additional sessions if they were needed in the future.

Follow-Up

One and a half years after the end of therapy, the therapist contacted Steve to obtain some follow-up data for this chapter. Steve reported that he had been well in the interim and was flourishing. He reported a BDI score of 0 and a Burns Anxiety Inventory score of 1. He endorsed only a few symptoms on the SCL-90R and no longer endorsed the item “Feeling that something bad is going to happen to you.” On the FSI, he reported that he was functioning “very well” to “extremely well” and was satisfied in most areas of life. The only domain in which he felt only “a little satisfied” was his home/neighborhood/community. He and his partner were considering another move, because Steve had been promoted and his new job entailed a very long commute from their current home. His partner’s cancer was in remission. The therapist felt some concern that Steve’s scores were too low—that is, that Steve had not entirely overcome his fear of negative emotions but was simply avoiding them. Nevertheless, the scores and Steve’s report about how well he had been doing provided evidence that treatment had had lasting results, as did a beautiful letter Steve wrote that described how much he had gotten from the therapy. He reflected back on the beginning of treatment and described himself as having been “in the middle of a crisis of confidence.” He reported that in therapy he had resolved the “deep inner conflict between value systems.” He wrote: “I was able to sink the juggernaut of my old beliefs and reconcile my new values with a much friendlier, humane God with the grace to accept me as I am. In some ways I had to learn to tolerate doubt, be honest and authentic, take care of myself, and trust myself to do my best in the process (and it’s OK because I can never be ‘perfect’ anyhow).”
Overview of the Case

The case of Steve illustrates several points. First, although Beck’s model provided a foundation for the case formulation and the treatment, the therapist also relied on other models to guide her formulation and treatment. After she learned that Steve was afraid of the mismatch of his beliefs about himself and the negative emotions that resulted, the therapist relied on the learning theory–based formulation underpinning exposure-based treatment of anxiety disorders to guide treatment of those fears. She and Steve developed a hierarchy of the thoughts and emotions he feared and systematically carried out exposures to them.

Second, the conceptualization and interventions Steve’s therapist used are also consistent with several other CB models. Steve’s formulation and treatment are consistent with the exposure-based cognitive therapy (EBCT) developed by Adele Hayes and her colleagues (2007), which applies principles of exposure and schema-focused therapies to the treatment of depression. In fact, the spike in Steve’s BDI scores early in treatment is quite consistent with the Hayes et al. model of the change process in their therapy.

Steve’s conceptualization and treatment also fit nicely with the conceptualization and treatment of PTSD developed by Ehlers and Clark (2000). PTSD often includes fears of negative emotions that arise when patients confront conflicting belief systems (e.g., the old belief that “the world is safe,” and a new one that “the world can be dangerous”) that are not integrated into a coherent biographical narrative. Ehlers and Clark encourage the person with PTSD to approach the feared emotions to learn that they are not dangerous and to work to integrate apparently conflicting ideas into a coherent narrative. Steve’s treatment could also be viewed as including elements of acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999), especially the emphasis on overcoming experiential avoidance.

The observation that the conceptualization and interventions Steve’s therapist used were consistent with several models and therapies highlights the point that multiple CB models are available to guide conceptualization and treatment. Steve’s therapist used more than one model to guide his treatment. We suspect that the use of multiple models to guide treatment for one patient is common in clinical practice, although, to our knowledge, this practice has not been subjected to formal study.

Although the availability of multiple models is a boon in many ways, it can also make the therapist’s job more difficult. The therapist can get lost in the forest of options. A case formulation provides a clear path through the woods. The strategy of developing a clear formulation, then using it to select interventions from multiple sources, can provide overall clarity and coherence to the treatment.

Third, Steve’s case was an unusually successful one. We speculate that contributing factors included the moderate severity of Steve’s symptoms and his strengths, especially the degree of leadership he took in his therapy. For
example, Steve himself proposed repeated exposure to the sermon that was so frightening to him, and he took steps to order a copy that he could listen to repeatedly. Steve was an unusually full collaborator in his treatment. We suspect that many patients could play a more active role in their treatment if therapists worked harder to permit and encourage such activity. As Miller and Rollnick (2002) point out, patients truly are the expert on their problems and can contribute hugely to their own treatment. We encourage therapists to engage their patients fully in the formulation and treatment processes.

FINAL DISCUSSION

This chapter describes and illustrates a framework for providing individualized CBT, of which the case formulation is a key element. The framework is depicted in Figure 6.1. The formulation (or formulations, because the therapist develops and uses multiple formulations at multiple levels over the course of treatment) serves as a hypothesis that the therapist uses to guide intervention and tests by collecting data to evaluate the process and progress of therapy. McCrady and Epstein (2003) have discussed the need for such a framework in the substance abuse field, and the American Psychological Association (2005) has described the need for such a framework in psychotherapy more generally. These frameworks, including the one described here, are not new therapies. They simply provide a heuristic for adapting evidence-based treatments to the case at hand in a thoughtful and systematic way. Nevertheless, these frameworks require evaluation in controlled studies to determine their utility in clinical practice.

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