CHAPTER 3

The case formulation

The case formulation is a hypothesis about the nature of the psychological difficulty (or difficulties) underlying the problems on the patient's problem list. This chapter begins with a description of the many roles of the case formulation in treatment. Next, the format of the case formulation is outlined and an example provided. Finally, the process of obtaining a formulation is described in detail, and five strategies for testing a formulation are described.

ROLE OF THE CASE FORMULATION

The case formulation is the therapist's compass; it guides the treatment. In general terms, the most important role of the formulation is to provide the basis for the treatment plan, which follows directly from the hypothesis about the nature of the underlying deficit producing the patient's problems. Clinical examples are used here to illustrate nine important roles of the case formulation. The case formulation helps the therapist:

1. Understand relationships among problems

The case formulation ties together all of a patient's problems. Without the formulation, the therapist may see the problems as a random collec-

tion of difficulties. In addition, patients sometimes seek treatment of only some of their problems. The formulation can help the therapist estimate whether this type of treatment plan is likely to be successful, as in the case of a 50-year old bachelor who seeks treatment for fears of contamination and extensive washing rituals dating from early adolescence. The washing rituals currently consume most of his waking hours. Mr. Bachelor is unemployed and has worked only one to two years since graduating from college more than 25 years ago; he has been supported by his family. He is also quite socially isolated. However, he states that he does not want to address the work and social problems in treatment; he wants to focus only on the contamination fears and the washing rituals. At the end of the evaluation session, however, it comes out that he is ambivalent about giving up these symptoms, because then he would face the need to go to work (he is running out of money) and to interact with others. Thus, the patient's contamination fears and washing rituals are reinforced by the fact that they protect him from confronting his fears of work and social interactions. This patient's central irrational fear appears to be, "Going out in the world is too dangerous for me." This formulation suggests that the fears of work and relationships must be included in treatment if it is to be successful. In fact, the formulation suggests that it may be necessary to treat these fears first.

2. Choose a treatment modality

A 35-year-old female assistant professor at a major university sought treatment for anxiety. She reported that she had had two panic attacks about eight months prior to seeking treatment, and high levels of anxiety since. The first panic attack occurred on the day she left the hospital with her new baby. This panic episode was resolved by calling her husband to come to the hospital to get her. The second attack occurred two weeks later, on a Saturday afternoon at home, while she was waiting for her husband to return from a bowling party with his friends. Except in the case of the two panic attacks, she was unable to say what situations or cognitions preceded the anxiety. The problem of assessment was complicated by the fact that as soon as she began treatment, the anxiety largely remitted.

What treatment ought the therapist to suggest? Without a formulation, the therapist might simply treat the symptoms. In this case, because the patient's presenting problem was anxiety, relaxation training might have been prescribed. The therapist did prescribe relaxation training, but it was presented as a helpful strategy, not a complete solution; this would

not be possible until a full understanding of the causes of the anxiety was obtained. To search for this information, the patient was asked to keep a log of anxious feelings, the situations in which they occurred, and thoughts occurring at those times. Log-keeping revealed that the patient felt anxious when her husband (a traveling salesman) was out of town.

A discussion of the patient's concerns when her husband was away and an investigation of the marital relationship showed that the patient tended to assume the role of caring for all of her husband's needs and those of the children and household as well. The couple had two children, a large home, and both worked full time at demanding jobs. In addition, the patient was recovering from a recent serious medical problem and major surgery. Her husband was out of town at least three days a week. He was accustomed to spending his weekends socializing with his friends and watching sports events on television.

This information led to the formulation that the young wife's panic was a result of the idea, "I can't get the help I need from my husband." As a result of her belief that she could not get help, she tended to assume excessive burdens and to avoid asking for help from others, assuming she would not get it. As a result, she felt overwhelmed, undersupported, and anxious. This hypothesis is consistent with the fact that the first panic attack was resolved by calling the husband to come to the hospital and that the second attack occurred when he was away from home. The formulation is also consistent with the fact that much of the patient's anxiety remitted when she began treatment (and felt she was receiving some support and help).

This pattern of assuming excessive responsibility had occurred before, in a relationship with a previous boyfriend who was a drug addict and in the patient's relationship with her parents. Her father was a charming but completely unreliable person (he agreed to pay the patient's college tuition; the patient learned he had not done so when when she received a notice cancelling her registration). Her mother depended so heavily on her children for emotional support that they were unable to rely on her.

The husband had a complementary belief, "I expect my wife to take care of my needs," which had its origins in his upbringing as an only child whose mother focused her life around him and his needs. This formulation (or pair of formulations) suggested that marital therapy was indicated. The couple agreed to this, and the outcome was successful.

3. Choose an intervention strategy

A young executive, recently recovered from a depressive episode, came to a therapy session feeling quite distressed, saying, "I've been rejected by

a woman." He reported that a young woman he had been dating for several weeks had decided to return to her boyfriend of six years, whom she had left about six months earlier. Although he could see, logically, that her decision to break off the relationship probably had nothing to do with him, he was still caught up in a stream of self-critical thoughts, and he kept repeating, "It must have been something I did. Women don't like me—they never have and they never will." He proposed, "I think I should do cognitive therapy homework for about an hour every morning to improve my mood before I leave my apartment, because I'm frequently in a bad mood in the morning and that turns women off."

The patient's homework suggestion makes a certain amount of sense. This young man did have a tendency to lapse into negative and hostile moods, and there is good empirical evidence that depressed, negative moods push others away (Coyne, 1976). Despite these considerations, the therapist's response was, "No, I don't think that's a good idea. In fact, what would be a better idea would be to go out every day in as negative a mood as possible and have as many interactions with as many people as possible. Keep a careful log of the results."

The patient was astonished by this recommendation. Why did the therapist propose this intervention rather than the one the patient suggested? The answer, of course, comes from the case formulation. This was an intensely self-critical young man who responded to every setback and negative event in life by saying to himself, "It must have been due to a mistake on my part. If I had done things correctly, this wouldn't have happened. My behavior must be perfect at all times or I'll be rejected by others. I must correct all the defects in my personality or I won't receive love from others." This belief had its origin in his relationship with his father, who was extremely critical about every aspect of his young son's behavior and appearance. The young child must have learned, "In order to gain approval and caring, I must be perfect."

He had a similar idea about his work ("My performance must be perfect in order for me to feel happy about my work and accomplish my goals."). The result was that he couldn't make good progress on various technical projects he was working on because he insisted on perfecting the work at every stage. As a result, he never got beyond the initial stages of the project.

If this formulation is correct, what this patient needs to do is not to abolish his negative moods but to learn that he can have caring and successful relationships with others even if he is sometimes in a bad mood. Paradoxically, of course, learning this lesson will improve his mood. The therapist operating with this formulation would recommend

against the patient's proposed homework plan, because this plan simply reinforces the patient's perfectionism.

The general point here is that the cognitive-behavioral view that mood changes can be accomplished by changing cognitions and behaviors does not tell the therapist what intervention to choose for any particular problem. More precisely, it does not tell the therapist what the problem is, exactly. Is this patient's negative mood in the morning a problem that needs correction? The goal of eliminating all the patient's negative moods is unrealistic, and in the case presented here, counter-therapeutic. In particular, treatment interventions that are not guided by the case formulation may fall into the trap of accepting the beliefs of patients who state, "I must learn to overcome all my negative moods," "If I experience a negative mood, that means there's something wrong with me," "I shouldn't feel angry," and similar perfectionistic ideas.

4. Choose an intervention point

It is unrealistic for the therapist to attempt to eliminate all the patient's distorted and maladaptive thinking. After all, overgeneralization and all-or-nothing thinking occur all the time in everyone (a distorted thought!). How does the therapist choose which distorted, maladaptive thoughts to take up in therapy? How does the therapist choose which problematic behaviors to work on? The case formulation helps the therapist to answer this question and to focus on problems and aspects of problems that are closely related to the patient's central difficulties.

Sometimes the patient comes to the session with two or three topics he wishes to discuss. Which one is it most useful to work on? The formulation can help the therapist focus on the problem most closely related to the patient's central difficulties. For example, a patient with the belief, "If I attempt something, I'll fail," and a pattern of beginning projects but then dropping them when she gets anywhere near the possibility of failure, comes to her therapy session wishing to discuss recent visits by relatives, but doesn't raise the topic of the status of a new approach to finding a job that she initiated last week. The therapist attending to the formulation knows she needs to ask about that project.

Similarly, a young woman with the beliefs, "I'm unimportant, my needs don't count, no one is interested in me," began her therapy session with the statement, "During the week I made a list of things I wanted to talk about here, but when I was sitting in the waiting room, I decided none of them was important." Without the case formulation, the therapist might respond to this statement by saying, "Well, let's follow up on

what we did last time. How did your homework assignment go?" hoping this would lead somewhere productive, which it probably would. However, an awareness of this patient's formulation suggests that a better intervention might be:

THERAPIST Oh . . . Do you see what's going on here?
PATIENT No.
THERAPIST Well, let's go over again what you just said: "During the week I had a list of things to discuss, but now they seem unimportant." Does this statement sound familiar to you?
PATIENT (silent)
THERAPIST This idea reminds me of the common idea you have, "No one is interested in me; my needs don't count." Does that ring a bell?
PATIENT Yes.
THERAPIST OK, now what does that tell us about what we should do about the thought, "Now the things I wanted to discuss seem unimportant"?
PATIENT (silent)
THERAPIST Well, I'd suggest we don't buy into it. What do you think?
PATIENT (smiles brightly and pulls out the list of topics she had drawn up earlier in the week)

5. Predict behavior

The ability to predict patients' behavior can be extremely useful to the therapist, and the formulation can predict some aspects of patients' behavior. For example: imagine that the therapist gives a new patient, who believes, "Unless I do things perfectly, I'll be unacceptable to others," the homework assignment to keep a log of angry outbursts and bring it to the session. The formulation can be used to predict that the patient is likely to feel quite anxious about presenting his log to the therapist; he is likely to have an automatic thought like, "It's no good—she'll think I'm a bad patient and tell me she can't work with me."

Thus, the formulation predicts the patient will feel anxious about the homework assignment. If the patient also holds the belief, "I can't cope with stress," avoidance responses may be predicted as well: the patient may forget the assignment, precipitate an emergency that takes priority over the assignment, cancel his appointment, or even drop out of therapy. Another more productive avoidance (of anxiety) response might be to spend hours perfecting the homework assignment.

6. Understand and manage noncompliance

Consider the case of a young woman graduate student who habitually reschedules therapy sessions at the last minute and runs in the door five minutes late for nearly every session. Several questions about this behavior arise. First, is this behavior a problem that needs attention, or does it make sense for the therapist to simply accept five minutes' tardiness as within the realm of normal behavior? If it is a problem, what causes it and what is the best way to handle it? The case formulation helps the therapist answer all these questions.

To determine whether the lateness and rescheduling merit discussion in the therapy, the therapist can examine the case formulation and ask: Is the lateness and constant rescheduling that happens with me also happening outside the session? Is this problem one of the problems on the patient's problem list? Might the proposed mechanism underlying all the patient's problems on the problem list underlie this problem as well?

In this particular case, the answer to all these questions was "yes." Similar problems occurred frequently outside the session. In fact, the chaotic, disorganized life that resulted was the patient's chief presenting problem. The therapist had hypothesized that this patient's central underlying irrational belief was, "I can't make a good decision for myself. Any decision I make will be wrong and will lead to a disaster." A closely related idea was, "I must make the optimal use of my time, every moment of the day, or I'll fail." It made sense that the lateness and rescheduling were a result of these ideas.

To verify the supposition that the patient's rescheduling and lateness in the therapy sessions were due to these fears, and to flesh out the way in which the fears led to these problematic behaviors, each time the patient arrived late the therapist reviewed with her the circumstances responsible for the lateness. It became clear that the rescheduling stemmed from the patient's fear of having scheduled the session at a bad time and her inability to tolerate the possibility that she might have made a mistake—she feared a catastrophe would result. Driven by her need to make optimal use of her time, she constantly reorganized her schedule, continually tried to squeeze activities in time slots too small for them; as a result, she arrived late to nearly every destination.

Once the lateness and rescheduling were understood in this way, we proceeded with several therapeutic steps. First, the process of working to understand the lateness was an intervention in itself, because the therapist's initiation of a discussion of the causes of the lateness whenever it happened had the result of making it happen less often, because the

patient found these discussions a little punishing; she had other, more important, matters she wanted to work on in therapy. In addition, active work on the types of irrational thoughts that pushed the patient to overschedule herself decreased this type of behavior. The therapist also announced that she was no longer willing to reschedule the patient's appointments (response prevention), and explained carefully why this plan was necessary (therapeutic for the patient, necessary for the therapist's sanity and for continued good doctor-patient relations). This set of strategies was quite effective; the young woman stopped telephoning to reschedule her appointments and began coming on time regularly. Concomitantly, the therapeutic relationship improved markedly. Similar improvements occurred outside the session.

7. Understand and work on relationship difficulties

A graduate student came to therapy because he was anxious and depressed, was "blocked" in writing his dissertation, and had problems in his relationship with his girlfriend. His therapy sessions were problematic as well. He had difficulty scheduling regular, weekly sessions, saying, "I don't want to become so dependent that I'll have to come to you for the rest of my life." This fear was partly related to his concern about the expense of the therapy.

His interactions with the therapist were also troubled. He had a great deal of difficulty setting an agenda and tended to wander from topic to topic, taking up a subject in an offhand way, as though it weren't really important, and then quickly dropping it for another that he handled in the same way. He spoke in a nearly inaudible tone and mumbled out of the side of his mouth. The therapist began working on the problem by addressing the patient's difficulty setting an agenda.

THERAPIST When you think about making an agenda, what thought do you get?

PATIENT I think, "If I choose the wrong topic, I'll waste the session, and I'll waste money, and I won't make progress in the therapy."

THERAPIST Do you see that this fear you have about choosing the wrong agenda item in the session is similar to your fear of choosing the wrong direction of work on your thesis?

PATIENT I guess so.

THERAPIST It also strikes me as similar to the kind of problem you have in your relationship: you're afraid of getting involved before you're sure it will work out. Here, you're afraid of getting involved in

working on a particular topic until you're sure it will be profitable.

PATIENT I guess it's all the same thing.

THERAPIST Sounds like it. Let's work on this by working on the problem of setting the agenda in the therapy session. What can you say to yourself, when you get the thought, "This might not be the best thing to work on?"

PATIENT (blank)

THERAPIST Let's think about your usual strategy. Seems like what you usually do is to kind of make a tentative start on something, but all the time worry that it's the right thing. How well does that strategy work?

PATIENT Not too well. I don't get very far.

THERAPIST OK, now imagine you were to do it differently. How would it go?

PATIENT I guess I'd just go ahead with something.

THERAPIST That sounds right to me. Now, what can you say to yourself to help you just go ahead with something?

PATIENT (pause) I'll try this.

THERAPIST That's not bad, but it sounds a little like your usual strategy. Any other ideas?

PATIENT I'll try it and stick with it for a while.

THERAPIST That sounds better. Now let's try it. What topic should we take up right now?

PATIENT (blank)

THERAPIST I know it's hard for you, but at this point you just need to take the plunge.

PATIENT OK. Let's talk about the writing.

THERAPIST Fine. Let's go ahead. If you feel the need to change the topic, let me know, and we'll work on it so you can stay with this topic and get something done.

8. Make decisions about "extra-therapy" issues

If the patient asks to delay payment during a financial crisis, should the therapist grant this request? The behavior therapist armed with a list of techniques for particular problems has no way of thinking about this question. In contrast, the case formulation helps him understand what's going on and make a plan for how to handle it. The therapist might decide to refuse the request for the patient whose central problem is the idea, "I can't solve problems on my own; I must get help from others," but to grant it for the patient whose central problem is the idea, "I must never ask anyone for help—this means I'm weak."

9. Redirect an unsuccessful treatment

The formulation provided the therapist with a way of understanding and managing treatment failure in the case of a 30-year old depressed graphic artist who sought cognitive therapy to work on the following problems:

1. Depression. The depression had two prominent aspects: feelings of anger toward others and himself, and feelings of worthlessness, failure, and incompetence.
2. Feeling incompetent as an artist, and working at a level below his potential. He procrastinated on everything and avoided completing important projects.
3. Poor relationships with others: frequent fights with his girlfriend, estrangement from a close friend, estrangement from his parents. Relationship difficulties appeared to arise when the patient became angry at others as a result of his perception of being criticized, put down, taken advantage of, or treated unfairly. He became angry with his father, for example, when his father asked him about his art because he perceived these questions as a put-down.
4. Excessive concern about health and physical problems. The patient ruminated about minor problems, fearing they posed a serious danger to his health.

The depression had begun three years previously, when he had moved to California to accept a new job, leaving behind his network of friends and family. At about the same time, his sister committed suicide. The patient was extremely angry at his parents and stated, "My parents didn't handle the situation adequately; if they had, my sister wouldn't have committed suicide."

The therapist postulated that this patient's central problem was the idea, "Others should do what I want them to do or I'll be miserable."

The proposed mechanism accounted for some—but not all—of the problems on the problem list. The depression (1) and the anger and relationship difficulties with others (3) could be understood as a natural result of the fact that others usually did not do what he expected and insisted they do. The formulation did not account for the concern about physical problems (4), nor did it account for the work problems (2).

The proposed mechanism had its origins in the patient's family history. He was the oldest of six children, reared by a demanding, highly critical father and a rather passive mother. As all six children were born in the

space of eight years, we can speculate that the patient did not receive much attention and support from his mother. As a result, he felt mistreated by his parents and was quite angry at them.

Using this formulation, the therapy focused on the patient's anger toward others and his unreasonable expectations of them, using cognitive techniques to decrease the anger and to increase his sense of self-efficacy and his assertiveness. After about eight sessions, it seemed clear that treatment was not very helpful; sessions seemed unproductive and the depression was unabated.

At this point the therapist reviewed the case in an attempt to revise the hypothesis about the underlying belief generating the patient's symptoms and problems. The therapist asked herself, "*Why* is the patient so angry? Perhaps another, more basic problem produces the anger." This line of thinking led to an alternative proposal about the patient's central underlying belief: "I'm worthless." This formulation appeared superior to the previous formulation because it accounted for the patient's work difficulties, as well as for his concern about his physical health, if the problem of poor self-esteem were extended to the physical arena. This formulation differed from the previous one in viewing the anger as secondary—a result of poor self-esteem, rather than the other way around.

Using this formulation, the treatment was refocused on increasing the patient's self-esteem, beginning with asking the patient to keep a log of self-critical thoughts, and then to work to add some positive thoughts and to decrease the number of self-critical thoughts. Patient and therapist reviewed both past and current episodes in which the patient evaluated his conduct as inadequate and unworthy, in order to arrive at a more balanced and less self-punitive view. This treatment approach was rapidly effective, and the patient's depression improved markedly in two months.

This example illustrates the role of the formulation when treatment is unsuccessful. The failure of an intervention based on a case formulation suggests that the formulation may be incorrect. After arriving at a new formulation, the therapist can test this hypothesis and intervene to solve the problem by making an intervention based on the new formulation. Without the case formulation to guide this process, the therapist may make unsystematic, blind changes in the treatment plan, or give up completely.

Summary: The central role of the formulation

Thus, the formulation, particularly the part that describes the patient's central underlying irrational belief, plays several key roles in treat-

ment. If the formulation is so helpful to the therapist, we might also expect it to be helpful to the patient in understanding and managing his behavior. Thus, many of the interventions outlined in the remainder of the book are directed toward teaching the patient the nature of his central problem.

FORMAT OF THE CASE FORMULATION

The case formulation has six parts: (1) the problem list, (2) the proposed underlying mechanism, (3) an account of the way in which the proposed mechanism produces the problems on the problem list, (4) precipitants of current problems, (5) origins of the mechanism in the patient's early life, and (6) predicted obstacles to treatment based on the formulation. The problem list was described in the previous chapter; the remaining parts of the formulation are described here.

Hypothesized mechanism

The hypothesized underlying mechanism is the heart of the formulation, and the term "case formulation" in this book generally refers to the underlying mechanism rather than to the six-part formulation described in this section.

After fleshing out the problem list, the therapist attempts to propose a single psychological problem or underlying mechanism that can account for all of the problems on the list. Often this can be stated in terms of a central irrational belief, such as, "If I get close to someone, I'll get hurt."

An example is provided by the case of a 39-year-old physician who sought treatment for the following problems:

1. Work problems, including procrastination, overpreparation, and performance anxiety. The patient's automatic thoughts had the theme, "Others will see I'm incompetent, and I'll be fired." Assessment of her actual performance suggested that her fears did lead to procrastination and lateness, but that she was quite competent at most of what she did.
2. Ambivalence about her sexuality. The patient had had several sexual relationships with women, but rejected a lesbian lifestyle and wanted a relationship with a man because it was culturally more acceptable and because she felt like a failure for not being able to succeed at relationships with men.
3. Relationship difficulties. Attempts to develop romantic relation-

ships with men never seemed to get anywhere; they either failed altogether or turned into friendships. Relationships with women were pursued in fits and starts.

4. Depression. She felt dissatisfied with her life, disappointed in herself, and hopeless about making any changes.

The central irrational idea underlying these problems appeared to be, "Unless I do things perfectly and conventionally, I will be rejected."

Relation of mechanism to problems

In this part of the formulation, the therapist attempts to specify clearly the way in which the hypothesized central problem leads to all of the problems on the problem list.

In the case of the physician, the work difficulties and the ambivalence about her sexuality (numbers 1 and 2 on the problem list) can be understood as resulting directly from her fear that if she does not do things perfectly she will be rejected; she fears being fired from her job for poor performance and rejected by friends and peers for an unconventional lifestyle. Relationships with men (3) stall both because she does not make a sexual connection with them due to her lesbian sexual orientation and because she distances herself because of her fears that if men she likes get to know her they will think badly of her. Romantic relationships with women (3) stall because her fears of acknowledging her lesbianism and of being condemned and rejected cause her to continually withdraw from relationships. Even non-romantic relationships fail (3) because the patient is so afraid of being judged negatively and rejected that she distances herself from others and leads an essentially solitary lifestyle. The depression (4) can be understood as an indirect result of the lack of gratification and satisfaction she experiences in her life, coupled with the intense self-criticism she levels at herself because of her failures; as the formulation suggests, she perceives her failures as due to her own personal inadequacies and character flaws.

Precipitants of current problems

The attempt to tie the proposed central mechanism to precipitants of the current problems is a test of the hypothesis about the central mechanism. For example, a patient who holds the belief, "Unless I'm loved I'm worthless," might be expected to become depressed following a rejection or a loss of love. If another type of event precipitated the current episode,

or if the loss of an important love does not precipitate symptoms, the formulation is called into question. Of course, many events that do not at first appear to involve a loss of love may carry this meaning to the patient, so an investigation not only of the event but also of the meaning of the event to the patient is indicated.

In the case of the physician described here, difficulties were long-standing, but an increased bout of anxiety and depression were precipitated by the occasion of her 39th birthday, which elicited the automatic thought, "I'll never have a baby and a conventional family, and without that I'll be rejected by others."

Origins of the central problem

Finally, the therapist attempts an account of the possible origins of the hypothesized mechanism (central problem) in the patient's history. Usually relationships with parents play a central role here.

The phobic physician had been reared by a father who was criticized harshly on a daily basis by his wife for his failings. The patient may have learned that incompetence of any sort leads to harsh negative judgments and rejection by important others.

Predicted obstacles to treatment

The formulation can be used to make predictions about obstacles that might arise in the course of treatment. The ability to predict difficulties makes it more likely that the therapist can prevent or solve them. In this case, the patient's belief, "Unless I do things perfectly I will be rejected," suggests that she will be unduly anxious about the therapist's evaluation of her performance in therapy. Given her behavioral pattern of coping with anxiety by avoiding, we can expect that she might avoid homework assignments through procrastination or forgetfulness.

Of course, patients with other problems will encounter other obstacles in treatment. The patient with the central belief, "I must gain the approval of others at all costs," might be expected to be extremely—and, in fact, excessively—compliant with any and all requests the therapist makes. In some cases, this can be helpful, as the patient may be willing to, for example, carry out tasks that are quite difficult for her or homework assignments she doesn't believe will be helpful, just because the therapist has requested it. However, the patient's inability to assert herself with the therapist may make it impossible for her to refuse to do a certain task, and the patient may even feel the only alternative is to drop out of

treatment. Or, she may become angry and resentful at the therapist for "forcing" her to do things she doesn't want to do. For another example, a patient whose central problem appears to be an impulsive decision-making style as a result of a deficit in responding to long-range consequences of his behavior is likely to wish to terminate treatment impulsively when he doesn't feel he is making immediate important gains. The therapist can intervene preventively, including setting explicit, achievable treatment goals and warning the patient that he may have the urge to end therapy prematurely.

The six-part format for the case formulation outlined here appears in Table 3.1, which can serve as a form for the therapist wishing to integrate the formulation into his writeup. The Table also includes a place for the Treatment Plan, which ought to follow logically from, and be based on, the hypothesized underlying mechanism.

THE PROCESS OF HYPOTHESIZING AN UNDERLYING MECHANISM

The process of developing a hypothesis about the underlying mechanism is one of the most difficult (and creative) parts of treatment, and some ideas about how to do this are offered here.

Examine the problem list

A good first start to obtaining an idea about the underlying mechanism is a very close look at the problem list. A central theme often becomes apparent when the therapist examines the problem list while asking himself the question, "What do all these problems have in common?"

A fine-grained look at the problem list can reveal nuances that provide clues to the underlying mechanism. For example, a problem described grossly as "depression" conceals many details. Individuals who report lots of self-criticism, feelings of failure, self-hate, and guilt may have central problems along the lines, "I must be perfect or I'm worthless." In contrast, those who are concerned that they are becoming old and unattractive may be dependent and fear rejection from others (Beck, 1983; Persons & Miranda, 1988).

A careful look at the patient's pattern of behavior can be helpful. Examine the patient's behavior, asking the question, "What belief would a person who is behaving like this have?" For example, the person is avoiding bridges, freeways, anxiety. This person must think, as Beck

Table 3.1 The Case Formulation

Identifying information:

Chief complaint:

Problem list:

1.
2.
3.
4.
5.
6.
7.
8.

Hypothesized mechanism:

Relation of mechanism to problems:

Precipitants of current problems:

Origins of the central problem:

Treatment plan:

Predicted obstacles to treatment:

points out, "I'm a weak and vulnerable and fragile person, and I cannot cope with anxiety or stress of any kind."

Examine the automatic thoughts

Automatic thoughts—that is, the cognitive components of the problems on the problem list—are often derivatives of the central underlying belief. Thus, a graduate student came to therapy to work on his problem writing his dissertation. His automatic thoughts were: "I haven't done enough, I haven't learned enough, I need to understand everything in the lab and everything in my experiment perfectly before I can write my dissertation." These automatic thoughts are a very close cousin of the therapist's hypothesis about the key underlying belief, which was simply a more general statement of these ideas about the dissertation: "I must be perfect in everything I do or I won't be successful in life."

Study the chief complaint

Careful attention to the chief complaint, as well as the words the patient uses to frame it, can also be informative. I once treated a young man who stated, when he telephoned for an appointment, "I think I'd like to start therapy because I think it would be a good business investment in myself." This phraseology suggested that he was frightened of admitting problems or inadequacies, and that his central fear might be something like, "If I fail at anything, I'm a failure." As it happened, the treatment process indicated that he had both a fear of failure and a fear of rejection, as in the case of the phobic physician above.

Look for antecedents and consequences

Carefully specifying the antecedents and consequences of the problems frequently leads to a formulation. Thus, the case formulation approach to assessment is related to the ABC's (antecedents, behaviors, consequences) of traditional behavioral analysis (Goldfried & Pomeranz, 1968).

An example is provided by the case of a 20-year old man of borderline intelligence (IQ probably about 80) who was brought in for treatment of repeated vomiting episodes for which no physical cause could be found. Episodes, occurring about once a week, had led to a tear in the esophagus which led to life-threatening bleeding during severe vomiting episodes. An interview with the patient yielded little information.

Interviews with the patient's family revealed that when the patient had a vomiting episode, the patient's father, who was otherwise distant and unavailable, mobilized himself to clean up the vomit, prop the patient up on the couch in front of the TV and wait on him hand and foot. When necessary, he spent long hours with him in the emergency room. This information suggested that attention from the father was a consequence of the vomiting behavior. Because this attention was highly valued by the patient, it seemed likely that it was serving as a positive reinforcer for the vomiting.

This model of the contingencies controlling the vomiting suggested that the vomiting behavior could be eliminated by eliminating the attention received for the vomiting, while adding attention for "well" behavior. The patient's father reluctantly agreed to the plan of requiring the patient to clean up his own vomit, sending the patient to the emergency room alone, and withholding attention when the patient vomited. The father was unwilling to give attention when the patient was well, however, so this part of the treatment was done with the assistance of the patient's sister-in-law, who arranged for the patient to attend a rehabilitiation and recreation center for mentally handicapped young adults. Within three months, vomiting had completely stopped.

Although this patient's problem was most easily formulated in terms of antecedents and consequences, it can also be described in terms of underlying beliefs. This young man behaved as though he believed "The only way to get attention from my father is by vomiting," and "My father is the only source of affection and attention available to me."

An example of the importance of understanding antecedents can be drawn from cognitive therapy sessions devoted to eliciting automatic thoughts and answering them with rational responses in order to alleviate negative moods. These sessions are often structured around the Thought Record (see Figure 7.2, Chapter 7). The "Situation" column of this record might be viewed as specifying the environmental antecedents of the negative moods, and the "Thoughts" column as specifying the internal antecedents. Understanding these antecedents makes it much easier to modify negative moods.

Use a standardized measure

Cognitive therapists have begun developing standardized paper-and-pencil measures to assess underlying beliefs. The Dysfunctional Attitude Scale (DAS) was developed by Weissman and Beck (Weissman, 1979; Weissman & Beck, 1978) to measure the dysfunctional beliefs characteristic of depressed patients; the DAS is reprinted in Burns (1980).

Failure to obtain a formulation

Occasionally the therapist is unable to propose a formulation. When this happens, symptom-oriented treatment can be initiated. Sometimes this treatment will be successful; sometimes it is not, but it yields additional information that can eventually lead to a formulation (Turkat & Carlson, 1984).

TESTING THE PROPOSED UNDERLYING MECHANISM

The therapist can never be certain her hypothesis about the underlying mechanism is correct and must always be prepared to revise or change it in the face of evidence. This is a continuous process; in fact, assessment and treatment are a continuous process of proposing, testing, reevaluating, revising, rejecting, and creating new formulations.

Five tests of the underlying mechanism

The first test of the mechanism is: How well does it account for the problems on the problem list? To conduct this test, it's helpful to review, systematically, each problem on the list, and attempt to "tell a story" about how the proposed mechanism might lead, directly, or indirectly, to the problem. If the mechanism does not readily account for all the problems on the problem list, it is unlikely to be correct.

Second, as described above, the patient's report of the events precipitating the current episode ought to fit with the formulation in an easily understandable way.

Third, the therapist can test the mechanism by making predictions based on it, then testing the predictions by collecting the relevant data. For example, the hypothesis that the patient is afraid that if she gets close to others she'll be hurt suggests she was reared in an abusive family. The patient's report that her family was close and harmonious calls either the formulation or the report into question.

Fourth, it's useful to ask for the patient's reaction to the proposed mechanism. If the patient feels the formulation is correct, I view this as a piece of supporting evidence; if the patient feels the formulation is wrong, I begin looking for a new one.

Finally, the outcome of treatment can be viewed as an indirect test of the accuracy of the formulation. Treatment failure can indicate that the mechanism on which the treatment was based is incorrect. Therefore, the therapist using the case formulation approach responds to treatment failure by examining the hypothesis about the underlying mechanism, at-

...mpting to propose a new one, and using this new formulation to devel-op a new treatment plan. Of course, the outcome of treatment cannot be viewed as a foolproof measure of the formulation, because treatment failure can have many other causes.

The process of testing the hypothesis about the mechanism

The process of developing a hypothesis about the underlying mechanism and testing it can begin immediately. If, when the patient telephones to schedule the initial appointment, she provides some information about her problems, I immediately begin taking notes. Then I take a few minutes prior to the initial session to use the notes to generate a hypothesis about the underlying mechanism and to prepare some questions that might test it.

For example, a 40-year-old man telephoned for an appointment, saying, "I have severe neck pain, and I've spent 15 years of my life and visited hundreds of doctors to try to get rid of this pain—without success. I can't do anything until I get rid of it."

The fact that the pain has been present for 15 years leads the therapist to hypothesize that the pain complaints are being reinforced (Fordyce & Steger, 1979). The statement that nothing else can be done until pain relief is obtained suggests that one of the reinforcements is the patient's nonparticipation in life. The therapist might then predict that the patient has important problems in the areas of interpersonal relationships and/or work, most likely both, given the chronicity and severity of the pain problem; this hypothesis can be tested in the process of collecting the personal and social history.

An exploration of this man's work history reveals he has worked for 20 years in a field he doesn't like and has always wanted to be an interior designer but never pursued it. Why not? The therapist might propose several hypotheses:

- fear of failure. Perhaps he avoids pursuing a career in interior design for fear he'll fail at it;
- fear of disappointing others. Perhaps the patient's parents (or other significant others) will criticize and reject him for this choice;
- fear of making the wrong choice. "I'm not sure I should pursue this direction—I might not be happy in it."

To test these hypotheses, the therapist might ask, "If you were going to take one step in the direction of being an interior designer, what would it be?"

PATIENT I'd take a course at night.
THERAPIST Where would you take it?
PATIENT At Johnston College. I've already looked into it—they have some good classes. I just can't get to them.
THERAPIST Imagine you actually get to class and you begin working with the class on a project, say a living room of a house in the country. What thoughts do you get?
PATIENT I'll have no talent. I won't be able to do it.

This answer supports the fear of failure hypothesis. Of course, the other hypotheses might also be correct, and the therapist might want to explore them by asking about the parents' or other significant others' likely reactions to the patient's career change.

A detailed family and social history, including information about parents (what were they like, how did they treat the patient), sibs, locale and environment of early upbringing, religious training, school (private or public, did the patient do well or poorly), friends, relationships with the opposite sex, marriage, job history, and children also helps to flesh out and test the formulation.

FROM ASSESSMENT TO TREATMENT

Obtaining the problem list (Chapter 2) and the case formulation (this chapter) are the main goals of the initial assessment process. Once this has been done, active interventions can begin. The next chapters focus on interventions directed at problematic behaviors and cognitions. However, it is important to remember that assessment and treatment occur in tandem, with changes (or failures to change) as a result of treatment leading to revisions in both the problem list and the case formulation.