The Case Formulation Approach to Cognitive-behavior Therapy

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and
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International Congress of Cognitive Psychotherapy
Hong Kong, June 24, 2014, 9:30 a.m. – 18:00 p.m.

Introductions and plan for the day

Why do case formulation-guided treatment?

Developing a formulation and using it to guide intervention

- Formulation and intervention at the level of the symptom/behavior
  11:00 – 11:30 COFFEE BREAK

- Formulation and intervention at the level of the disorder

- Formulation and intervention at the level of the case

  13:00 – 14:30 LUNCH BREAK

- Audiotape exercise: Develop an initial formulation of the case of Judy based on the first 12 minutes of the initial interview

Monitoring progress

  16:00 – 16:30 COFFEE BREAK

Putting it all together: Using the formulation and progress monitoring data to overcome failure

Finishing up: Review of goals and action plans

Handouts are available at www.cbtscience.com on the Training page
Goals for the Workshop Today

- 
- 
- 
- 

Action Items

- 
- 
- 
- 
-
Plan for the Day

- Why do case formulation-guided treatment?
- Developing formulations and using them to guide intervention
  - Symptom/behavior
  - Disorder/problem
  - Case
- Progress monitoring
- Putting it all together

Case formulation-driven CBT helps the therapist solve these problems

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

A Case Formulation-driven Approach to Cognitive-behavior Therapy

Assessment → Case Formulation (hypothesis) → Intervention

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Definition of Formulation

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

Most clients have multiple disorders and problems
case formulation-driven CBT helps the therapist solve these problems

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

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

- Dysthymia
- Most personality disorders
- Asperger's syndrome
- Somatization disorders
- Dissociative disorders
- "I want to get married and have a family."

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

- Steve, a young man who had psychogenic vomiting and mental retardation
Formulation of Steve's case was based on a transdiagnostic model: OPERANT CONDITIONING

A → B
Antecedents → Behavior → Consequences
## Functional Analysis

<table>
<thead>
<tr>
<th>Antecedents (A)</th>
<th>Behaviors (B) (actions, thoughts, or emotions)</th>
<th>Consequences (C)</th>
</tr>
</thead>
</table>
Plan for the Day

- Why do case formulation-guided treatment?
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  - Symptom/behavior
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- Progress monitoring
- Putting it all together

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Most patients have multiple disorders and problems
**BECK'S COGNITIVE MODEL OF DEPRESSION**

- Depressive symptoms (automatic thoughts, behaviors, emotions)
- Events → Schemas

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

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

**BECK'S COGNITIVE MODEL OF THE MULTIPLE-PROBLEM CASE**

- Problem 1
- Depressive symptoms
- Problem 3
- Problem 4
- Problem 5
- Events → Schemas

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

- Dysthymia
- Most personality disorders
- Asperger's syndrome
- Somatization disorders
- Dissociative disorders
- "I want to get married and have a family."

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

- Steve, a young man who had psychogenic vomiting and mental retardation

- "I'm a loser."
- "If I am not perfect, I'll be rejected."
- social anxiety and isolation: "If I say it, she'll think I'm a nerd."
- Procrastination at work: "I'll make a mistake and get fired."
- Depression: lack of enjoyment, guilt, "I'm a loser," self-criticism
Formulation of Steve's case was based on a transdiagnostic model: OPERANT CONDITIONING

A
Antecedents

B
Behavior

Consequences
The A-B-C's of Change

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

Case formulation-driven CBT helps the therapist solve these problems

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

Functional Analysis of Steve's Vomiting Behavior

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

Thought Record

<table>
<thead>
<tr>
<th>Date</th>
<th>Situation</th>
<th>Behavior</th>
<th>Emotions</th>
<th>Thoughts</th>
<th>Coping Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Difficulty settling therapy session agenda</td>
<td>Anxious</td>
<td>Apprehensive</td>
<td>I'll pick the wrong topic. The session won't help me. Therapy probably won't help me. I should try medications</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Antecedents (A)</th>
<th>Behaviors (B)</th>
<th>Consequences (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day treatment program</td>
<td>Vomiting</td>
<td>Clean up own vomit. Father takes to hospital, then leaves. No pampering at home after vomiting.</td>
</tr>
</tbody>
</table>

The formulation helps the therapist identify clinically-relevant behaviors and respond to them therapeutically

Adapted from Kurlenberg, R. J., & Tsai, M. (2001). Functional analytic psychotherapy.
case formulation-driven CBT helps the therapist solve these problems

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

Empirical Foundations of case formulation-driven CBT

- Evidence-based formulations and interventions
- ....
- ....
- ....
- Progress monitoring data the therapist collects to evaluate progress and test the formulation

Many patients do not respond to empirically-supported treatments (ESTs)

<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jacobson et al (1996) (RC=1.56)</td>
<td>Behavioral Activation (BA) 39% BA + Automatic Thoughts 42% BA + AT + Schemas 32%</td>
</tr>
<tr>
<td>Ogles et al (1995) (TDCP completers) (RC=1.96)</td>
<td>CBT 50% Interpersonal Therapy 36%</td>
</tr>
<tr>
<td>Westen et al (2001) meta-analysis</td>
<td>Depression (N=7) 63% Panic (N=14) 46% GAD (N=5) 57%</td>
</tr>
</tbody>
</table>

A Case Formulation-driven Approach to Cognitive-behavior Therapy

Assessment ➔ Case Formulation (hypothesis) ➔ Intervention ➔ Progress Monitoring

To summarize...
A Case Formulation-driven Approach to Cognitive-behavior Therapy

Assessment → Case Formulation (hypothesis) → Intervention → Progress Monitoring

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

BECK’S COGNITIVE MODEL OF DEPRESSION

Depressive symptoms (e.g., thoughts, behaviors, emotions)

Events → Schemas

Plan for the Day

- Why do case formulation-guided treatment?
- Developing formulations and using them to guide intervention
  - Symptom/behavior
  - Disorder/problem
  - Case
- Progress monitoring
- Putting it all together

BECK’S COGNITIVE MODEL OF THE MULTIPLE-PROBLEM CASE

Problem 1 → Problem 2 → Problem 3 → Problem 4 → Problem 5

Events → Schemas

case formulation-driven CBT helps the therapist solve these problems

✓ Multiple disorders and problems
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✓ Problem behaviors impede treatment
✓ Nonresponse is common
Beck’s Cognitive Model of Symptoms

Automatic Thoughts
Behaviors → Emotions

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Two Models Can be Used to Formulate Symptoms and Behaviors

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

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Operant Conditioning Model of Behavior

A
Antecedents

B
Behavior

Consequences

Thought Record

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<tr>
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<th>Situation (Event, memory, plan, etc.)</th>
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<tbody>
<tr>
<td></td>
<td>Urge to commit suicide, suicidal behavior</td>
<td></td>
<td></td>
<td></td>
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Thought Record

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</thead>
<tbody>
<tr>
<td></td>
<td>Severe and/or unremitting depression/pessimism</td>
<td>Urge to commit suicide, suicidal behavior</td>
<td>hopelessness</td>
<td>This pain will never end.</td>
<td>Anti-hopelessness interventions; behavioral experiment to test belief: &quot;I will never enjoy anything again.&quot;</td>
</tr>
</tbody>
</table>

Formulating Suicidal Behavior Using Operant Conditioning

<table>
<thead>
<tr>
<th>Antecedents (A)</th>
<th>Behaviors (B) (actions, thoughts, or emotions)</th>
<th>Consequences (C)</th>
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<tbody>
<tr>
<td>Overwhelming problems</td>
<td>Suicidal behavior</td>
<td>Hospitalization (escape from problems)</td>
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Treating Suicidal Behavior Using Operant Conditioning

<table>
<thead>
<tr>
<th>Antecedents (A)</th>
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<tr>
<td>Reduce/help the person solve the problems</td>
<td>Teach adaptive problem-solving and help-requesting skills</td>
<td>Prevent hospitalization, respond immediately to adaptive requests for help</td>
</tr>
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Two Models Can be Used to Formulate Symptoms and Behaviors

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

Behavioral chain and solution analysis

Chain Analysis of Problem Behavior

Vulnerabilities: ____________________________

Prompting Event  Links  Problem Behavior  Consequences

Behavioral Chain and Solution Analysis

Work with the patient to . . .

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

Unihan, 1993. CBT for Borderline Personality Disorder
Chain Analysis

Describe the problem behavior in detail

What things in myself or my environment made me vulnerable?

What event (in the environment) started the chain?

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

1st

2nd

3rd

4th

5th

6th

7th

8th

9th

10th

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

11th

12th

Adapted from Mansueto et al. (1999). Cognitive and Behavioral Practice, 23-43.
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(510) 652-4455 (tel) • (510) 380-2988 (fax) • www.sfbacct.com (website)
Chain Analysis

Describe the problem behavior in detail

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

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

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BECK'S COGNITIVE FORMULATION OF DEPRESSION

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

To Develop a Disorder Formulation, Start with the ESTs

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

Mental Process

Cognitive Formulation of Panic

Situation: Sitting in class thinking about final exam

TRIGGER: I have a little difficulty breathing

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

EMOTION: Fear

SOMATIC SENSATIONS: Rapid breathing, muscle tension, palpitations

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

INTENSIFICATION OF SENSATIONS

CATASTROPHIC INTERPRETATIONS: I'm suffocating! I might die!
Mechanisms/Treatment Targets in the Cognitive Formulation of Panic

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Cognitive Model of OCD

Beliefs
- Over importance of thoughts
- Control of thoughts
- Overestimation of danger
- Desire for certainty
- Responsibility
- Perfectionism
- Consequences of anxiety
- Fear of positive experiences
- Core beliefs
  - Self
  - Others

Environment & Experiences

Biology

Trigger

Intrusion
- Thought, image, impulse

Interpretation

Emotions

Behaviors
- Rituals
- Avoidance

Adapted from Wilhelm & Bruecke, 2005

Mechanisms/Treatment Targets in the Cognitive Model of OCD

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Elements of a Case Formulation

Elements of a Case Formulation

A problem is

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

A mechanism is

... a biological or psychological construct (e.g., maladaptive schemas, problematic contingencies, perfectionism, intolerance of uncertainty) that causes and/or maintains the person’s problems
Case Formulation for ________
Case Formulation (and partial case formulation) Examples

Case Formulation for Jim

- Social Isolation
- Work Problems
  - Unassertive
  - Poor performance
- Anxiety
  - "If I try, I'll fail."
  - Procrastination
- Depressive Symptoms
  - Procrastination
  - "If I try, I'll fail."
- Alcohol Problem
- Events
  - Promotion
  - Move to new city
- Schemas
  - "I'm inadequate."
  - "Others are critical, rejecting."
Functional Analytic Causal Model of headache pain in a child

O’Brien & Haynes, 1995

Problems

Compensatory Strategies

I am unlikeable

Rumination
Self-righteous anger
Social withdrawal

Low Self-esteem
Depressed Mood
Social Isolation

Unhappy in relationships
Unassertive
Anxious in relationships
Worry, Memory Loss, and Low Mood

- Increased anxiety
- Fixated on memory problems
- Poor memory
- Low mood
- Awareness of any memory problems

Jane's Problematic and Adaptive Responses to Upsetting Events and Emotions

**Problematic Responses**
- Ignoring emotions "I feel fine."
- Denial "This isn't happening."
- Self-invalidation "I shouldn't feel like this."
- Self-blame "It's my fault."
- Catastrophizing "It's a disaster."
- Helplessness "I can't do anything."

**Upsetting Event or Emotion**

**Adaptive Responses**
- Acknowledge emotions "I feel ---."
- Validate emotions "It makes sense that I feel ---."
- Self-compassion "It's too bad I am uncomfortable."
- Curious stance "What can I learn?"
- Problem-solving "What can I do?"
Interrelations among the identified problems for a complex case of PTSD

Obtaining a Comprehensive Problem List
Elements of a Case Formulation

Domains Assessed to Create a Comprehensive Problem List

- Psychological/psychiatric disorders and symptoms
- Medical disorders and symptoms
- Interpersonal
- Work
- Finances
- Housing
- Legal
- Leisure
- Healthcare difficulties
Guidelines for Developing a Problem List

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

Priority Order of Problems

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

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


Intake Measures Used at the
Cognitive Behavior Therapy & Science Center

- Adult Questionnaire
- Diagnostic Screen
- Depression Anxiety Stress Scales (DASS)
- Functioning and Satisfaction Inventory (FSI)
- Obsessive Beliefs Questionnaire
- Two scales assessing social support

Go to www.cbtscience.com, click on Treatment, then on Intake Forms
Developing a Mechanism Hypothesis

A strategy for developing a case-level formulation

Extend a symptom or disorder formulation to account for all of the patient’s problems and disorders
## Functional Analysis of Steve’s Vomiting Behavior

<table>
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<tr>
<th>Antecedents (A)</th>
<th>Behaviors (B)</th>
<th>Consequences (C)</th>
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</thead>
<tbody>
<tr>
<td>Boredom</td>
<td>Vomiting</td>
<td>Stimulation,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>activity</td>
</tr>
<tr>
<td>Nothing to do</td>
<td></td>
<td>Special</td>
</tr>
<tr>
<td></td>
<td></td>
<td>treatment (TV,</td>
</tr>
<tr>
<td>No meaningful</td>
<td></td>
<td>couch)</td>
</tr>
<tr>
<td>relationships</td>
<td></td>
<td>Attention from</td>
</tr>
<tr>
<td></td>
<td></td>
<td>father</td>
</tr>
</tbody>
</table>
BECK'S COGNITIVE MODEL OF DEPRESSION

Depressive symptoms (automatic thoughts, behavior, emotions)

Events → Schemas

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

Problem 1 → Problem 2 → Problem 3

Problem 4 → Problem 5

Events → Schemas

Beck's Cognitive Model of Symptoms/Problems

Automatic Thoughts

Behaviors → Emotions
Case Formulation for ________
Assessment Tools Useful for Developing Formulation (Mechanism) Hypotheses

Collections of Measures


Mechanism Assessment Tools


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

- Why do case formulation-guided treatment?
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  - Case
- Progress monitoring
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Outcome and Process

- Outcome
  - Symptoms (e.g., DASS, PHQ9)
  - Daily ratings of suicidality or urges or behaviors (e.g., DBT Diary Card)
- Process includes . . .
  - The therapeutic alliance
  - Client satisfaction with therapy
  - What the client reports s/he is learning
  - Homework compliance

A Case Formulation-driven Approach to Cognitive-behavior Therapy

Assessment ➔ Case Formulation (hypothesis) ➔ Intervention

Progress Monitoring

An outcome scale and/or a process scale are completed
- in writing or online
- before every therapy session
- reviewed in session and used to guide treatment

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

Tools to Monitor Outcome

Provided in the handouts:
- Patient Health Questionnaire-9 (PHQ-9)
- Depression Anxiety Stress Scales (DASS)
- Daily Log
# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use '✓' to indicate your answer)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

For office coding: $0 + ______ + ______ + ______$

=Total Score: ______

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

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
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Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.
PATIENT HEALTH QUESTIONNAIRE PHQ-9 FOR DEPRESSION

USING PHQ-9 DIAGNOSIS AND SCORE FOR INITIAL TREATMENT SELECTION

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

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

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

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

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

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

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DASS21

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

<table>
<thead>
<tr>
<th>Statement</th>
<th>0</th>
<th>1</th>
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<th>3</th>
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<tbody>
<tr>
<td>1 I found it hard to wind down</td>
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<tr>
<td>2 I was aware of dryness of my mouth</td>
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<tr>
<td>3 I couldn't seem to experience any positive feeling at all</td>
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<td>4 I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)</td>
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<td>5 I found it difficult to work up the initiative to do things</td>
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<tr>
<td>6 I tended to over-react to situations</td>
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<td>7 I experienced trembling (e.g., in the hands)</td>
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<tr>
<td>8 I felt that I was using a lot of nervous energy</td>
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<tr>
<td>9 I was worried about situations in which I might panic and make a fool of myself</td>
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<tr>
<td>10 I felt that I had nothing to look forward to</td>
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<tr>
<td>11 I found myself getting agitated</td>
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<tr>
<td>12 I found it difficult to relax</td>
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<tr>
<td>13 I felt down-hearted and blue</td>
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<tr>
<td>14 I was intolerant of anything that kept me from getting on with what I was doing</td>
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<tr>
<td>15 I felt I was close to panic</td>
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<td>16 I was unable to become enthusiastic about anything</td>
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<td>17 I felt I wasn’t worth much as a person</td>
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<tr>
<td>18 I felt that I was rather touchy</td>
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<td>19 I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)</td>
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<td>20 I felt scared without any good reason</td>
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<tr>
<td>21 I felt that life was meaningless</td>
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<tr>
<td>22 I thought about death or suicide</td>
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<tr>
<td>23 I wanted to kill myself</td>
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</table>
Depression Anxiety Stress Scales (DASS) Information Sheet

Description:
The DASS (Lovibond & Lovibond, 1995) is a 21-item measure that includes 3 subscales assessing symptoms of depression, anxiety, and stress. With permission from Peter Lovibond, the scale’s developer, we added two items to assess suicidality. The DASS is also available in a 42-item version. The DASS is quick to complete, suitable for most outpatients, and is responsive to treatment-related changes (Brown, Chorpita, Korotitsch, & Barlow, 1997).

The subscales of the DASS are:
- **Depression** – low positive affect, hopelessness, and anhedonia (e.g., “felt downhearted and blue,” “difficult to work up the initiative to do things”) (items 3, 5, 10, 13, 16, 17, 21)
- **Anxiety** – panic and physiological arousal (e.g., “felt I was close to panic,” “trembling”) (items 2, 4, 7, 9, 15, 19, 20)
- **Stress** – high negative affect, what Barlow (2002) terms “anxious apprehension” (e.g., “hard to wind down,” “rather touchy”) (items 1, 6, 8, 11, 12, 14, 18)

Two items assess suicidality:
- Suicidal ideation (“thought about death or suicide”)
- Suicidal wishes (“wanted to kill myself”)

Psychometric Properties:
The DASS has good test-retest reliability, high internal consistency, and adequate convergent and discriminant validity with other measures of anxiety and depression (Antony et al., 1998; Brown, Chorpita, Korotitsch, & Barlow, 1997). Little overlap has been found between the three subscales, which is consistent with the tripartite model (Clark & Watson, 1991) upon which the DASS is based. Brown and colleagues (1997) found the depression scale to be most strongly correlated with measures of depression and positive affect, the anxiety scale to be most strongly correlated with measures of physiological arousal and panic, and the stress scale to be most strongly correlated with measures of worry and negative affect than the other two scales. A list of publications related to the DASS can be found at http://www2.psy.unsw.edu.au/groups/dass/pub.htm.

Scoring:
Respondents rate each item to reflect how much it applies to their experience over the preceding week on a Likert scale ranging from 0 (“did not apply to me at all”) to 3 (“applied to me very much”).

Subscale score totals are multiplied by 2 in order to be comparable to the DASS means norms, which are based on the 42-item version of the scale. Thus, possible scores on each subscale range from 0 to 42. The two suicidality items (items 22 and 23) are not included in the subscales.

The cutoff scores for each subscale are as follows:

- **Depression**
  - 0-9 = normal range; 10-13 = mild; 14-20 = moderate; 21-42 = severe
- **Anxiety**
  - 0-7 = normal range; 8-9 = mild; 10-14 = moderate; 15-42 = severe
- **Stress**
  - 0-14 = normal range; 15-18 = mild; 19-25 = moderate; 26-42 = severe

Availability:
The DASS and an excel scoring program for it are available at www.cbtscience.com. Click on “Training” and then on “Training Resources.” The excel scoring document automatically scores the DASS, yielding subscale scores and indicating whether they are consistent with a “normal”, “mild”, “moderate”, or “severe” level of symptoms.

The measure is in the public domain. Detailed information can be found in the DASS manual (Lovibond & Lovibond, 1995) as well as at http://www2.psy.unsw.edu.au/groups/dass/
## Daily Log

Name ___________________________  Date ___________________________

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Additional Progress Monitoring Tools

- To obtain additional measures, including the Excel scoring tool for the DASS, go to: www.cbtscience, then to Training, then to Resources, then to Clinical Tools
- See “Collections of Measures” on the handout page titled Assessment Tools Useful for Developing Formulation (Mechanism) Hypotheses

Completing a standardized scale in the waiting room before the session
Problem List for Susan

1) **Family problems.** Angry at parents for ignoring and attacking her; feels responsible for mother and brother.
2) **Depression.** BDI = 20. Lack of enjoyment, guilt, feeling punished, disappointed in herself, crying, irritability, loss of interest in others, difficulty making decisions, fatigue.
3) **Anxiety.** BurnsAI = 39. Anxiety, fogginess, sense of impending doom, difficulty concentrating, racing thoughts, fears of going crazy and abandonment, palpitations, headaches.
4) **Social isolation.** No close friends/confidants.
5) **Financially dependent on parents.**

Intervention Strategies

- Teach the formulation.
- Cognitive restructuring to address thoughts like “If John is upset, it’s my responsibility to be there for him even if it makes me late for therapy.”
- Activity scheduling of things important to her.
- Teach skills to attend to and validate her emotions, preferences, wants.
- Assertiveness skills-training, especially to ask for what she wants and say no to others.

Schema Hypotheses for Susan

**Self**
- Responsible for what happens
- Inadequate
- Unimportant
- Others
- Unpredictable
- Critical
- Unconcerned about me
- Unsupportive
- World
- Unpredictable
- Overwhelming
- Lonely
- Dangerous

Obstacles predicted by the formulation

- Nonadherence (e.g., she came late to her session when boyfriend was upset about something).
- Premature termination when acute distress was down and parents disapproved of therapy.

Formulation of Susan’s Case

Judy learned from her needy, neglectful and attacking parents (ORIGINS) that others are helpless, unconcerned about me, and critical/attacking, and “I am responsible for others.” (MECHANISMS) These beliefs, triggered by Judy’s leaving her mother to go to college (PRECIPITANT) cause (PROBLEMS) her to feel resentful, guilty, resentful, depressed, and anxious about her family problems, and impede her from focusing on school and developing friends.

Progress Monitoring Examples
Example: A great outcome

Using Outcome Monitoring to Identify a Response to Medication

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

Tool to Monitor Process

Provided in the handouts.
- Session Assignment and Feedback Scale (SAFF)

Using the Formulation to Understand Plot of Outcome Scores

The SAFF Gives Feedback about Therapy Process

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

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

Today's Date and Session # ________________  Next Session ________________  ID # ______

Instructions: Complete this form and bring it to your next therapy session.

I. Assignments

<table>
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<tr>
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<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
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</table>

Complete immediately after session

II. What are 1-2 things you want to remember from session?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

III. What did you find unhelpful, unclear, or bothersome?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

IV. 1. How well did you feel heard and understood in session?
    2. How well did we agree on what is causing your problems?
    3. How well did today’s session help address your problems?
    4. How confusing was today’s session?
    5. How confident are you that you are progressing toward your therapy goals?

<table>
<thead>
<tr>
<th></th>
<th>Not at All</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Very</th>
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Complete before next session

V. What do you want to discuss next session?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

VI. 6. How helpful were the assignments?

<table>
<thead>
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<th>Not at All</th>
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</tbody>
</table>

Hong, J.J., Beckner, V., Persons, J.B., Ling, A., Liu, H. & Owen, D.J. (2012). Session Assignment and Feedback Form - v.12 (SAFF). Oakland, CA. Please let Janie Hong (jhh@sfbacdt.com) know if you use this form for research purposes.
Session Assignment and Feedback Form (SAFF)

Instructions for Completing the Session Assignment and Feedback Form (SAFF)

This form is designed to help you and your therapist work together to maximize your learning and progress toward your therapy goals.

I. This section lists assignments that you and your therapist agree you will do before your next session. Check the appropriate day of the week box when you work on an assignment on that day.

Complete immediately after session

II. Write down one or two things from your therapy session that you would like to remember. Completing this section will help you solidify your learning and create a record of important things you learned in treatment that you can keep and refer to later.

III. Write down anything that was unhelpful, unclear, or bothersome during your therapy session. This information will help your therapist better understand your needs and tailor your therapy accordingly.

IV. Rate your therapy session on these five items. Extreme ratings should be reserved for sessions in which you feel you made tremendous progress, had a break-through, or the opposite (e.g., you disagreed with your therapist, you didn’t feel heard). Liking your therapist does not mean that you should give him/her the highest ratings possible. Please be as honest as possible with your ratings.

Complete before next session

V. Think about what you’d like to discuss in your next therapy session and jot it down.

VI. Complete this item based on your experience with the assignment(s). This information can guide you and your therapist to plan assignments that will be most helpful.

Hong, J.J., Beckner, V., Persons, J.B., Ling, A., Liu, H. & Owen, D.J. (2012). Session Assignment and Feedback Form - v.12 (SAFF). Oakland, CA. Please let Janie Hong (jih@sfhacct.com) know if you use this form for research purposes.
Plan for the Day

- Why do case formulation-guided treatment?
- Developing formulations and using them to guide intervention
  - Symptom/behavior
  - Disorder/problem
  - Case
- Progress monitoring
- Putting it all together

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

Exposure Hierarchy – Fear of Cancer

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

Putting it all together:
Using the formulation and progress monitoring data to overcome treatment failure

Mr. “I might have cancer”

A Case Formulation-driven Approach to Cognitive-behavior Therapy

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

<table>
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<tr>
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Collecting Additional Assessment Data to Revise the Formulation

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

Revised Formulation and Treatment Plan

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

Thought Record

<table>
<thead>
<tr>
<th>Date</th>
<th>Situation</th>
<th>Behavior(s)</th>
<th>Emotions</th>
<th>Thoughts</th>
<th>Coping Responses</th>
</tr>
</thead>
</table>
| Colleague says, “Oh you’re sick again.” | Colleague says, “Oh you’re sick again.” | | | | It could be cancer.
I’ll miss work.
I’ll drop a ball.
I’ll lose my job.
I’ll be humiliated. |

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

<table>
<thead>
<tr>
<th>Task</th>
<th>MEDIAN</th>
<th>1ST QUARTILE</th>
<th>3RD QUARTILE</th>
<th>MAXIMUM</th>
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<tbody>
<tr>
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<td>30</td>
<td>20</td>
<td>40</td>
<td>100</td>
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<tr>
<td>Nervous before a speech (100 people)</td>
<td>40</td>
<td>30</td>
<td>50</td>
<td>100</td>
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<tr>
<td>Nervous sitting in the audience (100 people)</td>
<td>30</td>
<td>20</td>
<td>40</td>
<td>100</td>
</tr>
<tr>
<td>Nervous speaking to the audience (100 people)</td>
<td>40</td>
<td>30</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Nervous in a group discussion with colleagues (100 people)</td>
<td>30</td>
<td>20</td>
<td>40</td>
<td>100</td>
</tr>
<tr>
<td>Nervous when presenting a new idea to management (100 people)</td>
<td>40</td>
<td>30</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Nervous during a meeting with colleagues (100 people)</td>
<td>30</td>
<td>20</td>
<td>40</td>
<td>100</td>
</tr>
<tr>
<td>Nervous during a meeting with colleagues (100 people)</td>
<td>30</td>
<td>20</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>
Table 2: Self-report anxiety ratings of public speaking hierarchy items at four time points

A Case Formulation-driven Approach to Cognitive-behavior Therapy

Hypochondriacal episodes during interventions focusing on hypochondriasis and on public speaking

Conclusions

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

THANK YOU!
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Cognitive Behavior Therapy & Science Center
Readings on Case Formulation and Progress Monitoring


