Case Formulation

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Abstract

In the case formulation approach to cognitive behavior therapy (CBT), the therapist works collaboratively with the patient to develop a formulation of the patient's case and uses the formulation to guide the treatment. The formulation is a hypothesis about the major factors that cause and perpetuate the patient's problems. I begin this commentary about case formulation written in honor of Aaron T. Beck with a brief description of the case formulation approach to CBT. I describe my path to developing the case formulation approach to CBT, beginning with learning cognitive therapy from Dr. Beck and his colleagues as a graduate student. I highlight the importance to the case formulation model of three of Beck's contributions in particular: the cognitive conceptualization, the practice of monitoring the patient's progress and collecting feedback from the patient, and an empirical approach to approach to clinical work. I highlight contributions to ideas about the case formulation in CBT by Ira Turkat, Joseph Wolpe, Judith Beck, Kuyken et al. (2009) and others too numerous to mention here. I conclude with a call for more research on the role of the case formulation in cognitive behavior therapy.

Case Formulation

I'm honored to have the opportunity to write this commentary on the topic of case formulation in this special issue honoring Aaron T. Beck. I begin with a brief description of the case formulation approach to cognitive behavior therapy (CBT). I describe my path to developing this model, beginning with learning cognitive therapy from Dr. Beck and his colleagues as a graduate student. I conclude with a call for more empirical study of the role of the case formulation in CBT.

The case formulation approach to CBT

In the case formulation approach to CBT, the therapist adopts an empirical hypothesis-testing approach to the treatment of each case. The therapist begins by conducting a comprehensive assessment to develop, with the patient, an idiographic (that is, personalized) formulation of the patient's case that is based on evidence-based cognitive behavioral theory, and

to set idiographic goals for the patient's treatment. The formulation is an idiographic hypothesis about the psychological factors that predispose, precipitate, perpetuate and patient's symptoms and problems. As treatment proceeds, patient and therapist collect and review data each session to evaluate the patient's progress toward the goals and to identify what the patient is learning in therapy and whether the factors that the formulation proposes as perpetuating factors are changing. Patient and therapist work collaboratively together to use those data to make intervention and other decisions, solve problems, and revise the formulation as needed, in an empirical approach to the treatment of each case (Persons, 2008).

Beck's cognitive therapy

I began learning Beck's cognitive therapy in 1976 when I was a second-year graduate student in clinical psychology at the University of Pennsylvania. I had heard murmurings that a new therapy was being developed in the Department of Psychiatry and I wanted to find out about it. My first-year research project had focused on cognitive theories underpinning symptoms of thought disorder in schizophrenia. But I did not view that line of research as likely to lead to interventions. In those days, at least in the U.S. and before Dr. Beck's and others' contributions to the development of CBT for schizophrenia, there was no notion that psychotherapy could be helpful to individuals with schizophrenia. I was seeking a model that would integrate theory about the cognitive mechanisms underpinning psychopathology with treatment. So I was eager to learn Beck's cognitive therapy for depression.

I spent a practicum year at Dr. Beck's Mood Clinic on the 6th floor of the Girard Bank building in West Philadelphia. I received the training provided to the therapists in one of the early randomized trials of cognitive therapy. We passed around a mimeographed (!) copy of a manuscript that later became Beck, Rush, Shaw and Emery (1979), and I read drafts of chapters of *Feeling Good* (Burns, 1999). David Burns supervised some of my practicum cases, and very generously gave me and some of my fellow trainees an hour or two of his time to consult on our cases every Friday afternoon throughout the years of my graduate school training.

The case formulation

I began to develop my ideas about case formulation after I finished my training and started a private practice. A common experience: Patient came into my office saying, "I'm depressed. I read *Feeling Good* and I want cognitive therapy." I'm thinking, "Fine. I can do that." Then I start doing the therapy and I learn many sessions later that my patient has not filed income tax returns for five years, a problem I am not sure how to think about or treat and had not thought to assess. I learned this lesson again and again when I began teaching and providing supervision to trainees in Ricardo Munoz's Depression Clinic at San Francisco General Hospital at the University of California at San Francisco. The patients who came to the Depression Clinic had exceedingly high rates of medical and psychiatric comorbidity, extensive racial, ethnic, cultural and all other types of diversity, and were economically disadvantaged. I realized that I needed to learn how to adapt cognitive therapy to conceptualize and treat not just psychiatric disorders or symptoms, but the whole patient.

I also needed help solving a host of problems I encountered in my work. Patients did not always complete the therapy homework I assigned, some frequently cancelled their sessions, and one that I remember as particularly challenging became angry and antagonistic when I attempted cognitive restructuring interventions. Many did not improve and some got worse. I was able to

devise some ad hoc solutions to some of these problems for some of my patients. But I wanted a more comprehensive and systematic approach to the difficulties I encountered.

I began reading. I read the behavior analysts, especially Turkat (1985) and Wolpe (1980). The behaviorists had a long intellectual tradition of the study of the individual case. They used their nomothetic behavioral conceptualization to develop an idiographic hypothesis about each case that they used to guide their treatment and problem-solving efforts. It was an elegant approach that was grounded in the scientific method. So I imported the notion of the idiographic case conceptualization from behavioral analysis into cognitive therapy, and I learned to develop an idiographic conceptualization of the case based on the Beck's nomothetic conceptualization of psychopathology to guide my clinical work. I learned to develop a comprehensive problem list during my initial assessment so I did not get taken by surprise later by things like unpaid tax bills. Because Beck's cognitive model of psychopathology was so flexible, it was easy to use it as the foundation for a transdiagnostic approach to CBT that addressed multiple problems and disorders (Persons, 1989). Later I learned from Judy Beck (1995) and (2005) to use the cognitive conceptualization format she developed, and from Kuyken, Padesky, and Dudley (2009) about the importance of building a collaborative formulation that includes an account of the patient's strengths and assets.

Beck's cognitive formulation of psychopathology is more important than the therapy

Although the therapy he developed made huge contributions that improve peoples' lives and well-being daily, Beck's major innovation was not cognitive therapy, but the *cognitive theory*, or *conceptualization*, of symptoms of psychopathology. Why do I say this?

First, without the theory we would not have the therapy. The therapy flows directly out of the theory. The cognitive theory proposes that symptoms of psychopathology result from the perpetuating factors of automatic thoughts and behaviors that result when the predisposing factors (the schemas and dysfunctional attitudes), are activated by precipitants. Beck's cognitive therapy consists of interventions to change the perpetuating and predisposing factors described in the theory.

Second, the extension of Beck's therapy to multiple disorders and problems, including anxiety, PTSD, psychotic symptoms, schizophrenia, delusions, insomnia, and others, was made possible by the theory, not by the treatment protocol provided in Beck et al. (1989). To apply cognitive therapy to new problems, Beck and other treatment developers extended the model or conceptualization to those problems, and then developed therapeutic strategies based on their model. The huge flexibility of Beck's cognitive conceptualization permitted the expansion of cognitive therapy to address many disorders and problems.

Third, the fact that Beck's cognitive therapy is based on a theory that is grounded in basic science allows the practitioner to tie their work to that literature and thereby gain a lot of power to understand and work with clinical phenomena as they arise in the session. For example, I've frequently found it helpful to teach my patients about the phenomenon of mood-state dependent retrieval of negative thoughts (Clark & Beck, 1999) to help them understand why, if their mood drops, they may experience a flood of negative thoughts.

Finally, although the interventions described in the protocols are important to the clinician, the conceptualization is even more important. A conceptualization of the case can

suggest many unique interventions that aren't written in any protocol, as in the case of my patient who worked to shift her view of herself as solely responsible for her father's well-being to a view of herself as a contributor to his well-being by drawing pictures of those two views of herself that she posted in a prominent place at home and reviewed frequently. In one picture, she stood next to her father and was much larger than her sibs and the caretakers, and in the other (the healthier view), she placed herself in the background and shrank her size to nearly match that of her father's other caretakers. And the formulation is an essential problem-solving tool. The case formulation gives the patient and clinician, working together (c.f. Kuyken et al (2009)), a systematic way to *think about* problems that arise in the therapy. Working with a formulation is like taking a trip guided by a map. If impediments arise, a map allows you to locate another route. But if you are guided by a set of directions and one of the directions is impossible to implement, you are stuck. The formulation is a map that I know is always there for me and the patient to rely on when obstacles arise.

Monitoring progress and obtaining feedback

Although they receive less attention than they deserve, two of Beck's key contributions to psychotherapy are his practice of collecting symptom data at the beginning of every session to monitor the patient's progress in therapy and of collecting feedback during the session to assess what the patient learned in the session. Beck's interest in progress monitoring contributed to his development of the Beck Depression Inventory, an important assessment instrument that is in wide use to this day. The feedback element was built into the therapy, and is included in the Cognitive Therapy Rating Scale (Young & Beck, 1980), but the progress monitoring piece is not, perhaps as part of the effort to standardize the therapy to promote its study in randomized controlled trials.

Beck's practice of collecting feedback from his patients played a central role in his development of cognitive therapy, as we learn from the interview that Philip Kendall conducted with him as part of the ABCT Presidential Panel series (available at www.abct.org). Beck described developing cognitive therapy based in part on things he learned from his patients. He observed that his depressed patients did not seem to have anger turned inward, as the psychoanalytic theory he had been taught predicted. Instead, they had a raft of irrational negative thoughts about themselves, others, the world, and the future. Beck collected feedback from his patients about what they were learning in the psychoanalytic therapy he was being trained to provide, and he listened carefully when some reported they were learning that their thinking "was all fouled up" and that they needed to think about problems in a more reasonable way and take action to solve them. Beck's observations went completely against the grain of mainstream psychiatry at the time, which was dominated by psychodynamic and psychopharmacological models. Beck was undaunted. The rest of us collect feedback to learn about what is helping each patient we treat and use it to inform our decision-making for that patient. Beck collected feedback from his patients and used what he learned to develop a new model of psychopathology and psychotherapy.

An empirical approach

Beck's practices of collecting progress monitoring data and feedback from his patients were part of a larger commitment to empiricism. He devoted much of his career to collecting data to test his theory of psychopathology and the efficacy of his therapy. His commitment to

science allowed him to make monumental contributions that others will draw on for generations to come.

Thus, Beck contributed a hugely important cognitive conceptualization of psychopathology. He also taught us to collect progress monitoring data and feedback from our patients and to take an empirical approach to our clinical work. All these elements appear in the case formulation approach to CBT described at the beginning this article.

The future of case formulation in cognitive behavior therapy

Although practitioners are convinced of the central role of the case formulation in treatment, empirical data supporting this notion are sparse. Reviews by Easden and Kazantzis (2018) and Persons and Hong (2016) summarize the state of the literature and point to the need for additional empirical research to evaluate the role of the case formulation in CBT, especially to test the hypothesis that the formulation contributes to improved treatment outcome.

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