

Essential
Components of
Cognitive–Behavior
Therapy for
Depression

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Individualized Case Formulation and Treatment Planning

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You've got to be careful if you don't know where you're going because you might not get there. (Yogi Berra)

A case formulation is an idiographic (individualized) theory that explains a particular patient's symptoms and problems, serves as the basis for an individualized treatment plan, and guides the therapy process. In this chapter, we teach the process of formulating and treatment planning based on Beck's (1976) cognitive theory of depression. We present

- a rationale for the use of an individualized case formulation
- levels of cognitive-behavioral case formulation
- components of the cognitive-behavioral case formulation and treatment plan
- guidelines for developing an initial formulation
- the process of developing a cognitive-behavioral formulation
- solving problems arising in formulation and treatment planning
- practice exercises
- further readings
- an example of a completed case formulation and treatment plan
- list of assessment tools for measuring therapeutic progress in depressed patients
- Cognitive-Behavioral Formulation and Treatment Plan form
- Progress Plot form.

Rationale for the Use of an Individualized Case Formulation

We recommend that clinicians develop an individualized case formulation to guide treatment rather than relying solely on a standardized protocol or working in an unplanned way for three reasons. The formulation provides a systematic method for individualizing the treatment, allows the therapist to take an empirical approach to the treatment of each case, and provides assistance during the treatment process.

SYSTEMATIC METHOD FOR INDIVIDUALIZING TREATMENT

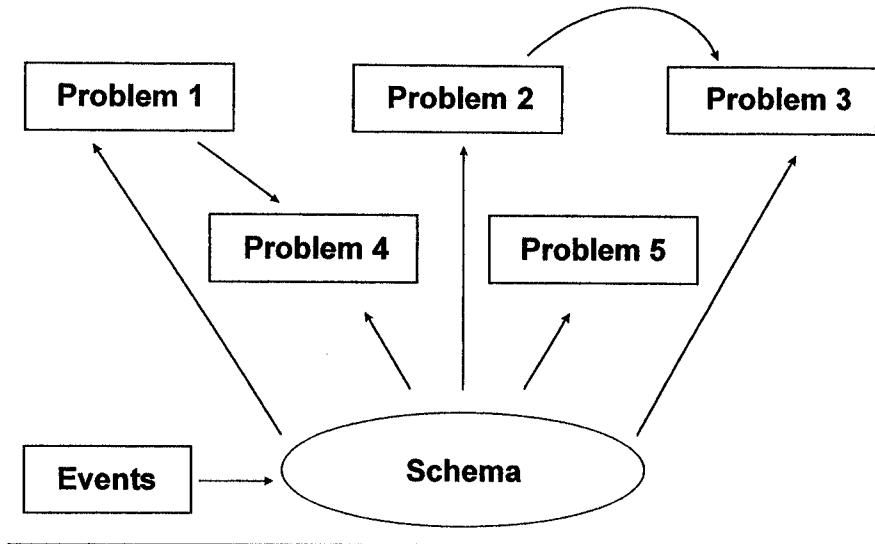
Although the standardized treatment protocols studied in the randomized controlled trials (RCTs) are themselves based on a formulation, it is a nomothetic (general), not idiographic (individualized), formulation. In carrying out the protocol, the therapist must individualize it for the patient at hand. A case formulation provides a systematic method for doing this. When based on Beck's (1976) cognitive theory, the individualized case formulation specifies *which* life events activated *which* schema to produce *which* symptoms and problems and describes some of the cognitive-behavioral-mood components of the patient's depressive symptoms.

The format we provide for the individualized case formulation includes an exhaustive list of all of the patient's problems in all domains and describes some of the relationships among these problems. This information is particularly useful to therapists treating patients with multiple problems. Depressed patients frequently have multiple psychiatric, medical, and psychosocial problems, especially those treated in clinical practice rather than RCTs. An exhaustive problem list is helpful when setting and prioritizing treatment goals and when developing a working hypothesis (see p. 32) for these types of cases.

We use Beck's (1976) cognitive theory of psychopathology as a template for an individualized case formulation that explains all of the depressed patient's presenting problems and symptoms, as shown in Figure 2.1 (Persons, 1989). This use of Beck's theory is supported by the fact that his theory, originally developed as an account of depressive symptoms (Beck, 1976), has also been shown to provide useful accounts of numerous other psychiatric and behavioral symptoms and problems, including anxiety (Beck et al., 1985), substance abuse (Beck et al., 1993), couples problems (D'Attilio & Padesky, 1990), personality disorders (e.g.,

FIGURE 2.1

Applying Beck's cognitive theory of psychopathology to the multiple-problem case.



Beck et al., 1990), anger (Beck, 1999), and irritable bowel syndrome (Blanchard, Schwarz, & Neff, 1988).

AN EMPIRICAL APPROACH TO THE INDIVIDUAL CASE

A formulation-driven approach to treatment allows the therapist to take an empirical approach to the treatment of each case. In an empirical, hypothesis-testing approach to treatment using a case conceptualization, the therapist views the treatment of each case as an experiment, with $N = 1$. The therapist's hypothesis is the case formulation; the treatment plan is based on the formulation (see Hayes, Nelson, & Jarrett, 1987; Persons & Tompkins, 1997; and Turkat, 1985). The therapist collects data to assess the patient's response to interventions as the therapy proceeds. When the treatment response is poor, the therapist reviews the formulation, considers whether an alternative formulation might generate some new treatment interventions, and collects data to evaluate the patient's response to the new interventions. When proposing a new formulation, a therapist might rely on the nomothetic model on which the original formulation was based or he or she might draw on other empirically supported models of depression, including Lewinsohn's (Lewinsohn, Hoberman, & Hautzinger, 1985) behavioral theory, Nezu and Nezu's (1993) problem-solving theory, and Rehm's (1977) self-control

theory. Without such a formulation, the therapist would make clinical decisions in a hit-or-miss manner and would have no systematic way of proceeding when treatment does not go smoothly (see Kendall, Kipnis, & Otto-Salaj, 1992).

ASSISTANCE DURING THE TREATMENT PROCESS

The case formulation assists the therapist during the treatment process in numerous ways. A formulation shared by the patient and therapist can strengthen the therapeutic alliance and enhance the patient's motivation to comply with treatment. The formulation guides treatment planning, as we emphasize later in this chapter (see also Haynes & O'Brien, 2000; and Turkat & Maisto, 1985). The formulation, particularly the Problem List, guides the choice of treatment goals, which in turn guides the choice of agenda items in the therapy session.

The specification of problems in terms of mood, behavioral, and cognitive components, as described later, often leads directly to behavioral (see chap. 4) and cognitive (chap. 5) intervention suggestions. For example, one student's procrastination problem may be a consequence of his belief that "there's no point tackling this project unless I have at least 3 hours to devote to it," whereas another may procrastinate because of his belief that "I can't learn this material."

The working hypothesis section of the formulation describes relationships among presenting problems and can yield suggestions about the order in which problems are best treated (see Haynes, 1992). For example, a working hypothesis that proposes that a woman's marital conflicts are caused in part by excessive drinking leads to a treatment plan that includes interventions to address the alcohol abuse. A working hypothesis that proposes that one cause of a lawyer's depression is self-critical thoughts about procrastination leads to a treatment plan that includes interventions to address both procrastination and self-criticism.

The formulation guides the therapist when he or she chooses a line of attack on a clinical problem, as in the case of Flora, a depressed housewife. Flora came to her therapy session complaining that she felt too depressed to drive to Sacramento to visit her cousin Rose, as she had promised to do. The therapist, guided by his formulation that Flora's view of herself was "my needs don't count; my role in life is to care for others" chose to work with her on this aspect of her problem and to encourage her to call Rose to say she would not be coming to visit. In contrast, the therapist operating without a formulation or with a different formulation ("I'm weak and fragile and can't do anything") might have chosen to help Flora "push" through her depression to make the visit.

The case formulation guides the clinician as he or she makes clinical decisions throughout the treatment process. For example, when a patient proposes to end his treatment, the formulation helps the therapist evaluate whether the proposed termination is premature (driven by a schema such as "my needs and health are unimportant"), appropriate (treatment goals have been met), or overdue (treatment goals have been met except that the patient believes that "if a problem arises, I won't be able to solve it on my own").

The formulation helps the therapist anticipate, understand, and effectively manage problems that arise in the therapy, including homework noncompliance and problems in the therapeutic relationship (Tompkins, 1997; Turkat & Brantley, 1981). For this reason, the case formulation includes a section in which the therapist uses the formulation to predict and anticipate potential obstacles to therapeutic success in the hope that if the therapist can anticipate them, some of these obstacles might be forestalled or prevented.

An example of the clinical value of an individualized case formulation is provided in the case of Ginger. When her therapist asked her in an early session to propose items for the agenda, Ginger, whose self-schema was "I am unimportant; no one is interested in me," stammered hesitantly that there was nothing in particular she wanted to discuss. After some probing, however, she revealed that just prior to the session, she had sat in the waiting room and made a list of things she wanted help with but then tore it up, believing the therapist would not be interested in her concerns. The therapist who guides interventions by a formulation can remain alert for, understand, and make therapeutic use of this type of event.

Levels of Cognitive– Behavioral Case Formulation

Cognitive–behavioral case formulation can occur at three levels: the case, the syndrome or problem, and the situation. The formulation at the level of the *case* is an attempt to understand the entire case as a whole, particularly the relationships among the patient's presenting problems and the schema that appear to underlie many or all of the problems. In this chapter, we primarily focus on the formulation at the level of the case, which uses the format described in the next section of this chapter (see Appendix 2A).

A formulation at the level of the *syndrome or problem* provides a conceptualization of a particular syndrome or problem, such as depressive symptoms, social anxiety, fatigue, or binge eating. Beck's (1976)

cognitive theory of depression is a formulation at this level. In fact, when we use Beck's theory to conceptualize at the case level, we are extrapolating from his theory of the depressive syndrome, as noted above.

The third level of formulation occurs at the level of the *situation*; a situation-level formulation based on Beck's (1976) model contains information about a particular situation and information about the cognitive, behavioral, and mood components of the patient's reaction to that situation. For example, an insurance salesman came to his therapy session wanting to understand why he had suffered from insomnia the previous night and what could be done to prevent this from happening again. To answer these questions, the therapist using Beck's model would collect information about the details of the situation and about the cognitive, behavioral, and mood components of the salesman's reaction to the situation in an attempt to obtain a hypothesis about what happened. We sometimes call a formulation at this level of situation a "miniformulation."

At all levels, the formulation yields intervention suggestions. The therapist's hypotheses about the elements of the formulation at the level of the syndrome or the case are often based on observations of behaviors, moods, and cognitions that recur frequently in formulations at the situation level (J. S. Beck, 1995). Themes that emerge in multiple situations may reflect general schema, and recurring behaviors and moods may reflect syndromes or problems that belong on the Problem List of a case-level formulation.

Components of the Cognitive-Behavioral Case Formulation and Treatment Plan

A complete Cognitive-Behavioral Case Formulation and Treatment Plan has several components, as shown in Appendix 2A and described in detail here. In the following discussion, we describe each component of the formulation in detail; we provide the details therapists need as they write a formulation and treatment plan for a patient.

IDENTIFYING INFORMATION

This is where the therapist lists the patient's name, age, marital status, ethnicity, gender, occupational status, and living situation. Referral source is sometimes indicated here as well.

PROBLEM LIST

A comprehensive problem list describes any problems the patient is having in any of the following domains: psychological–psychiatric symptoms, interpersonal, occupational, medical, financial, housing, legal, and leisure. A comprehensive problem list allows the therapist to develop a formulation that provides the therapist (and patient) with a “big picture” view of the entire case.

Linehan (1993) provided a useful set of guidelines for ranking clinical problems; it can be used to prioritize the problem list items and treatment goals. Linehan’s list in priority order includes the following:

- **Suicidality.** Suicidality is a high priority problem because if the patient is dead, none of his or her other problems will get solved.
- **Therapy-interfering behaviors.** Examples of these include homework noncompliance, medication noncompliance, repeatedly arriving late to the therapy session, not working collaboratively in the therapy session, and not getting along with the therapist. These behaviors are given a high priority, with the rationale that if they are not solved, the patient will not receive help solving any of the other problems on the problem list.
- **Behaviors that are dangerous or that interfere with quality of life.** These problems if not solved will likely prevent the patient from solving any other problem. Examples of these behaviors include major substance abuse, shoplifting or other criminal behavior, high-risk sexual behaviors, staying with a physically abusive partner, repeatedly getting fired, being unemployed, being homeless or at risk of being homeless, and not showing up for work.
- **Other problems.** These are problems the therapist observes or the patient describes that are not included in any of the other categories.

Because we are using Beck’s (1976) theory as a template for the formulation, we describe as many of the problems on the problem list as possible using the three-component system Beck used of cognition, behavior, and mood to describe depressive symptoms. Viewing problems in these terms leads directly to intervention suggestions.

DIAGNOSIS

Psychiatric diagnosis is not, strictly speaking, a component of a case formulation. We include it on our form because diagnosis is helpful in formulating a case and planning treatment. Empirical findings suggest that depressed patients hold certain typical schema about themselves, others, the world, and the future (Ingram et al., 1998); therefore, a diagnosis of depression can suggest some schema hypotheses. The di-

agnosis can help the therapist with the problem list by alerting the therapist to look for typical disorders and problems that are comorbid with a depressive disorder. A psychiatric diagnosis also serves as a link to RCTs, in which researchers generally select patients on the basis of psychiatric diagnosis. Thus diagnosis, through its link to the RCTs, suggests empirically supported nomothetic formulations and treatment interventions.

WORKING HYPOTHESIS

This section has four subheadings: schema, precipitants and activating situations, origins, and summary; we describe each briefly here. These subheadings, of course, flow from Beck's (1976) theory. If the therapist were using a different cognitive-behavioral theory, the subheadings of this section would differ. A functional formulation, for example, would include sections for antecedents and consequences and would describe functional relationships (Haynes & O'Brien, 2000).

Schema

Schema or core beliefs are deep cognitive structures that enable an individual to interpret his or her experiences in a meaningful way (Beck et al., 1979). On the basis of Beck et al.'s work, we recommend that therapists propose hypotheses about the patient's views of self, others, the world, and the future. Sources of schema hypotheses for depressed patients include descriptions of clinical depression and writings about common comorbid conditions seen in depressed patients, including anxiety disorders (Beck et al., 1985), substance abuse problems (Beck et al., 1993), and Axis II disorders (Beck et al., 1990; Young, 1999).

Precipitants and Activating Situations

Precipitating events and activating situations are two types of external events. The term *precipitant* refers to large-scale events that appear to have caused an episode of illness. For example, a depressive episode might be precipitated by leaving home to go to college or by the breaking up of an important relationship. Sometimes the depressed person is not able to report precipitants of his symptoms, which may be chronic and longstanding, but can report what caused him to seek treatment, perhaps because the symptoms got worse or their presence became more intolerable than in the past. For example, a chronically depressed executive sought treatment when he found himself in a new, more challenging job in which his usual passive style of working was no longer tolerated by his superiors.

The term *activating situations* refers to small-scale events that trigger negative mood or maladaptive behaviors. Often these are smaller scale events that trigger the same schema activated by the precipitating event: For example, a student whose depression was precipitated by the breakup of his relationship with his girlfriend finds his mood is particularly low when he is sitting home alone on Saturday night, a time he and his girlfriend usually spent together. In this example, the precipitating event (rejection by girlfriend) and an activating situation (alone on Saturday night) both trigger his self-schema ("I'm worthless.").

The matching hypothesis (see chap. 1, p. 16) suggests that careful attention to the types of events and situations that are problematic for an individual can yield schema hypotheses, as in the example of the jilted student just given. Information about the activating circumstances and the schema hypotheses leads to intervention suggestions: Activity scheduling (see chap. 4) can help the student make some plans for Saturday night that he will enjoy more than staying home and moping, and a Thought Record (see chap. 5) can be used to identify the maladaptive schema and cognitive distortions and to begin to change them.

Origins

In the origins section, the therapist provides information from the patient's early learning history that explains how the patient might have learned his or her problematic schema. The therapist does this with a simple statement or with a brief description of one or two particularly poignant or powerful incidents that capture the patient's early experience. For example, "Janet's parents abused alcohol, neglected her, and had frequent angry outbursts over minor infractions when they were drinking. As a result, Janet learned that 'my needs are unimportant' and 'others cannot control their emotional reactions.'" Origins can also include modeling experiences or failures to learn important behaviors, as in the case of a patient who has significant social skills deficits due in part to growing up in a family in which both parents had marked social skills deficits.

Summary of the Working Hypothesis

This is the heart of the formulation. Here the therapist "tells a story" that describes how the patient learned the schema that are now being activated by external events to cause the symptoms and problems on the patient's problem list. The summary of the working hypothesis can be stated verbally or with a diagram with arrows linking the components of the formulation (see Haynes, 1992; and Persons & Davidson, 2000). In the summary of the working hypothesis, the therapist may explain

some problems as resulting from schema activation and some from other problems. For example, depressive symptoms may result from activation of the schema that "I'm a failure" by a job setback; the depressive symptoms and resulting passivity may contribute to marital problems.

STRENGTHS AND ASSETS

This section of the formulation appears between the working hypothesis, which describes the psychopathology, and the treatment plan. This placement is intended to encourage the therapist to draw on the patient's strengths and assets when designing interventions to treat the psychopathology. Strengths and assets can include good social skills, the ability to work collaboratively, a sense of humor, a good job, financial resources, a good support network, a regular exercise regimen, intelligence, personal attractiveness, and a stable lifestyle.

TREATMENT PLAN

We place the treatment plan after the formulation because it flows from and is based on the formulation. This section has several subheadings, some of which are a standard part of any clinical writeup (modality, frequency, and adjunctive therapies) but are not specific to a cognitive-behavioral case formulation. We focus here on the components of the treatment plan that are specific to the cognitive-behavioral approach.

Goals (Measures)

Treatment goals must be mutually agreed on. The patient and therapist do not always agree on the problem list (we discuss this problem later, in the section titled Patient and Therapist Disagree About the Problem List or Treatment Goals). However, we believe patient and therapist must agree on the goals, for the reason stated by Yogi Berra at the beginning of this chapter; namely, a patient and therapist are unlikely to be very successful in accomplishing their goals if they do not agree on what they are.

It is important to describe goals concretely for several reasons. Clear, concrete goal statements facilitate the work of the therapy. For example, a vague goal statement that reads "Frida will feel better about herself" does not provide much guidance about what is or is not a relevant agenda item for the therapy session. However, specific goal statements, such as, "Frida will feel more confident at work and will contribute more often in staff meetings," "Frida will have fewer depressive symptoms," and "Frida will feel less upset and recover more quickly following

arguments with her husband," provide clear guidance to the agenda-setting process (see chap. 3).

Stating goals concretely also facilitates outcome assessment. After stating each goal, we recommend that the therapist note what measures are used to track progress toward the goal. The topic of assessing progress in treatment is a substantial one that is beyond the scope of this book (to learn more about this topic, see Barlow et al., 1984; Bloom, Fischer, & Orme, 1995; and Ogles, Lambert, & Sawyer, 1995).

We recommend that clinicians ask their depressed patients to complete a self-report scale to assess depressive symptoms prior to each therapy session. Widely used measures include the BDI and the Burns Anxiety Inventory (details about these and other measures are provided in Exhibit 2.1). Other self-report measures can be used to track progress on other treatment goals; Fischer and Corcoran (1994a, 1994b) provided a useful compendium of measures. All these measures, of course, are nomothetic measures; to address the specific needs of the patient at hand, the therapist may wish to work with the patient to develop an idiographic measure tailored to the patient's particular difficulties. Self-monitoring methods (see Foster, Lavery-Finch, Gizzo, & Osantowski, 1999) are invaluable in this regard.

We recommend the use of a graph to track the patient's progress on depressive symptoms and other problems addressed in treatment; we provide a Progress Plot for this purpose (see Appendix 2B). A plot, where the session date is noted on the X axis, and the patient's score on the measure (e.g., a measure of depressive symptoms) is noted on the Y axis, is extremely useful in many ways (Kazdin, 1993). For example, if there is a marked perturbation (improvement or deterioration) in the patient's score, the clinician can ask about this; if a cause is ascertained (e.g., a vacation, a fight with the spouse, a change in the treatment plan), this can be noted on the plot and its implications for treatment can be discussed.

Interventions

The conceptual model used here states that the interventions of the therapy flow from the formulation. Thus, the interventions proposed in the treatment plan should be related to the deficits described in the working hypothesis, address some of the problems on the problem list, and facilitate the accomplishment of the goals. For example, assertiveness training is a logical intervention for a depressed woman whose symptoms are viewed as due in part to inhibited assertion because of her beliefs that her needs are unimportant and others will not be responsive to her. The depressed patient who is passive and inactive, spending hours every day in bed watching television, is likely to benefit

EXHIBIT 2.1

List of Assessment Tools for Measuring Therapeutic Progress in Depressed Patients

- **Beck Depression Inventory (BDI).** Forms I and II are available from the Psychological Corporation, 555 Academic Court, San Antonio, TX 78204-9990. The BDI is a 21-item self-report scale assessing the severity of depressive symptoms. An advantage is that it is widely used in the randomized controlled trials (RCTs); therefore, clinicians who use it can compare their findings with those in the RCTs. BDI Form I is in Beck et al.'s (1979) book *Cognitive Therapy of Depression*. The BDI was revised in 1996 and relabeled "BDI-II." The Psychological Corporation catalogue describes the relationship between the BDI and BDI-II as follows: "Items on the new scale replace items that dealt with symptoms of weight loss, changes in body image, and somatic preoccupation. Another item on the BDI that tapped work difficulty was revised to examine loss of energy. Also, sleep loss and appetite loss items were revised to assess both increases and decreases in sleep and appetite."
- **Burns Anxiety Inventory, Burns Depression Checklist.** These and other cognitive therapy forms are available from David Burns, MD, as part of the Therapist's Toolkit (see Dr. Burns's webpage on the World Wide Web: <http://www.feelinggood.com>).
- **Symptom Checklist-90 Revised (SCL-90R).** This 90-item instrument was developed by Leonard Derogatis in 1975 to assess overall psychological distress. It measures symptoms on nine dimensions: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The SCL-90R may be purchased from National Computer Systems, Inc., P. O. Box 1416, Minneapolis, MN 55440; 800/627-7271.
- **CAGE Questionnaire.** This questionnaire is a 4-item screening tool developed by Mayfield, McLeod, and Hall (1974) to assess for alcohol problems.
- **Yale-Brown Obsessive Compulsive Scale (Y-BOCS).** For permission to use Y-BOCS, contact Dr. Wayne Goodman, University of Florida College of Medicine, Gainesville, FL 32610. The original version was published by Goodman et al. (1989) in their article "The Yale-Brown Obsessive Compulsive Scale I: Development, Use, and Reliability."

Note. For other useful measures, see Fischer and Corcoran's (1994) *Measures for Clinical Practice: A Sourcebook. Vol. 1: Couples, Families and Children and Vol. 2: Adults.*

from activity scheduling. Data supporting the notion that interventions tailored to the patient's deficits are particularly helpful when treating depressed patients were provided by McKnight, Nelson, Hayes, and Jarrett (1984) in their single-case study entitled "Importance of Treating Individually Assessed Response Classes in the Amelioration of Depression." McKnight et al.'s depressed patients who had social skills deficits benefited most from social skills training and those with cognitive deficits benefited most from cognitive restructuring. To strengthen the empirical foundation of the therapy, we recommend that therapists use, when possible, interventions described in protocols that have been shown in RCTs to provide effective treatment for depression.

Obstacles

In this section of the formulation, the clinician uses information from any part of the formulation (e.g., problem list, schema) to make predictions about difficulties that might arise in the therapy. If the therapist can anticipate obstacles, he or she may be more successful in preventing or overcoming them than if they are unanticipated. For example, we have learned from experience that depressed patients who believe that "my needs don't count; my role in life is to care for others" tend to wish to terminate treatment prematurely. Although these patients sometimes seek treatment when they are extremely uncomfortable, as soon as they get some relief and their distress is manageable, their view of themselves as unimportant and not worth caring for causes them to want to end their treatment. If the therapist can anticipate and predict this tendency, he or she can initiate a discussion of this issue with the patient early in the treatment in an attempt to prevent a premature termination. For an example of a completed Cognitive-Behavioral Case Formulation and Treatment Plan form, see Exhibit 2.2.

Guidelines for Developing an Initial Formulation

Formulation and treatment planning are an ongoing, iterative process, with the formulation leading to a treatment plan, data evaluating the outcome of the treatment plan leading to revisions of the formulation and to new intervention ideas, and so on. This process occurs throughout treatment. Although the formulation is constantly subject to revision, we do recommend that after three or four sessions, the therapist write down an initial formulation and treatment plan using the format in Appendix 2A. We also recommend that the therapist review the formulation and treatment plan periodically, especially if the process or outcome of treatment is problematic.

The initial part of the formulation and treatment planning process is particularly important to the success of the treatment; therefore, we focus on it here. We recommend that the therapist use the following general guidelines (see Exhibit 2.3) during the initial formulation process.

1. *Make a comprehensive problem list.* We believe it is important to collect a comprehensive problem list, even though the treatment plan is likely to focus on only some of the patient's problems (Linehan, 1993; Nezu & Nezu, 1993; Turkat & Maisto, 1985). Without a comprehensive problem list, the therapist may fail to

EXHIBIT 2.2**Cognitive-Behavioral Case Formulation and Treatment Plan for "Jenna"****Name:** Jenna**Identifying Information:** 34 MWF, not working, living with husband and 5-year-old daughter.**Problem List:**

1. Depressive symptoms. BDI = 22. Sadness, lack of enjoyment, feeling like a failure, self-criticism, lack of energy, suicidal thoughts but no plan or intent, difficulty making decisions, loss of interest in others, insomnia, loss of appetite. "Things are not good. Nothing much matters. Sometimes I don't care if I live or die."
2. Not working. Believes work would help "pull her out" of depression, as it did in the past, but "I don't know what I want to do, and I don't have any energy to do it. I just can't get moving." Enjoyed working as an editor for 5 years, "but I don't know what my long-term career goals are."
3. Marital problems. Following a stillbirth, she wanted to consider adoption, but her husband did not and refused to discuss it. He wanted her to "let go [of her distress about the stillbirth] and move on"; she is resentful that he does not acknowledge her pain, loss, suffering. She describes the miscarriage as a "black hole" in their marriage. She fears asserting herself with him, saying that when she speaks up about her resentment, "he just throws it back at me." They do not fight, but they are distant, estranged.
4. Fear of freeway, bridge driving. "There are a lot of bad drivers, and I'm very vulnerable in a car on the freeway." "I could turn the steering wheel and slam into a wall." Fear of panic attacks while driving, onset following several panic attacks while driving several years ago. She avoids busy streets, freeways, and bridges and rarely drives outside a 2-mile radius surrounding her home.
5. Socially isolated. Jenna has two women friends, mothers of children that are her daughter's friends, but she is not close to either, does not initiate any activities with them.

Diagnosis:*Axis I:* Major depressive disorder, panic disorder with agoraphobia*Axis II:* Dependent personality disorder*Axis III:* None. History of miscarriage, stillbirth.*Axis IV:* Unemployed, marital problems, socially isolated.*Axis V:* 50**Working Hypothesis:***Schema:*

Self: "I'm not ready for and can't handle adult responsibilities." "I can't make good choices/decisions." "I'm weak and vulnerable and need lots of nurturing, support."

Other: "My husband doesn't care, doesn't want to be supportive of my needs." "My husband is to blame for my unhappiness; he must change if I am to be happy."

World: "Life shouldn't be so hard; it should be easier."

World/future: "Bad things can happen to me, my child, such as disease, death, accident."

Precipitants: Move to California about 5 years ago; as part of this transition, Jenna gave up her job that had been a confidence builder. Other precipitants include several miscarriages and a stillborn child.

(continued)

EXHIBIT 2.2

Activating situations: Challenging driving situations (freeways, bridges), a need to speak up to her husband about her emotional distress, wanting to seek work.

Origins: Parents modeled difficulty handling loss of a child who died of leukemia; it was never discussed in the family, and the patient learned about her dead brother from her grandmother when she was 9 years old. The patient's mother was fearful and overprotective: "Don't try some thing if you're not sure you can do it—something bad might happen."

Summary of the working hypothesis: Jenna's move to California and the loss of her job that had given her some direction, satisfaction, and feedback that she can make decisions and handle adult responsibilities activated her beliefs that she cannot handle adult/demanding decisions/responsibilities. In response to these beliefs and the anxiety they produced when activated, she withdrew from responsibilities, including looking for a job and driving in challenging freeway and bridge situations, which left her isolated, resulting in a loss of potential sources of gratification, leading to her depression. Jenna's beliefs that she cannot make good choices and cannot choose a career path, coupled with driving problems, inertia from depression, and resentment toward her husband, block her from seeking work. The stillbirth and miscarriages and resulting unhappiness supported or activated Jenna's beliefs that she needs lots of support/nurturing, that her husband is unsupportive, and that he is responsible for her unhappiness, contributing to her depression, inertia, and marital problems.

Strengths and Assets: Stable life circumstances (husband who supports the family), a good network of friends, well educated, bright, psychologically minded.

Treatment Plan:

Goals (measures):

1. Reduce depressive symptoms (BDI).
2. Increase comfort while driving freeways and bridges (measured through patient's ratings of items on a fear hierarchy). Increase the distance (now about 2 miles) she is willing to drive from home.
3. Return to work.
4. Reduce marital tension and estrangement, as measured by spending more enjoyable time together as a couple.

Modality: Individual cognitive-behavior therapy **Frequency:** Weekly

Interventions

1. Activity scheduling to increase sources of pleasure and mastery, alone and perhaps with husband.
2. Build a hierarchy and use gradual exposure to alleviate driving fears.
3. Teach anxiety-management skills, including diaphragmatic breathing.
4. Interceptive exposure (exposure to internal somatic sensations; see Barlow, Craske, Cerny, & Klosko, 1989).
5. Cognitive restructuring to work on fears that she cannot handle driving or other challenges, beliefs that her happiness depends on her husband, fears that bad things could happen, beliefs she cannot choose and act on a professional goal.
6. Schema change methods to tackle her belief that she is weak/vulnerable.
7. Assertiveness training, especially with her husband.

Adjunct therapies: Consider antidepressant medications, couples therapy.

Obstacles:

1. Jenna's view that others are responsible for her happiness may make it difficult for her to work aggressively in treatment to overcome her problems.

Note. MWF = married, white female; BDI = Beck Depression Inventory; 50 = score on Global Assessment Functioning Scale.

EXHIBIT 2.3**Guidelines for Developing an Initial Formulation**

- Make a comprehensive problem list.
 - Describe problems in concrete, behavioral terms.
 - Base the formulation on a well-validated theory.
 - Begin formulating early.
 - Share the formulation with the patient.
-

obtain important pieces of the puzzle needed to understand the case (hence to develop a good working hypothesis) and propose an effective treatment plan. If the therapist is not aware of the larger context of the patient's disorder (what Taylor, 1971, called the "predicament"), the treatment may be derailed when a problem the therapist had not anticipated (e.g., the patient cannot pay the rent) suddenly becomes a crisis.

2. *Describe problems in concrete, behavioral terms.* Beck (1976) proposed that depressive (and other symptoms) consist of cognitive, behavioral, and mood components. Therefore, we recommend that therapists attempt to describe patients' problems in these terms. Describing problems in terms of mood-cognition-behavior components can readily lead to interventions (cognitive restructuring and activity scheduling) to modify those components of the problem. Concrete, behavioral descriptions also make it easier to translate problems into measurable goals and into therapy session agenda items.
3. *Base the formulation on a well-validated theory.* We recommend that therapists base their formulation on a nomothetic theory that is well-supported empirically, underpins a therapy that has been shown effective in RCTs, or both. This strategy strengthens the empirical foundation of the therapist's clinical work. If treatment based on the well-validated nomothetic theories fails, treatment plans that are based on unvalidated theories can be attempted after informing the patient about the experimental nature of the treatment.
4. *Begin formulating early.* We (and others; see Sackett et al., 1997; Turkat & Maisto, 1985) recommend that clinicians begin developing a formulation right away, as soon as any information is collected, rather than collecting a lot of information before beginning to hypothesize about the case. Studies of medical problem solving (Elstein, Shulman, & Sprafka, 1978) indicate that highly competent physicians develop initial diagnostic hypotheses very early in the assessment process.

5. *Share the formulation with the patient.* A shared formulation builds collaboration and the patient's allegiance to the treatment plan. In addition, the patient's reaction to and input about the formulation can provide valuable feedback. One of us (J. B. P) once proposed to her patient, a personnel manager who was having panic attacks in response to stressful work conflicts, the hypothesis that the manager appeared to believe, "I can't cope with these conflicts." When the therapist proposed this formulation, the manager responded resentfully: "No, that's not it. My belief is 'I shouldn't have to cope with this nonsense!'" This feedback was invaluable—in fact, the manager's formulation was superior to the therapist's. The manager's formulation explained not only her panic symptoms but also her resentful, frustrated mood and her reluctance to work hard in treatment to overcome her panic symptoms. It is not possible or useful to share with the patient every formulation hypothesis the therapist entertains. However, we encourage therapists to use their patient's self-knowledge and problem-solving abilities when developing and testing formulations.

The Process of Developing a Cognitive–Behavioral Case Formulation

A complete cognitive–behavioral case formulation contains a lot of information, as Appendix 2A's format shows. A fully elaborated discussion of the assessment strategies the clinician can use to obtain this information is beyond the scope of this book (see J. S. Beck, 1995; Bellack & Hersen, 1998; Bloom et al., 1995; Haynes & O'Brien, 2000). We focus here on a few highlights of the process of gathering information for formulation and treatment planning.

Collecting some of the information needed for the formulation is straightforward. For example, as illustrated in the videotape *Cognitive–Behavior Therapy for Depression: Individualized Case Formulation and Treatment Planning* (Persons, Tompkins, & Davidson, 2000), the therapist can ask the patient directly about problems in all the various domains to be assessed. In addition, the therapist can ask the patient and perhaps others to complete rating scales or collect monitoring data, interview family members or others (e.g., teachers), conduct behavioral assessments (e.g., measuring in feet how close to a snake the snake-phobic patient will go), and collect physiological data.

Therapists find the process of developing schema hypotheses to be a particularly challenging one. We recommend three general strategies: attend to repeated automatic thoughts (particularly to those that occur across a variety of situations), use the "downward arrow" method, and use self-report scales. We describe each in turn.

As an example of the strategy of attending to repeated automatic thoughts, an attorney who came to his therapy session quite anxious and agitated about several work stresses began speaking rapidly and agitatedly about his situation. As the therapist listened carefully, she heard the patient repeatedly say "I'm out of control; I can't handle this." When the therapist pointed this out to the attorney, he immediately evaluated his self-statement as incorrect, asserting "I *can* handle all this stuff. I always do." He admitted, however, that the thought "I can't handle it" was a frequent one and, based on the brief sample observed in the therapist's office, probably recurred dozens of times a day. Because of the prominence of the "I'm out of control; I can't handle this" thought in the attorney's stream of thinking, the therapist hypothesized that it reflected an aspect of his self-schema.

Cognitive theory and current models of information processing suggest that automatic thoughts occurring in multiple and diverse situations are more likely to arise from underlying schema than are automatic thoughts activated only in certain particular situations. One of us (J. B. P.) treated a depressed chemist (Dr. P.) who had multiple problems: His marriage was in trouble, he was not performing up to par at work, and he was procrastinating on many minor and major personal matters (e.g., filing his income tax return). When the therapist asked him to propose an agenda item for his therapy session, Dr. P. was silent. When asked about this, he reported "I don't know where to start. Nothing I try will help anyway." Dr. P. also had great difficulty completing therapy homework assignments, finding himself easily overwhelmed and immobilized if an unanticipated obstacle arose; when this happened, he simply shut down and stopped trying. These problems in therapy and many of Dr. P's problems outside of therapy appeared to be related to his prevailing automatic thought, namely, "I can't tackle that task. I'll fail." This recurring pattern of thinking in multiple situations suggested that Dr. P's schema about himself was "I'm a failure. I can't do anything right" and that his schema about the world was "the world is overwhelming, unsolvable, unmanageable."

To pinpoint themes in patients' thinking, we recommend that the therapist retain in the patient's clinical record copies of their completed Thought Records done as homework or during the therapy session (see chap. 5) and review them periodically to search for themes. If patients are keeping a notebook for their therapy materials, they can review

them as well. Frequently repeated automatic thoughts yield good schema hypotheses.

Another useful method for arriving at schema hypotheses from automatic thoughts is the "downward arrow," or "vertical arrow," method described by David Burns (1999). To use the downward arrow method, choose an automatic thought that occurs in a particular situation, ideally one that recurs frequently and in multiple situations. Begin by saying to your patient, "Assume that thought is true. Tell me why is this upsetting to you? What does it mean about you?" Repeat as often as necessary until you seem to reach "the bottom"—a core belief about the self, others, the world, or the future.

For example, a depressed graduate student who used the downward arrow method produced the following series of automatic thoughts: "If I try that project, I won't be able to do it," "If I'm not able to do it, this means I'm incompetent," "If I'm incompetent, this means I'm a loser," and "If I'm a loser, no one will want to be with me."

Self-report scales can also serve as sources of schema hypotheses. The two best known measures of this sort are the Dysfunctional Attitude Scale, a version of which is published in *Feeling Good* (Burns, 1999), and the Young Schema Questionnaire developed by Jeffrey Young (1999).

Solving Problems Arising in Formulation and Treatment Planning

TIME

Individualized formulation and treatment planning is time consuming. Writing up a complete formulation and treatment plan can require 1½ hours or more, and this time is not usually directly billable. Spending this amount of time on a formulation and treatment plan is particularly demanding when treatment is brief. One solution to the time problem is to carry out at least some of the formulation work in the session; this is consistent with the goal of making the formulation process as collaborative as possible. For example, the patient and therapist can work together during an early therapy session to make a comprehensive problem list. Some patients can be asked to make a list of goals as an early homework assignment; in other cases, a patient and therapist can develop these together in the therapy session.

DIFFICULTY OBTAINING A PROBLEM LIST

Most depressed patients are quite responsive to the therapist's request to make a comprehensive problem list. However, some patients have difficulty tolerating this task and assiduously avoid it. In our experience, some of the patients who avoid this task do so because they hold beliefs such as "If I acknowledge any weakness, this means I'm a total loser and I'm vulnerable to domination (or humiliation, attack, or criticism) by others, including my therapist." That is, the process of describing problems activates the patient's schema, produces negative emotions, and prompts escape, avoidance, defensive, or even aggressive behaviors. When working with these patients, it is often necessary to proceed slowly and provide a lot of empathy and support in addition to the usual problem-solving strategies (Linehan, 1993). The therapist may wish to accommodate this patient by approaching the collection of a problem list a bit at a time rather than in a single session. If the patient and therapist are able to form a solid, trusting working relationship, it may be possible to get the patient's fear of discussing problems and vulnerabilities "out on the table" and work on it as a problem in its own right.

PATIENT AND THERAPIST DISAGREE ABOUT THE PROBLEM LIST OR TREATMENT GOALS

A patient and therapist do not always hold the same view of the patient's problem list or goals of treatment. Common areas of disagreement include substance abuse and marital problems. Sometimes the patient and therapist can handle a disagreement by simply monitoring it or by agreeing to disagree, but occasionally the disagreement aborts the treatment altogether.

Disagreement about goals is highly undesirable because treatment goals are often difficult to accomplish even when patient and therapist agree on them. Disagreement about items on the problem list is common and sometimes can be problematic. A useful principle for deciding whether a problem list disagreement is manageable or not is the following: If the disagreement is not likely (in the therapist's judgment or as determined empirically) to prevent the patient from reaching his or her goals or to lead to a catastrophe (e.g., financial insolvency), then divergence is acceptable.

For example, a graphic artist who sought treatment for depression described his marriage as happy but also described frequent arguments with his wife, which suggested that his marriage was probably not going smoothly. When the therapist pointed out this discrepancy, the patient became defensive and insisted he had a happy marriage. In this case, the therapist placed the item "possible marital problem" on the patient's

problem list and moved forward to work with the patient on his depression, keeping the marital issue in mind as a problem that might need to be taken up if the patient did not make good progress with a treatment plan that ignored the marital issue. As often happens, the marital problem boiled up again, more seriously, several weeks later; at that point, the patient agreed to seek couples therapy to address it.

Similarly, a young computer programmer sought treatment for anxiety and was eager to learn relaxation and time-management skills. This young executive also had a significant social skills deficit, but when the therapist raised this issue for discussion, the executive denied that social interactions were a problem for him. The therapist agreed to move ahead with a treatment plan to address the young man's anxiety; after making good progress on these problems, the executive was able to acknowledge his social skills problem and agreed to tackle it.

Although disagreement about the items on the problem list can be benign, as in the examples just presented, disagreement about treatment goals is more problematic. However, sometimes a successful treatment can be carried out even when the patient and therapist disagree about the goals, particularly if the disagreement is about a lower priority goal. Sometimes, as in the examples just presented, the therapist has a covert goal that the patient acknowledges and agrees to tackle a certain problem that the therapist perceives but the patient does not.

Substance abuse is a common area of disagreement. It is not uncommon for the therapist to view a patient's substance use as a problem and to want the patient to set a treatment goal to reduce or stop it, but the patient insists that it is not a problem and refuses to address it. Sometimes a disagreement of this sort can be addressed through an empirical test, as in the case of Terry, a depressed attorney. Terry drank nearly a bottle of wine a day, usually while socializing after work with his colleagues. He sought treatment for depressive symptoms, which were making him miserable and interfering with his work. He also had a tumultuous and conflictual relationship with a girlfriend. The therapist hypothesized that Terry's alcohol use was contributing to his various difficulties and recommended that Terry set a treatment goal of reducing his drinking. Terry refused, insisting that he wanted to work on his depression and that the drinking was not a problem and, in fact, helped him cope.

The therapist adopted an empirical approach, proposing to Terry "I'll work with you on the depression for 3 months. I'll ask you to complete a Beck Depression Inventory (BDI) weekly to monitor your progress. If after 3 months we are making good progress, I will continue working with you. If at that point we have not made good progress, I will not be willing to continue treating you unless you agree to renegotiate your treatment plan to address your alcohol use." Terry was agreeable to this

plan and tried it. Unfortunately, after 3 months of treatment, Terry's depression, as evaluated with the BDI, was essentially unchanged, and his life was increasingly dominated by chaotic interactions with his girlfriend. He had stopped drinking for 1 week during the 3-month treatment period, and he admitted that during that week his mood improved and his relationship settled down considerably. However, he resumed drinking. When treatment was reviewed at the end of 3 months, he had to admit that he had not made any gains in alleviating his depression. However, Terry was still not willing to work on his drinking, so he reluctantly terminated his treatment.

PATIENT AND THERAPIST DISAGREE ON THE FORMULATION AND TREATMENT PLAN

We recommend that the therapist share all or parts of the proposed formulation, especially the working hypothesis, with the patient (see Guideline 5). This can provide the therapist with information leading to a useful reworking of the formulation. But sometimes the patient and therapist disagree on key elements of the formulation or treatment plan.

When the patient and therapist disagree on the working hypothesis, it is ideal if this disagreement can be put out on the table and examined collaboratively. A depressed young architect with a major marital problem was drinking nearly a bottle of wine 1 or 2 evenings a week. The therapist's formulation was that this drinking contributed to her marital problems because the architect became irritable and feisty when she drank and provoked nasty verbal conflicts with her husband. When the therapist proposed this hypothesis, the patient did not agree with it—but she did agree to collect data to test it. After 3 weeks of data collection, the architect saw that fights with her husband were, after all, linked to her drinking, and she agreed to set a treatment goal of reducing her drinking.

Occasionally the disagreement between the patient and therapist on the formulation or treatment plan is so fundamental that the treatment cannot go forward. A depressed freelance copy editor sought treatment for depression. He lived alone and worked at home. He was quite isolated, with only one friend he saw rarely. He experienced debilitating pain following a botched surgical procedure, and he was drinking large quantities of alcohol to manage his pain. He had filed a lawsuit against the physician whom he believed was responsible for his condition. He owned a gun and was contemplating using it to kill himself if things got too bad. After evaluating the case, the therapist proposed a treatment plan that required the patient to surrender the gun, to meet for twice-weekly therapy sessions, to agree that reducing his alcohol intake was a top priority, and to do homework outside the therapy session. In ad-

dition, the therapist warned the patient that if he did not make rapid improvement, a day treatment or pain treatment program would be necessary. The patient refused to agree to this treatment plan, insisting that he could not do homework outside the therapy session. His therapist then secured treatment for the patient with another provider.

As these examples illustrate, the process of formulating and treatment planning is complex and obstacles do arise. The case formulation itself can be a fruitful source of hypotheses about the obstacles to the process of formulation and treatment planning, as illustrated in the example of the patient who was unable to make a problem list because acknowledging problems activated his fears of being dominated and humiliated.

Summary and Conclusion

In this chapter, we described in detail the reasons for, format of, and process of developing an individualized Cognitive–Behavioral Case Formulation and Treatment Plan. The formulation guides the use of the activity scheduling, cognitive restructuring, and schema change interventions described in the next three chapters of this book.

Practice Exercises

These exercises are intended for the use of clinicians who wish to practice the formulation and treatment planning strategies taught in this chapter.

1. Choose the case of a patient who is not making good progress in treatment and take the time to write up a complete case formulation and treatment plan using the format presented in Appendix 2A. After completing that task, follow these steps:
 - (a) List in the obstacles section of your treatment plan any new ideas you have about why this patient is not making progress.
 - (b) List in the interventions section of your treatment plan any new intervention ideas that arise from this formulation.
 - (c) Discuss with the patient the issue of treatment progress and your ideas about why he or she is not making progress and what new interventions might be attempted.
 - (d) If you attempt new interventions, monitor outcome to evaluate the value of the new formulation and treatment plan.

2. Choose a complex, multiproblem case. Then walk through the following steps:
 - (a) Write down, alone or working collaboratively with your patient, a complete list of the patient's problems in all of the following domains: psychological-psychiatric symptoms, interpersonal, occupational, medical, financial, housing, legal, and leisure.
 - (b) Using the problem list, work with your patient to arrive at a clear list of treatment goals.
 - (c) Develop with your patient a collaborative agreement about the priority order of the goals.
3. Choose one of your cases and suggest to your patient that you work together to make a short list of treatment goals. Do this in one of the therapy sessions or ask the patient to do this task as a homework assignment and bring the list of goals to the next session for review. For as many of the goals as possible, devise a method to measure progress toward the goal.
4. Obtain a self-report scale of depressive symptoms (see Exhibit 2.2. Assessment Tools for Measuring Therapeutic Progress in Depressed Patients). Ask one of your depressed patients to complete the scale prior to each session. Or ask your patient to provide daily ratings on a mood scale, ranging from 0 (*feeling fine*) to 100 (*totally depressed*). Graph the scores on the Progress Plot (Appendix 2B). Review the plot each week with your patient. To remind yourself to give the measure to the patient the next time you meet, place the depression scale and the Progress Plot in the front of the patient's chart.
5. If you believe your patients will dislike the process of completing a self-report scale to measure depressive symptoms and bringing it to the therapy session, collect some data to test your hypothesis. Provide the rationale for collecting weekly assessments of progress, obtain a measure of depressive symptoms (see Exhibit 2.2), and propose to your patient that he or she complete the measure weekly. Track scores on a Progress Plot (Appendix 2B). Afterward, ask your patient the following: "Was this helpful? How did it feel?" Ask yourself the same questions.
6. Read the following two vignettes and answer the accompanying questions. (Answers are provided at the end of this question.)
 - (a) Sam, a retired businessman, described two recent problematic situations. On Sunday evening, after a weekend in which he had cancelled some dates with friends because he felt too depressed to go out, he felt really down and had the following thoughts: "I can't do anything; I can't get anything done; I make plans, but then I can't follow through. I'll never get

better." The following day he received a call from a client who wanted him to provide some business advice. He put off meeting with his client because of the following thoughts: "I have nothing to contribute, and it will be a huge effort to drive to his office to see him."

- (b) Jeannie, a married, working mother, reported two problematic situations. On Friday afternoon, she had planned to visit with her best friend after work, something she and her friend rarely found the time to do. In the late afternoon, her daughter called, needing a ride home after school. When her mother asked her to take the bus, the child became angry, complaining "You never help me out when I need you!" Her husband also called, asking her to cook dinner so that he could have more time to work at home during the evening. In response to these two calls, Jeannie canceled her plans to visit her friend, picked her daughter up at school, and cooked dinner for her family. She felt depressed that evening and had the following thoughts: "My daughter is angry and pulling away from me. I'm not a very good mother. I try hard, but it's never enough. It's never going to change."

At work the next day, her boss asked her to take on a new project that would require lots of overtime for the next 2 months. Jeannie did not want to accept the project, but she agreed to do it anyway. Later, she felt upset, thinking "I should have said 'no'; I'm already dropping too many balls at home. But if I don't take on this project, my boss will be disappointed in me, and I might get a negative evaluation and lose my job."

Question: As the therapist, on the basis of this information, propose a hypothesis about Sam's and Jeannie's self-schema. Propose a preliminary Working Hypothesis about the relationship among activating situations, schema, automatic thoughts, mood, and behaviors for these patients.

Answers

- (a) Sam's view of himself appears to be the following: "I can't do anything; I'm helpless, ineffectual, ineffective, impotent." When situations require him to take action, his negative self-schema are activated, he feels anxious and depressed, and he has thoughts about how hard it will be to take action and how ineffectual his actions will be. Behaviorally, he withdraws and avoids; these behaviors provide further support for his belief that he is incapable and ineffective.
- (b) Jeannie's view of herself appears to be the following: "My needs are not important; I'm not worthy." Her view of others

appears to be that "others are demanding, needy, unable to manage on their own." She also appears to believe that "If I do not meet others' needs, they will reject me." When others make requests of her, her schema are activated and she has thoughts that drive her to accommodate others before herself. As a result of pushing herself to meet others' needs, she feels emotionally unsupported, overwhelmed, and depressed. Taking action to meet others' needs and ignoring her own produces more evidence supporting her view of herself as unworthy.

Further Readings and Videotapes

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**APPENDIX 2A: COGNITIVE-BEHAVIORAL CASE FORMULATION
AND TREATMENT PLAN**

Name: _____

Identifying information: _____

Problem List

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

Diagnosis

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Working Hypothesis

Schema

Self: _____ Others: _____

World: _____ Future: _____

Precipitants: _____

Activating situations: _____
Origins: _____

Summary of the Working Hypothesis:

Strengths and Assets: _____

Treatment Plan:

Goals (measures)

1. _____
2. _____
3. _____
4. _____

Modality: _____ Frequency: _____

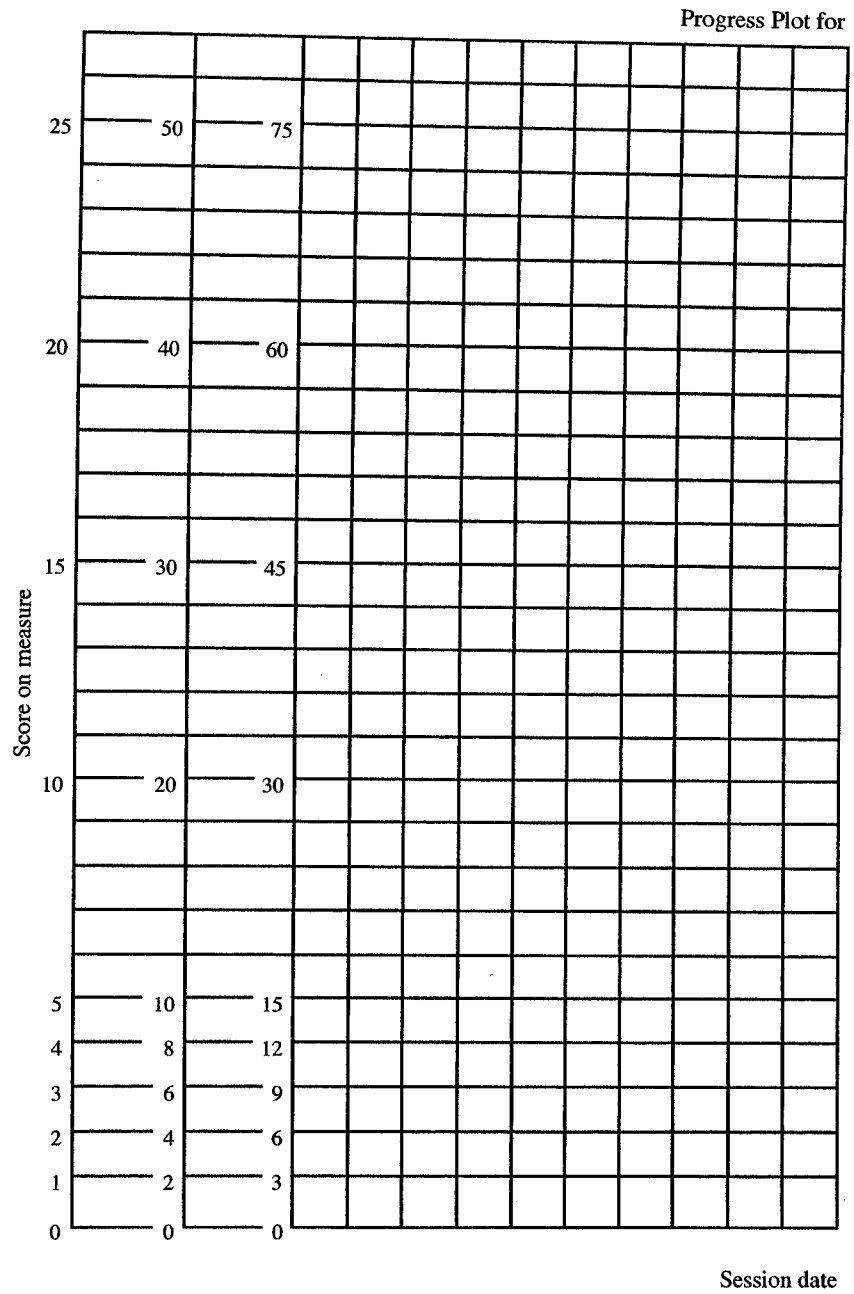
Interventions: _____

Adjunct therapies: _____

Obstacles: _____

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APPENDIX 2B: PROGRESS PLOT



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