CHAPTER 1

The case formulation model

This chapter describes the case formulation model of psychological problems that serves as the basis for the assessment and intervention strategies described in the remainder of the book. The first sections of the chapter describe the model itself; later parts of the chapter describe the role of the case formulation in clinical work.

PSYCHOLOGICAL PROBLEMS OCCUR AT TWO LEVELS

The case formulation model conceptualizes psychological problems as occurring at two levels: the *overt difficulties* and the *underlying psychological mechanisms*. *Overt difficulties* are "real life" problems, such as depressed mood, panic attacks, procrastination, difficulty getting along with others, suicidal thoughts, shoplifting, or inability to drive on freeways and bridges. *Underlying psychological mechanisms* are the psychological deficits that underlie and cause the overt difficulties. The underlying mechanisms can often be expressed in terms of one (or a few) irrational beliefs about the self. For example, a young accountant who was socially isolated, anxious about his work, and depressed held the belief, "Unless I'm perfect in everything I do, I'll fail." This belief produced his overt difficulties. It led him to avoid social interactions

because he feared any blunder in interacting with others would lead to rejection. Similarly, his fear of making a mistake led to anxiety (and paradoxically, to poor performance as a result) at work. His depression resulted from his social isolation and his feelings of incompetence at work.

The first part of the chapter describes overt difficulties and underlying mechanisms in detail, beginning with overt difficulties.

OVERT DIFFICULTIES

At a "macro" level, overt difficulties include such things as depression, relationship difficulties, poor work performance, obesity, and fear of going out alone. These are problems as they might be described in the patient's own terms.

At a "micro" level, problems can be described in terms of three components: cognitions, behaviors, and moods (Lang, 1979). For instance, a secretary's difficulties working with a supervisor might involve distorted cognitions ("If I make a mistake, he'll fire me"), behavioral problems (poor attendance, palpitations, and sweating), and negative moods (fear and anger). All three components of problems usually reflect the irrational, maladaptive nature of the underlying mechanism. The cognitive, behavioral, and mood components of three typical overt difficulties are illustrated in Table 1.1.

Cognitions

A cognitive component can be found for nearly every problem patients report—even problems that do not appear to involve cognitions. As Beck (1972) pointed out, negative mood states usually involve negative automatic thoughts. For example, a depressed, hopeless patient might report cognitions like, "I can't cope—suicide is the only solution."

Automatic thoughts are also related to problematic behaviors like procrastination, poor work performance, interpersonal squabbles, overeating, and so on. For example, when a piece of laboratory equipment failed, an engineer experienced a barrage of automatic thoughts, including: "I'll never solve this problem, I'm incompetent in the lab, I'm going to be fired, I'll never be a success in my field, Everyone else who works here is more competent than I am." These self-critical thoughts inhibited her from searching for solutions to the problem; instead, she burst into tears and ran out of the lab.

In addition to thoughts, cognitions can also include images, dreams,

Table 1.1 Psychological problems represented as constellations of cognitions, behaviors, and moods

Problem	"Generalized anxiety"	School problems	Confusion about career goals
Cognitions	"I'm trapped." "I don't want to be here."	"I must be perfect." "My Dad insists I get A's."	"If I try working at something I enjoy, I might fail."
Behaviors	Palpitations, sweating, tightening of facial muscles, dizziness, requests for reassurance, avoidance	Stomach cramps, procrastination	Lack of energy, excessive sleeping, overinvolvement with household errands and duties, procrastination
Mood	Fear, anxiety, resentment	Anxiety, depression	Depression, boredom, anhedonia

daydreams, and memories. For instance, a bank clerk experienced feelings of rage and a powerful image of dripping blood whenever she thought about her supervisor.

Behavior

Three types of behaviors are considered here: overt motor behaviors, physiological responses, and verbal behaviors.

Overt motor behaviors that play a role in psychological problems include such things as spending hours lying in bed reading novels, overeating, arguing with others, and avoiding bridges.

Physiological responses relevant to psychological problems often include increased heart rate, sweating, dizziness, and other symptoms associated with panic. Physiological aspects of depressed mood can include insomnia, anorexia, and fatigue. Physiology tends to get short shrift in

discussion of problems of depression, but often plays a central role in anxiety.

Problematic verbal responses include continual requests for reassurance, frequent hostile demands, or suicidal threats. Pain complaints can constitute a significant part of the clinical problem (Fordyce & Steger, 1979).

Behavioral components of patient's problems are usually best described as problematic or maladaptive, although the term *irrational*, usually reserved for cognitions, can sometimes be helpful in describing behaviors as well.

Mood[1]

The term "mood" is used here to refer to the patient's subjective report of his emotional experience. Moods that play a role in psychological problems are typically negative and unpleasant: depression, anxiety, panic, boredom, frustration, anger, jealousy, hopelessness, and so on. Depressed patients often seek treatment for their mood problem, unaware that cognitions and behavior are important aspects of their problem.

Relationships among the components

SYNCHRONY. Usually a problem in one component indicates that problems in other components are also present. An underlying deficit is usually manifested in all three components at the overt level, not just one or two. Thus, a person complaining of depressed mood typically shows closely related behavioral and cognitive problems as well.

Occasionally this does not happen; and in that case the components of a problem are said to be desynchronous (Rachman, 1978, Chapter 1). Thus, a person may have a severely depressed mood, but little or no disruption of normal behavioral patterns, or a physiological fear response to cats, but no avoidance.

INTERDEPENDENCE. The synchronous relationships between cognitive, behavioral, and mood components of problems suggests that a change in any one component is likely to produce changes in the other components. These interdependent relationships are indicated by the arrows connecting behavior, cognitions, and mood in Figure 1.1. Thus, if a depressed, inactive person increases his activity level, we would expect an improvement in mood and a reduction in negative thinking as well.

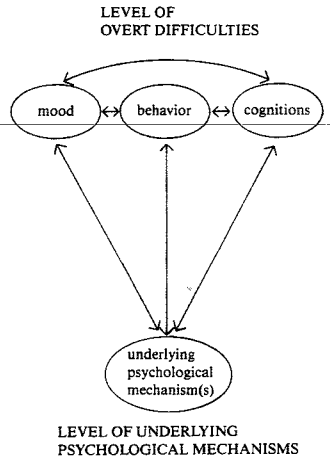
[1]Although in the model presented here the term "mood" refers to the patient's subjective report of his emotional experience, this view is an oversimplification of Lang's (1979) model, which suggests that mood is more accurately described in terms of all of the systems described here: cognitions, motor behavior, physiology, and verbal behavior.

The notion that changes in cognitions can produce changes in mood is the key idea of Beck's cognitive therapy, and the idea that behavioral changes can produce changes in mood is central in Lewinsohn's behavioral treatment and in exposure treatments for fears. The interdependence of the components makes this possible.

The interdependence of the cognitive, behavioral, and mood aspects of problems is particularly important to the clinician treating a mood problem, because therapists have not developed strategies for directly manipulating mood (Rachman, 1981). Thus, although later chapters in this book focus on interventions directed at the behavioral and cognitive aspects of problems, there is no comparable chapter for mood interventions.

The interdependence hypothesis is supported by studies showing that interventions directed at one system appear to produce changes in all systems. Zeiss, Lewinsohn, and Muñoz (1979) treated depressed patients with cognitive therapy, behavior therapy, or social skills interventions. Patients did not show a superior treatment response in the system that was treated; instead, they showed changes in all systems. Rehm, Kaslow, and Rabin (1987) and Simons, Garfield, and Murphy (1984) reported similar results.

Figure 1.1 A two-level model of psychological problems.



UNDERLYING MECHANISMS

The underlying psychological mechanism is a problem or deficit that produces, or is responsible for, the individual's overt difficulties. Direct, objective measures of underlying psychological mechanisms are not yet available. As a result, the therapist's ideas about the underlying cognitions operating in any given case are best viewed as working hypotheses.

Underlying beliefs are often well-expressed in an "if-then" format, such as, "If I get approval and caring from others, I'll be happy," "If I do what others want and expect of me, they'll give me the approval and caring I want," or "If I'm extremely successful, others will accept me." However, sometimes underlying beliefs are simpler, blanket statements, such as, "I'm worthless," "No one cares about me," or "I can't cope." Young (1987) has suggested that patients with personality disorders hold this type of unconditional belief, which he labels an early maladaptive schema (EMS). We might expect these types of underlying beliefs to be more difficult to change than the conditional ones.

Sometimes the patient's central problem is not efficiently described in terms of an underlying belief. For example, the central problem of an impulsive, violent young adolescent may be a lack of problem-solving skills. Empirical work by Linehan and her colleagues (Linehan, Camper, Chiles, Strosahl, & Shearin, 1987) suggests that deficits in problem-solving may underlie suicidal behavior.

Although the therapist attempts to arrive at one clear statement of the proposed underlying mechanism, this can be difficult to do. Various forms and permutations of the mechanism may be operative, depending on the external situation arousing the mechanism and the associated behaviors, cognitions, and moods (cf. Horowitz, Marmar, Krupnick, Wilner, Kaltreider, & Wallerstein, 1984). Or the individual may have more than one problem. When this happens, one problem usually plays a central, dominant role, and the others seem to be somewhat less important.

The question of the malleability of the underlying irrational beliefs is a fascinating topic about which we unfortunately know very little. Many patients, discussing their automatic thoughts, and irrational beliefs, can say, "I *know* I'm not worthless, but I just keep buying into feeling worthless and inadequate." These patients appear to have alternatives to their pathological beliefs already available to them—although they may take some looking for.

Other patients do not seem to have any available alternatives to their central pathological beliefs. In response to the therapist's proposal that

the patient is not worthless, this type of patient may say, "What you say makes intellectual sense, but it just doesn't have any emotional impact for me." For these patients, their self-concept and worldview are entirely determined by their irrational ideas. Christine Padesky (personal communication, April, 1986) has suggested that the unavailability of healthy self-perceptions might be a definitive characteristic of people with personality disorders, and others (Young, 1987; Guidano & Liotti, 1983) have made similar suggestions. Obviously, patients who do not have alternative, healthy, cognitive structures will be much more difficult to work with. The therapist's task is not simply to teach the patient to look for or access these structures; instead, they must be created from whole cloth (Padesky, 1988).

An example

The model states that the underlying central problem produces the overt difficulties. For example, the depression, social isolation, and overeating problems experienced by a newspaper writer can be understood as a result of his belief, "If anyone really gets to know me, he/she will see how repulsive I am and reject me." He is socially isolated because his belief causes him to avoid others. He is depressed both because his social isolation causes him to lose out on lots of positive reinforcers and because his isolation reinforces his negative thinking, as he concludes, "The fact that I don't have any friends just proves how unacceptable I am." He overeats because he uses eating as a way of coping with depression and loneliness. The resultant weight gain, of course, exacerbates his fear of rejection.

Common underlying mechanisms

Several writers have described the psychological mechanisms underlying various psychological symptoms and problems. This section reviews some of the most widely known proposals, with the caveat that little empirical evidence is available to support these propositions as yet (exceptions include Hammen, Marks, Mayol, & deMayo, 1985; Persons & Miranda, 1988; Zuroff & Mongrain, 1987). However, they may assist the therapist in generating hypotheses about the mechanisms underlying patients' symptoms.

Cognitive (and psychodynamic) theorists have described two types of irrational beliefs that underlie depressive symptoms: problems of autono-

my and problems of social dependency (Arieti & Bemporad, 1980; Beck, 1983; Blatt, 1974).

Persons with problems of autonomy require independence, accomplishment, and achievement in order to feel worthwhile. They have beliefs along the lines, "Unless I am extremely successful and accomplish a lot, I am worthless." Depressive symptoms are precipitated by experiences of failure, and when they become depressed, these individuals are self-blaming and self-critical.

Persons with problems of dependency must be liked, loved, approved of, and cared for by others in order to feel worthwhile. They have beliefs along the lines, "Unless I am loved, I am worthless." Depressive symptoms are precipitated by rejection and other interpersonal difficulties, and when they become depressed, these individuals feel lonely and isolated and are quite concerned about their attractiveness to others, a concern that stems directly from their view that acceptance and love from others are central to their well-being.

In their description of the cognitive view of anxiety, Beck and his colleagues (Beck, Emery, & Greenberg, 1985) proposed that anxious individuals irrationally view themselves as vulnerable to danger and unable to cope.

Jeffrey Young (1987) recently proposed 15 early maladaptive schema (EMS), divided into four groups: autonomy, connectedness, worthiness, and limits and standards. The 15 EMS are summarized in Table 1.2.

RELATIONSHIP BETWEEN OVERT DIFFICULTIES AND UNDERLYING MECHANISMS

A schematic of the relationships between the elements of the model is presented in Figure 1.1. The arrows pointing from the underlying mechanism to the overt difficulties indicate that the underlying difficulties cause, or generate, the overt difficulties. The arrows in the opposite direction indicate that the overt difficulties support, or maintain, the underlying difficulties. The bi-directional arrows suggest that changes at one level can produce changes at the other level.

The overt and underlying levels of problems are closely related. Thus, for example, the patient who has the central pathological underlying belief, "I'll fail at everything I do," has a large set of cognitions, behaviors, and moods consistent with this belief. She repeatedly experiences the automatic thoughts, "I won't be able to do it, it's too much for me, I'm inadequate, I don't measure up, I never could handle responsibility," and so on. She procrastinates on challenging tasks at work, avoids interac-

Table 1.2 Early maladaptive schemas

AUTONOMY

1. DEPENDENCE. The belief that one is unable to function on one's ov and needs the constant support of others.
2. SUBJUGATION/LACK OF INDIVIDUATION. The voluntary or involuntar sacrifice of one's own needs to satisfy others' needs, with an accompan ing failure to recognize one's own needs.
3. VULNERABILITY TO HARM OR ILLNESS. The fear that disaster is about to strike at any time (natural, criminal, medical, or financial).
4. FEAR OF LOSING SELF-CONTROL. The fear that one will involuntarily lose control of one's own behavior, impulses, emotions, mind, body, et

CONNECTEDNESS

5. EMOTIONAL DEPRIVATION. The expectation that one's needs for nurturance, empathy, affection, and caring will never be adequately me by others.
6. ABANDONMENT/LOSS. Fear that one will imminently lose significant others and then be emotionally isolated forever.
7. MISTRUST. The expectation that others will willfully hurt, abuse, cheat, lie, manipulate, or take advantage.
8. SOCIAL ISOLATION/ALIENATION. The feeling that one is isolated from the rest of the world, different from other people, and/or not a part of any group or community.

WORTHINESS

9. DEFECTIVENESS/UNLOVABILITY. The feeling that one is *inwardly* defective and flawed or that one is fundamentally unlovable to significant others if exposed.
10. SOCIAL UNDESIRABILITY. The belief that one is *outwardly* undesirab to others (e.g., ugly, sexually undesirable, low in status, poor in conver sational skills, dull and boring).
11. INCOMPETENCE/FAILURE. The belief that one cannot perform competently in areas of achievement (school, career), daily responsibili ties to oneself or others, or decision-making.
12. GUILT/PUNISHMENT. The belief that one is morally or ethically bad or irresponsible, and deserving of harsh criticism or punishment.

(continue

Table 1.2 (Continued)

13. SHAME/EMBARRASSMENT. Recurrent feelings of shame or self-consciousness experienced because one believes that one's inadequacies (as reflected in schemas 9, 10, 11, or 12) are totally unacceptable to others and are exposed.

LIMITS AND STANDARDS

14. UNRELENTING STANDARDS. The relentless striving to meet extremely high expectations of oneself, at the expense of happiness, pleasure, health, sense of accomplishment, or satisfying relationships.
15. ENTITLEMENT/INSUFFICIENT LIMITS. Insistence that one be able to do, say, or have whatever one wants immediately. Disregard for: what others consider reasonable; what is actually feasible; the time or patience usually required; or the costs to others. Or difficulty with self-discipline.

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tions with others, and puts off doing her therapy homework. She feels lonely, anxious, and depressed. Thus, the cognitive, behavioral, and mood components of her overt difficulty are tightly linked, mutually supportive, and consistent, because they are all reflecting, and linked by, the central underlying irrational belief. The link between the cognitive component of the overt difficulties and the underlying mechanism often seems particularly direct, perhaps because both are expressed as cognitions. Thus, the anxious woman's recurrent automatic thoughts are often derivatives, or even direct statements, of her central, underlying belief.

ROLE OF ENVIRONMENTAL FACTORS

Dysfunctional cognitions, behaviors, and moods, and irrational underlying beliefs alone do not cause problems. Environmental factors play a powerful role. For example, if a person who holds the belief, "Unless I'm loved, I'm worthless," is receiving daily infusions of love and caring from a close family, he may not experience any emotional distress or problems in living. If, however, his wife leaves him for another man, he may plunge into depression, despair, and suicidal behavior. Similarly, a person who believes, "I can't cope alone," may do well in a structured,

supportive working environment, but not at home, where she lives alone and has few friends. Thus, situational and environmental factors play a role in triggering and eliciting underlying beliefs and the overt difficulties that accompany them.

The underlying irrational beliefs, according to Beck's cognitive theory, play a long-term causal role in the development of episodes of anxiety and depression. According to the theory, these beliefs are trait-like attributes, that is, relatively fixed, that persist throughout an individual's life. They are latent until activated by a particular life event or experience. For example, the person who believes, "I'm worthless unless I'm extremely successful" may function relatively smoothly, without depression, until her application for a promotion is turned down, when she suffers a loss of self-esteem and a clinical depression.

COMPARISON WITH OTHER MODELS

The model presented here is not particularly original. It draws heavily on Beck's cognitive theories of depression and anxiety (Beck, 1972; Beck, Emery, & Greenberg, 1985), Lang's (1979) multiple systems view of fear, the model of fear and fear reduction presented by Foa and Kozak (1986), and the case formulation approach described by Turkat and others (e.g., Turkat & Maisto, 1985). Similar ideas have also been described by Safran, Vallis, Segal, and Shaw (1986).

However, the model does differ significantly from two other prominent models: the biological model, and a behavioral model that does not discuss underlying mechanisms. The role of diagnosis in this model also differs from the conventional psychiatric approach.

Biological models

The discussion of underlying mechanisms presented here emphasizes psychological mechanisms, but mechanisms underlying psychological problems may also be biological. Recent data suggest that obesity, alcoholism, depression, anxiety disorders, manic depressive illness, among others, may have biological bases. Thus, many patients receiving cognitive behavioral treatment may also benefit from medication or another type of biological treatment as well (see Burns, 1980, Chapter 17 and Klein, Gittelman, Quitkin, & Rifkin, 1980).

The presence of a possible underlying biological problem indicates that biological treatment may be an option, but does not mean that biological treatment is required. One reason for this is that psychological

and biological mechanisms are not mutually exclusive. Both may be operating. In addition, psychological and biological mechanisms appear to be closely linked. We know that biological treatment (antidepressant medication) produces cognitive changes (Simons, Garfield, & Murphy, 1984); it seems likely that psychological treatment can produce biological changes as well. In addition, the distinction between causal factors and maintaining factors reminds us that, although a problem may have genetic or biological origins, other factors may be maintaining the problem.

Models without underlying mechanisms

Although a model that includes underlying mechanisms may appear radical to some behaviorists, it is not a new idea. Similar ideas have been proposed by Beck (1972), Wolpe (1973), Turkat (e.g., Turkat & Maisto, 1985) and others. However, this model does differ from behavioral approaches that do not postulate underlying mechanisms. The question of which approach is more effective is unanswered at this point, because the needed empirical studies have not been done.

Role of diagnosis

In physical medicine, the diagnosis is a statement about the nature of the physiological mechanism underlying the symptom (e.g., fever). Treatment decisions are made on the basis of the diagnosis. Thus, fever due to malaria is treated differently from fever due to pneumonia.

If the same rule applied in psychiatry, diagnosis would be based on the nature of the underlying pathological *psychological* mechanism (Boorse, 1976; Persons, 1986b). Unfortunately, the nature of the underlying pathological psychological mechanisms in psychiatric illnesses is largely unknown at this time. Therefore, psychiatric diagnoses are defined largely in terms of symptom clusters, not underlying mechanisms. For this reason, diagnoses are not very helpful in making treatment decisions. Therefore, the assessment process described here focuses on developing a problem list and a hypothesis about the psychological mechanisms underlying the problems.

Validity of the case formulation model

Which model is most accurate? Which leads to most effective treatment? These are empirical questions, and unfortunately, little evidence is available to answer them. Some indirect evidence supporting the Foa and

Kozak (1986) model was reviewed by those authors, and quite a lot work has been done to test Beck's cognitive theory (cf. Beck, Bro Steer, Eidelson, & Riskind, 1987; Eaves & Rush, 1984; Hamilton Abramson, 1983; Hammen, et al., 1985; Persons & Rao, 1985; Sil man, Silverman, & Eardley, 1984), and Lewinsohn's behavioral the (Lewinsohn & Graf, 1973; Lewinsohn & Libet, 1972; Youngren & Lev sohn, 1980), but much more evidence is needed.

Of course, although the approach to treatment described in this b relies heavily on the case formulation model, most of the interventi described here are drawn directly from standard cognitive behavi treatment approaches, and a great deal of evidence supports the effic of those approaches (see Barlow & Waddell, 1985; Marks, 1981; Mille Berman, 1983; Rachman & Wilson, 1980; Steketee & Foa, 1985). Wh er reliance on the case formulation makes an important difference mains to be seen.

Implications of the model for the cognitive therapist

What does the case formulation model mean for the practicing co tive behavior therapist? The case formulation has several important r in clinical work.

First, the case formulation guides the therapist's choice of interven strategies. For example, the evidence shows that depressed patients ca effectively treated with pleasant events, cognitive disputation, or med tion. Effective treatments for anxious patients include exposure, rel tion, biofeedback, and assertiveness training. How does the thera choose?

The case formulation model proposes that the therapist's understa ing of the three overt components, along with her hypothesis about mechanism underlying the depression, guide the choice of interven strategies. The therapist who hypothesizes that Mrs. Jones' depressic a response to a low level of reinforcement and that Mr. Smith's depres is a response to a constant stream of self-critical statements would w to increase Mrs. Jones' pleasant activities and to decrease Mr. Sm self-critical statements.

For another example, consider two patients with insomnia. One has insomnia because of a fear of losing control finds relaxation trai anxiety-provoking (Heide & Borkovec, 1984) but responds well t flooding treatment for the fear of losing control (Persons, 1986a). An er, whose sleeplessness is due to overscheduling and overcommitn

because of a fear of being unsuccessful in his work, responds well to treatment of the fear of failure.

Consider two patients who sought treatment for their tendency to procrastinate on participating in a regular exercise program. The therapist addressed this problem in both cases with scheduling (p. 71 below), asking the patients to schedule exercise (aerobics in one case, jogging in the other) and to bring the schedule to the next session for review. The intervention was successful for the jogger but not the aerobic exerciser. Why?

A formulation of the jogger's case would have shown that one of his central problems was his inability to make a plan and follow through on it in a consistent way. His failure to jog was due to a chaotic lifestyle in which activities were not scheduled or planned. He simply bounced from one activity to another, depending on the demands of the moment. Use of a schedule addressed this problem and helped him make and follow through on a planned commitment. However, the aerobic exerciser's failure to go to exercise class was due to a fear of how she would look in her leotard and what other members of the class might think about her; because these fears were not addressed by the schedule, the intervention failed.

Thus, the formulation, particularly the therapist's hypothesis about the underlying mechanism, plays a central role in guiding the therapist's choice of interventions. In addition, a major part of a formulation-based treatment involves alerting the patient to the nature of his central irrational belief and the way it causes his behavioral, mood, and cognitive problems, as well as teaching strategies for solving these problems that at the same time produce some adaptive change in the underlying pathological beliefs.

An alternative to using the formulation to plan the treatment is to barrage the patient with all the interventions the therapist can think of, in the hope that one will work. One difficulty with this approach is that it is time-consuming, and the patient may become discouraged and drop out of treatment if the first interventions attempted are unsuccessful. Another disadvantage is that interventions applied in the absence of a formulation may actually be counterproductive and make the problem worse.

Another advantage of the formulation-based approach to treatment, in contrast to the intervention-list approach, is that it allows the clinician to understand and treat unusual problems he may not have encountered before but that may respond well to cognitive behavior therapy: shoplifting, nailbiting, somatic symptoms (e.g., loss of voice or pain) with no physiological basis, and so on.

The formulation also helps the therapist understand and manage difficulties that arise in the therapy, including resistance to behavioral and cognitive change, failure to do homework, misunderstandings or other difficulties in the therapeutic relationship, and treatment failure. The case formulation model suggests that the moods, cognitions, and behaviors making up these problems can be understood in the same way as the moods, cognitions, and behaviors making up all the other problems on the problem list are understood. Furthermore, a collaborative approach to solving them can be undertaken, even—or especially—when problems in the therapeutic relationship are involved. If the case formulation model is correct, these moods, cognitions, and behaviors are likely to spring from the same irrational beliefs as the patient's other problems. This model for understanding and working with these typical difficulties gives the therapist a structure and a way of thinking about and responding to these difficulties that can be surprisingly powerful and satisfying. An example is provided in the next section; additional examples occur throughout the book.

In addition, as the final chapter of the book describes, the therapist's understanding of his own underlying vulnerabilities can be quite helpful in understanding and managing negative reactions and difficulties he encounters in his work with patients.

AN EXAMPLE: THE MAN WHO THOUGHT HE WAS DEFECTIVE

A young man came to therapy complaining of depression. A review of various areas of his life revealed that he was quite inactive. He neither worked nor went to school, although he frequently made forays into the work or student worlds, only to retreat after a few weeks or months. He had been living with a girlfriend for 10 years, but maintained an ambivalent, distant connection, never feeling quite satisfied with the relationship but never making a move to improve it or break it off. Based on this and other information, the therapist hypothesized that this patient's central irrational belief was, "I'm defective and inadequate." In the area of work this belief was expressed in the fear, "Whatever I attempt, I will fail at." In the area of interpersonal relationships, he felt weak and vulnerable fearing, "I'll become overdependent on others, and I'll do what they tell me instead of what's in my own best interest."

This patient's central irrational belief appeared in dozens of ways throughout the therapy. A close examination of a single therapy session

illustrates the way his central irrational beliefs appear repeatedly in his cognitions and behaviors.

At about the one-year point in treatment, the patient came to the session reporting that he was feeling good and didn't really have much to talk about. He had been doing well for several weeks and wanted to discuss the possibility of decreasing the frequency of his therapy sessions (he was coming weekly at that point). However, he had difficulty raising this topic because of the thought, "If I reduce my therapy, something bad might happen, and I won't be able to cope." This thought can be seen as a restatement of his central irrational belief.

After the therapist pointed this out, and we worked through this problem (he scheduled a session for one month later), we moved to a discussion of his homework for the college courses he had recently begun. He had decided he wanted to make up a schedule for doing his homework, but didn't follow through and do it. When the therapist asked, "When you think about making up a schedule, what thought do you get?" he responded, "I'll make a schedule, but I won't follow it." This statement is also a restatement of his central irrational belief.

Next, he moved to a discussion of an essay he was working on for his geology class. He reported that he had at first thought of doing an essay on a topic that was of particular interest to him, a topic that he had written a related essay on for another course at another college some years before. However, he had abandoned this idea, thinking, "It would be cheating to do that." This idea was closely related to the core idea, "I'm defective," and was linked to a feeling that he did not get from his family the training in mores and ethics that most other people received. Notice the recurring behavioral pattern: thinking of doing something and then pulling back. This behavioral pattern also appears to be directly related to his central underlying belief.

After we discussed the question of whether using the old essay to get started on a new essay on a similar topic was "cheating" (he decided it was not), we moved on to a discussion of another essay for another class. The patient had begun research on an obscure topic, but after reading one book on the subject that fascinated him, he felt at a loss for obtaining new materials. He had the thought, "I can't get an essay out of this topic," and he abandoned the topic, beginning a search for another. Again, his pattern of thinking and behavior is directly related to his underlying belief about himself.

This patient's central underlying belief appeared in dozens of other ways in the therapy. He readily took on homework assignments, but typically came to therapy sessions reporting he had not completed them

(frequently he started, but not completed them), and feeling that what h had done was inadequate. He felt he ought to reread *Feeling Goo* (Burns, 1980) on a regular basis, so he could learn to analyze and imm diately respond to all his thinking errors. He was reluctant to engage i the therapy, for fear of becoming overdependent on the therapist, and one point insisted on coming every other week so he could afford to see hypnotherapist on the alternate weeks.

Thus, this patient's central underlying belief about himself was a gui ing theme in the therapy, influencing the automatic thoughts and beha ioral patterns seen in the therapy, the patient's way of handling hom work, and the therapeutic relationship. An understanding of the ca formulation helps the therapist understand and manage all these issues.

WHERE DOES THE THERAPIST INTERVENE?

One question the case formulation model raises is: Where does t therapist intervene? If psychological problems occur at two levels, whe does the therapist intervene? Does she work to expose and change t underlying mechanisms? Or does she work to change overt behavio cognitions, and moods?

The approach to assessment and treatment described in this bo emphasizes a "top-down" approach. Cognitive behavior therapists belie that work on overt difficulties produces more change in both overt dif culties and underlying beliefs than work at the underlying level. F example, a depressed man who has the underlying belief, "I must everything perfectly to get any pleasure or satisfaction at all" can impro his mood and chip away at the underlying belief in one stroke if he carr out a homework plan to play a mediocre game of tennis with a frien Although the approach presented here emphasizes top-down work, t question of which direction of work is most effective is ultimately empirical one.

Of course, therapy inevitably involves both types of work. The directional arrows in Figure 1.1 indicate that changes in overt difficult can produce changes in the underlying attitudes, and changes in under ing attitudes can produce changes in overt difficulties.

Although the intervention strategies described here focus on overt d ficulties, treatment does have the goal of changing underlying mec nisms as well. There is evidence that changes at the overt level that do r involve changes at underlying levels may be short-lived. Researchers h shown that depressed patients who terminated treatment with mark improvement in symptoms but little or no improvement in underlyi

irrational beliefs were more likely to relapse than those who had experienced changes in their underlying beliefs (Simons, et al., 1984). Foa, Steketee, Turner, and Fischer (1980) showed that obsessive-compulsives who were treated with in vivo exposure to their feared situations were more likely to relapse than patients treated with both in vivo exposure and imaginal exposure to their central underlying fears.

If top-down work does in fact produce changes in underlying beliefs, and if the core underlying beliefs do, as postulated, underlie all the patient's overt difficulties, then good therapeutic progress on one problem ought to be accompanied by improvement even in untreated problems. This idea, of course, is subject to empirical test (e.g., Persons, 1986a).

Because of the emphasis on top-down work, intervention strategies described in this book fall into two classes: interventions directed at behavior (Chapters 4 and 5) and those directed at cognitions (Chapters 6 and 7). Interventions directed at mood are not described because they have not been developed.

The two classes of interventions again raise the question: where does the therapist intervene? To change cognitions or to change behaviors? In general, the answer depends on the nature of the relationships between the components, as described by the case formulation. In addition, pragmatic considerations about which component the patient feels most able to change are quite relevant. Sometimes cognitions seem to cause behaviors. For example, a young woman is unable to refuse an unwanted invitation because she thinks, "If I say no, it will be devastating to him." Cognitive interventions to expose the irrationalities in this thinking may facilitate behavioral change. In other situations, behaviors seem to cause cognitions and to be more malleable. For example, a young woman with very low self-esteem worked to improve her self-image by buying some nice clothes for herself, even though she believed she didn't deserve them.

GETTING STARTED

To make clinical use of the case formulation model, the therapist begins by assessing the two levels of the patient's problems: overt difficulties and underlying mechanisms. That is, the therapist obtains a comprehensive problem list and proposes a hypothesis about the psychological mechanism underlying the problems on the list. These two topics are addressed in the next two chapters.