Chapter 1 ────────────────────────────

A FRAMEWORK FOR CLINICAL CASE FORMULATIONS

About to face a client for the first time, beginning therapists wonder, *How am I going to know what to do*? Later, we plead to supervisors, *What should I do*? As we gain experience, the question matures: *When I face any new client, how do I create a treatment plan that is the best match?* The answer: case formulation skills—the focus of this book.

> A clinical case formulation is "a conceptual scheme that organizes, explains, or makes sense of large amounts of data and influences the treatment decisions" (Lazare, 1976).

I discovered the need for case formulation skills from my own frustration as a trainee and new therapist. My supervisors did not teach me how to think critically and creatively about cases; instead, they expected me to either follow the rules of a specific orientation or trust in a process of trial and error. When I expressed my anguish, supervisors assured me that most beginners had similar feelings and that I was doing fine. My humanistic supervisor said that developing good relationships with clients was enough. From my psychodynamic supervisor's perspective, I had a countertransference issue, namely a need for structure and control. In a behavioral clinical setting, I found structure, but it was not the best fit for every client. I was discovering the principle that is the core of this book:

> You must create a formulation that fits the client, rather than squeeze the client into your preferred formulation.

Teachers, supervisors, and program administrators are generally not aware that it is possible to teach case formulation skills in a systematic way; they probably learned their skills in a haphazard way in the apprenticeship model of clinical training, through mentorship relationships with supervisors and their own trial-and-error learning. They assume that conceptualization abilities flow naturally from native intelligence, experience, and unstructured conversations with supervisors. This book presents an alternate viewpoint: Case formulation skills can be directly taught, by using a structured framework and providing step-by-step guidelines.

Figure 1.1 shows all 30 hypotheses. They are listed in Appendix I, Chart I.B; it is recommended that you copy that chart and laminate it for convenience. Chart I.C gives examples of useful treatment ideas for each hypothesis and serves as a convenient reference tool.

The framework in this book originated with the Problem-Oriented Method, developed in medicine (Weed, 1971) and adapted for psychiatry (Fowler & Longabaugh, 1975).

Overview

Part I: A Step-by-Step Process for Creating a Case Formulation

- Gathering data (Chapter 2)
- Defining problems (Chapter 3)
- Specifying outcome goals, the desired change in the client's functioning (Chapter 4)
- Organizing and presenting the database (Chapter 5)
- Creating the formulation by applying core clinical hypotheses (Chapter 6)
- Writing a treatment plan and monitoring progress (Chapter 7)

A list of 28 standards for evaluating the application of this method is in Appendix I, Chart I.A. The chapters in Part I explain each of these standards.

Part II: Thirty Core Clinical Hypotheses

Hypotheses are essential ideas from different theoretical orientations, mental health intervention models, and social science research: They have been freed from theoretical jargon; given names, codes, and brief descriptions; and organized into seven categories.

1. Crisis, Stressful Situations, Transitions, and Trauma (**CS:** Chapter 8)
2. Body and Emotions (**BE:** Chapter 9)
3. Cognitive Models (**C:** Chapter 10)
4. Behavioral and Learning Models (**BL:** Chapter 11)
5. Existential and Spiritual Models (**ES:** Chapter 12)
6. Psychodynamic Models (**P:** Chapter 13)
7. Social, Cultural, and Environmental Factors (**SC:** Chapter 14)

Chapter 15 integrates both parts of the book, and provides activities and suggestions for producing competent case formulation reports.

This method provides structure to the problem-solving skills that are taught in many fields: Problems and goals are clearly defined; we do not rush to solutions without coming up with possible explanations; and interventions are focused on resolving problems. When you take your car to a mechanic, you expect a demonstration of the same problem-solving framework. Mechanics *identify the problem* (e.g., car will not start; funny noise when brakes are applied), *seek out explanations* (e.g., fuel pump is broken; brake pads are worn down), and *implement a plan* to resolve the problem (e.g., replace bad parts with new parts). The quality of the work is evaluated not by the elegance of the theory or by research findings from studies of other cars but by the attainment of the desired *outcome goals* with this particular car: It starts when you turn the key, and it stops when you step on the brakes.

Quite simply, clients come to therapy because they have problems, and they want to leave therapy with their problems resolved—or at least with better tools for coping with them. The clinician needs knowledge and skills to come up with strategies for achieving desired outcome goals. The terms *problem-oriented* or *problem-solving* have been associated with directive, short-term approaches such as cognitive-behavioral therapy (CBT) and strategic family therapy. Therefore, you may mistakenly assume that taking a problem-oriented approach means that you must use these problem-focused therapies.
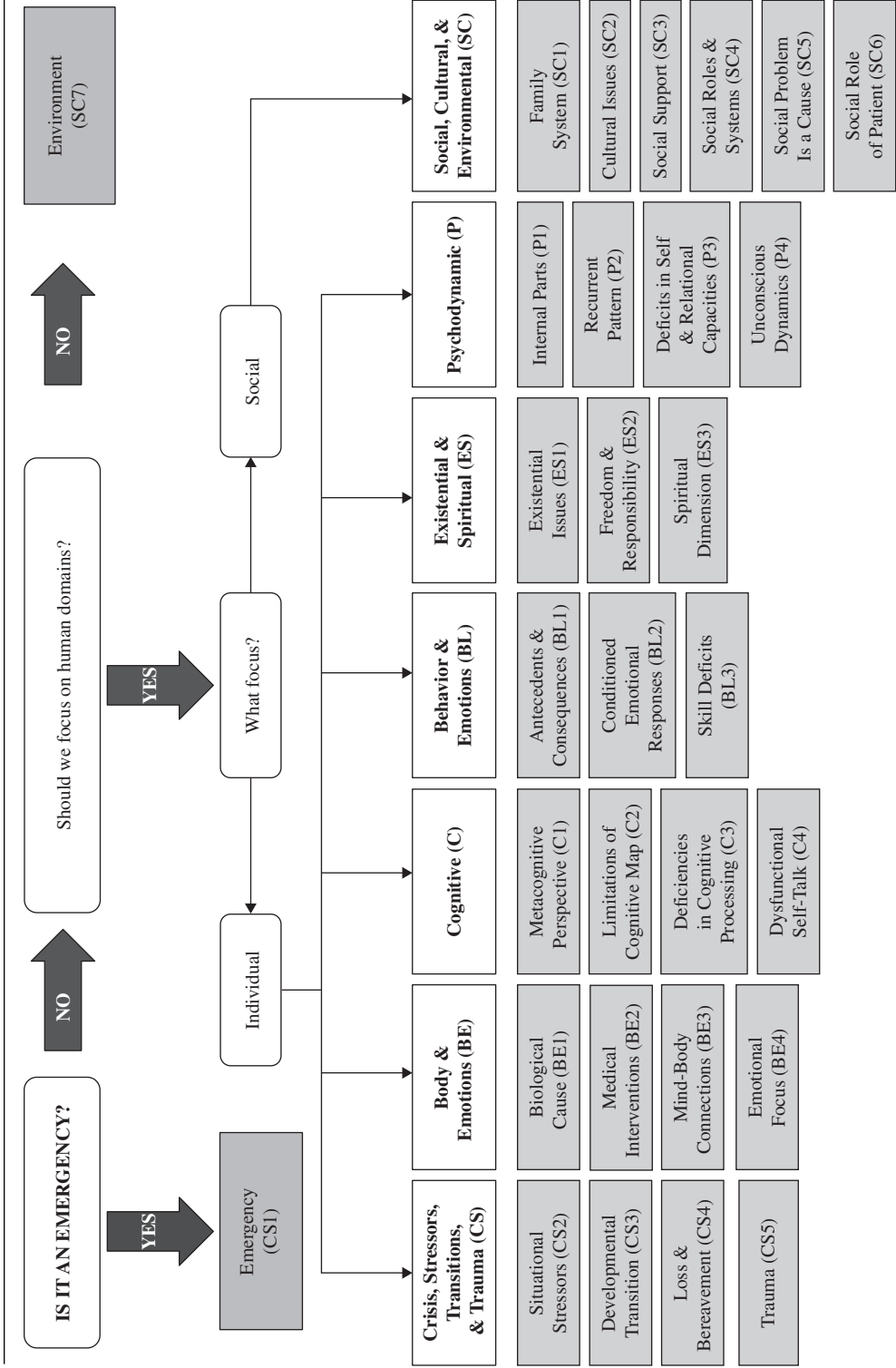
IS IT AN EMERGENCY?

YES → Emergency (CS1)

NO → Should we focus on human domains?

NO → Environment (SC7)

YES → What focus?

Individual — Social

Individual:
- Body & Emotions (BE)
- Cognitive (C)
- Behavior & Emotions (BL)

Social:
- Existential & Spiritual (ES)
- Psychodynamic (P)
- Social, Cultural, & Environmental (SC)

Crisis, Stressors, Transitions, & Trauma (CS)
- Situational Stressors (CS2)
- Developmental Transition (CS3)
- Loss & Bereavement (CS4)
- Trauma (CS5)

Body & Emotions (BE)
- Biological Cause (BE1)
- Medical Interventions (BE2)
- Mind-Body Connections (BE3)
- Emotional Focus (BE4)

Cognitive (C)
- Metacognitive Perspective (C1)
- Limitations of Cognitive Map (C2)
- Deficiencies in Cognitive Processing (C3)
- Dysfunctional Self-Talk (C4)

Behavior & Emotions (BL)
- Antecedents & Consequences (BL1)
- Conditioned Emotional Responses (BL2)
- Skill Deficits (BL3)

Existential & Spiritual (ES)
- Existential Issues (ES1)
- Freedom & Responsibility (ES2)
- Spiritual Dimension (ES3)

Psychodynamic (P)
- Internal Parts (P1)
- Recurrent Pattern (P2)
- Deficits in Self & Relational Capacities (P3)
- Unconscious Dynamics (P4)

Social, Cultural, & Environmental (SC)
- Family System (SC1)
- Cultural Issues (SC2)
- Social Support (SC3)
- Social Roles & Systems (SC4)
- Social Problem Is a Cause (SC5)
- Social Role of Patient (SC6)

Figure 1.1   Map of 30 core clinical hypotheses

On the contrary, the problem-oriented framework organizes the clinician's thinking regardless of preferred theory.

The designers of the problem-oriented method developed an acronym to organize the elements of a formulation: SOAP. The letters S and O stand for two types of data (information about the client), called *subjective* and *objective* (explained in the following section). The P stands for *plan.* In the middle, the A stands for *assessment*—a term with multiple meanings, such as diagnosis, psychological testing, and opinion about progress in chart notes. Better terms are *formulation*, *explanation*, *conceptualization,* or *clinical hypotheses.* In this book, the term *hypothesis* (or *hypotheses section* of report) will substitute for *assessment*, resulting in the SOHP acronym. That acronym can be pronounced as "soap" but reminds us that we will be *formulating with clinical hypotheses* instead of plugging in a simple diagnostic label. Table 1.1 gives a summary of the elements of a case formulation report for a client with a single problem.

Table 1.1   How to SOHP a Problem

Identifying data: Age, gender, ethnic or cultural group, marital status, occupation or status in school, living situation, and other descriptive and demographic details.

Reasons for seeking therapy: Presenting complaints, the source of referral, and information about whether therapy is voluntary or mandated. For student assignments, when it is not a "real" client, this section explains why the person agreed to be a volunteer.

Background information: An organized narrative of the life history, summarizing data that do not fit specifically under a problem title. Data relevant to a specific problem title are best placed in the S section following the problem title. However, when several problems are using the same data, instead of repeating the information, you can put it in this section.

Problem title: A statement of the difficulty, dysfunction, or impairment for which the client seeks help. The problem title must be clear, specific, and free of theoretical jargon. You may follow the title with a few sentences that give concrete details about the problem.

Outcome goal: A statement of the desired state at the end of therapy. The outcome goal is directly related to the problem title and contains no description of how the goal will be attained.

S—Subjective Data (Story)
This section contains data reported by the client or client's family, relevant to the problem title. Be sure to provide direct quotations from the client and include information about strengths as well as problems. Be careful that conceptualizations and theoretical constructs do not appear in this section.

O—Objective Data (Observations)
The primary source of data in this section is the therapist's observations. The therapist uses technical terminology to describe the client's mental status and the process between client and therapist. Other examples of objective data are test results, reports from professionals, and written records.

H—Hypotheses Section (Formulation)
This section contains the clinician's conceptual scheme for understanding the problem. The ideas in this section must be consistent with the data and should lead to plans that will resolve the problem. New data may not be introduced in this section. However, data that were previously presented may be repeated to make a specific point.

P—Plan
This section describes how the therapist will work with the client to achieve the goals of treatment. It contains process goals and treatment strategies that follow logically from the previous conceptualization, and also addresses the client-therapist relationship, including cultural factors. The plan includes evaluation of the client's progress toward goals.

TASKS AND PROCESSES OF CASE FORMULATION

The tasks and processes of creating a formulation are not linear. They can occur simultaneously as you can go back and forth between steps; the process is also circular, as new data is gathered as you implement plans.

Figure 1.2 is a diagram of the six tasks of formulating. A list of 28 standards is provided in Appendix I, Chart I.A; standard numbers from that list are used throughout this book.

1. Gather Data

The formulation process begins with gathering data—we will be using the term *database* for the body of information available for a specific client. The term *data* is acceptable to practitioners who use scientific models (e.g., the medical-psychiatric model and the research-based cognitive-behavioral model), but it might sound dehumanizing to people who describe themselves as humanists. Bear in mind that the terms *data* and *database* simply mean *information* and are theory free.

> The contents of the database must be free of theoretical assumptions, inference, diagnoses, and interpretation: Different professionals would agree about the content of the database, regardless of their orientation.
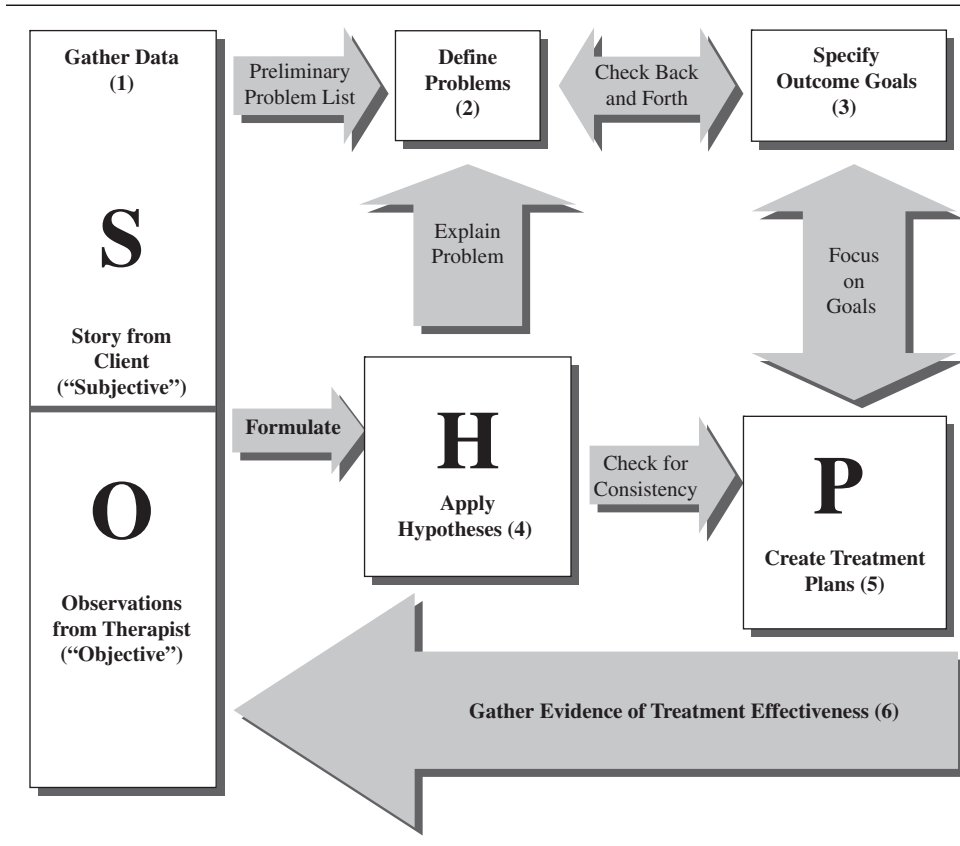

Figure 1.2   Overview of case formulation tasks and processes

The medical profession developed terms for two categories of data: *Subjective data* come from what the patient and the patient's family reports about the symptoms, the onset, impairments in daily functioning, allergies, medications, family history, and medical/surgical history. *Objective data* come from observations, physical exam, lab work, imaging studies, and other diagnostic procedures. This distinction translates well to mental health problems.

> **The distinction between S and O data is the SOURCE:**
> **The source of subjective data:** *the client's Story*
> **The source of the objective data:** *the clinician's Observations*

Data gathering usually starts before the therapist sets eyes on the client, with a phone call to make an appointment. The first session is a major source of information about the client; however, the data-gathering process occurs in every session. In the beginning, your focus is on identifying and exploring problems. Later in therapy, data are gathered for evaluating whether treatment is effective in helping the client achieve outcome goals.

Because the clinical interview is the main tool of data gathering, the clinician must be a competent interviewer or the validity of the database is compromised. Therapists need to become aware of their personal values, cultural biases, and possible countertransference issues that could lead to biased or incomplete data. In clinical training, the building of case formulation skills should be integrated with the development of interviewing skills.

Chapter 2 presents suggestions for gathering a comprehensive, unbiased database, and Chapter 5 presents guidelines for organizing and presenting data.

There are four standards for presentation of the database:

Standard 12. The database does not contain formulation concepts (unless they are quotations from the client).
Standard 13. The database is comprehensive, with sufficient data so that multiple hypotheses can be applied.
Standard 14. The subjective and objective data sections contain the correct type of information.
Standard 15. The subjective section is well organized, appropriately selective, and condensed.

2. Define Problems

We all have a tendency to rush to explanations and solutions, instead of spending time identifying the problem or problems. The ability to create good problem titles might be the most important skill taught in this book. A preliminary list of problems is derived from the client's initial complaints, as well as from your focused questions and clinical observations. Occasionally, problems are identified through complaints from people who know the client. In defining problems, you will make many judgments and decisions. Certain complaints need to be "normalized," instead of targeted for treatment. As new

data are gathered, problem definitions may change. Problem titles must be agreeable to practitioners of all orientations.

> Give each problem a clear, specific, and understandable title, worded without theoretical jargon.

Chapter 3 explains the problem identification and definition process.

There are seven standards for problem definition:

Standard 1. Problems are defined as solvable targets of treatments.
Standard 2. Problem titles refer to the client's real-world problems and current level of functioning.
Standard 3. Problem titles are descriptive, designed for a specific client, and justified by the data that have been collected.
Standard 4. Problem titles do not contain theoretical, explanatory concepts.
Standard 5. Problem titles reflect the client's values, not the therapist's personal or cultural bias.
Standard 6. *Lumping* and *splitting* decisions are justified in that they lead to good treatment planning.
Standard 7. The problem list is complete and comprehensive.

3. Specify Outcome Goals

Outcome goals are the desired state at the end of therapy, referring to the client's behavior outside of the therapy session—in real life. The wording of outcome goals must be free of theoretical jargon. For instance, "to make the unconscious conscious" or "to become a fully actualized person" are faulty outcome goals: They (a) contain theoretical constructs and (b) are too idealistic and utopian to be achieved. The wording of these goal statements must be changed so that the goal is specific, realistic, and attainable.

Outcome goals must be defined in a way that allows verification of whether they are attained. The concept of *evidence-based practice* is not possible unless we are clear about the evidence that represents effective therapy. By specifying outcome goals, we determine how we know that we have achieved problem resolution and that it is appropriate to terminate therapy. Reference to outcome goals in the plan helps to focus your intervention strategy. Furthermore, outcome goals do not contain any clues about the "how" of therapy or the techniques used in the process. Thus therapists from different orientations will agree on what a successful outcome is, even as they prepare to use different treatment strategies to attain it.

The definition of problems and the specification of outcomes are bidirectional processes. Defining a problem leads to specification of goals, and sometimes goal setting comes first and helps define a problem. As the vision of the desired future becomes clearer, the wording of the problem may be modified.

There is a logical relationship between a problem title and a goal. When you write a clear problem title, the outcome goal often seems self-evident, as in this example:

Problem: *Lack of friends*
Outcome: Initiate and maintain a friendship

The identification of the desired outcome can shape the wording of the problem title:

Outcome: Decide on a career goal
Problem: *Indecision and ambivalence about career goals*

During therapy, you will continually reassess the goals of treatment. As goals are met, you can cross problems off the problem list. If new problems are defined, outcome goals can be specified and changed. Certain goals may be recognized as too costly in time and effort.

In creating goals for clients, distinguish between *outcome goals* and *process goals*, and be sure that the outcome goal does not mention process. Outcome goals refer to desired client functioning at the termination of therapy, such as "demonstrate competence in handling conflict." Process goals refer to desired in-session experiences (e.g., ventilation of feelings, demonstration of insight, behavioral rehearsal, or building a hierarchy of feared situations). Process goals, unlike outcome goals, are based on the therapist's conceptualization. If a goal refers to the therapist's actions and intentions (e.g., to help, to facilitate, to support, or to challenge), it is a process goal.

Chapter 4 provides guidelines for outcome goals; process goals are discussed in Chapter 7 as part of treatment planning.

There are four standards for outcome goals:

Standard 8. Outcome goals are directly related to the problem title and endorsed by the client.
Standard 9. Outcome goals do not contain the therapist's conceptualization.
Standard 10. Outcome goals are realistic, attainable, and testable with evidence of the client's real-world functioning.
Standard 11. Outcome goals do not contain the "how" of the treatment plan.

4. Apply Hypotheses

The term *hypothesis* is used in the scientific method, which we all learned even before arriving in college. Even if we cannot produce a technical definition on the spot, we know that it is a tentative, proposed explanation for phenomena that can be observed. Once hypotheses are verified through rigorous experiments, they can be unified into a theory. When therapists work from a theoretical orientation, they are basing treatment choices on a cluster of hypotheses, although they may not think of their theory that way.

A personalized formulation starts with hypotheses that are consistent with the data we have gathered; these hypotheses can be tested by conducting experiments (interventions) to see what kinds of change in functioning occur.

Lazare (1976) recommended the use of clinical hypotheses in our first meetings with new clients, and provided this definition:

> A *core clinical hypothesis* is a single explanatory idea that helps to structure data about a given client in a way that leads to better understanding, decision making, and treatment choice.

Lazare explained that clinicians bring their "partial formulations" to the interview as hypotheses to be tested: "The clinician, by thinking in terms of hypotheses, keeps himself from being bombarded or overloaded with large amounts of unstructured data. Each new observation can now be considered in terms of its relevance to a limited number of hypotheses under consideration instead of being one out of thousands of possible facts" (pp. 96–97).

The application of clinical hypotheses is the heart of case formulations. Eells (2007), editor of a book on diverse approaches to case formulation, defines a *psychotherapy case formulation* as "a hypothesis about the causes, precipitants, and maintaining influences of a person's psychological, interpersonal, and behavioral problems" (p. 4). (I would modify that definition to say "a *set* of hypotheses.") S. Sue (1998), expert in multiculturalism, described cultural competence as "scientific mindedness" in therapists who "form hypotheses rather than make premature conclusions about the status of culturally different clients, who develop creative ways to test hypotheses, and who act on the basis of acquired data" (p. 445).

Every theoretical orientation can be broken down into core hypotheses. When we remove the "brand names" from these hypotheses, we discover that many different theorists are actually using the same ideas, just packaging them with different jargon. For instance, cognitive-behavioral, existential, and narrative therapists all explain problems (using different terminology) as stemming from faulty cognitive constructions of life experiences. Chemistry provides an analogy: A theoretical orientation is like a complex chemical compound, and a single hypothesis functions like a pure chemical element. The same element (hypothesis) can appear in many different formulas (orientations), and a compound (single orientation) can be broken down into component elements (hypotheses). As in chemistry, we need to avoid the assumption that our list of elements is complete: Two new elements were added to the periodic table in 2011. The introduction to Part Two explains the development of the list of 30 hypotheses.

The application of relevant hypotheses involves multiple tasks and competencies.

Interviewing

Your interview begins with open questions so that data pour in without your using the hypotheses to structure the interview. Once you have recognized the preliminary fit of a specific hypothesis, you can gather more data in an unbiased way (without communicating your expectations) to test the goodness-of-fit of that hypothesis. The focus of the interview becomes gathering data to rule "in" or "out" that hypothesis. If you commit to a specific hypothesis too quickly, the search for information will be biased by your expectations.

Brainstorming

Once you have a thorough database, you can review the entire list of hypotheses and exclude those that are not compatible with the data for the specific client. You want initially to be as inclusive as possible: There is already a great tendency for therapists to have tunnel vision and to only look for what they want to find, so brainstorming helps you keep an open mind.

Select "Best Fit" Hypotheses

Now you are ready to sort through the relevant hypotheses, and to select those that lead to treatment plans that you think will be effective. You need to write a sentence or two to explain how the hypothesis provides an explanation. Chapter 6 introduces a three-column chart for organizing your ideas; if you are a busy clinician with a full practice, you might not get beyond this stage. However, to produce the best possible formulation, you should write a formal essay (for the H section of SOHP)—the best tool for improving analytic thinking. As you implement your plan, if your client does not show improvement, you may need to go back to the hypotheses on the brainstorming list. This tentative, nondogmatic approach to formulation is expressed in these words:

> Flirt with your hypotheses; don't marry them.

There are five standards for the hypotheses section:

Standard 16. The hypotheses are consistent with the database.
Standard 17. The hypotheses section does not introduce new data.
Standard 18. The hypotheses section focuses on the specific problem of the specific client.
Standard 19. Hypotheses all lead to treatment plans.
Standard 20. Hypotheses are discussed with professional-level thinking and writing skills.

5. Create Treatment Plans

The end product of a formulation is the creation of a treatment plan, designed for a specific individual, which describes a strategy for attaining the desired outcome goals. The plan cannot be created by a computer program or by a nonprofessional, just based on a problem title. Nor can you select an empirically supported treatment manual and implement it with a client without using clinical judgment and demonstrating empathy, flexibility, and sensitivity to cultural and relationship factors.

> The plan must be tailor-made for each client. The prescribed interventions in the plan follow logically from the chosen hypotheses.

The bridge between hypotheses and the plan is *process goals*. Unlike outcome goals, process goals may contain language that belongs to a specific theory and constructs that cannot be observed or verified (e.g., utilize the transference, integrate disowned parts of

the personality, and resolve unfinished business). Every hypothesis must be followed by process goals and a specific strategy in the plan section. If you write ideas in the plan that were not addressed in the hypotheses section, go back to that section and insert the rationale for the plan.

To reach many outcome goals, it is necessary to set intermediate objectives—short-term goals that are steps toward achieving outcome goals. Process goals and intermediate objectives can overlap. For instance, if the outcome goal is for the client to be appropriately assertive with his boss and coworkers, an intermediate objective might be for the client to role-play an assertive encounter in the session. This is a process goal because it refers to activity in the session, and it is also an intermediate objective because the client is demonstrating attainment of new skills that would transfer outside of therapy and contribute to achievement of his outcome goal.

There can be many different strategies for achieving a process goal, and your choices will depend on multiple factors, including your own training and level of competence, the cultural and personal values of the client, and the institutional context. The written plan is a guide, but, as therapy progresses, new choices will be made. Although the clinical case formulation is organized in a linear structure, the implementation of plans is fluid, flexible, and creative. There is room for intuition, trial and error, and snap decisions that bubble up from our unconscious, which—as explained by Gladwell (2005) in *Blink*— stem from both expert knowledge and the ability to process information faster than we code our thoughts into words.

There are eight standards for treatment plans:

Standard 21. The plan is focused on resolving the identified problem and achieving outcome goals.

Standard 22. The plan follows logically from the hypotheses and does not introduce new data or hypotheses.

Standard 23. The plan is informed by knowledge of research literature.

Standard 24. There is clarity regarding strategy, subgoals and process goals, procedures and techniques, priorities and sequencing, and the desired client–therapist relationship.

Standard 25. The plan is tailored to the specific client: Such factors as gender, ethnicity, sexual orientation, spirituality, and personal values are considered.

Standard 26. The plan is appropriate for the treatment setting, contractual agreements, and financial constraints.

Standard 27. The plan appropriately incorporates community resources and referrals.

Standard 28. The plan appropriately addresses legal, ethical, and mandated reporting issues.

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6. Gather Evidence of Treatment Effectiveness

The effectiveness of therapy is judged by a comparison of pretherapy (problem) and post-therapy (outcome) functioning, with three possible evaluations: (1) improvement (successful therapy), (2) deterioration (harmful therapy), and (3) no change (ineffective therapy). We cannot consider ourselves *accountable* for the effectiveness of our treatments unless we specify the goals that clients are working toward and monitor their success in reaching those goals.

The quality of a formulation is evaluated by examining the impact that treatment has on the client's real-life, outside-of-therapy functioning: You gather data about the change in the client's functioning to confirm the formulation's merit. The interventions in the treatment plan can be viewed as experiments: "If my hypothesis is correct, this strategy should resolve the problem and achieve the desired outcome." Does it work? Does it help? Does it lead to the desired outcome? If not, then you must cycle back through the formulation tasks. You should watch for signs that the interventions are making problems worse or creating new problems. What you may label as *resistance* must be viewed as a source of useful data and a clue that you probably need to improve the formulation.

Two important criteria for evaluating the quality of formulations are effectiveness and cost-effectiveness:

1. **Effectiveness:** A formulation is effective when its prescribed interventions lead to desired change in the client's functioning and achievement of the client's goals.
2. **Cost-effectiveness:** A formulation is cost-effective when, compared to alternative effective approaches, it achieves the desired outcome with less time and effort and in a more economical manner. This criterion is especially important when resources are scarce or when third parties, such as insurance or managed care companies, are providing payment.

When you understand how to monitor the effects of treatment, you will worry less that you might inflict harm on clients because of inexperience. This scientific attitude means that you are as concerned about empirical validation for treatment as are researchers in large institutions who are conducting random clinical trials. The data you gather to evaluate effectiveness become part of the general database, and if your expectations of improvement are not met, the formulating tasks begin again—more data gathering, hypothesizing, and planning.

EVIDENCE-BASED PRACTICE AND CASE FORMULATION SKILLS

Evidence-based practice in psychology (EBPP) is defined by the American Psychological Association as the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. Evidence-based practice means that you recognize the value of interventions that have been tested by rigorous research, disseminated in manuals, and endorsed by organizations such as the Society of Clinical Psychology (Division 12, APA) as "treatments that work."

Rubin (2008) teaches how to find and critically appraise research studies and "differentiate between acceptable limitations and fatal flaws" (p. xiv). When you study a manual for a research-supported treatment, with the list of core clinical hypotheses in hand, you will be able to "unpack" the empirically supported treatment and identify the hypotheses that guide the interventions. By doing so, you are better equipped to design a treatment plan that uses the efficacious elements in a manner that is individualized for the specific client. Chapter 7, on treatment planning, addresses incorporating research-supported interventions: Standard 23 states *"The plan is informed by knowledge of research literature."* The chapters in Part Two describe many such treatments and provide useful references.

Lambert, Garfield, and Bergin (2004), in a massive review of empirical literature in psychotherapy, offered the view that empirical validation can come from clinical, single-case

methodology, not just from quantitative research studies and random clinical trials. It is sound scientific practice to evaluate the effectiveness of a treatment plan by implementing it with a client and monitoring, by data collection, the changes in the client's functioning. George Stricker (2009) agrees that an ongoing monitoring process is "probably the most evidence-based treatment that is available at the present time" (p. 46), and uses the term *local clinical scientist model* for this approach to evidence-based practice. By using the case formulation skills in this book, you are committed to scientific principles: keep data separate from speculation, test the validity of hypotheses with data, and treat interventions as experiments.

CULTURALLY COMPETENT FORMULATING

Within the list of 30 hypotheses, one hypothesis is called **Cultural Issues (SC2)***.* It would be incorrect to conclude that a client's culture is only relevant when using that hypothesis. That is definitely not the case:

> Culture is a necessary consideration with every client and every hypothesis.

This book teaches that each person exists in a specific cultural/social/historical context, and that therapists must understand the client's multiple identities, including gender, race, ethnic group, sexual orientation, religion, and age cohort, to create the best treatment plan.

Cultural competence has unquestionably become a mandatory learning outcome for clinical training; three domains of cultural competence are (1) knowledge of culture and diversity, (2) therapeutic skills for working with clients of different cultures, and (3) therapist self-awareness (Smith, 2004). Many useful books on this topic are available, with chapters organized in different ways: by ethnic groups (e.g., Vacc, DeVaney, & Brendel, 2003), by settings and populations (e.g., Tseng & Streltzer, 2004), or by case studies (e.g., Ancis, 2004). Journals such as *Cultural Diversity and Ethnic Minority Psychology*, *Journal of Multicultural Counseling and Development*, *Journal of Cross-Cultural Psychology*, and *Journal of Multicultural Social Work*, are sources of articles on theory, research, and clinical applications. The clinical literature should be supplemented with books on cross-cultural psychology that incorporate perspectives from sociology and anthropology (e.g., Shiraev & Levy, 2010). Knowledge is gained not only by reading, academic courses, and supervised clinical experience but also through interaction with informants from different cultures and reading fiction and memoirs written by members of other cultural groups.

The literature on cultural competence for therapists focuses primarily on the minority groups that have been oppressed and whose identity is recognized by physical appearance: African Americans, Latino/as, Native Americans (American Indians), and Asians. In each of these groups, there is considerable diversity based on differences in place of birth, country of origin, religion, tribal affiliation, and level of acculturation. Depending on where you practice, other cultural groups may have large populations. For instance, in Los Angeles County, there are large groups of Armenians, Israelis, and Persians. Moreover, there is a tendency to view Caucasians as a homogeneous group not requiring

cultural sensitivity; however, religion, national origin of grandparents, and geographic region of birth all exert profound influences.

Cultural competence requires intense self-examination so that we understand our biases and prejudices. As therapists, we must be able to recognize the lens of our culture and how it influences our worldview, values, and expectations. We need to understand attitudes and beliefs that might negatively influence work with clients from diverse cultures and sexual orientations. Tinsley-Jones (2003) cites research studies that demonstrate the subtle forms that racism takes in individuals who regard themselves as unprejudiced. Ideally, training of clinicians includes culturally diverse experiential groups where members are challenged to explore their unconscious prejudices and to learn about each other's life experiences. This goal requires sensitive facilitation to avoid the risk of triggering hostile, defensive reactions rather than curious self-exploration.

INTEGRATIVE CASE FORMULATION

My commitment to an integrative approach stemmed from my years in graduate school when I recognized that every theory has something of value to offer but is not sufficient as a sole guide for therapy. In a case study about "Ms. Q" (Ingram, 2009a), I explain how I was in a postdoctoral program to be trained in psychoanalytic approaches. "When I started seeing the client, my intention was to put aside my prior methods and techniques, and wholeheartedly embrace the psychoanalytic approach that I was studying. Instead, I discovered that I was constitutionally incapable of not being integrative" (p. 2). At the time, I felt guilty to confess this to my supervisor; subsequently it became a point of pride. My objection to the advice to "choose an orientation" can be expressed as a rhetorical question:

> How can it be good practice to select a ready-made formulation before the therapist lays eyes on a new client?

Furthermore, when we study old and new theories of psychotherapy, it becomes clear that what we view as unitary theories are, in fact, integrations of hypotheses—in short, all psychotherapy is integrative. In the introduction to Part Two, I give examples of how I "unpacked" well-known theories to identify core hypotheses.

In an integrative approach, the therapist combines ideas, skills, and techniques from different theoretical approaches to create a unique formulation that is tailor-made for each client's problems, personality, and sociocultural context. Most experts on integrative therapy (e.g., Norcross & Goldfried, 2005; Stricker, 2009) define four approaches to integration:

1. **Technical eclecticism:** Procedures are drawn from different sources, without the clinician subscribing to the theories. A good example is the multimodal therapy of Lazarus (1981).
2. **Theoretical integration:** There is a synthesis of two or more therapies, and the combination is expected to be more effective than either therapy alone. Wachtel's (1977) integration of psychoanalysis and behavior therapy is a prominent example.

3. **Common factors:** Emphasis is placed on the core ingredients that different therapies share in common, and that may contribute more to the success of therapy than those procedures specific to a theory. Jerome Frank pioneered this approach (J. D. Frank & J. B. Frank, 1991), which has been extensively researched (e.g., Duncan, Miller, Wampold, & Hubble, 2009; Imel & Wampold, 2008).

4. **Assimilative integration:** There is a primary theoretical model of psychotherapy with ideas and techniques selectively incorporated. This approach combines elements of technical eclecticism and theoretical integration; it is commonly used by therapists who have been trained in one system and then add other tools when they discover the limitations of their original approach.

The approach to case formulation taught in this book appears at first to be technical eclecticism because there is no attempt to provide an overarching theoretical integration. However, in contrast to technical eclecticism, there is integration of hypotheses (the conceptual level) rather than interventions (the technical level). The formulation task thus leads to a unique theoretical integration for each client, one that must meet standards of coherence and consistency.

THE LEARNING PROCESS

The transition from classroom to therapy room is a momentous change in the life of a future psychotherapist, and it is normal to feel anxiety and self-doubt. The more compassionate and responsible you are, the more you worry about doing harm. The more you worry, the harder it is for you to draw from your academic knowledge and feel calm and confident as you face clients. There is generally a sharp disconnect between what you learn in the classroom and what is expected in your face-to-face contacts with clients. The words of a former (anonymous) student express the experience of starting fieldwork, providing justification for learning the clinical case formulation method in this book:

Students are simply thrown into field placements with only theoretical knowledge from their academic courses in psychotherapy. Perhaps they have been taught some generic counseling skills and a few specific techniques. What they lack is the judgment about when and why to use specific strategies and techniques. They desperately need skills of conceptualization and analysis to help them tap into their own knowledge and creativity without interfering with the quality of the therapeutic relationship. They need a practical, easily understood framework to allow them to draw from their academic knowledge in order to make decisions that are appropriate at any given moment. They need to know how to create a road map for treatment that is flexible, reliable, and valid in the eyes of their supervisor.

The case formulation method in this book is a tool to help you to think creatively and to develop good treatment plans. One thing that this book does not teach is how to convince your supervisors to endorse an integrative approach if they do not already lean in that direction. Many training programs will limit your ability to implement an integrative treatment plan. Luckily, the method in this book, while intended to promote integration of hypotheses, also serves well as a format for organizing your thoughts and plans within a single theoretical orientation. Be advised that the method taught here is not for keeping chart notes or writing official reports. In fact, the notes that you write in charts—which

are legal documents open to scrutiny in many different contexts—emphatically do not contain the creative speculation that is part of a good formulation.

The long list of standards can make the method seem overly complicated and difficult. However, you are not starting with a blank slate but instead are building on abilities and attitudes that fit within a rubric of *scientific-mindedness*, including:

- The ability to distinguish between data and theory and between evidence and conclusions. This skill can also be described as the ability to differentiate between sensory experience (what you saw and heard) and conceptualization (what you think).
- The ability to generate hypotheses consistent with available data and to identify data needed to test hypotheses.
- An attitude of flexibility rather than dogmatism, which allows you to realize that there is more than one possible approach with each client.

The learning process is much smoother when we accept that, as with most skills, competence comes with experience, practice, and feedback. The development of case formulation skills is an ongoing, continual process, and improvement will occur in stages, as you gain more clinical experience and learn more about the clinical hypotheses. Chapters 8 through 14, on the clinical hypotheses, serve as an introduction or a review; they are not sufficient for learning a theory that you have never studied. Reading about ideas for treatment is not the same as learning how to implement those plans in therapy. Nevertheless, you will benefit from practicing conceptualization skills even when you are not yet skilled in all of the treatment approaches you will want to recommend.

Chapter 15 concludes this book with a set of activities to prepare you to face new clients with the skills to create treatment plans that match their unique needs.

SUGGESTED READINGS

Duncan, B. L., Miller, S. C., Wampold, B. E., & Hubble, M. A. (Eds.). (2009). *The heart and soul of change* (2nd ed.). Washington, DC: American Psychological Association.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University Press.

Ingram, B. L. (2009a). The case of Ms. Q: A demonstration of integrative psychotherapy guided by "core clinical hypotheses." *Pragmatic Case Studies in Psychotherapy, 5*(1), Article 1, 1–42. Available: http://hdl.rutgers.edu/1782.1/pcsp_journal

Norcross, J. C., & Goldfried, M. R. (2005). *Handbook of psychotherapy integration* (2nd ed.). New York, NY: Oxford University Press.