“Peter Sturmey and Mary McMurran have edited an excellent book on forensic case formulation for this Wiley-Blackwell series. The authors of the chapters are well-respected experts in the forensic field. Readers who work in forensic services will find the chapters on case formulation both informative theoretically and helpful clinically. Work with offenders will be enhanced by assimilating the ideas and suggestions in this book.”

Kate Davidson, Professor of Clinical Psychology, University of Glasgow, UK

Effective assessment and treatment of offenders is important for reducing the likelihood of further offending. Understanding the processes which initiate and maintain offending behavior is integral to the design and evaluation of appropriate, individually tailored interventions. Forensic Case Formulation describes the principles and application of case formulation specifically for forensic clinical practice.

In this edited volume, contributors review the fundamental aspects of case formulation, including definitions, reliability, and validity. The practical applications of case formulation applied to violence, sexual offenses, personality disorder, and substance abuse are described, and illustrated with case studies. Also covered is the interrelationship between case formulation and risk assessment. Forensic Case Formulation offers rich insights into the use of case formulation with forensic clients.

Peter Sturmey is Professor of Psychology at Queens College and The Graduate Center, City University of New York. He has published extensively on developmental disabilities, applied behavior analysis, and on issues relating to staff and parent training.

Mary McMurran is Professor of Personality Disorder Research in the University of Nottingham’s Institute of Mental Health. She has written extensively on personality disorders, alcohol-related aggression, and readiness to engage in therapy.

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FORENSIC CASE FORMULATION
WILEY SERIES IN
FORENSIC CLINICAL PSYCHOLOGY

Edited by

Clive R. Hollin
School of Psychology, University of Leicester, UK
and
Mary McMurran
Institute of Mental Health, University of Nottingham, UK

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FORENSIC CASE FORMULATION

Edited by

Peter Sturmey
Queens College and City University, New York, USA

and

Mary McMurry
Institute of Mental Health, University of Nottingham, UK
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SERIES EDITORS’ PREFACE

ABOUT THE SERIES

At the time of writing it is clear that we live in a time, certainly in the UK and other parts of Europe, if perhaps less so in areas of the world, when there is renewed enthusiasm for constructive approaches to working with offenders to prevent crime. What do we mean by this statement and what basis do we have for making it?

First, by “constructive approaches to working with offenders” we mean bringing the use of effective methods and techniques of behaviour change into work with offenders. Indeed, this view might pass as a definition of forensic clinical psychology. Thus, our focus is the application of theory and research in order to develop practice aimed at bringing about a change in the offender’s functioning. The word constructive is important and can be set against approaches to behaviour change that seek to operate by destructive means. Such destructive approaches are typically based on the principles of deterrence and punishment, seeking to suppress the offender’s actions through fear and intimidation. A constructive approach, on the other hand, seeks to bring about changes in an offender’s functioning that will produce, say, enhanced possibilities of employment, greater levels of self-control, better family functioning, or increased awareness of the pain of victims. A constructive approach faces the criticism of being a “soft” response to the damage caused by offenders, neither inflicting pain and punishment nor delivering retribution. This point raises a serious question for those involved in working with offenders. Should advocates of constructive approaches oppose retribution as a goal of the criminal justice system as a process that is incompatible with treatment and rehabilitation? Alternatively, should constructive work with offenders take place within a system given to retribution? We believe that this issue merits serious debate. However, to return to our starting point, history shows that criminal justice systems are littered with many attempts at constructive work with offenders, not all of which have been successful. In raising the spectre of success, the second part of our opening sentence now merits attention: that is, “constructive approaches to working with offenders to prevent crime”. In order to achieve the goal of preventing crime, interventions must focus on the right targets for behaviour change. In addressing this crucial point, Andrews and Bonta (1994) have formulated the need principle:
SERIES EDITORS’ PREFACE

Many offenders, especially high-risk offenders, have a variety of needs. They need places to live and work and/or they need to stop taking drugs. Some have poor self-esteem, chronic headaches or cavities in their teeth. These are all “needs”. The need principle draws our attention to the distinction between criminogenic and noncriminogenic needs. Criminogenic needs are a subset of an offender’s risk level. They are dynamic attributes of an offender that, when changed, are associated with changes in the probability of recidivism. Non-criminogenic needs are also dynamic and changeable, but these changes are not necessarily associated with the probability of recidivism. (p. 176)

Thus, successful work with offenders can be judged in terms of bringing about change in noncriminogenic need or in terms of bringing about change in criminogenic need. While the former is important and, indeed, may be a necessary precursor to offence-focused work, it is changing criminogenic need that, we argue, should be the touchstone in working with offenders.

While, as noted above, the history of work with offenders is not replete with success, the research base developed since the early 1990s, particularly the meta-analyses (e.g. Lösel, 1995), now strongly supports the position that effective work with offenders to prevent further offending is possible. The parameters of such evidence-based practice have become well established and widely disseminated under the banner of “What Works” (McGuire, 1995, 2008).

It is important to state that we are not advocating that there is only one approach to preventing crime. Clearly there are many approaches, with different theoretical underpinnings, that can be applied. Nonetheless, a tangible momentum has grown in the wake of the “What Works” movement as academics, practitioners, and policy makers seek to capitalise on the possibilities that this research raises for preventing crime. The task that now faces many service agencies lies in turning the research into effective practice.

Our aim in developing this Series in Forensic Clinical Psychology is to produce texts that review research and draw on clinical expertise to advance effective work with offenders. We are both committed to the ideal of evidence-based practice and we will encourage contributors to the Series to follow this approach. Thus, the books published in the Series will not be practice manuals or cook books: They will offer readers authoritative and critical information through which forensic clinical practice can develop. We are both enthusiastic about the contribution to effective practice that this Series can make and look forward to continuing to develop it in the years to come.

ABOUT THIS BOOK

Although the context may be different, when it comes to practitioner skills in working with offenders, the same rules of good practice apply as they would with any other group. One of the bedrocks of practice lies in assessment and case formulation: The process of gathering information and then making sense of it, formulating it, within a given theoretical framework. Of course, formulation is independent of theory, so that meaningful formulations of, say, a given behaviour
can be made from different theoretical perspectives. The point of a case formulation is to guide practice based on the available case material, theoretical strictures, and extant empirical knowledge.

In this book an impressive list of authors cover every angle concerning case formulation. The chapters range from discussion of the finer points of the theory and practice of case formulation, to applying these principles to specific offender and groups and to specific types of offences. There is a great deal to be taken at many levels from this book and we are pleased to see it as part of the growing body of work addition the Series represents.

Clive Hollin
Mary McMurrnan

REFERENCES

Clinical case formulation is understood by forensic clinical psychologists and forensic psychiatrists to be key in designing appropriate and so potentially effective treatments for offenders. In forensic work, what is effective in treatment is usually taken to mean that an individual’s risk of reoffending is reduced. While treatments to ameliorate other problems are part of the work of forensic mental health professionals, they cannot ignore the expectation that their treatments should aim to reduce risk. This places an unusual burden upon this group of people in that they are to some degree responsible for their clients’ behavior and for any harm to others that this may cause. If case formulation is indeed the key to effective interventions, then it is imperative that it should be done well.

Research into some of the basic issues in case formulation is lacking in the forensic literature and this lack urgently needs to be addressed. Fortunately there is some evidence about reliability, validity, and utility from clinical work in general, and we present this information here for forensic practitioners to draw upon. Additionally, there are forensic practitioners who have given a great deal of thought to the principles upon which forensic case formulation should rest. These ideas are also presented in this book.

We are indebted to the authors who have made such excellent contributions to this volume. We hope that by drawing together this body of work we might create an impetus for further research in this important area.

Peter Sturmey
Mary McMurran
December 2010
PART I

GENERAL ISSUES
Chapter 1

THEORETICAL AND EVIDENCE-BASED APPROACHES TO CASE FORMULATION

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Our task in this chapter is to introduce the concept of case formulation. We begin by discussing the definition, functions and goals of case formulation, including why formulation is important. We continue by reviewing theoretical and evidentiary sources of information to guide the development of a formulation. Next, we summarize several structured case formulation models that have been developed to increase reliability and validity. Finally, we propose a general framework the therapist can use to structure a formulation and conclude with some practical tips.

WHAT IS A CASE FORMULATION?

Our working definition of case formulation comes from a cross-theoretical perspective: “A psychotherapy case formulation is a hypothesis about the causes, precipitants, and maintaining influences of a person’s psychological, interpersonal and behavioral problems” (Eells, 2007, p. 4). A formulation involves inferences about predisposing vulnerabilities, a pathogenic learning history, biological or genetic factors, sociocultural influences, currently operating contingencies of reinforcement, conditioned stimulus–response relationships, or schemas, working models, and beliefs about the self, others, the future or the world. The aim of the formulation is to explain the individual’s problems and symptoms. The specifics of the formulation will vary depending on the theoretical orientation of the case formulator. As a hypothesis, a formulation is always subject to empirical test and to revision as new information becomes available.
A case formulation serves multiple functions (Eells, 2007). First, it provides a structure to organize information about a person and his or her problems. Clients produce enormous amounts of information in therapy, including verbal, behavioral, prosodic, gestural, affective, and interactional. Formulation facilitates the management of this information cascade. Second, formulation provides a blueprint guiding treatment. Its primary purpose is to help the therapist develop and implement a treatment plan that will lead to a successful outcome. The formulation therefore enables the therapist to anticipate future events, for example, therapy-interfering events, and to prepare for them. Third, a formulation serves as a gauge for measuring change. Indices to assess change may come from goals included in the formulation, from relief of problems identified in the formulation, or from the revision of an inferred explanatory mechanism that did not seem adequate when tested. Fourth, a formulation helps the therapist understand the patient and thereby exhibit greater empathy for the patient’s intrapsychic, interpersonal, cultural, and behavioral world.

Kuyken, Padesky and Dudley (2009) offer another definition of case formulation, emphasizing its collaborative and resilience-building aspects. They define formulation as a “process whereby therapist and client work collaboratively first to describe and then to explain the issues a client presents in therapy. Its primary function is to guide therapy in order to relieve client distress and build client resilience” (p. 3). Using the metaphor of a crucible and focusing on cognitive-behavioral therapy (CBT), these authors emphasize that formulation integrates and synthesizes a client’s problems with CBT theory and research. Essential ingredients of a productive conceptualization are empirical collaboration between therapist and client, the development of the formulation over time from the descriptive level to an explanatory level, and the elicitation of both client strengths and problems. These authors also describe functions of a CBT case formulation. These include (1) synthesizing client experiences, relevant CBT theory and research; (2) normalizing and validating clients’ presenting issues; (3) promoting client engagement; (4) making complex and numerous problems more manageable for the client and therapist; (5) guiding the selection, focus, and sequence of interventions; (6) identifying strengths and suggesting ways to build resilience; (7) suggesting cost-efficient interventions; (8) anticipating and addressing problems in therapy; (9) helping the therapist understand nonresponse to therapy; and (10) facilitating high-quality supervision.

Persons (2008) embeds her approach to formulation within a framework of clinical hypothesis testing. She emphasizes that the formulation is fundamentally a hypothesis that is constantly refined in the course of treatment. She views a complete formulation as one that ties the following elements together into a coherent whole: (1) the patient’s symptoms, disorders, and problems, (2) hypotheses about the mechanisms causing the disorders and problems, (3) precipitants of those disorders and problems, and (4) a statement of the origins of the mechanisms. Following similar lines, Tarrier and Calam (2002) define formulation as “the elicitation of appropriate information and the application and integration of a body of theoretical psychological knowledge to a specific clinical problem in order to understand the origins, development and maintenance of that problem. Its purpose is both to provide an accurate overview and explanation of the patient’s problems that is open to verification through hypothesis testing, and to arrive collaboratively with the
patient at a useful understanding of their problem that is meaningful to them” (pp. 311–12). The case formulation is then used to inform treatment or intervention by identifying key targets for change.

WHY FORMULATE?

Multiple mental health care disciplines view case formulation as an essential clinical skill. A core competency for psychiatrists trained in the United States is the ability “to develop and document an integrative case formulation that includes neurobiological, phenomenological, psychological and sociocultural issues involved in diagnosis and management” (American Board of Psychiatry and Neurology, 2009, p. 1). Similarly, the American Psychological Association promotes evidence-based practice, which includes the application of “empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention” (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 284). The British Psychological Society views formulation as a core skill (Division of Clinical Psychology, 2001, p. 2). Multiple authors support the importance of case formulation as a “lynchpin concept” (Bergner, 1998), the “first principle” underlying therapy (J. S. Beck, 1995) and the “heart of evidence-based practice” (Bieling and Kuyken, 2003).

Formulation is a core skill for several reasons. First, and most importantly, formulation is where theory and empirical knowledge about psychotherapy, psychopathology, personality, development, culture, and neurobiology merge to inform the understanding and treatment of an individual, group, couple, or family. Formulation provides a structure to apply nomothetic knowledge to an idiographic context.

Second, current nosologies are almost exclusively descriptive and symptom-focused. Thus, they provide no account of why a client has symptoms, what the origins of those symptoms are, and what triggers and maintains them. Major depressive disorder, one of the most commonly diagnosed disorders, is a case in point. According to the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (American Psychiatric Association, 1994, DSM-IV) to be diagnosed with this condition, one must meet five of nine criteria for two weeks, including depressed mood or loss of interest or pleasure. In addition, one must exhibit distress or impairment in one’s social or occupational functioning and meet other rule out criteria. The criteria say nothing about biochemical, psychological, behavioral, situational, or environmental factors that may be producing the depression. Formulation fills this explanatory gap between diagnosis and treatment.

A third reason that formulation is essential is that diagnosis alone does not provide a sufficient guide to treatment selection. The same diagnosis might be treated with different types of empirically defensible treatments and interventions, creating the dilemma of which one to choose. Further, few psychotherapy outcome studies include diagnosis by treatment interactions and thus do not address the sensitivity and specificity of treatment for a specific diagnosis (Sturmey, 2008). A single treatment that is found effective for one diagnosis may also be effective for other diagnoses.

Fourth, a case formulation approach tailors treatment to address individual circumstances. Empirically supported treatments (EST) do not provide guidance in
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a number of situations (Persons, 2008). These include when the client has multiple disorders and problems, when multiple providers are treating the individual, when a situation arises that is not addressed by an EST, when no EST is available, when the client does not adhere to an EST, when establishing a collaborative therapeutic relationship proves problematic, and in cases of treatment failure. With regard to the latter point, as many as 40–60% of individuals do not respond to a first-line empirically supported treatment (Westen, Novotny and Thompson-Brenner, 2004).

THE GOALS OF FORMULATION

If a formulation is to serve the above functions, it should meet at least five goals. First, a formulation should be accurate and fit the individual for whom it is constructed. The benefits of an accurate formulation have been demonstrated in a number of studies (Crits-Christoph, Cooper and Luborsky, 1988; Crits-Christoph et al., 2010; Silberschatz, 2005b). One way to assess accuracy of an individual formulation is to evaluate the patient’s response to a formulation-consistent intervention and to compare those responses to how the patient responds to formulation-inconsistent interventions. If the patient responds as the formulation predicts, one has evidence of its accuracy. Another way to assess accuracy is to share the formulation with the patient and get the patient’s opinion. Opinions vary as to whether and to what degree a formulation should be shared with a patient. CBT therapists tend to prefer sharing the formulation and see this as an important component of developing a collaborative relationship with the patient (Kuyken et al., 2009) More psychodynamically oriented therapists have expressed caution in sharing the formulation. Luborsky and Barrett (2007) advise sharing it in its component parts rather than as a whole. Curtis and Silberschatz (2007) advise deciding whether to share or not on the basis of what the formulation predicts the patient’s response will be. Ryle’s (1990), cognitive-dynamic model, on the other hand, includes sharing the formulation, composed as a letter from the therapist to the patient, as part of treatment.

A second goal of formulation is that it have treatment utility (Hayes, Nelson and Jarrett, 1987). The formulation should contribute to the treatment beyond what would have been achieved in the absence of a formulation. One measure of utility is the contribution of the formulation to treatment outcome. There is little research in this area, and research that has been done has produced equivocal results (Bieling and Kuyken, 2003; Kuyken, 2006). Another index of treatment utility is the extent to which the formulation benefits the process or efficiency of the delivery of the therapy. Further, a formulation may have benefits for the therapist that filter indirectly to the patient and therapeutic process, for example by increasing the therapist’s confidence or improving his/her communication with the client. For example, Chadwick, Williams and Mackenzie (2003) found that while formulation-guided therapy did not predict alliance ratings among a group of psychotic patients, it was associated with improved therapist ratings of the therapeutic relationship.

A third goal of formulation is that it should be parsimonious yet sufficiently comprehensive. Some problems and clients require relatively simple and circumscribed formulations whereas others need multifaceted and complex formulations,
especially when the client behaves in contradictory ways, meets criteria for multiple disorders, or has major problems in multiple spheres of functioning. The formulation should provide a structure to optimally and efficiently represent enough information about the patient to benefit treatment, but not more. A fourth goal of formulation is to strike the right balance between description and explanation. Research has shown that it is difficult to achieve good reliability when formulations are based on psychological constructs that are too distant from the experience and behavior of the patient (Seitz, 1966). On the other hand, if a formulation is to be genuinely explanatory, it must do more than summarize biographical information about a client. Notwithstanding this distinction, it is noteworthy that description and explanation can blur as one proposes an underlying mechanism. As Kazdin (2008, p. 12), wrote, “Depending on the detail, level of analysis, and sequence of moving from one to the other, description can become explanation” (p. 12).

A final goal of formulation is that it should be evidence-based. The APA Task Force on Evidence-Based Practice in Psychology stated that evidence-based formulations apply the best research, knowledge, experience, and expertise to the task: What constitutes appropriate evidence in a case formulation? Various types of evidence may best be viewed in relative terms along a continuum. At the most clearly evidence-based end, one could imagine compelling outcomes from empirically supported treatments, well-demonstrated mechanisms underlying forms of psychopathology, powerfully predictive epidemiological data, or well-documented and replicated findings about basic psychological processes, for example, the age at which reliable autobiographical memories can be formed. At the other end of the continuum one might place a therapist’s hunches or intuitions. These might offer valuable insights that could be tested, but in themselves probably would not be described as evidence-based by most observers. Between these two end-points might be included data such as psychological test findings, rating scale results, a patient’s narrative of a relationship episode, a dream account, a thought record, a patient’s account of automatic thinking or an assertion by the client or therapist that a thought is a core belief. No consensus currently exists on what constitutes appropriate evidence for a case formulation. Therefore, our advice is that therapists create a plausible continuum and use their best judgment in evaluating evidence they gather as they formulate cases.

If the above five goals of case formulation are met, the therapist is well on the way toward developing a productive tool to facilitate treatment. In the following section, we discuss two major sources of hypotheses about clients: theory and evidence.

THEORY AS A GUIDE TO FORMULATION

Earlier we stated that the most important reason to formulate a case is because it provides an opportunity to apply theory and evidence to a specific case. In this section, we provide an overview of some primary sources of theory, illustrating the application of these sources to case formulation. We begin with four major theories underlying broad models of psychotherapy: psychodynamic, cognitive, behavioral, and humanistic.
Psychodynamic Theory

Psychodynamic theory originates in the work of Freud and provides a rich source of inference for case formulation. Beginning with his early formulation that “hysterics suffer from reminiscences” (Breuer and Freud, 1955), Freud has contributed a multitude of ideas that have shaped our understanding of normal and abnormal psychology. Most prominently, these include the notion of psychic determinism and unconscious motivation. The former entails the assumption that all human thought has a specific cause, nothing is random or accidental. The latter is the idea that majority of mental activity is outside of awareness and is goal-directed or purposeful. Other ideas contributed by Freud are that of overdeterminism, the symbolic meaning of symptoms, symptom production as a compromise formation, ego defense mechanisms as stabilizers of the psyche, and the tripartite theory of the mind, that is, its division into id, ego, and superego. Messer and Wolitzky (2007) succinctly grouped contemporary psychodynamic theory, at least as practiced in North America, into three broad categories: the traditional Freudian drive/structural theory, object relations theory, and self-psychology. We will briefly describe each with a focus on what is formulated and why.

The drive/structural theory proposes that human behavior is driven by intrapsychic conflict originating in sexual and aggressive drives that seek pleasure and avoid pain (the “pleasure principle”) but become thwarted when they confront obstacles such as fear, anxiety or guilt. The structural component of the drive model involves the tripartite division of the mind into the id, which is the repository of drives, the superego, which contains both our conscience and who we ideally would become (the “ego ideal”), and the ego, which mediates between the impulses of the id and the strictures of the superego. The ego utilizes defense mechanisms in an attempt to avoid anxiety and maintain psychic equilibrium. When these attempts fail, neurotic symptoms develop. These mental structures and specific defenses arise as the individual navigates through four psychosexual stages – oral, anal, phallic, and genital – each of which is associated with specific conflicts that if not resolved persist into adulthood. The key feature of a case formulation based on the Freudian drive/structural theory is an “emphasis on unconscious fantasy, the conflicts expressed in such fantasy, and the influence of such conflicts and fantasies on the patient’s behavior”, and further, the assumption that these conflicts originate in childhood (Messer and Wolitzky, 2007). Treatment focuses on helping patients appreciate the nature and pervasiveness of their unconsciously driven motives and the ways that they avoid awareness of them.

The object relations perspective on psychodynamics focuses on mental representations of self and other and models of affect-laden transactions between the two. The approach tends to dichotomize self and other into “good” and “bad” components that are often viewed as compartmentalized and not integrated. Defense mechanisms such as projective identification, splitting, and role reversal are used frequently by practitioners of this perspective. Relationships constitute basic drives rather than instinct. Case formulations based on this perspective focus on this inability to integrate, the disavowal of rage toward attachment figures that are also loved and needed. The individual may project an image of self as “good” while projecting the “bad” onto others.
The self-psychology (Kohut, 1971, 1977) perspective emphasizes the development and maintenance of a cohesive and coherent sense of self. Kohut viewed the self as the center of intention and experience, as the core of our being (Galatzer-Levy, 2003, p. 479). Cohesion refers to a sense of the self as maintaining continuity across time and place. Temporal coherence is the experience of oneself as a person with sameness and history across time. Spatial coherence refers to the sense that various aspects of oneself are alive and share a common intention. Kohut’s primary tool for understanding others was through empathic connection and comprehension. He viewed empathy as the ability to understand another’s psychological experience, as a kind of vicarious introspection. Using this approach, he identified a number of disturbances in the development of self in his patients. For example, they seemed to experience “empty” depressions, in which life appeared colorless, alienating, pointless, and lacking in vitality. Others experienced traumatic states in which experiences could not be integrated into a coherent sense of self. Kohut also treated people subject to seemingly unexpected, situationally discrepant states of rage. Kohut explained these experiences in terms of caretakers’ failure to provide sufficient empathic responsivity to enable one to develop a cohesive sense of self.

One of Kohut’s most distinctive concepts is that of the “selfobject”. He posited that the presence of others in one’s life is an essential prerequisite for mental well-being. A selfobject is an unconscious mental representation of a connection between self and other, as if the other is an extension of oneself. He identified two basic types of selfobject: idealized and mirroring. An idealized selfobject is revealed in the experience of feeling alive, vital and powerful through one’s connection to another whom one admires. As Messer and Wolitzky write, one with an idealized selfobject seems to be saying, “I admire you, therefore my sense of self and self-worth are enhanced by my vicarious participation in your strength and power.” A mirroring selfobject vitalizes the self through the sense of being affirmed by others to whom one feels connected. Messer and Wolitzky characterize the mirroring selfobject as, “You admire me, and therefore I feel affirmed as a person of worth.” Formulations from the self-psychology perspective emphasize explanations of disturbances in a cohesive sense of self due to failures of empathic responsiveness from caretakers. The nature of the patient’s transference to the therapist – as idealizing or mirroring – is an important component to understanding the patient.

Practitioners of psychodynamic therapy can draw from any or all of these basic perspectives in drawing up a case formulation; however, according to Messer and Wolitzky (2007), who in turn draw from Rapaport and Gill (1959), a comprehensive contemporary psychodynamic case formulation should contain five components. First, it should address the patient’s major dynamic conflicts, for example, between wishes and the feared consequences of those wishes. Second, it should address those aspects of the patient’s personality involved in the conflicts, for example, the id, ego, supergo, or inferred selfobjects. Third, the formulation should address the antecedent and developmental events leading to the conflicts. For example, what were the crucial experiences in childhood that gave rise to the patient’s current concepts of self and others? Or, what were the episodes of failed empathic responsiveness on the part of caretakers that led to a disturbance in self cohesion? Fourth it should address the adaptive and maladaptive compromise formations that comprise the patient’s defensive and coping strategies. Which compromises
Cognitive Theories

Theories underlying contemporary cognitive therapies can be traced to the “cognitive revolution”, which took place in the mid-twentieth century as a response to what was increasingly perceived as the inadequacies of behavioristic, stimulus-response models of learning that discounted the role of mentation and human agency (Mahoney, 1991). Borrowing terminology and concepts from information theory, computer science, and general systems theory, the interests of cognitive scientists turned toward “understanding and influencing the fundamental processes by which individual humans attend to, learn, remember, forget, transfer, adapt, relearn and otherwise engage with the challenges of life in development” (Mahoney, 1991, p. 75). As Bruner (1990) put it retrospectively, “that revolution was intended to bring ‘mind’ back into the human sciences after a long cold winter of objectivism” (p. 1). It was further intended “to establish meaning as the central concept of psychology – not stimuli and responses, not overtly observable behavior, not biological drives and their transformation, but meaning” (p. 2). Influential writings at the time included works by Bruner (e.g., Bruner, Goodnow, and Austin, 1956), Chomsky (1959), Festinger (1957), Kelly (1955), Postman (1951), and Simon and Newell (1958).

As the cognitive revolution filtered into the social sciences and psychiatry, multiple theories of cognitive therapy took shape. More than 15 years ago, Kuehlwein and Rosen (1993) identified ten different models of cognitive therapy alone. As Nezu, Nezu and Cos (2007) pointed out, there is no single cognitive therapy, but rather a collection of therapies that share a common history and perspective. They hold in common not only their heritage within the cognitive revolution, but also the assumption that our appraisals of events are much more crucial to our mental well-being than are the events themselves. In this section we will review some of these theories and discuss their implications for formulation. In doing so, we recognize that most of these models also blend elements of behavior theory, which will be discussed later in the chapter. With regard to cognitive theories, we will emphasize Beck’s model since it is the most influential and has been subject to the most empirical scrutiny.

Beck’s (1963) cognitive theory originated from observations of persistent thought patterns in depressed patients he interviewed. These individuals expressed views of themselves as inferior in areas of their lives that mattered to them. They viewed the world as depriving and saw the future as bleak. These observations led Beck to develop his now well-known “cognitive triad”, which is a framework he proposed to describe the automatic and systematically biased thinking of depressed patients. It was later expanded to describe a wide range of problems and psychological conditions. Automatic thoughts are brief, episodic, and often emotionally laden forms of thinking that occur unbidden and are often at the threshold of awareness. For example, one might think, “Writing this chapter is too hard. I’ll