Name: _____ Gender: _____ Age: _____ Marital Status: _____ Religion/Ethnicity: _____ Occupation: _____

Living Situation: _____ Referral Source: _____

Reason for Referral: _____

Psychotropic Medications: _____ Prescribing Physician: _____

Problem List:	Diagnosis:	Goals:
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

Causal or Maintenance Factors	Hypothesis	Hypothesis-Based Interventions	Outcomes
Medical			
Core Problems of ASD *Social Cognition* *Emotion Regulation* *Sensory–Motor Regulation* *Executive Function*			

(continued)

FIGURE 3.1. Case formulation worksheet.

Schemas *Self* *Others* *World* *Future* *Origins* *Activating Event*			
Behavior *Antecedents (A)* *Consequences* (*C*)			
Strengths and Resiliency Factors			

Potential Obstacles to Treatment:	Prevention Strategies for Obstacles:
1. 2. 3.	1. 2. 3.

FIGURE 3.1. *(continued)*

Name: _____ Gender: _____ Age: _____ Marital Status: _____ Religion/Ethnicity: _____ Occupation: _____
Living Situation: _____ Referral Source: _____
Reason for Referral: _____
Psychotropic Medications: _____ Prescribing Physician: _____

Problem List:	Diagnosis:	Goals:
1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.

Causal or Maintenance Factors *Consider all of the following when generating hypotheses.*	Hypothesis *What factors may be causing or maintaining the problems listed above? Explain how they contribute to the presenting problems.*	Hypothesis-Based Interventions *What intervention should be built into the plan to minimize each factor?*	Outcomes *What is the expected outcome? Describe how it will contribute to the attainment of a goal (indicate which goal by writing the number).*
Medical	*How might medical or psychopharmacological issues be causing/maintaining problem(s)?*	*Which cognitive-behavioral interventions will help coping or compliance with medical issues?* *Which referrals to medical professionals are needed?*	*How will the medically related interventions help attain the global therapy goals?*
Core Problems of ASD *Social Cognition* *Emotion Regulation* *Sensory–Motor Regulation*	*How might core/associated ASD impairments be causing/maintaining problem(s)?* *How might social-cognitive deficits be causing/maintaining problem(s)?* *How might ER issues be causing/maintaining problem(s)?* *How might sensory–motor regulation issues be causing/maintaining problem(s)?*	*Which skill-building or coping strategies will compensate for core deficits?* *What referrals to adjunctive therapies (speech, occupational therapy) might be needed?*	*How will the skill-building, coping, or adjunctive interventions help attain the global therapy goals?*

(continued)

FIGURE 4.1. Guidelines for generating hypotheses and planning treatment.

Executive Function	*How might EF deficits be causing/maintaining problem(s)?*		
Schemas *Self* *Others* *World* *Future* *Origins* *Activating Event*	*How does schema about self cause/maintain problem(s)?* *How does schema about others cause/maintain problem(s)?* *How does schema about the world cause/maintain problem(s)?* *How does schema about the future cause/maintain problem(s)?* *What are the historical origins of schemata?* *What large- or small-scale events activate distorted thinking?*	*What strategies will modify maladaptive schemas?*	*How will the schema-changing interventions help attain the global therapy goals?*
Behavior *Antecedents (A)* *Consequences (C)*	*How are the patient's overt behaviors causing/maintaining problem(s)?* *What are the antecedents for these behaviors?* *How are consequences causing/maintaining behavior?*	*What strategies will modify antecedents and consequences of maladaptive behavior in order to bring about behavioral change?*	*How will the behavioral interventions help attain the global therapy goals?*
Strengths and Resiliency Factors	*What strengths and coping strategies of the patient have served as protective or resiliency factors?*	*How can the patient's strengths and talents be optimized and used as tools for the intervention plan?*	*How will the utilization of the patient's strengths and talents help attain the global therapy goals?*

Potential Obstacles to Treatment:	Prevention Strategies for Obstacles:
1.	1.
2.	2.
3.	3.

FIGURE 4.1. *(continued)*

Name: *Bob* Gender: *M* Age: *29* Marital Status: *S* Religion/Ethnicity: *Jewish* Occupation: *Unemployed*

Living Situation: *House w/parents* Referral Source: *Evaluating psychologist*

Reason for Referral: *To address severe symptoms of anxiety and depression trigged by World Trade Center disaster*

Psychotropic Medications: *Prozac, Effexor, and Geodon* Prescribing Physician: *Dr. Jones (psychiatrist)*

Problem List:	Diagnosis:	Goals:
1. *Obsessions—intrusive thoughts about terrorist attacks, worrying about impending acts of terrorism* 2. *Compulsive behavior—perseverative questioning of family members about terrorism* 3. *Depressed mood (BDI = 51)—extreme irritability, hopelessness, poor self-worth, recurrent thoughts of death* 4. *Avoidance of self-care—negligence of diabetes regimen, dependence on parents in all activities of independent living* 5. *Social isolation—premorbid social skill deficits*	1. *Obsessive–compulsive disorder w/fair insight* 2. *Major depressive disorder; recurrent severe* 3. *Autism spectrum disorder, Level 1 severity w/o intellectual or language impairment (Asperger's disorder)* 4. *R/O-dependent personality disorder* 5.	1. 2. 3. 4. 5.

Causal or Maintenance Factors	Hypothesis	Hypothesis-Based Interventions	Outcomes
Medical	*Unstable blood sugar levels could contribute to mood instability. The rigors of caring for diabetes are chronic stressors. Original diagnosis with the disease at age 21 was traumatic.*		
Core Problems of ASD *Social Cognition*	*Difficulty attending to nonverbal communication of other people, difficulty with perspective taking, flat affect, and poor expression of own mental states and needs. All deficits contribute to misattributions that result in social anxiety and anger and reinforce negative schema about others.*		

(continued)

FIGURE 4.2. Generating hypotheses for Bob.

Emotion Regulation	Negative thoughts and distressing emotions are unacceptable and are suppressed; uncertainty is intolerable.		
Sensory–Motor Regulation	Mild tactile sensitivity may affect self-care.		
Executive Function	Planning and organization deficits make basic independent living tasks overwhelming and reinforce negative schema about self. Cognitive rigidity makes adaptation to change very difficult.		
Schemas			
Self	"I am helpless and powerless." "I cannot take care of myself." "I am defective." "I should not have negative thoughts or feelings."		
Others	"Others must take care of me." "Others must protect me from harm." "People are usually out for themselves." "People are not trustworthy."		
World	"The world is an unsafe place." "The world gives people what they deserve."		
Future	"The future is full of danger that is unpredictable." "I will never be normal."		
Origins	Bob was aware that he did not function the same way as other students in elementary school (due to a learning disability). A sense of not fitting in made him feel vulnerable. Peers were unkind to him due to his behavioral differences. He relied on his parents to advocate for him, but in adolescence began resenting them for not protecting him from stressors. The trauma of the diabetes diagnosis strengthened his belief that his parents were failing him, because they could not protect him from the disease.		

(continued)

FIGURE 4.2. *(continued)*

Activating Event	Small scale—any situation that Bob perceives to include pressure to take care of self, pressure to achieve social success, reminders that parents may not be able to take care of him. Large-scale precipitants—9/11, which reactivated the traumatic aspects of his diabetes diagnosis 8 years before, triggering beliefs that others should be able to protect him from all bad things and that they have failed him.		
Behavior *Antecedents (A)* *Consequences (C)*	1. Repetitive questioning of family members; seeking reassurance about terrorism. A—Intermittent exposure to TV or Internet reports about 9/11 and increased anxiety. C—Reassuring statements by family members, which result in temporary reduction in anxiety. 2. Social withdrawal/passivity A—Social situations where Bob is uncertain about the other people and/or how he should behave; lack of conversation skills. C—Anxiety reduction results from withdrawal; passivity relieves pressure. 3. Verbally aggressive behavior (sudden outbursts of anger toward others) A—Social situations where Bob attributes negative intent to another person's behavior and escape is not possible; lack of assertiveness skills. C—Other people act hostile toward Bob and reject him, reinforcing negative schema about others.		

(continued)

FIGURE 4.2. *(continued)*

Strengths and Resiliency Factors	*Bob is bright, articulate, has enjoyed writing and believes he expresses himself best that way, can use humor as a coping strategy, and has formed positive connections with some people. He was also active in a bowling league and frequently played tennis prior to 9/11.*		

Potential Obstacles to Treatment:	Prevention Strategies for Obstacles:
1.	1.
2.	2.
3.	3.

FIGURE 4.2. *(continued)*

Name: *Bob* Gender: *M* Age: *29* Marital Status: *S* Religion/Ethnicity: *Jewish* Occupation: *Unemployed*

Living Situation: *House w/parents* Referral Source: *Evaluating psychologist*

Reason for Referral: *To address severe symptoms of anxiety and depression trigged by World Trade Center disaster*

Psychotropic Medications: *Prozac, Effexor, and Geodon* Prescribing Physician: *Dr. Jones (psychiatrist)*

Problem List:	Diagnosis:	Goals:
1. *Obsessions—intrusive thoughts about terrorist attacks, worrying about impending acts of terrorism* 2. *Compulsive behavior—perseverative questioning of family members about terrorism* 3. *Depressed mood (BDI = 51)—extreme irritability, hopelessness, poor self-worth, recurrent thoughts of death* 4. *Avoidance of self-care—negligence of diabetes regimen, dependence on parents in all activities of independent living* 5. *Social isolation—premorbid social skill deficits*	1. *Obsessive–compulsive disorder w/fair insight* 2. *Major depressive disorder; recurrent severe* 3. *Autism spectrum disorder, Level 1 severity w/o intellectual or language impairment (Asperger's disorder)* 4. *R/O-dependent personality disorder* 5.	1. *Reduce frequency of obsessions and compulsions* 2. *Decrease depressive symptoms* 3. *Increase self-reliance and independence* 4. *Increase quality and quantity of relationships* 5.

Causal or Maintenance Factors	Hypothesis	Hypothesis-Based Interventions	Outcomes
Medical	*Unstable blood sugar levels could contribute to mood instability. The rigors of caring for diabetes are chronic stressors. Original diagnosis with the disease at age 21 was traumatic.*	*Teach self-monitoring strategies for compliance with regimen and taking more active role in endocrinology appointments.*	*Increased sense of independence and control over diabetes, decreased stress (2, 3)*
Core Problems of ASD *Social Cognition*	*Difficulty attending to nonverbal communication of other people, difficulty with perspective taking, flat affect, and poor expression of own mental states and needs. All deficits contribute to misattributions that result in social anxiety and anger and reinforce negative schema about others.*	*Teach perspective-taking skills/reading nonverbal cues of others. Teach assertive communication.*	*Increased competence and confidence in social situations, less anger (4)*

(continued)

FIGURE 4.3. Choosing interventions and setting goals for Bob.

Emotion Regulation	Negative thoughts and distressing emotions are unacceptable and are suppressed; uncertainty is intolerable.	Emotion education, using tools to teach the purpose of emotions and how to identify and label them.	Acceptance of Bob's own emotions (1, 2, 3, 4)
Sensory–Motor Regulation	Mild tactile sensitivity may affect self-care.	Reassess if self-care problems persist after depressive symptoms improve.	Increased number of tasks completed without help, decreased stress (3)
Executive Function	Planning and organization deficits make basic independent living tasks overwhelming and reinforce negative schema about self. Cognitive rigidity makes adaptation to change very difficult.	Design task management systems that are suited to Bob's learning style.	
Schemas		Schema-Changing Techniques:	
Self	"I am helpless and powerless." "I cannot take care of myself." "I am defective." "I should not have negative thoughts or feelings."	Teach cognitive restructuring to modify maladaptive schemas.	Increased ability to challenge maladaptive automatic thoughts (2, 3, 4)
Others	"Others must take care of me." "Others must protect me from harm." "People are usually out for themselves." "People are not trustworthy."		
World	"The world is an unsafe place." "The world gives people what they deserve."	Use successes in other areas of treatment plan (e.g., successful completion of daily living tasks without help) as evidence that is counter to negative views.	Expression of new beliefs about self—"I am capable and competent"; and about others—"Others do not have to take care of me." (2, 3, 4)
Future	"The future is full of danger that is unpredictable." "I will never be normal."		
Origins	Bob was aware that he did not function the same way as other students in elementary school (due to a learning disability). A sense of not fitting in made him feel vulnerable. Peers were unkind to him due to his behavioral differences. He relied on his parents to advocate for him, but in adolescence began resenting	Teach cognitive restructuring to reappraise stressful situations.	Decreased perception of pressure, decreased stress (1, 3)

(continued)

FIGURE 4.3. *(continued)*

	them for not protecting him from stressors. The trauma of the diabetes diagnosis strengthened his belief that his parents were failing him, because they could not protect him from the disease.		
Activating Event	Small scale—any situation that Bob perceives to include pressure to take care of self, pressure to achieve social success, reminders that parents may not be able to take care of him. Large-scale precipitants—9/11, which reactivated the traumatic aspects of his diabetes diagnosis 8 years before, triggering beliefs that others should be able to protect him from all bad things and that they have failed him.		Large-scale precipitants will no longer be viewed as having catastrophic impact on daily life (1, 3)
Behavior *Antecedents (A)* *Consequences (C)*	1. Repetitive questioning of family members; seeking reassurance about terrorism. A—Intermittent exposure to TV or Internet reports about 9/11 and increased anxiety. C—Reassuring statements by family members, which result in temporary reduction in anxiety. 2. Social withdrawal/passivity A—Social situations where Bob is uncertain about the other people and/or how he should behave; lack of conversation skills. C—Anxiety reduction results from withdrawal; passivity relieves pressure. 3. Verbally aggressive behavior (sudden outbursts of anger toward others) A—Social situations where Bob attributes negative intent to another person's behavior and escape is not possible; lack of assertiveness skills. C—Other people act hostile toward Bob and reject him, reinforcing negative schema about others.	1. Exposure + response prevention: • Assign Bob task of exposing self to news media in a scheduled, structured, and systematic way. • Have Bob monitor SUDs. • Instruct family to implement response prevention; provide them with a script for Bob's questions. 2. and 3. Teach perspective-taking skills/reading nonverbal cues of others and assertive communication (as mentioned above).	Bob will become desensitized to the news. Taking active versus passive role over consumption of current events information will increase sense of control and decrease need for parent involvement. (1,3) Increased initiation of social engagement (2, 4) Decreased frequency of angry outbursts (2, 4)

(continued)

FIGURE 4.3. *(continued)*

Strengths and Resiliency Factors	*Bob is bright, articulate, has enjoyed writing and believes he expresses himself best that way, can use humor as a coping strategy, and has formed positive connections with some people. He was also active in a bowling league and frequently played tennis prior to 9/11.*	*Activity scheduling*	*Increased expression of talent and frequency of enjoyable activities (2, 3, 4)*

Potential Obstacles to Treatment:	Prevention Strategies for Obstacles:
1. *Bob's belief that others are untrustworthy and his reliance on hostile behavior to protect himself may interfere with building a working relationship with the therapist. It may be worsened by his tendency to misinterpret what others are doing and saying to him.* 2. *Bob's planning and organization deficits may interfere with managing the tasks of therapy.* 3. *Bob's belief that he is helpless and incapable may interfere with his taking an active role in the therapy process; he may remain passive and avoid doing exercises and homework.*	1. *Assume a slow pace; use a lot of reflection and validation in the early sessions.* 2. *Break down tasks into small subtasks; accompany verbal instruction with visual aids.* 3. *By assigning tasks that are small and manageable (described above), the probability of Bob's willingness to try may be increased.*

FIGURE 4.3. *(continued)*

Name of the person to whom you may disclose your diagnosis: _____

Please answer each of the questions below.

1. Why do you want this particular person to know about your diagnosis?

2. How do you think it will improve your interactions with this person if he or she knows about your ASD?

3. Are you prepared to ask this person to support you in a different way because of this new information? ____ Yes ____ No

   If yes, list below the things he or she can do to be more helpful to you.

4. What are the risks of telling this person?

5. If the person is someone with whom you are not very close (e.g., a coworker), are there other ways you could ask for specific types of help and support without telling him or her about your ASD?

FIGURE 5.1. Disclosure worksheet.

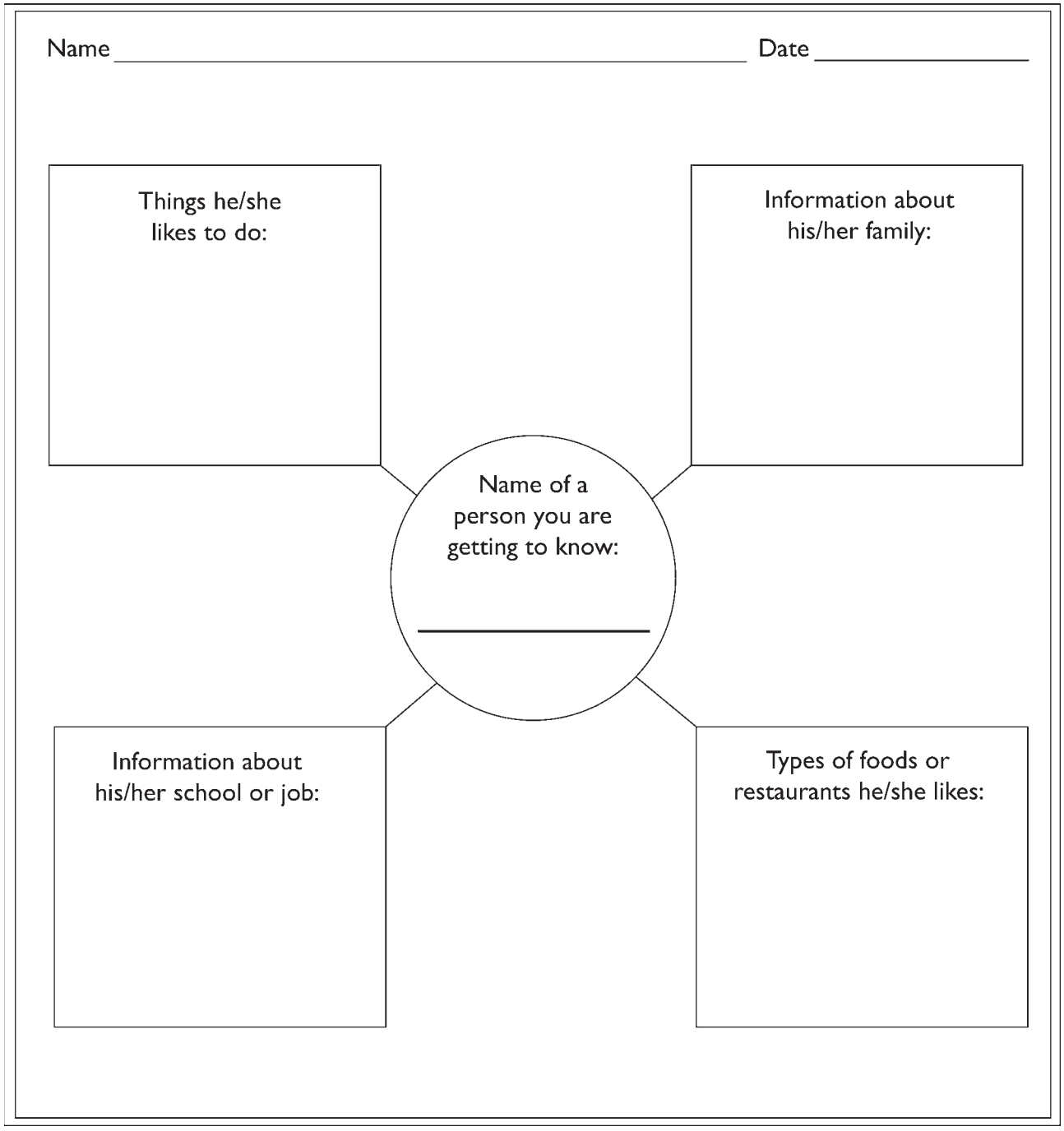

FIGURE 6.1. Worksheet: Visual web of what you remember about others. From Winner (2002). Copyright © 2002 Michelle Garcia Winner. Reprinted by permission.

Your brain holds all the information for what you think and know. Getting to know someone else means you have to store that information in a file in your brain. You have to work at remembering to put the information into your brain. Then the next time you see that person, you can brainstorm, which means when you think hard about that person, you will be able to open your file about them!

Below, brainstorm what you remember about the different people you have met in this group.

I remember 3 things about

_____

1. _____
2. _____
3. _____

I remember 3 things about

_____

1. _____
2. _____
3. _____

I remember 3 things about

_____

1. _____
2. _____
3. _____

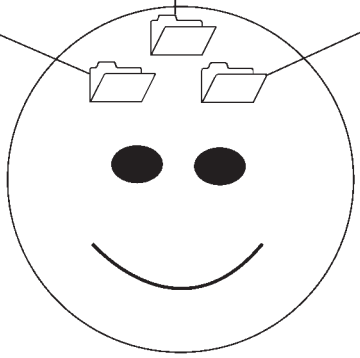

FIGURE 6.2. Worksheet: Creating files in your brain to remember about others. From Winner (2002). Copyright © 2002 Michelle Garcia Winner. Reprinted by permission.

Go through these steps in order by answering each question. Try to focus on one step at a time and be sure to complete all eight steps without skipping any.

1. **Problem identification:** *What is bothering me in this situation?*

2. **Goal selection:** *How do I wish it could be different?*

3. **Identification of obstacles:** *What is getting in my way?*

4. **Generation of alternatives:** *What are the possible solutions for the obstacles?*

5. **Consideration of consequences:** *What are the pros and cons of each solution?*

6. **Decision making:** *Which solution(s) should I try first?*

7. **Implementation:** *Now I will try the solution(s) and track my progress.*

8. **Evaluation:** *Did it meet my goal, or do I need to try a different solution?*

FIGURE 6.3. Problem-solving worksheet.

1. What is bothering me in this situation?

PROBLEM

2. How do I wish it could be different?

GOAL

3. What is getting in my way?

OBSTACLE

4. What are the possible solutions for the obstacle(s)?

POSSIBILITY LIST

5. What are the pros and cons of each solution?

CONSIDER EACH POSSIBILITY

6. Which solutions should I try first?

CHOOSE

7. Now I will try the solution(s) and track my progress.

IMPLEMENT AND TRACK

8. Did the solution meet my goal, or do I need to try a different solution?

EVALUATE, CELEBRATE, OR

ADJUST PLAN

FIGURE 6.4. Problem-solving steps. From Gaus (2011). Copyright © 2011 The Guilford Press. Reprinted by permission.

Month _____ Year _____

Please answer the four questions each night before you go to bed.

Daily Data Collection

Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Did you attend a leisure activity outside the house today?																															
Did you practice healthy eating today?																															
Did you exercise for 20 minutes today?																															
Did you attend day treatment for the full scheduled time?																															

Key: ☑ = completed task

☒ = did not complete

N/A = not required on this day

Month-End Evaluation of Goals

Goals	Month-End Tally	Percentage of Success
1. Attend two leisure activities outside per week, or 8 days/month.	/8	
2. Increase the number of days per month of healthy eating, or more days than previous month.	/30 or /31	
3. Exercise for 20 minutes 4x/week, or 16 days/month.	/16	
4. Attend day treatment program on all scheduled days, or 12 days/month.	/12	

FIGURE 7.8. Monthly activity schedule.