SCIENCE-BASED & CULTURALLY INFORMED **CASE CONCEPTUALIZATION**

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Questions for Reflection

- What do you need to know to understand and help your patients?
  - What questions would you ask?
  - What factors do you make sure you consider?
  - Why is it important to consider these factors?
- How do you know you have a good understanding of their problem?
- How do you know you are taking the best approach?

What is a Case Conceptualization?

- A model or map that captures a clinician's understanding of a patient's set of problems and the historical/distal and proximal factors that contribute to (cause or maintain) the problems *(Note: Diagnosis ≠ Case Conceptualization)*
- A set of hypotheses based on data gathered by the clinician using both idiographic and nomothetic assessment tools
- Guides clinicians in planning interventions and tailoring evidence-based treatments
- Testable and modifiable (dynamic process)
- "The heart of evidence-based practice" (Bieling & Kuyken, 2003)

Functions of Case Conceptualization

Table 1. Ten functions of case conceptualization in CBT

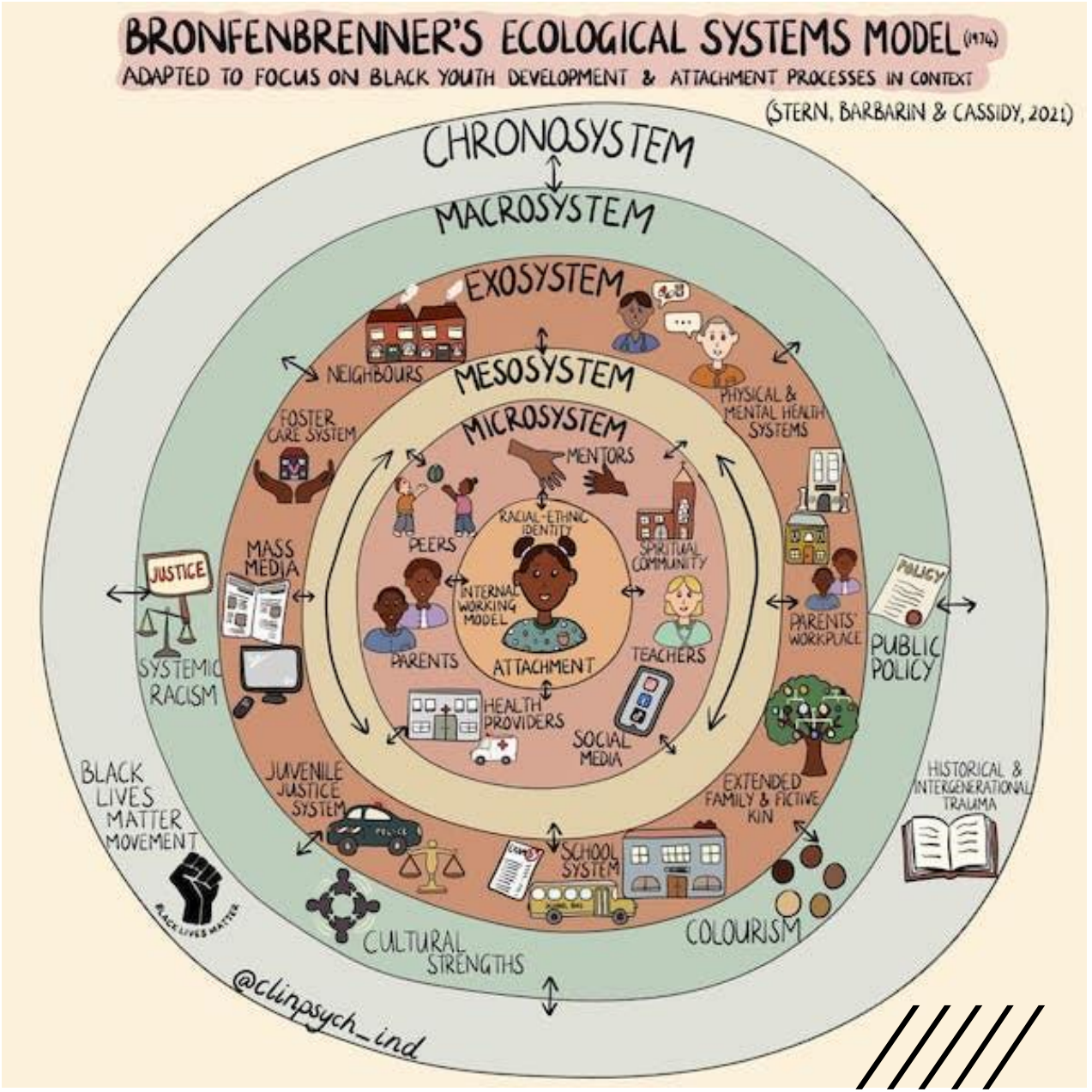
1. Synthesizes client experience, CBT theory, and research
2. Normalizes presenting issues and is validating
3. Promotes client engagement
4. Makes numerous, complex problems more manageable
5. Guides the selection, focus, and sequence of interventions
6. Identifies client strengths and suggests ways to build client resilience
7. Suggests the simplest and most cost-efficient interventions
8. Anticipates and addresses problems in therapy
9. Helps understand non-response in therapy and suggests alternative routes for change
10. Enables high quality supervision

Kuyken, Padesky & Dudley (2008*), Behavioural & Cognitive Psychotherapy, 36(6)*, 757-768.

Helps us…

- identify factors that contribute to the presenting problem, as well as supports that lead to resilience
- see the big picture and visualize interactions among factors
- discern which factors are within the sphere of our influence
- become culturally responsive

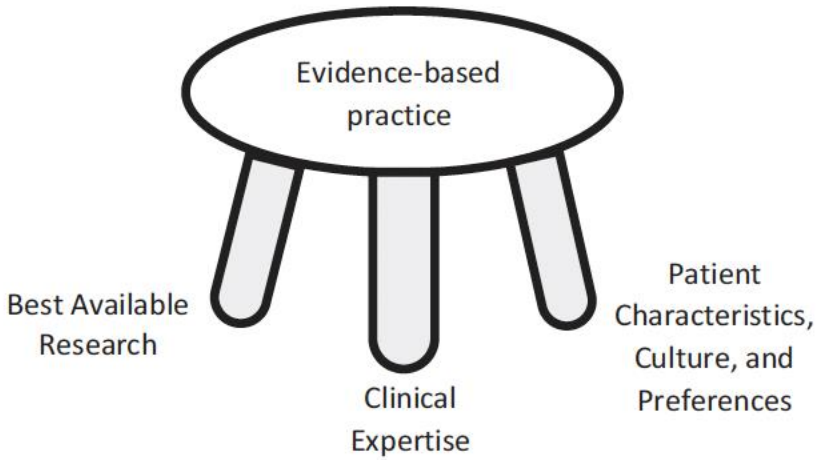
Question: What is the benefit of taking a systems perspective when conceptualizing cases?



SCIENCE-BASED

What is Evidence-Based Practice in Psychology?

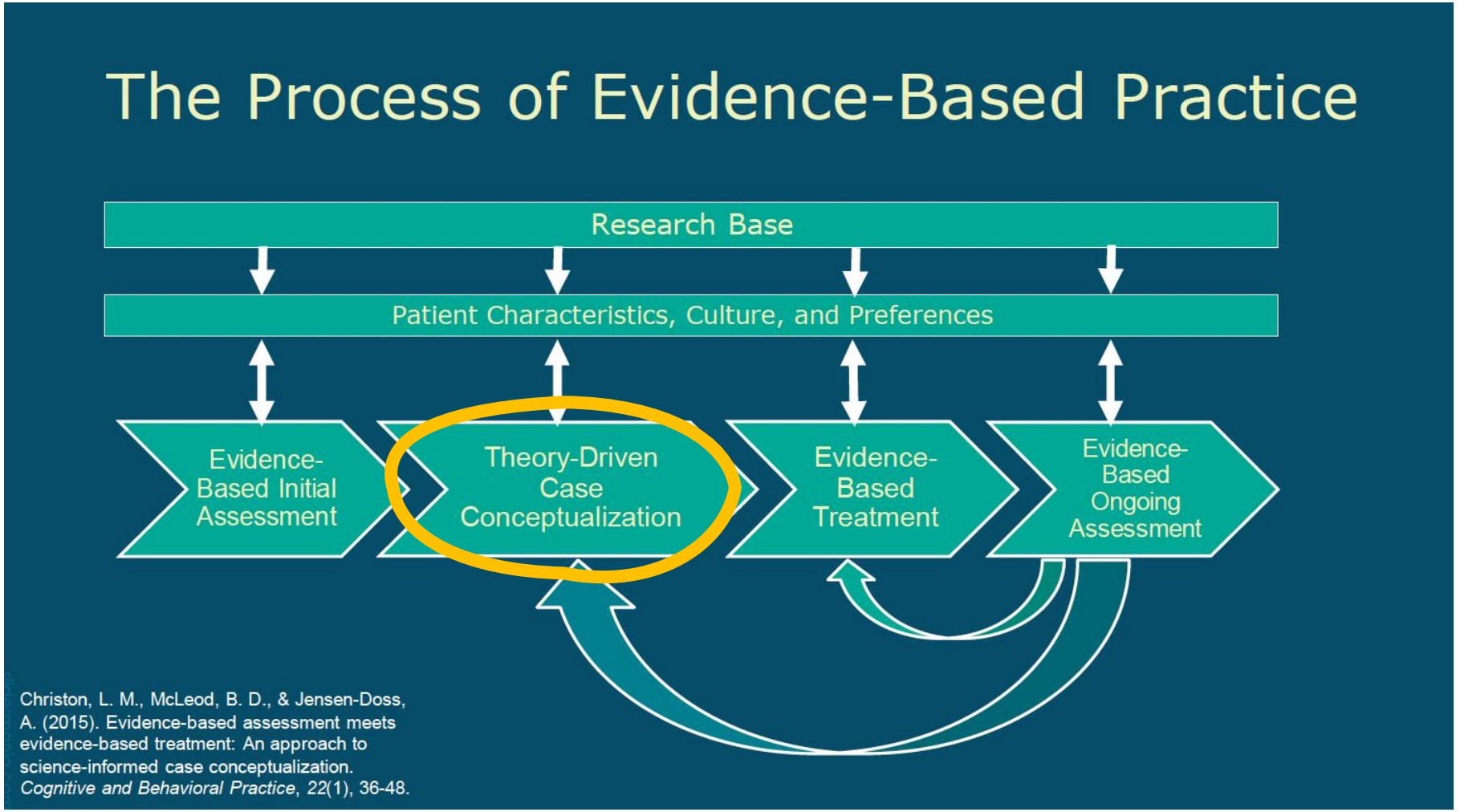
Figure 1
The Evidence-Based Practice "Three-Legged Stool"



"Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences." *APA Policy Statement on EBPP*

APA Presidential Task Force on Evidence-Based Practice, 2006; Melchert et al. 2024

Case Conceptualization as Part of EBP



From: Christon, Jensen-Doss & McLeod, Guiding the Psychotherapy Journey Workshop, 12/6/2024

Science-Informed Case Conceptualization

STAGES

- ***Stage 1***: Identify and quantify presenting problems, causal/maintaining factors, and historical/contextual factors
- ***Stage 2***: Assign diagnoses
- ***Stage 3***: Develop initial case conceptualization
- ***Stage 4***: Proceed with treatment plan and selection
- ***Stage 5***: Monitor and evaluate treatment outcomes and revise case conceptualization as necessary

Christon, McLeod & Jensen-Doss (2015), Cognitive & Behavioral Practice, 22, 36-48.

Table 1
Guidelines to Science-Informed Case Conceptualization

Stage	Potential EBA methods
Stage 1: Identify and quantify presenting problems, causal/maintaining factors, and historical factors.	• Administer broad symptom rating scales • Administer specific symptom rating scales • Administer standardized clinical interviews • Use idiographic tools to identify presenting problems (e.g., Goal Attainment Scaling, Kiresuk & Sherman, 1968; Top Problems measure, Weisz et al., 2011)
Stage 2: Assign diagnoses.	• Review results of rating scales and standardized clinical interviews • Consider following the evidence-based medicine approach to diagnosis (Youngstrom et al., 2015–in this issue)
Stage 3: Develop initial case conceptualization.	• Develop specific hypotheses about connections between variables identified in Stage 1 • Complete figural drawings of relationships between variables (e.g., Figures 2 and 3)
Stage 4: Proceed with treatment plan and selection.	• Consult treatment outcome studies and online searchable databases of treatments • Consider using Probability of Treatment Benefit charting (Lindheim et al., 2012)
Stage 5: Monitor and evaluate treatment outcomes and revise case conceptualization as necessary.	• Administer specific symptom rating scales designed for repeated measurement • Conduct mood check-ups in session • Ask client to engage in self-monitoring • Engage in behavioral observations • Use Top Problems measure for tracking outcomes • Integrate data using clinical dashboards or graphing • At termination, re-administer broad symptom rating scales and standardized clinical interviews to confirm progress and diagnostic status

Note: This aims to be a comprehensive list; not every method listed will be used within a single case.

Christon, McLeod & Jensen-Doss (2015), Cognitive & Behavioral Practice, 22, 36-48.

Data Collection Methods

- ***Idiographic***
  - Clinical interview (e.g., Cultural Formulation Interview, APA)
  - Behavioral observations, mood checks/monitoring, etc.
  - *nuanced, individualized, provides a deeper understanding of the presenting concerns and patients' understanding of the problem*
- ***Nomothetic***
  - Structured interviews (e.g., K-SADS, MINI Kid, SCID-5, etc.)
  - Normed questionnaires (e.g., CBCL, MASC-2, CDI, BDI-II, etc.)
  - *helps with diagnosing, gauging severity, symptom monitoring, comparing to group norms*

Definitions

- ***Historical Variables***
  - non-modifiable variables relevant to understanding what is happening
- ***Causal Factors***
  - modifiable factors with the client or surrounding systems (environment) that set the stage for the target problem
- ***Antecedents***
  - factors that immediately precede the target
- ***Maintaining Factors***
  - factors that serve to increase the likelihood that the target problems will continue in the future

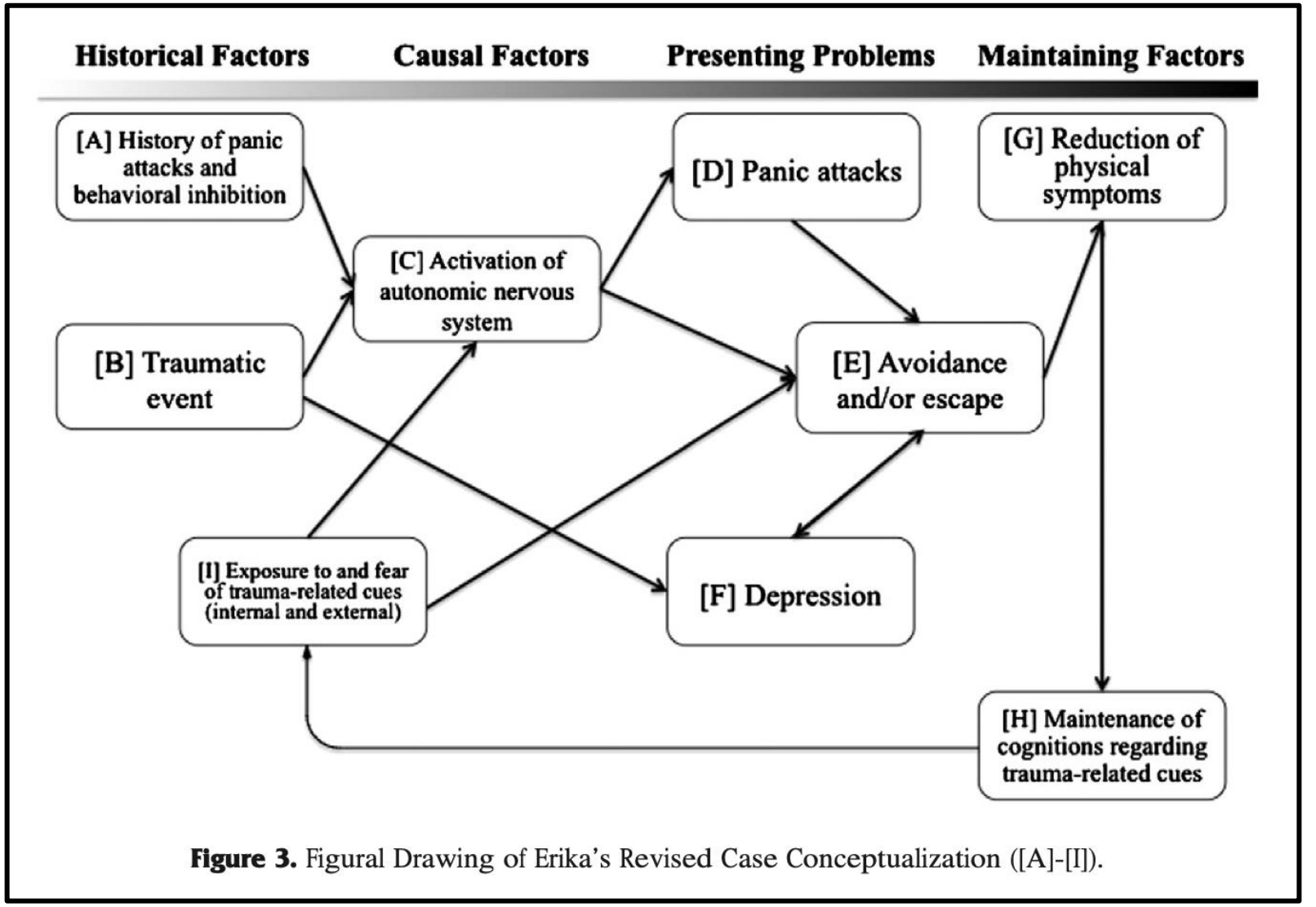


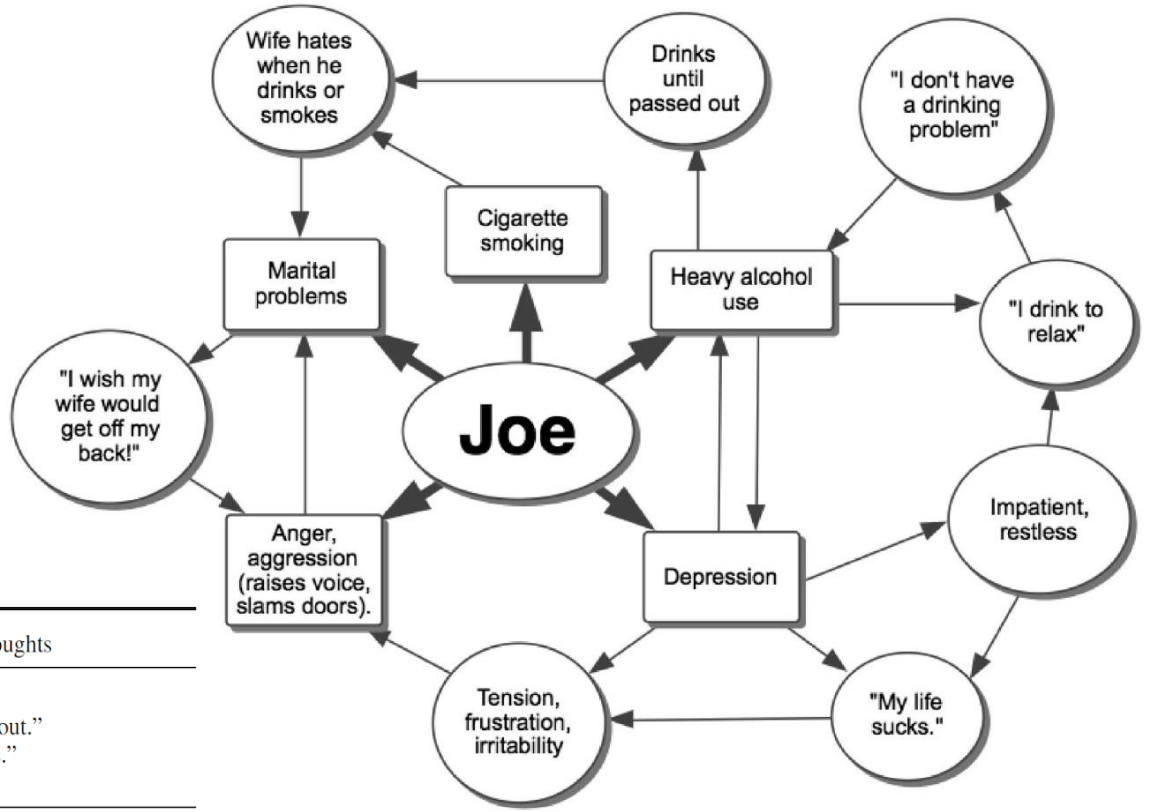
Figure 3. Figural Drawing of Erika's Revised Case Conceptualization ([A]-[I]).

Christon, McLeod & Jensen-Doss (2015), Cognitive & Behavioral Practice, 22, 36-48.

Problem Grid & Concept Map

Table 1
Joe's Problem Grid, Including Associated Behaviors, Feelings, and Thoughts

Problem	Behaviors	Feelings	Thoughts
Depression	• Withdraw from wife, other family members, and friends. • Withdraw from hobbies, social, and recreational activities.	• Impatient • Restless • Unhappy • Tense	• "My life sucks." • "Nothing works out." • "I'm tired of this."
Anger, aggression	• Become visibly angry. • Raise voice. • Slam doors.	• Annoyed • Frustrated • Angry	• "Sometimes I just need to blow off steam." • "People piss me off."
Heavy alcohol use	• Drink alcohol and pass out every night while watching television.	• Tense until drinking begins • Relief after first drink	• "I don't have a drinking problem." • "I drink to relax."
Cigarette smoking	• Continue to smoke 2 packs of cigarettes per day, despite the fact that wife has asked him to stop on many occasions.	• Urges and cravings prior to smoking • Relief while smoking and for some time afterwards	• "I wish people would just get off my back about smoking." • "I'll quit when I'm good and ready."
Marital problems	• Anger, aggression towards wife. • Raise voice at wife. • Refuse to stop drinking, smoking.	• Angry that his wife is critical of him • Furious when wife threatens to leave	• "My wife doesn't understand me." • "My marriage sucks." • "My wife is always on me about something."



Liese & Esterline (2015*), Psychotherapy, 52*, 190-194.

CULTURALLY INFORMED

Factors to Consider

- ***Sociocultural***
  - demographics, cultural values, immigration history, financial and/or acculturative stress, race-based/intergenerational trauma
- ***Developmental***
  - pregnancy or delivery complications or problems
- ***Genetic, Biological & Medical***
- ***Family and Social***
  - family relationships, home structure, parental influence, psychiatric history, friendships
- ***Learning, Academic & School***
  - cognitive abilities, learning difficulties, achievement, peer influence, teacher/staff issues
- ***Cognitive Processing***

Table 1
Cultural Formulation Interview Main Components

Cultural Definition of the Problem
Definition of the problem as described by patient and explained to social network/community
Cultural Perceptions of Cause, Context, and Support
Causes as described by patient and social network/community
Stressors and supports (e.g., immigration, discrimination, lack of resources, community violence, problems with family, religion, and spirituality)
Role of cultural identity (e.g., important aspects of background or identity, challenges and strengths associated with cultural identity)
Cultural Factors Affecting Self-Coping and Past Help Seeking
Self-coping
Past help seeking (usefulness of past help seeking, e.g., medical care, mental health treatment, support groups, work-based counseling, folk healing, religious or spiritual counseling, other forms of traditional or alternative healing)
Barriers to help seeking (e.g., language, cost, discrimination, stigma)
Cultural Factors Affecting Current Help Seeking
Patient and social network therapy preferences
Clinician-patient relationship (possible concerns, e.g., structural/interpersonal racism, language barriers, communication)

Cultural Formulation Interview (2013), APA; Sanchez, Comer & LaRoche (2022*), Cognitive & Behavioral Practice, 29*, 750-770.

Table 2
Culturally Informed Case Conceptualization

Original Science-Based Case Conceptualization	Culturally Informed Case Conceptualization

Stage 1
Identify and quantify presenting problems, causal/maintaining factors, and historical/contextual factors
• Administer broad and specific symptom rating scales, standardized clinical interviews, and idiographic tools to identify presenting problems
	Stage 1
	Identify and quantify presenting problems, causal/maintaining factors, and historical/contextual factors
	• Administer broad and specific symptom rating scales **(normed for specific patient population and background)**, standardized clinical interviews, and idiographic tools to identify presenting problems
	• Identify and quantify presenting problems
	  • **CFI 1: What is patient's/caregiver's description of their problem?**
	  • **CFI 2: How does patient/caregiver describe their problem to their family or community?**
	  • **CFI 3: What troubles the patient/caregiver most about their problem?**
	• Causal/maintaining factors
	  • **CFI 4: What does the patient/caregiver think is causing their problem?**
	• Historical/Contextual factors
	  • **CFI 8: What are the most important aspects of the patient's/caregiver's identity?**

Cultural Formulation Interview (2013), APA; Sanchez, Comer & LaRoche (2022*), Cognitive & Behavioral Practice, 29*, 750-770.

Stage 2
Assign diagnoses
• Review results of rating scales and standardized clinical interviews
• Consider following the evidence-based medicine approach to diagnosis
	Stage 2
	Assign diagnoses
	• Review results of rating scales and standardized clinical interviews
	  • **Review cultural definition of the problem (CFI 1-3)**
	• Consider following the evidence-based medicine approach to diagnosis
	  • **Review the literature for potential cultural phenomenon that may better explain presenting problem**
	  • **Review DSM 5 cultural contexts of distress**

Stage 3
Develop initial case conceptualization
• Develop specific hypotheses about connections between variables
• Complete Figural Drawings
	Stage 3
	Develop initial case conceptualization
	• Develop specific hypotheses about connections between variables
	  • **Review cultural definitions of the problem (CFI 1-3)**
	  • **CFI 4: What does the patient/caregiver think is causing their problem?**
	  • **CFI 5: What do others in their family/community think is causing the problem?**
	  • **CFI 7: Are there stressors that make the patient's problem worse?**
	  • **CFI 9: Are there aspects of the patient's/caregiver's background that make a difference to their problem?**
	  • **CFI 10: Are there aspects of patient's/caregiver's background that are causing other difficulties for them?**

Cultural Formulation Interview (2013), APA; Sanchez, Comer & LaRoche (2022*), Cognitive & Behavioral Practice, 29*, 750-770.

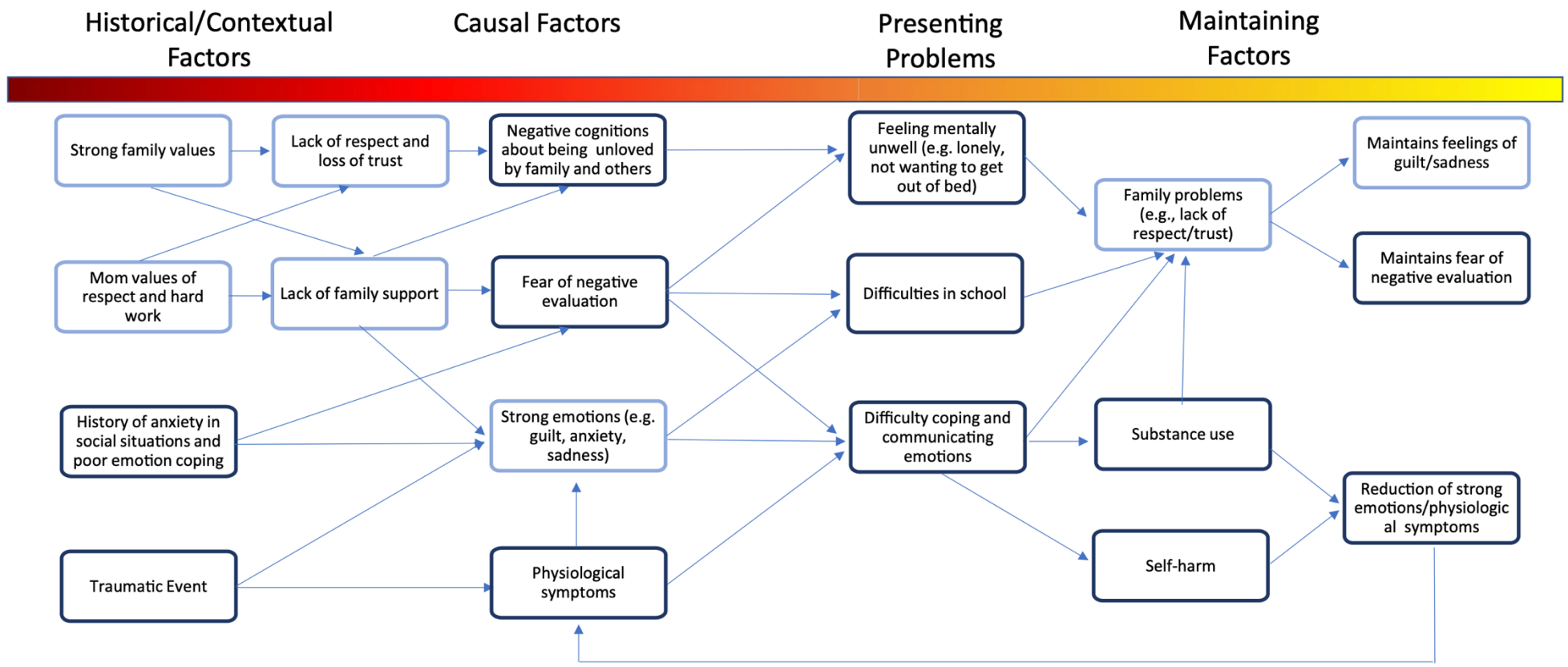


Figure 1. *Figural Drawing of Mónica's Case Conceptualization. Note.* Lighter boxes represent culturally specific factors gathered from the CFI, however all factors were assessed from the family's perspective. Based on Christon et al. (2015) science-based model figural drawing.

Sanchez, Comer & LaRoche (2022*), Cognitive & Behavioral Practice, 29*, 750-770.

Case Conceptualization → Treatment Plan

- Use figural drawing and concept map to identify where and how to intervene, and which intervention to prioritize

- Intervention should target various factors/links in the system, e.g.,
  - patient's thoughts/behaviors (CBT, DBT, exposure)
  - parental response (parent skills training, psychoeducation)
  - family/peer relationships and interactions (increase social support)
  - school/academic functioning (advocacy)
  - medical

Stage 4
Proceed with treatment plan and selection

- Consult treatment outcome studies and online searchable databases of treatments.

Stage 4
Proceed with treatment plan and selection

- Consult treatment outcome studies and online searchable databases of treatments
  - **Share treatment options with patient and collaboratively develop the treatment plan**
- **Review CFI 1-10**
- **CFI 6: Are there any kinds of supports that make the patient's problem better?**
- **CFI 11: What has the patient/caregiver done to cope with the problem?**
- **CFI 12: What types of help have been most and least useful to the patient/caregiver?**
- **CFI 13: Has anything prevented the patient/caregiver from getting the help they needed?**
- **CFI 14: What kinds of help does the patient/caregiver think would be most useful now?**
- **CFI 15: Are there other kinds of help that others have suggested would be helpful for the patient?**
- **CFI 16: Has the patient/caregiver had difficult experiences with current or previous providers?**
- **Consider potential tailoring of EBT:**
  - **Review evidence for treatment adaptations for patient population**
  - **Review CFI of develop person-centered adaptations or augmentations to treatment**

Cultural Formulation Interview (2013), APA; Sanchez, Comer & LaRoche (2022*), Cognitive & Behavioral Practice, 29*, 750-770.

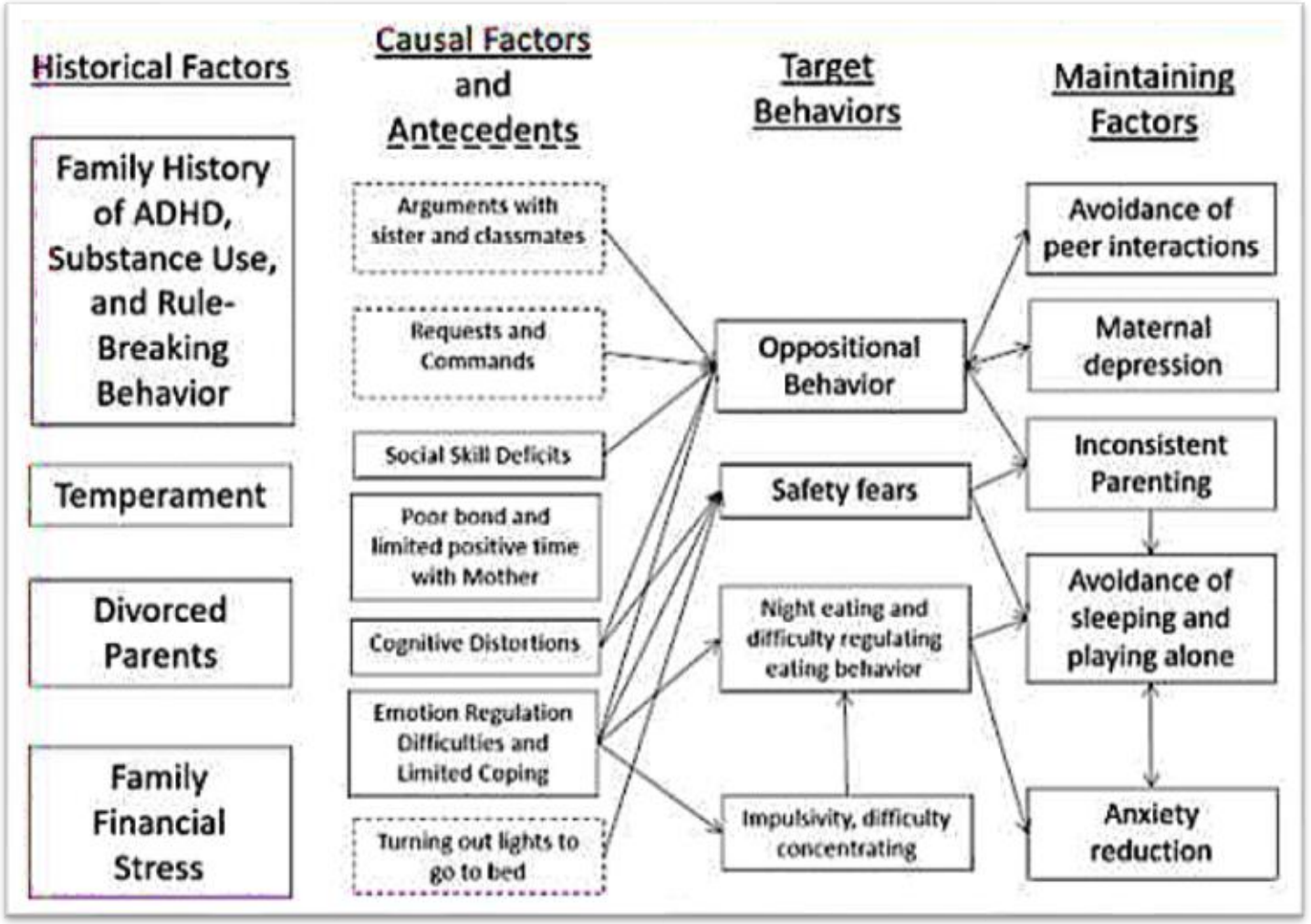
**Case example available upon request.*

Case Example*

- What are the important factors/data to highlight?
- What is/are the possible diagnosis/es?
- What are the relationships among the factors you highlighted?
- How will you draw the concept map?
- What would the concept map look like with historical, causal and maintaining factors incorporated?
- What factors are modifiable?
- What are the the target behaviors for treatment?

**Case example available upon request.*

Case Example*



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Next Steps: Collaboration

- Sharing the conceptualization
  - Who will you talk/collaborate with to develop the hypotheses?
- Treatment planning
  - Who will participate in the planning of treatment? How much input will the parent or child have?
- Treatment
  - Who will participate in treatment?
  - What will be the treatment goals and treatment targets?
  - What kind of treatment approach will you recommend? available? prioritize?
  - What option/s is/are the family considering that is aligned with their values?
  - What are the pros-cons of the available option?

Final Thoughts & Tips

- Collaboration with the patient/family leads to effective intervention
- Use of cultural knowledge and skills is vital
  - understand culturally normative behaviors, rituals, values, thoughts
  - use cultural consultants (along with your own research)
  - provide culturally responsive care from intake to termination
- Revising case conceptualization is part of evidence-based practice
- Monitor and re-assess hypotheses periodically/routinely

References & Further Reading

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