Case Conceptualizations: The Missing Link Between Theory and Practice

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A good case conceptualization should effectively link a client’s presenting problem to a treatment plan as well as provide the basis for tailoring treatment to client need and expectations. Case conceptualization can also provide a tangible marker of a trainee’s capacity to link or integrate theory and practice. Unfortunately, family therapy has been notably silent about case conceptualizations and either of these links, despite the fact that case conceptualization is probably indispensable when health issues impact couples or family dynamics. This article discusses these considerations. It then describes pattern analysis, a clinically useful strategy for case conceptualization and sequencing treatment for individuals, couples, and families and applies it to the impact of health issues on family dynamics. A case example illustrates the linking functions of a case conceptualization and the application of pattern analysis to the planning and sequencing of treatment involving adolescent diabetes in a family context.

Keywords: case conceptualization; family health; pattern analysis; treatment planning; diabetes

A core goal of most graduate training programs in counseling is to integrate theory and practice. Similarly, a common objective for many courses in such programs is that students will demonstrate the capacity to achieve such an integration. Although this programmatic goal and specific course objective sounds laudatory and is believed to be essential for effective counseling practice, it is largely ignored in many training programs. Considerations such as how does one learn such integration and how does one teach or facilitate its learning do not seem to be a priority for many faculty. Faculty may contend that theory and practice are first-order abstractions and thus are elusive and difficult to measure, and instead focus their efforts on more achievable programmatic priorities. The end result is that many have unwittingly abrogated responsibility for this goal.

On the other hand, at least one state legislature and licensing board presumes that linking theory and practice promotes quality care and protects the public and has made this goal a licensure requirement. Candidates for licensure in marital and family therapy in the state of California must pass an examination that assesses their competency in developing a detailed theory-based treatment plan. A theory-based treatment plan involves a case conceptualization that reflects a common family therapy theory or approach. Such a conceptualization explains how the case is formulated, and treatment is planned based on a particular theory. In short, the exam requires therapists to integrate theory and practice in treatment planning.

Case conceptualization has become a core skill in cognitive therapy and in some psychoanalytic approaches (Eells & Lombart, 2003). This is reflected in a growing training and research literature in individual therapy (Falvey, 2001; Ladany, Marotta, & Muse-Burke, 2001). Interestingly, there seems to be minimal interest in case conceptualization in the couples and family training and research literature. This is surprising given that case conceptualization seems to offer even more clinical value when couples and family issues are central in therapy. That is because conceptualizing, planning, and implementing effective interventions with couples and families can be exceedingly more complex given that family dynamics are intertwined with individual dynamics (Gehart & Tuttle, 2003). This is particularly notable when family health issues are involved.

This article focuses on case conceptualization: what it is, its centrality in graduate training programs, and its value in dealing with family health issues. Three dimensions of case
A treatment formulation follows from a diagnostic and clinical formulation and serves as an explicit blueprint governing treatment interventions. Informed by both the answers to the “What happened?” and the “Why did it happen?” questions, the answer to the “What can be done about it and how?” question is the treatment formulation. A well-articulated treatment formulation provides treatment goals, a treatment plan, treatment interventions, and predictions about the course of treatment and its outcomes.

The most clinically useful case conceptualizations are those that emphasize the unique context and the needs and resources that the individual, couple, or family brings to treatment. Such case conceptualizations are informed by a theoretical framework that is sufficiently broad and can integrate and incorporate biological, psychological, and social factors in all three formulation dimensions: diagnostic, clinical, and treatment (Sperry, 2001). The pattern analysis method described later in the article provides such a framework.

INDUCTIVE REASONING IN CLINICAL AND TREATMENT FORMULATIONS

On the other hand, the more data that is available (i.e., symptoms, social and developmental history), the more complex and difficult it is to develop and feel confident about a clinical formulation. The reason is that deriving a clinical formulation requires inductive reasoning. Unlike deductive reasoning, the inductive reasoning process involves synthesizing from a group seemingly unrelated bits of data about symptoms, functioning, and history a single, unifying concept or theme that connects all that disparate data into a meaningful explanation of why the client is experiencing these particular problems in this particular context at this particular time.

The following exercise illustrates the difficulty of finding a single, unifying concept that is the heart of inductive reasoning. You are given two pieces of data: a portable DVD player...
and a cell phone charger. The link or common concept you come up with might be “electronic devices.” Then add crossword puzzles. Coming up with a link now is a bit more challenging. You might say it could be “things that entertain and pass the time.” Including a car and a bottle of water to the list of three items makes the task much more difficult. Maybe you come up with the concept of “inanimate objects.” Although this link is relatively obvious to you, it may not be particularly satisfying. Then add parents and an 11-year-old child. The concept that links all five items you come up with might be “family trip.” You learn that the complete data list includes these pieces of data, “map,” and 44 other discrete pieces of data.

For many, the prospect of finding a common meaning among 50 discrete pieces of data might be daunting and even maddening. That is why having a clinical theoretical framework aids the process of developing a clinical formulation. Not only does a theoretical framework provide a way of meaningfully linking collected data together, it also provides a map for eliciting and attending to selected pieces of data while “ignoring” other data. For instance, let’s say that the theoretical framework of Therapist A (an acknowledged master therapist) would have her elicit four pieces of data: parents, child, car, and map for which the linking theme is “family trip.” Compare this to Therapist B (a beginning counseling practicum student) who, guided by no theoretical framework, collects all 50 pieces of data in no particular order. As is often the case, students and therapists with little or no training and experience in deriving clinical formulations tend to engage in premature closure. Thus, in the illustrated exercise, they might take the first three pieces of data presented and arrive at “things that entertain” as their formulation.

CASE CONCEPTUALIZATION AS A MAJOR CHALLENGE FOR TRAINING PROGRAMS

The task of synthesizing disparate pieces of data into a meaningful and clinically useful case conceptualization is one that often seems beyond the capacity of many beginning counselors and therapists. Although it is true that individuals with talent for analytic thinking and synthesis tend to approach the case conceptualization process with ease, ability, while necessary, is not sufficient.

Training in case conceptualization is essential. Case conceptualization, particularly clinical formulation, is the requisite skill for effective treatment planning (Eells & Lombart, 2003). This skill can only be acquired through didactic instruction, supervision, and continued practice. If training programs fail to provide opportunities for learning to conceptualize cases, and if faculty do not teach and model effective case conceptualization, trainees are less likely to develop effective treatment plans and interventions. The end result is that even though they might achieve some positive treatment outcomes with some clients, these outcomes will not be as great, nor will as many clients profit from their therapeutic encounters with such trainees and therapists.

Excellence in teaching case conceptualization is a major challenge for training programs. Trainees who have developed some competency in case conceptualization have developed one of the most valuable clinical competencies necessary for effective counseling practice (Falvey, 2001). In addition, they also tangibly demonstrate the capacity to integrate theory and practice, which, as was mentioned previously, is perhaps the most elusive of all the programmatic goals in graduate counseling training.

PATTERN ANALYSIS AS A THEORETICAL FRAMEWORK FOR CASE CONCEPTUALIZATION

Pattern analysis, including its intervention planning and sequencing strategies, provides a critical “missing link” between theory and practice. As noted earlier, pattern is described as the predictable and consistent style or manner of thinking, feeling, acting, coping, and defending self in stressful and nonstressful circumstances (Sperry et al., 1992). Pattern analysis is the process of examining the interrelationship among four elements or factors: precipitating factors, predisposing factors, perpetuating factors, and presentation factors, including relational response factors.

Precipitant: The triggers or stressors that activate the pattern.
Presentation: The client’s characteristic response to precipitants. The type and severity of symptoms, history, course of illness, diagnosis, and individual, relational, and systemic behaviors including collusion, coalitions, communications, and level of well-being.
Perpetuants: Processes by which a client’s pattern is reinforced and confirmed by both the client and the client environment.
Predisposition: All the intrapersonal, interpersonal, and systemic factors, including attachment style and trauma, that render a client vulnerable to maladaptive functioning.

In other words, a client’s pattern or predictable style of behavior and functioning reflects and is reflected in all four factors: precipitant, presentation, perpetuants, and predisposition.

Although it may appear that predisposing factors such as traumatic events, maladaptive beliefs or schemas, defenses, personality style, or systemic factors primarily “drive” one’s thoughts, feelings, and actions, the contention is that both individual and systemic dynamics are a function of all four factors and thus should be included in a pattern analysis. Because pattern analysis includes all of these and associated individual and systemic dynamics, it provides a comprehensive basis for developing and articulating a clinically useful clinical formulation.
CASE CONCEPTUALIZATION WITH FAMILY HEALTH ISSUES

Individual or family counseling and therapy that involves health-related issues and concerns can be particularly challenging for counselors and therapists. Too often the health issue is either ignored as if it had no place in the context of counseling or it is given precedence over other family interventions. Health issues must be processed like any other issues impacting the family, but the timing and sequencing of interventions are critical. Typically, the therapist will begin treatment by immediately focusing on the health issue. It seems counterintuitive to offer health counseling interventions last rather than first. As the following case demonstrates, it is only when the impact of individual and family dynamics bearing on the health concern are recognized and effectively and sufficiently processed that specific health recommendations or changes can be addressed.

Case Example: Treating Diabetic Ketoacidosis in the Context of Family Therapy

Jeremy is a 14-year-old Caucasian male who was referred for a family evaluation and treatment a week or so after his release from the hospital following treatment for a diabetic coma. Jeremy had been treated for juvenile-onset diabetes since he was 7. His diabetes was reasonably well controlled with diet and daily insulin injections and blood sugar checks, which he did himself. Besides this chronic medical problem, his health was good. He is the younger of two siblings, his sister being 8 years older. His mother admits that Jeremy was an unplanned pregnancy and that her moderate social drinking during her pregnancy might have had some bearing on his diabetic condition. Jeremy had done reasonably well in school, had a few friends at his school, and was quite involved with both scouting and coin collection. Jeremy’s sister is married and living out of state. His parents separated about 7 months ago, and Jeremy has been living with his mother in the family home, although he spends most weekends with his father, who is living in a nearby apartment. Jeremy’s father continued the affair that had led to the separation, and Jeremy’s mother had begun dating. Needless to say, Jeremy was confused and frightened by these changes.

Three weeks prior to the evaluation, Jeremy’s father said that he was planning on getting married in 6 weeks. Later that day, Jeremy stopped taking his insulin and went off his diet. Two days later, he was found unconscious in his room by his mother, who rushed him to the emergency room where he was diagnosed with diabetic ketoacidosis, treated, and released. Jeremy’s parents immediately rushed to his bedside and, putting their animosity aside, planned how they could support Jeremy as best they could. His father moved back into the family home and spent all his free time with Jeremy. The family was back together again, at least for a while. As things stabilized, his father moved back to his apartment and went forward with his wedding plans. The next day, Jeremy was taken by ambulance to the hospital where he was treated for a diabetic coma. The pediatric endocrinologist who consulted on the case told the parents that Jeremy had nearly died and that his body was unlikely to sustain another incident such as this. Recognizing that family dynamics were involved, the doctor made the referral.

Case Conceptualization

Diagnostic formulation. In terms of DSM-IV-TR, Jeremy might meet criteria for the diagnosis of an adjustment disorder and a V-code of parent-child problems. Of more value from an assessment and formulation perspective is the pattern analysis summarized in Table 1.

Clinical formulation. Pattern analysis reveals that when his parents begin talking of divorce and remarriage, Jeremy responds by going off his diet and stopping his insulin. The result is diabetic ketoacidosis, which can result in coma and death if not aggressively treated. An evaluation of individual dynamics reflects his self-view of being weak and physically defective in a world that is dangerous and the unexpected happens and where people try to be caring but let him down and hurt him. His strategy is then to seek comfort and safety using whatever means and at any cost to him. His self-harming behavior is his way of drawing his family back together where he can feel secure, connected, and cared for. In terms of
systemic dynamics, it appears that the family's narrative is one of independence and self-reliance wherein everyone is expected to take care of themselves and their own needs. This narrative “permits” the parents to find other partners and go on with their individual lives if the marriage does not work out. Similarly, it is acceptable that Jeremy’s sister is living on her own in another state. Unfortunately, Jeremy’s schemas are a poor fit with family narrative. Even his hobbies reflect his need for security (coin collecting) and connectedness and caring (scouting) rather than independence and self-reliance.

Treatment formulation. Based on the clinical formulation above, the following short-term and longer-term treatment goals can be specified. Table 1 summarizes these interventions and their potential sequencing. Note that the numbering represents the order in which interventions are sequenced (i.e., parental coaching is first and third, whereas schema work and re-storying are second, etc.).

Given that Jeremy’s health behavior (i.e., blood sugar drops and diabetic ketoacidosis and coma) is relationally specific (i.e., to his parents’ talk of divorce and remarriage) and have not generalized, a conservative treatment strategy would be to focus on the short-term goal of reducing or modifying this trigger. This could involve a few sessions with parents in which they are coached to reduce “triggering” future health crises. It had been elicited that the parents no longer spoke with each other but would channel information about themselves through Jeremy and so the therapist would help them understand the overall pattern and find ways of communicating directly with each other (Intervention/Sequence 1).

Next, treatment would include individual sessions with Jeremy with a focus on his defectiveness and rejection schemas and sessions including his parents in which the family schema or narrative of independence-self-reliance would be addressed. Coming from the narrative therapy tradition, re-storying involves focusing on previously unexamined or unemphasized aspects of those experiences (White & Epston, 1990). The resulting story includes pieces of meaning and understanding that are new or different and that allow for a positive shift in the original family narrative. In this case, re-storying involved a bit less emphasis on the self-reliance-independence and more on caring and connectedness with one another (Intervention/Sequence 2).

In addition, the parents would be coached about the value of regularly scheduling time together—at least once a week—with Jeremy to show their support and caring for him. Even if divorce and remarriage occurred, this planned family time together was preferable to emergency meetings in the hospital and certainly less life threatening (Intervention/Sequence 3). Efforts to achieve such family time would likely fail if this intervention preceded work on the family narrative.

Finally, health-focused counseling (Sperry, Lewis, Carlson, & Carlson, 2005) is directed at maintaining stable blood sugar levels and adherence to diet and insulin regimen. Attempts to provide this kind of counseling prior to parent coaching and focusing Jeremy’s schemas would most likely have been futile (Intervention/Sequence 4).

Case Commentary

In this example, the case conceptualization did guide treatment planning and implementation. The parents were quite responsive to parent coaching sessions and work on the family narrative, as was Jeremy. The result was that Jeremy’s health stabilized and has remained stable for 2 years. Although his father did remarry about a year ago, the family regularly continues to meet weekly. It is noteworthy that the pattern analysis provided a framework not only for planning interventions based on the clinical formulation, but also just as important, it offered a strategy and rationale for sequencing the interventions. As was previously noted, it is counterintuitive to offer health counseling interventions last rather than first, as this case illustrated.

CONCLUDING NOTE

This article has been a reflection on the most elusive of all training goals of a graduate counseling program: integrating theory and practice. It made the case that case conceptualization is a tangible marker of a trainee’s capacity to integrate theory and practice. More specifically, it focused on a theoretical framework, pattern analysis, that can provide trainees and therapists a strategy for the case conceptualization-treatment planning process. Another theme of this article has been that academic training in marriage and family counseling and therapy has been notably silent with regard to case conceptualizations despite the fact that case conceptualization is probably indispensable when health issues are involved. Hopefully, this article provides a voice for such inclusion.

REFERENCES


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