Case Conceptualization Practice

Practice Case: Mary

Mary is a 36 year old, married, Caucasian female who was came in for therapy because of extreme anxiety that she experiences in most social situations. She is easily embarrassed and can spend long portions of therapy sessions crumpled up in her chair, eyes averted, hand blocking her eyes, silent, with occasional shaking of her head. During these periods she is unresponsive to most verbal input. Afterwards, when she is able to speak about what happened, she says that she was "extremely embarrassed." She does not elaborate further and if pressed will typically "become embarrassed again" and crumple back up in her chair. Mary reports being very sensitive to perceived criticism from others and often feels that others are being critical of her. She avoids most social situations and if she does engage with them, does so only with extreme distress. She particularly avoids speaking and being touched. When she does speak, it is often in a whisper that can be hard to hear. She reports being very unassertive such that she is unable to ask for a change in a menu item at a restaurant or return an item at a store.

She states that her initial goal for therapy is "to get rid of this embarrassment so that I can be normal." She says that "it's stupid that I still feel like this" and "I should have gotten over this a long time ago." She feels that her embarrassment and anxiety has caused her to be a bad mother to her two daughters and she feels extremely guilty about this. At one point she worked outside the home as an administrative assistant. This ended when there was a misunderstanding at work and she was blamed for something she didn't do. She didn't come back to work the next day and has not worked since. She has a few friends, but even with them, she maintains a distance and frequently feels that they are not being considerate of her or are pushing her to do things she doesn't want to do. When asking about her relationship with her husband she says, "It's great. There's no problems there at all." She used to be a long-distance runner, but quit this when she had an illness a few years ago that resulted in symptoms that were similar to those she would feel when she had run a long distance.

Several sessions into therapy, Mary also discloses that she is a painter and used to work as a portrait artist. She would like to take more painting classes, but is afraid of embarrassing herself and being criticized. She also doesn't allow anyone to see her work any more and rarely even paints any more. She describes how she has signed up for a few classes over the last few years, but always cancelled at the last minute as her worry and anxiety built in anticipation of the event. She now feels very discouraged and hopeless about things ever changing.

Mary is very conscientious, always arriving to sessions on time and always having done her between session practice, if she agrees to it in session. However, she also hesitates to commit to any out of session or in session exercises that could arouse any anxiety or embarrassment. She is extremely hesitant to do any exercises that involve another person or the possibility that someone may see her doing any exercise.

1) Begin with reformulating the presenting problem from an ACT perspective:

What is the client's formulation? How does the client see their problem at the present time? What do they think they need to do to make things better? What are their goals for therapy and their life? Explore the client's conceptualization of the "problem" that brings them into therapy. Your job here is to draw out the verbal system that may have them stuck in the problem they are presenting.
Presenting problem(s) in client's own words:

Reformulate the presenting problem in an ACT consistent way (if necessary). ACT formulations usually focus on helping clients *live* better and get better at *feeling*, while reducing the emphasis on feeling *good*. At a deeper level this reformulation needs to be consistent with the client's most cherished life goals and values and be detailed enough to create a treatment contract around the initial goals and methods of treatment. For example, clients often identify negative feelings, thoughts, memories, or sensations (e.g., depression) as "the problem." This will often be fundamentally reformulated in therapy. For example, a client may come into therapy complaining that "I just don't care about anything anymore. I can't stand feeling so lifeless. It's hopeless." Eventually this might be reformulated into something more like "undermines close relationships and work commitments in order to avoid feelings of rejection and failure." Another client's presenting complaint might be "I want help feeling better about myself. I need to have higher self-esteem." An ACT case conceptualization may end up looking more like "fusing with negative evaluations of self and in the process missing out on opportunities that life offers" (i.e., the problem is the struggle itself).

ACT reformulation of presenting problem:

2) What are the most central thoughts, feelings, memories, sensations, and situations that the client is avoiding or fused with?
Thoughts:

Emotions:

Memories/Images:

Other:

3) What behaviors does the client engage in to avoid or escape the events described in the previous step.

Experiential avoidance can take many forms, such as overt behavior, internal verbal behavior, or combinations of the two. Examples:

a. *Internal avoidance behaviors* (e.g., distraction, excessive worry, dissociation, telling oneself to think differently, daydreaming)

b. *Overt emotional control behaviors* (e.g., drinking, drugs, self-injury, thrill-seeking, gambling, overeating, avoiding physical situations or physical reminders)

c. *In-session avoidance behaviors* (e.g., topic changes, argumentativeness, aggressiveness, dropping out of therapy, coming late to sessions, always having an acute crisis that demands attention, laughing, focusing on the positive)

How pervasiveness is experiential avoidance as a controlling factor in the client's life?

Limited 1 2 3 4 5 Very extensive

4) What valued domains of living is the client engaged in an excessively narrowed or constricted manner or completely absent from?

ACT is fundamentally about helping clients create full, meaningful, vital lives. Thus, we want to investigate functioning across a broad range of domains of the client's life. Consider the 2-3 domains where the client's behavior is most narrowed and inflexible and where this constriction appears to result in ongoing suffering. These domains are where the therapist is most likely to have leverage for client behavior change. Describe how behavior is limited or constricted in each domain if applicable.

5) Consider other domains of psychological inflexibility and flexibility:
Behavior patterns that occur at a particularly high-rate, are invariant, and/or are consistent across situations often involve psychological inflexibility. Consider the following:

Defusion process. Cognitive fusion refers to the tendency of human beings to get caught up in the content of what they are thinking, resulting in rigidity and inflexibility. Example patterns include: *A strong belief that unworkable control strategies will eventually work or continuing to engage in unworkable strategies even while aware that they are not working. Highly logical or rigid thinking patterns*.

Self process. The conceptualized self consists of our autobiographical stories and our evaluations of ourselves that we use to justify and explain out behavior. Examples include: *Being strongly identified with a particular way of viewing themselves or self concept. A strong belief that one cannot change or that a better life is not possible for them combined with a strong attachment to a life story that supports this idea.*

Present moment process. Fusion, avoidance, and attachment to self as content tend to pull people out of the moment and away from their direct experience. This can result in a lack of ability to notice and to describe what is present or what they are thinking, feeling, remembering, and sensing in the moment. Examples include: *The client poorly tracks their ongoing, moment-to-moment experience. Being excessively caught up in the conceptualized past or future.*

Values process. Experiential avoidance, reason giving, & fusion can increasingly come to dominant a person's behavior such that short term goals such as feeling good, being right, and defending a conceptualized self dominate over behavior oriented toward long-term desired qualities of life (i.e., values). Examples include: *The client is unable to describe wants, goals, or values that are not heavily socially determined or influenced by the presence of the therapist or other major figures. The client's behavior is so dominated by escape and avoidance that he or she is unable to articulate goals and values that are heart-felt or meaningful.*

Committed action process. Because of experiential avoidance and its amplification through these other processes, clients develop larger and larger patterns of action that are detached from their longer term goals and life desires. Behavior is oriented toward getting through, getting by, or surviving the moment (i.e., avoidant persistence), rather than building a life that will be more rewarding, satisfying, meaningful or workable in the long run. Examples include: *Living a life relatively free of acute experience of pain, but also relatively narrow and unsatisfying. Engaging in impulsive or self-defeating behavior.*

6) Factors influencing motivation for change.

7) The client's social and physical environment and its influence on the client's ability to change.

8) Client Strengths (and how you might use them in treatment).

9) Finally, describe a comprehensive treatment plan that considers the particular processes, interventions, and measures you might want to use with this particular client.

10) Review and update plan in an ongoing fashion during treatment

Outline of ACT Case Conceptualization Process (Adapted from *Learning ACT*)

1. Begin your assessment with the presenting problem, as understood by the client

How does the client see his or her problem at the present time? What does the client think he or she needs to do to make things better? What are the client's goals for therapy and for life? Explore the client's conceptualization of the "problem" that brings him or her into therapy.

One assumption that guides early work in ACT is how what the client has been doing to solve the problem is typically part of the problem. The final part of this step is to reformulate the client's version of the presenting problem in an ACT-consistent way, if necessary. ACT formulations usually focus on helping clients live better and *feel* better (i.e., get better at *feeling*), while reducing the emphasis on feeling *good*. At a deeper level, this reformulation needs to be consistent with the client's most cherished life goals and values (the outcome goals) and be detailed enough to create a treatment contract focused on the initial goals and methods of treatment. Clients typically identify negative feelings, thoughts, memories, or sensations (e.g., depression) as "the problem." Often, this problem is fundamentally reformulated during therapy. For example, a client may come into therapy complaining, "I just don't care about anything anymore. I can't stand feeling so lifeless. It's hopeless." Eventually, this statement might be reformulated as "undermines close relationships and work commitments in order to avoid feelings of rejection and failure." Another client may come with the presenting complaint "I want help feeling better about myself. I need to have higher self-esteem." An ACT case conceptualization in this case might be "fusing with negative evaluations of self, and in the process missing out on opportunities that life offers" (i.e., the problem is the struggle itself).

2. Discover the Most Central Thoughts, Feelings, Memories, Sensations, and Situations the Client Is Avoiding or Is Fused With

The most central and difficult private experiences are often identified by clients as part of the presenting problem. In some cases, the therapist has to dig to discover them. This can often be accomplished by getting descriptions of the presenting complaint in fairly concrete terms. For example, the therapist might ask, "What do you mean when you say you are anxious?" or "Can you give me some examples?" General, open-ended questions can invite additional information; for instance, "If I were on the inside of your head, what would I be hearing in that situation?" It can help to ask about specific dimensions, such as, "Do these issues show up in your bodily sensations at all?"

Fusion with thoughts will often be seen in evaluations of themselves, their experiences, or their situation. This form of fusion can be a bit tricky to detect in that the fused evaluation is generally not presented as a thought, but rather as an implicit characteristic of the event being described (e.g., "I have really bad anxiety"). If the client externalizes or chronically avoids, the psychologically active features of the situation may be vague. For example, a client who has avoided calling a friend to ask that person to do something because the friend saying no would mean the client was a "loser," might initially present the issue as if the problem were the avoidance of calling. Thus, if a client avoids particular physical situations, the therapist should attempt to discover the particular feelings, thoughts, or other experiences that show up during the event and that might be difficult for the client. Usually, this is what the client is avoiding, not the situation itself. The purpose of recording the content of the avoided thoughts and feelings is not to change or modify them, but rather to make them available for use later in treatment as the target of experiential exercises focusing on acceptance and defusion.

3. Consider Behaviors That Function as Experiential Avoidance of the Events Described in the Previous Step

Usually, both the therapist and client need to develop a better ability to track the particular patterns of behaviors the client uses to avoid difficult internal experiences, such as thoughts, feelings, memories, and sensations. Experiential avoidance can take many forms, including overt behavior, internal verbal behavior, or combinations of the two. Sometimes the therapist can see these patterns directly, and at other times has to rely on the client's report.

4. Consider Domains in Which Behavior Is Excessively Narrowed or Constricted, or in Which Living Is Avoided Altogether

Investigate a broad range of domains in the client's life (e.g., family, health, relationships, spirituality, and work) to get an overview of the client's functioning in these important domains. At one extreme, clients may completely drop out of some or all valued life domains. Alternatively, engagement may be excessively narrowed, inflexibile, or inconsistent. Engagement with a domain in a defended manner may result in limited expression, effectiveness, or vitality. On the case conceptualization form, begin by writing about the two or three domains in which the client's behavior is most narrow and inflexible and in which this constriction appears to result in ongoing suffering. The therapist is most likely to have leverage for client behavior change in these domains. Consider such domains as family, couple, parenting, friend and social relationships; work; education; recreation; spirituality; community, and physical self care. Describe how behavior is limited or constricted in each domain, if applicable.

5. Consider Other Processes that Contribute to Psychological Inflexibility and Their Treatment Implications
See handout on six processes for what to consider in these domains.

- **Defusion process**
- **Self process**
- **Present moment process**
- **Values process**
- **Committed action process**

6. Consider Factors That Can Limit Motivation for Change

Consider your clients' motivation to change. For example, a client may be out of contact with the cost of experiential avoidance, especially if values are unclear, but experiential contact with the cost of avoidance is essential before doing acceptance or exposure work that requires significant motivation. Research has shown that the therapeutic relationship is a powerful motivator to change. In assessing the quality of the therapist-client relationship, you should look for signs that the client is present, caring, and engaged. Signs that the client feels coerced or misunderstood are also important. Another kind of motivational problem occurs when clients are strongly attached to fears about the consequences of confronting feared events. This can suggest the need for a greater focus on defusion and self as context prior to any work that involves significant contact with feared events.

7. Consider the Client's Social and Physical Environment and Its Influence on the Client's Ability to Change

Clients do not live in a vacuum, and you need to know whether some of the same ACT-relevant processes that apply to the individual level can be played out at the social level or even physical level. Reinforcement for engaging in behaviors that promote the status quo can occur at financial, social, familial, or institutional levels. For example, a client can be motivated to stay stuck in order to keep disability payments, a spouse can be unsupportive because the client's change is difficult or challenging to him or her, or an addicted client can be without any sober friends. A spouse can be so terrified of real intimacy that the client is encouraged to pretend everything is fine, even if it means not knowing his or her own feelings.

8. Examine Client Strengths That Could Be Harnessed to Build Psychological Flexibility

The therapist can examine how a client might have engaged with life difficulties in the past in ACT consistent ways. Sometimes past behavior can serve as a template for currently needed change, and effective behavior in one domain can serve as a template for effective behavior in a domain in which the behavior is not as effective.

9. Describe a Comprehensive Treatment Plan

a) Consider finding and adapting a specific, relevant treatment manual that has evidence for its effectiveness with this type of client presentation (see http://www.contextualpsychology.org/treatment_protocols or various ACT books).
b) Consider what ACT process and outcome measures might be relevant (see http://www.contextualpsychology.org/act-specific_measures).
c) Consider social (e.g., family therapy, couples therapy, spiritual guides/ministers, mentors/advisors, support groups), financial, and vocational resources (e.g., training or educational resources) available for use during treatment.
d) Consider use of other compatible techniques and theories that may be relevant but not be obviously theorized about in ACT (e.g., contingency management, cue exposure, education).
e) Consider potential life skills deficits. If so, consider direct, first-order change or education efforts such as social skills, time management skills, study skills, assertiveness skills, parenting skills, or problem solving skills training.
f) Consider client strengths and how these might be harnessed to potentially move through the process more quickly.
g) Review your conceptualization and the treatment implications in sections 1-8 and given the information, consider how much to focus on:
1. Confronting the system/creative hopelessness (client continues to persevere in the unworkable change agenda)
2. Developing knowledge & direct experience with emotional control as the problem & practicing willingness (client does not experientially understand the paradoxical effects of control; life goals blocked by experiential avoidance)
3. Developing and practicing defusion (client is fused with content of own thought, caught up in evaluation, or trapped by reason-giving; client needs experience with private events as non destructive)
4. Generate experiences of self as context (client is unable to separate self from thoughts, feelings, memories, sensations, stories, and self as conceptualized; client needs safe place from which to engage in exposure)
5. Make contact with the present moment/mindfulness (client lives in conceptualized future; client is not learning from contingencies present in their environment)
6. Values exploration (client is unable to articulate a set of stated values or has little guide for behavior outside of fusion and avoidance; client has little motivation to engage in exposure)
7. Committed action (client needs help developing consistent patterns of behaving in line with chosen values)
8. Reevaluate the Conceptualization Throughout Treatment; Revise Functional Analysis, Targets, and Interventions

Acceptance Process Abbreviated Anchors

Circle only one number for the entire acceptance process dimension:	1 2 3 4 5	
Attempts to change experience common	1 ⟷ 5	Attempts to change experience rare
Minimizes or rationalizes difficult events in session	1 ⟷ 5	Describes and experiences difficult events in session
Implicit requests for social exchange	1 ⟷ 5	No implicit requests for social exchange
Many avoided events	1 ⟷ 5	Few avoided events
Fights, tolerates, or resigns to difficult experience	1 ⟷ 5	Chooses difficult experiences in service of valued living
Does not notice when avoiding	1 ⟷ 5	Notices when avoiding
No change or more avoidant with direction	1 ⟷ 5	More open with direction

Client

Therapist

- When do I over prepare? Under prepare?
- How do I try to look like I'm in charge? Or when I agree with everything?
- When do I try to look like an expert (e.g., explain theory, techniques)?
- When I do make clever or insightful comments for the client?
- When do I find myself working harder than the client in session?
- When do I offer comfort to the client? Consolation?
- What do I avoid in session?

Defusion Process Abbreviated Anchors

Circle only one number for the entire defusion process dimension:	1 2 3 4 5	
Single aspect of experience dominates without choice	1 ⟷ 5	No single aspect of experience dominates, except by choice
Frequently judges, justifies, or explains	1 ⟷ 5	Rarely judges, justifies, or explains
Frequently uses must/can't, should/shouldn't, right/wrong, among others	1 ⟷ 5	Rarely uses must/can't, should/ shouldn't, right/wrong, among others
Expectations and rules limit perspective	1 ⟷ 5	Expectations and rules held lightly
Stories repeated rigidly	1 ⟷ 5	Stories seldom repeated rigidly
Little or no sense of workability of thoughts	1 ⟷ 5	Chooses assumptions strategically, with a focus on workability

Client

Therapist

- When do I compare myself to other therapists?
- "But" statements: "That sounds fine, but…"
- When do I find myself trying to convince your client of something?
- When do I feel the client's situation is hopeless?

Present-Moment Process Abbreviated Anchors

Circle only one number for the entire present-moment process dimension:	1 2 3 4 5	
Speech stereotyped and insensitive to instruction for pace and content	1 ⟷ 5	Speech fluid and sensitive to instruction for pace and content
Physical presentation takes away from connection	1 ⟷ 5	Physical presentation adds to connection
Worry and rumination common	1 ⟷ 5	Worry and rumination rare
Perseverates and shifts abruptly	1 ⟷ 5	Shifts attention easily and gently
Categorical speech common, details difficult to elicit	1 ⟷ 5	Categorical speech uncommon, details readily elicited
Doesn't notice when not present	1 ⟷ 5	Notices when not present
No change or less present with direction	1 ⟷ 5	More present with direction

Client

Therapist

- When do I find myself not paying attention to the client?
- When do I passively listen to the client? Wait for session to end?
- When do I feel bored?

Self Process Abbreviated Anchors

Circle only one number for the entire self process dimension:	1 2 3 4 5	
Experience of self constrained and in only limited domains	1 ⟷ 5	Experience of self flexible and broad
Frequently gets stuck in content areas	1 ⟷ 5	Transitions easily among content areas
No experience of self apart from content	1 ⟷ 5	Experiences self apart from content
Rarely able to shift perspectives	1 ⟷ 5	Readily able to shift perspectives

Client

Therapist

- What stories to you tell yourself about who you are as a therapist?

Values Process Abbreviated Anchors

Circle only one number for the entire values process dimension:	1 2 3 4 5	
Valued directions rarely chosen, and limited by perceived possibility and pain	1 ⟷ 5	Valued direction chosen freely, regardless of perceived possibility or pain
Valued directions chosen with defensiveness	1 ⟷ 5	Valued directions chosen without defensiveness
Valued directions held at the expense of other domains	1 ⟷ 5	Valued directions held in a way that doesn't interfere with other domains
Few behaviors described as values consistent	1 ⟷ 5	A variety of behaviors described as values consistent
Behavior restricted by expectations	1 ⟷ 5	Behavior consistent, even when outcome unknown or expected to be painful
Resists discussing values and valued living by judging, justifying, explaining, or apologizing	1 ⟷ 5	Discusses values and valued living openly
Experiences values as aversive and restrictive of experience	1 ⟷ 5	Experiences values as appetitive and facilitative of experience

Client

Therapist

- When do I behave in therapy in ways that are inconsistent with the therapist I want to be?

Committed Action Process Abbreviated Anchors

Circle only one number for the entire committed action process dimension:	1 2 3 4 5	
Behavior in valued domains characterized by avoidant inaction, impulsivity, or persistence	1 ⟷ 5	Flexible and creative in valued living
Difficulty generating goals, and goals limited and inflexible	1 ⟷ 5	Chooses values-consistent goals easily and freely
Rarely notices inconsistency of behavior with values	1 ⟷ 5	Notices inconsistency of behavior with values
No change or further from valued direction with instruction	1 ⟷ 5	Returns to valued direction with instruction
Much rumination and worry about commitments	1 ⟷ 5	Little or no rumination about commitments

Client

Therapist

- When do I think about doing something with a client, such as interrupting, but find myself unable to follow through?

Out-of-Session Contingency (example):

Antecedent Conditions	Behavior	Consequences
Anxiety Outside of house Shopping Socializing	Isolate self Return home	Anxiety reduction Inconvenience with chores Loss of social opportunities

Out-of-Session Contingency (your client):

Antecedent Conditions	Behavior	Consequences

Out-of-Session Contingency (your client):

Antecedent Conditions	Behavior	Consequences

In-Session Contingency (example):

Antecedent Conditions	Behavior	Consequences
Values questions from therapist	No clear answer Questions source of anxiety	Mindfulness activities Approval of client

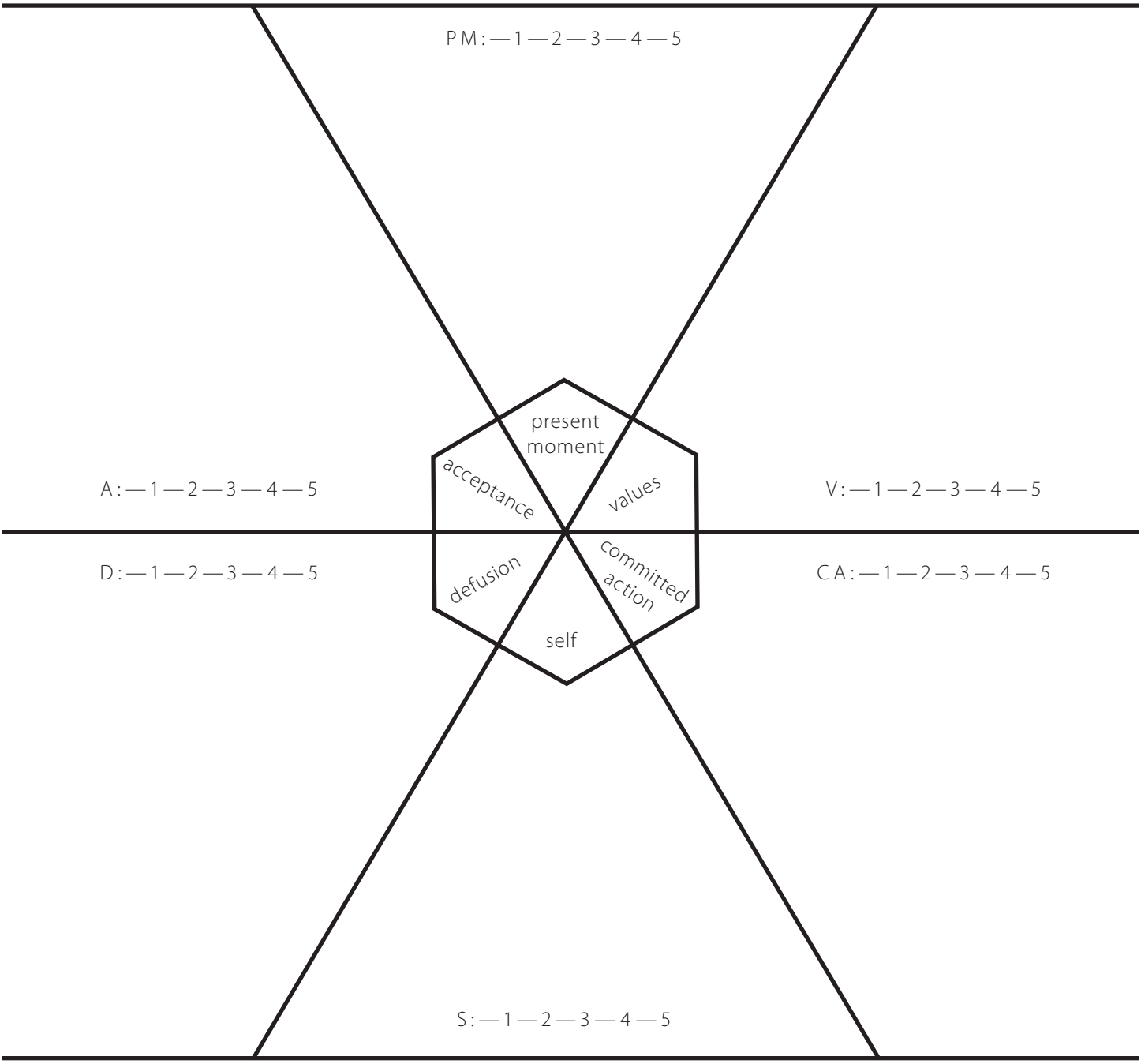
In-Session Contingency (your client):

Antecedent Conditions	Behavior	Consequences

In-Session Contingency (your client):

Antecedent Conditions	Behavior	Consequences

Hexaflex Diagnostic and Assessment



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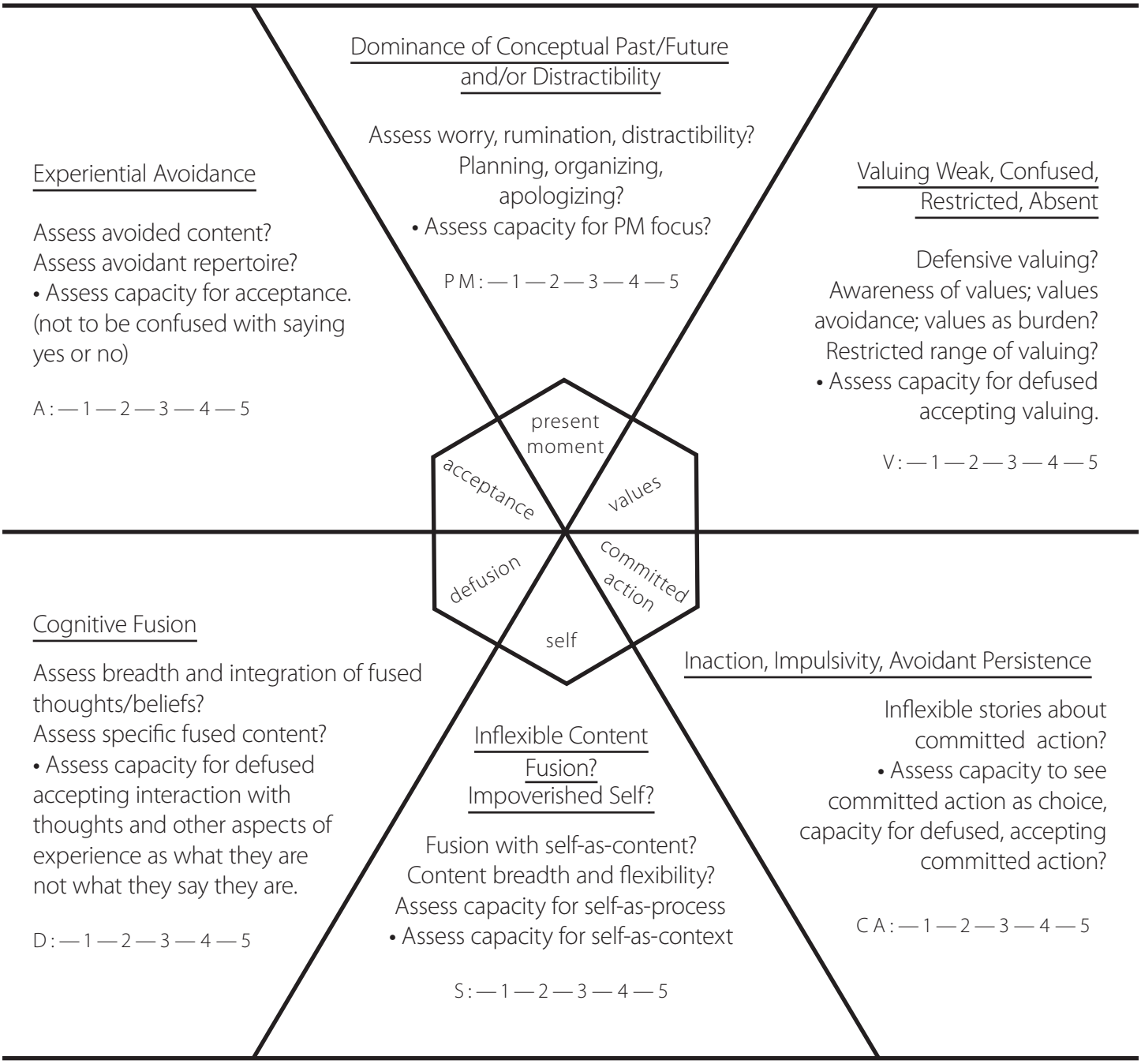
HFDEI Diagnostic and Assessment



Hexaflex Diagnostic and Assessment Worksheets

The hexaflex diagnostic is a functional dimensional approach to case conceptualization, assessment. and "diagnosis." It is intended to link assessment of functioning on clinically relevant dimensions to interventions. The approach is explicitly tied to a ACT and behavior theory more generally. The diagram above provides some domain specific orientation to common clinical difficulties within the dimension. The rating scale for each domain is intended as a general estimate of functioning within the domain with 1 as low functioning and 5 as high functioning. The worksheets should not be approached as a mere gathering of information. Deliberate, present moment focused questioning will give the best estimate of both capacities and for areas for therapeutic focus.

Hexaflex diagnostic note pages can be used to conceptualize therapist and client functioning in a given session. High scores connote optimal functioning. Low scores connote poor functioning. Note sheets can also be used as case notes to describe focus of intervention in a session and functioning with each noteworthy domain