

# Ten Things I Wish I Had Known About . . .

## Case Conceptualization

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Conceptualizing the primary contributing factors to a client's case is a sometimes overlooked piece of an MFT Intern's training. Case conceptualization is important for developing a good treatment plan and enables you to speak intelligently about your client in supervision, collaboration, and consultation; plus, it helps immensely in job interviews and passing the exam. So, what goes into a good case conceptualization?

- 1. MENTAL STATUS EXAM** A mental status exam (MSE) consists of a short list of quick observations that contribute to your case conceptualization. There is no need for a formal checklist; it is something you should always have in the back of your mind. Is my client's affect congruent with the situation? Is she dressed as I would expect? Does she seem oriented to person, place and time? Other factors to note in the MSE are: age, gender, culture, marital status, appearance, mood/affect, speech, non-verbal cues, presence of hallucinations or delusions, suicidality, homicidality, drugs, and ETOH (alcohol). It is a quick snapshot into the presenting status of the client. If communicating with another professional, you could mention how you obtained the information, e.g., unstructured clinical interview, structured clinical forms, or combination thereof.
- 2. PRESENTING PROBLEM** It is important to note that the presenting problem is the reason the client has come to therapy; it is not what you, the clinician, thinks the problem is. The BBS wants to know that you will not assign your agenda to a client and may design questions to ensure you understand that.
- 3. HISTORY** There are many categories of history that are important to weave into the picture of the client's life to this point. This section of the case conceptualization should include treatment history, medical history, drug & alcohol history, and (with a lengthier focus) relational history.
- 4. DIAGNOSIS** You may not have seen the client long enough to make a formal diagnosis, in which case your diagnosis would be provisional. Familiarize yourself with the Axis system found in the beginning of the DSM IV, although note that by spring of 2013, it will change with the DSM 5.
- 5. JUSTIFICATION OF DIAGNOSIS** Even if your Dx is provisional, you will need to explain why you think it is this Dx and not something else. Here you will begin to weave your analysis into the client's situation using elements from his history,

- MSE, and stated goals that you think are influencing the case. Your justification may even be different from the presenting problem.
6. **THEORETICAL ORIENTATION** If you have not decided on your orientation or choose to practice “eclectically”, it is a good idea to determine which theory might help this client best and why. Is your theoretical choice based on the symptoms you see, your personal choice, patient’s goals, or imposed by your agency?
  7. **TREATMENT PLAN & COURSE OF TREATMENT** This is the dynamic road map to your client’s recovery. There is no hard and fast rule for what it looks like, but in general, a good clinician would establish 1-5 short and long-term goals, with several interventions tied to each goal. The goals and interventions should be congruent with the theory you have chosen and specific to your client’s situation. Forming a therapeutic alliance is almost always a first goal. Crisis situations should be addressed first and foremost. If you have been seeing this client for some time, you can analyze and report the progress your client is making toward the goals you have established. You will cover client reactions to interventions, the evolving nature of your relationship, changes in diagnosis and why certain interventions may not have worked.
  8. **HUMAN DIVERSITY CONSIDERATIONS** Diversity issues are often thought to strictly mean someone’s ethnic culture, but there are numerous things that contribute to a client’s diversity. Anything that makes the client different from those around him can impact the client’s experience in the world. Such issues can be ethnicity, marital status, age, religion, socioeconomic status, death, and specific group affiliations, among others.
  9. **LEGAL & ETHICAL ISSUES** Keep in mind your legal and ethical obligations as you conceptualize your case. Do you have any possible mandates? Have you gotten signed releases? Minor consent? Are there dual relationship conflicts? DV Safety Plans? Have you made referrals?
  10. **PROGNOSIS** Finally, you will report on what factors would indicate improvement and what could impede improvement from happening. Based on your clinical judgment and experience of this person, how likely is he to improve or decompensate?

The above is a useful format for a formal case presentation in group supervision or case consultation. In a job interview where you are given a scenario without much information about the client, your interviewers want to see that each of the above elements are things about which you would be curious and want to know more as you form your case conceptualization. Now, go forth and conceptualize away!