Title: Collaborative Case Conceptualization: Client Knows Best

Author: Christine A. Padesky

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Abstract: There appears to be a link between high quality case conceptualization and therapy outcomes. Unfortunately, case conceptualization is a complex skill that appears to lag behind other CBT skills development. Two simple forms of case conceptualization are illustrated that could prove easy for therapists to learn. As an added benefit, they collaboratively engage clients in their construction which can lead to greater client understanding, empowerment, and treatment adherence. Each offers a better understanding of presenting difficulties using client language and provides a platform to collaboratively devise treatment plans. The 5-part model can be used with any combination of client issues to broadly describe current difficulties in terms of links among thoughts, behaviors, physical reactions, moods, and environmental/situational factors. A second model called "Box/Arrow In/Arrow Out" helps clients identify triggers and maintenance factors for specific issues of concern. Each model is illustrated with a case example and discussion of how client strengths can be linked with that model of case conceptualization and the treatment plans that follow. To make it easier for therapists to learn and apply these conceptualization approaches, this article details the steps involved in each and highlights standard therapist questions and statements that can be used to prompt client engagement in co-construction of these models.

Keywords: case conceptualization; 5-part model; Box/Arrow In/Arrow Out; strengths; cognitive behavioral therapy; trans-diagnostic

There is a need to develop methods that can help therapists construct useful case conceptualizations with greater ease. Case conceptualization is considered a core CBT therapist skill (Muse, McManus, Rakovshik, & Thwaites, 2017). Recent research shows links between high quality case conceptualizations and better client outcomes (Abel, Hayes, Henley, & Kuyken, 2016). Nonetheless, developing individualized conceptualizations and linking these to treatment is a complex skill that can be difficult for new CBT therapists to learn (Waltman, Hall, McFarr, Beck, & Creed, 2017). Expert CBT therapists, compared to novice CBT therapists, seem able to develop more useful case formulations and use these more effectively to choose apt treatment options (Dudley, Ingham, Sowerby, & Freeston, 2015). However, even more experienced CBT therapists rate their case conceptualization skills lower than they rate their overall CBT skills (Zivor, Salkonskis, & Oldfield, 2013).

Kuyken, Padesky, & Dudley (2009) propose that the construction of high quality case conceptualizations can be achieved more readily by teaching therapists to construct case conceptualizations collaboratively in session with clients. Collaborative case conceptualization means that therapists and clients literally co-develop and write/draw conceptualizations together in session using client language. Rather than "one conceptualization" for each client, Kuyken et al. propose that case conceptualization can evolve naturalistically over the course of therapy, incorporating just enough information to facilitate the tasks of that stage of therapy. They describe three common levels of conceptualization capture this progression:

(1) *Descriptive case conceptualizations* that therapists and clients form early in therapy to demonstrate links among presenting client issues and thoughts, behaviors, moods, physical reactions and environmental factors.

(2) *Cross-sectional conceptualizations:* Over time, information is gathered to construct

models that identify cross-situational triggers and maintenance factors for specific presenting issues.

(3) *Longitudinal case conceptualizations* link current difficulties with early developmental factors, core beliefs, predisposing and protective factors across a lifetime.

Although many therapists are taught to construct longitudinal case conceptualizations early in therapy, there is a difference between what might inform therapist thinking and what is helpfully included in a case conceptualization that is collaboratively constructed with a client. In fact, there is some preliminary evidence that a focus on core beliefs in the early months of therapy might be detrimental to client progress (Hawley, et al., 2017). To date, there is no empirical evidence that longitudinal case conceptualizations are more helpful for clients in the early months of therapy than the more present-focused descriptive and cross-sectional levels of case conceptualizations. Any historical factors that clients consider essential to understanding current issues can be incorporated into descriptive or cross-sectional case conceptualizations.

Descriptive and cross-sectional conceptualizations as highlighted in this paper keep clients focused on change opportunities in the here and now and are recommended by this author as the best starting points for collaborative case conceptualization. Therapists only need to work with clients to construct a longitudinal conceptualization when therapy issues are more chronic and treatment plans derived from the first two levels of conceptualization are not successful. For a more thorough discussion of this recommendation, see Kuyken, Padesky, and Dudley (2009) and Padesky (2020, pp. 173-177; 375-380).

TWO COLLABORATIVE CASE CONCEPTUALIZATION MODELS

This article illustrates how to construct the first two levels of Kuyken and colleagues' collaborative case-conceptualization (description and cross-sectional). The models illustrated are

readily understood by clients and are constructed following standard steps. Therapists attending workshops taught by the author report these case conceptualization models are easy to learn and employ with a wide variety of clients. Standardized steps, questions, and statements are noted in each therapist-client dialogue so therapists can use this article as a template to follow. For most clients, these two types of case conceptualization will prove sufficient to understand presenting issues and individualize a treatment plan that makes sense to both therapist and client:

(1) The 5-part model (Padesky & Mooney, 1990) is a robust form of descriptive case conceptualization that can be used with any client issue to describe current difficulties in terms of links among thoughts, behaviors, physical reactions, moods, and environmental/situational factors. It is appropriate to use with straightforward as well as complex cases that include comorbidity. Because it incorporates environmental/life factors it is well-suited to conceptualize issues triggered or complicated by environmental or sociocultural factors (e.g., discrimination, financial stress, chronic illness, sexual harassment, family violence). Clients find this model easy to understand; it is the main conceptualization model presented in the widely used self-help book, *Mind Over Mood* (Greenberger & Padesky, 2016, p.7).

(2) Box/Arrow In/Arrow Out is a cross-sectional conceptualization model that guides clients in the identification of triggers and maintenance factors for specific issues. It is commonly used as a secondary level of conceptualization after a descriptive conceptualization is constructed. However, it can also be the first conceptualization approach used, especially with clients who want to better understand anxiety disorders, addictions, interpersonal issues, and other problems maintained by underlying assumptions, maladaptive behavior patterns and/or avoidance.

Both of these approaches can incorporate an understanding of client strengths and cultural factors. Also, each of these models map onto collaborative treatment planning when clients are asked to consider which parts of the model would be easiest for them to modify. These two models actively engage clients to consider how different aspects of their life experience fit together and contribute to the issues for which they seek help (case conceptualization). In turn, each provides a visual map that clients and therapists can use collaboratively to begin to construct a treatment plan. Thus, clients are empowered to participate more actively and with greater understanding in each step of therapy. This could prove an important factor in increasing clinician-client communication and alliance throughout therapy, factors associated with better client treatment adherence (Thompson & McCabe, 2012) and psychotherapy outcomes (Tryon, Birch & Verkuilen, 2018).

5-Part Model: Interview Guidelines

Filling out the 5-part model (Padesky & Mooney, 1990; Greenberger & Padesky, 2016) can be quite straightforward if it follows an intake session. During the intake session, most CBT therapists will ask questions to identify moods, thoughts, behaviors, and physical reactions associated with presenting issues. In addition, therapists typically inquire about historical and current life and cultural factors that have relevance to whatever will be the immediate focus of therapy. When planning to use the 5-part model for case conceptualization, therapists are advised to make note of which of these five parts of experience (life/environment, moods, thoughts, behaviors, and physical reactions) the client mentions first in telling you their story and which one(s) the client wants to change.

At the end of the intake or in the following session, the 5-part model can be co-created as a written summary of information relevant to change target(s). When therapists begin with

whichever of the five parts the client mentioned first during the intake, this summary will closely match the client's personal narrative. As with all therapy tasks, it is important for therapists to express appropriate empathy throughout case conceptualization processes and proceed at a pace that is appropriate to the client's energy, mood, and cognitive understanding. Low energy clients often become more engaged during this process, especially when the therapist pauses and asks the clients to remind them of information already discussed (e.g., "Can you remind me how you described the changes in your sleep?") and invites the client to write this on the appropriate part of the 5-part model (e.g., physical). If clients are in crisis or some other issue is going on that suggests case conceptualization is not an appropriate therapy task in a given session, the 5-part model can be constructed later in therapy when the timing is more opportune.

5-Part Model: Case Illustration

Mateo was a 38 year old bus driver who came to therapy for help with recurrent major depression, chronic worry and insomnia. His most recent episode of depression began seven months earlier. Shortly before his depression began, he discovered his daughter was smoking "weed." He and his wife began arguing about how to respond to her drug use. Their disagreement remained unresolved which was a longstanding pattern in their emotionally distant relationship. Mateo thought they should forbid their daughter to use drugs and his wife thought they should just leave her alone. Mateo stated that he thought his wife drank too much alcohol; he only drank beer with friends or family on weekends and reported that his wife drank several glasses of wine daily. Mateo was a devout Catholic and blamed drugs and alcohol for his family's estrangement from the Catholic Church; he attended church services weekly.

About three months ago, Mateo experienced a traumatic incident at work when four youths surrounded and taunted him for being Mexican-American. They aggressively pointed

fingers in his face and shouted, “Go home [to Mexico]! You aren’t a real American!” He was quite shaken by this experience. Even though Mateo was a second generation American citizen, he worried that the current political climate in his city made him a potential target for physical attacks or even legal difficulties. He read in the newspaper that immigration raids in another state led citizens to be detained until they could prove their citizenship. He worried this could happen to him or his family. In the first few weeks after this incident, Mateo experienced an increase in tension whenever people boarded his bus and treated him curtly. He reported intrusive nightmares, sleep disturbance, and other symptoms that indicated he may have met criteria for acute stress disorder in the immediate aftermath of that confrontation.

At intake, Mateo scored 28 on the Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996), 21 on the Beck Anxiety Inventory (Beck & Steer, 1990) and 8 on the Beck Hopelessness Scale (Beck & Steer, 1988). These scores indicated moderate levels of depression and anxiety as well as mild hopelessness. He stated that he sometimes wished he would not wake up in the morning but denied suicidal intent because it “would be a sin.” He reported occasional thoughts of suicide without a clear plan. According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th Ed.; DSM-5; American Psychiatric Association, 2013) Mateo met diagnostic criteria for Recurrent Major Depression and Generalized Anxiety Disorder. He no longer met full criteria for Acute Stress Disorder but still experienced hypervigilance for danger, especially when people acted unfriendly toward him.

In the first session after the intake, Mateo’s therapist actively engaged him in creating a case conceptualization of his presenting issues using the 5-part model. By asking him questions and writing down his exact words at each step, she encouraged him to collaboratively construct this model. She sometimes gave him the pen and asked him to write down information as they

discussed it. Figure 1 shows the summary of the conceptualization that she and Mateo wrote. The following dialogue recaps the order in which this information was elicited and written.

Notice that she began by giving him a rationale for co-creating the 5-part model. Next she asked Mateo to help her summarize the life/environment issues that Mateo discussed at the beginning of his intake interview as well as connections between these and his mood. This choice was made because he was seeking therapy for depression and, during the intake session, he described his depression as a direct consequence of these life events. As the following dialogue shows, psychoeducation about the links among thoughts, behaviors and moods can naturally flow from use of the 5-part model via client analyses of their own experience. Thus, therapists can avoid didactic mini-lectures that some clients experience as invalidating, especially when these "challenge" clients who assert life events caused their depression.

In the following dialogue, therapist statements, questions, and interventions that are fairly standard regardless of client presenting issues are noted so readers can see the template for using this case conceptualization model.

[Standard] Therapist: Thank you for telling me in our last session about the experiences that brought you to therapy. I know it can be distressing to discuss some of the details of your experiences but those details help me understand what you have been going through. What was the last appointment like for you?

Mateo: It was OK. I hope you can help me.

[Standard] Therapist: Yes, I certainly do want to help you. One of the things that will help us figure out what types of help will be best is to create a summary picture of what is going on and how these different experiences you have been having might fit together. Will you help me do that?

Mateo: I'm not sure what to do but I'll try.

[Standard] Therapist: Thank you. Let's start by writing down some of the things going on in your life just before and since you began feeling depressed. *(Draws large circle and writes "Life/Environment" at the top of it); draws smaller oval inside larger circle and writes "Mood" inside it)*. I'm going to write depressed here under mood. Up here, under where I wrote "Life / Environment," we should list some of the things you told me about that happened in the last year that might somehow be connected to your depression.

Mateo: Like fighting with my wife?

Therapist: Yes. If you think that affected your depression, let's write it down under Life/Environment. (*Writing).*

Mateo: Yes. I get more depressed when we fight.

Therapist: And you were fighting about your daughter. Do you think finding out your daughter was smoking weed contributed to your depression?

Mateo: Yes. And it also made me more worried and anxious because I can only imagine what will happen to her.

Therapist: What do you imagine?

Mateo: I have visions of her getting into worse drugs. And sitting in an alley somewhere with boys and men who are getting high. And they could sexually hurt her.

[Standard] Therapist: Okay. That's really good information. Take this pen and write under "Life / Environment" that you learned your daughter was using drugs (*Pauses while Mateo writes "daughter smoking weed").* Then, under "Mood" add the new mood you mentioned, anxious (*Pauses while Mateo writes).* Now, if I could borrow the

pen, I want to add a new section that seems important, "Thoughts" (*Therapist writes "Thoughts" in an oval inside the larger circle on the left side).* You mentioned two types of thoughts you started to have and I want you to write them in that section – worry (*Pauses while Mateo writes "worry" under "Thoughts")* and images about what will happen to your daughter. Write the word images and then a reminder of this image you had about her using drugs in the alley with the boys and men.

Mateo: (*Writes "images of drugs, men, sex attack"*). That really makes me anxious. And I feel so helpless to stop her, especially when her mother won't back me up. I think that feeling added to my depression.

Therapist: Where should we write "helpless" on this model? Do you think it was just a feeling or a thought, like "I'm helpless to stop my daughter?"

Mateo: Yes. That is exactly what I think.

Therapist: Why don't you write that down on this picture under "Thoughts" then?

Mateo: *(Writing, "I'm helpless")*. I feel helpless to make anything better. And when I think this way, I find it hard to get out of bed. I just feel like giving up.

Therapist: I'm sorry you feel that way. Since it is hard to get out of bed, do you think you are spending more time in bed? Or avoiding doing some things you used to do?

Mateo: Yes, I do less than I used to. I used to do projects and chores on the weekends. Now I just watch TV.

[Standard] Therapist: If I can borrow that pen back, I want to write "Behavior" on this picture. Let's list some of these changes in your behavior that you notice.

Mateo and his therapist continued to talk about and add details to their written model, adding the attack he experienced at work and additional thoughts, behaviors, and physical experiences.

[Insert Figure 1 about Here]

Figure 1. Mateo's initial case conceptualization using the 5-part model.

[End Figure 1 about Here]

[Standard] To tap additional behavioral changes, his therapist asked, "Are there any behaviors you do more or less since you started to feel and think these ways?" and "Is there anything you avoid doing, now that this is going on?" To capture coping or safety behaviors, she asked, "Is there anything you try to do to stop these situations from getting worse?" Mateo did not spontaneously mention physical symptoms so she asked him, "When you are feeling and thinking these things, what do you notice happening in your body?" and also more specifically, "Have you noticed any changes in your sleep or appetite over the past few months?" She drew an oval near the top of the inner circle of this model labeled "Physical" and asked Mateo to write his physical changes there.

Once Mateo's details were listed on the 5-part model shown in Figure 1, she asked him questions to begin to capture the links between these five parts of Mateo's experience. The dialogue below shows how she asked him to notice connections between these different parts of his experience and draw arrows to capture what he observed. Notice how she persisted in asking questions until he became aware of the mutual interactions among all the parts of this model:

[Standard] Therapist: This big circle includes some of the things going on in your life that are connected to your depressed and anxious moods. Can you see connections between fighting with your wife, your daughter smoking weed, being attacked and your physical reactions, moods, behavior and thoughts?

Mateo: Yes. A lot of my thoughts are about those things and I feel depressed and anxious when I think about them.

Therapist: Do you think your physical reactions and behaviors are also connected?

Mateo: Yes, when I think about these things I don't sleep very well. And when I feel so bad, it is easier to just stay in bed.

[Standard] Therapist: Those are really good observations you just made, Mateo. It sounds like in addition to these things in your life that affect what you think about, your thoughts affect your moods and can keep you awake at night. And your moods can affect your behavior, what you do.

Mateo: Yes, they do.

[Standard] Therapist: Take this pen and draw an arrow from your thoughts to your moods and to your physical reactions so we don't forget these connections. *(Pauses while Mateo draws arrows from the thoughts oval to the moods and physical ovals).* And then draw another arrow from your mood to your behavior. *(Pauses while Mateo draws this arrow)*. Hmm… I wonder if these should be one-way or a two-way arrows.

Mateo: What do you mean?

[Standard] Therapist: For example, we have this arrow here [*pointing*] showing your thoughts affect your physical reactions, like sleep. Do you think it works the other way, too? That is, can you think of any times when your physical state of being tense or tired or having trouble sleeping affected your thoughts?

Mateo: *(Pause while he thinks).* Sometimes when I have trouble sleeping that is when I start worrying about my daughter and I begin thinking about being a failure too.

[Standard] Therapist: Do you think we should put an arrow on the other side of the line too, then? Showing that our physical experiences also affect our thoughts?

Mateo: Yes. (*Drawing the arrow head on the other side of the arrow between "Physical" and "Thoughts.")*

Therapist: How about this arrow between mood and behavior. Do you think your behavior also affects your mood?

Mateo: Definitely. When I stop doing things, I feel worse. (*Drawing arrow head on the other side of the line linking mood and behavior).* I also think my behavior affects my thoughts because when I spend a day watching TV I'm more likely to get frustrated with myself and think I'm just a failure.

[Standard] Therapist: Good observation. Why don't you draw that arrow too?

Mateo: And I can see how it works the other way, too. My worries and these images make me listen to my daughter on the phone and stay up when she is out (*drawing two headed arrow between "Thoughts" and "Behavior").*

[Standard] Therapist: How about your physical experiences and behavior and mood? We don't have any arrows there.

Mateo: I can see the connections there, too. My mood affects my tension and sleep and when I'm tired that drags my mood down. Also, feeling tired makes it harder to do things and, the less I do, the more I'm upset with myself when I go to bed and that makes it harder to sleep.

[Standard] Therapist: Okay. Draw those connections on our picture too. *(Pauses, while Mateo draws that last two-headed arrows, completing the 5-part model as shown in Figure 1).* What do you think of this drawing?

Mateo: It looks like my life is pretty much a mess.

[Standard] Therapist: It certainly shows us how distressed you are right now and the problems you face. In the big circle, we have listed some of the things that have happened in your life this past year. We can see how those events interact with the four parts of your personal experience: physical, moods, thoughts, and behaviors. (*Pause)*. You know, I actually see some good news in this picture.

Mateo: You do? Where is it? I don't see it.

[Standard] Therapist: The good news I see is in the arrows. This picture and these arrows tell the story of how distress can grow and get bigger and bigger. Changes in one area lead to changes in the other areas. As you begin to feel worse in each area it can spread to the other areas until you have gotten into a pretty deep hole.

Mateo: That's the good news?

[Standard] Therapist: No, sorry (smiling). The good news is, that just like negative changes can eventually lead to bigger negatives in all the areas, small positive changes can begin to lead to other small positive changes in the other areas and gradually we can get you out of this "mess" you are in. Does that make sense?

Mateo: I guess so. But what changes can I make?

[Standard] Therapist: I need your help figuring that out. I'd like us to figure out what are the smallest changes you could make that could eventually lead to big improvements in this whole picture. When you look at this picture, do you have any ideas where we might start?

Mateo: For a small change?

Therapist: Well, small changes are usually easier to make but I'll back any changes you are willing to make this week that might help you feel better.

Mateo: (*Quietly studying his 5-part model in Figure 1)*. I think if I didn't feel depressed and anxious it would be easier.

Therapist: I can see that. How would you change those this week?

Mateo: I thought you could tell me that.

Therapist: If they were easy to change in a week, I surely would. But moods can take a while to shift. These other areas all have arrows to your moods. Are there any changes that might be easier to make in any of these other areas that could begin to help shift your moods?

Mateo: Okay. Well, I am tired. I think if I was sleeping better that would help. But maybe a change I could make right away would be to watch less TV and maybe talk to my wife about some stuff so it isn't so tense at home.

[Standard] Therapist: Those sound like some promising places to start. Let's talk about what you might do this week and really think it through together so you have a good chance at making at least one positive change. We can see if that change leads to any other positive changes in this picture. If it does, we can build on that and if it doesn't we'll figure out a different path. How does that sound?

Mateo: Good. I feel a little bit of hope.

[Standard] Therapist: Me, too. Let's figure out what this first step will look like.

Changes that build on existing strengths are often easier to achieve (Padesky & Mooney, 2012). Therapists can help clients identify strengths as Mateo's therapist did a few minutes later in the interview:

[Standard] Therapist: Before we get more specific about what new behaviors you would like to try this week, I realize I don't know that much about what things in your life are going well. Can you tell me about a few areas of your life that help you feel better? Maybe there are even small things you look forward to during the day that lift your spirits.

Mateo: I am Catholic and it helps me to pray about things.

Therapist: Would you say praying helps you feel better? Is it a source of strength for you?

Mateo: Yes, both things.

Therapist: That's good for me to know. Perhaps your prayers can help you in the weeks ahead. Let's put it on a list of some of the strengths you have that can help you. In terms of this 5-part model, where do you think prayers connect to these other parts of your experience?

Mateo: I guess they could be either a thought or a behavior. When I pray about something, it often helps me to act. Maybe I could use prayers to help make some of the changes in my behavior that I want to make this week.

Therapist: That's a good idea. [*Pause*]. Is there anything else that lifts your spirits or that you look forward to during the week?

Mateo: Well, I like to watch soccer. And I look forward to seeing certain people who ride my bus every day.

Therapist: Those are good to know. Let's add those to our lists of strengths that can help you.

5-Part Model: Discussion

Notice that the 5-part model is trans-diagnostic and can involve conceptualization of several interconnected issues at once. As they proceeded to fill out the model, Mateo identified thoughts and images connected to anxiety before he identified thoughts connected to depression. In the discussion of behaviors, he identified ones linked to depression before noting behaviors linked to anxiety. Since the 5-part model is designed to capture the whole picture, it not currently necessary to link specifics to particular moods. As Mateo began to add elements of his experience to the emerging model, his therapist listened carefully to anything he mentioned that could naturalistically lead her to add the thought, behavior and physical ovals to the model. When one of these five aspects was missing from his report (physical changes), she directly asked about that area in order to complete the model.

When clients and therapists have differing views of where things belong on a case conceptualization model, allow the client's ideas to prevail. For example, some clients list "hopeless" as a mood rather than a thought. Allow the client to list hopeless as a mood if this is their experience. The 5-part model is a picture of the client's story as they understand it when therapy begins. Therefore, their view is the correct view until you can draw their attention to self-observations that support an alternative understanding that makes more sense to the client.

Some CBT therapists could question why the 5-part model does not include a functional analysis of behavior or require the therapist to gather details about underlying assumptions or core beliefs. Actually, asking the client to construct a broad overview of their issues that links life circumstances and events to physical reactions, moods, behaviors and thoughts provides a good introduction to the CBT model. The 5-part model is intended to be a starting conceptualization framed in clients' language that can be readily understood and constructed by

them, enhancing their active participation in therapy. A benefit of this approach is that it meets the clients where they are at the beginning of therapy and links their introductory story to a CBT framework. More detailed conceptualizations of any portions of this model can be collaboratively constructed later with the client when behaviors, thoughts, moods, physical reactions or challenging situations become center stage for change efforts.

Mateo's therapist was aware of evidence-based models for understanding and treating depression and generalized anxiety disorder and held these in her mind during the collaborative construction of his 5-part model. For example, she actively inquired about avoidance and safety behaviors because these types of behaviors usually accompany anxiety. She probed for the types of negative thoughts that characterize depression. When he proposed changing his moods as a first small step, she was aware that changes in behavior and thinking would be ideal first steps. Rather than contradicting his choice, she remained collaborative and asked him if he had ideas for how to directly change his moods in the next week. When he did not, she pointed to the model he had constructed and asked which of the other areas (since the arrows indicated each of them could affect mood) could be more easily changed and perhaps lead to mood improvement.

Most clients choose behaviors as a first choice for "easy" and "small" change. This fits with empirical models for treating depression (e.g., behavioral activation) and anxiety disorders (e.g., overcoming avoidance). Thus, a collaboratively constructed 5-part model offers a written framework and a rationale for clients to be actively engaged in interventions that are likely to prove helpful. At best, clients even choose and help craft these interventions themselves.

Inquiries about strengths in relation to this model can give rise to creative pathways for change. For example, prayer was an important part of Mateo's life that his therapist might not have known to access if she hadn't asked directly about "small things you look forward to during

the day that lift your spirits." Mateo had better success with behavioral and cognitive change efforts when he supported these with prayer. His interest in soccer led Mateo to envision creative ideas for change that otherwise would not have occurred to either he or his therapist. For example, he described to his therapist how soccer matches required sustained effort over a large field for a long time before a goal might be scored. His observation was incorporated as a therapy metaphor and encouraged him to make sustained efforts over long periods of time even when achieving his goals was "blocked by others or his own missteps." Thus, this model empowered Mateo to apply existing strengths to his current struggles.

Once strengths are identified, clients and therapists can decide whether to add them to the 5-part model or to put them on a separate list. If Mateo decided to add them to Figure 1, his therapist would ask him where to write them. For example, based on the interview above, Mateo would have written prayer on the line connecting thoughts and behavior. Other clients choose to put prayer and spiritual beliefs in the center of the 5-part model and some put them outside the circle to represent a higher power surrounding them. Rather than write the identified strengths on Figure 1, Mateo chose to make a list of ideas that could help support his change (e.g., "prayer", "soccer smarts") and labeled his list, "Things that Can Help."

Box/Arrow In/Arrow Out: Interview Guidelines

The 5-part model offers an overview of the links among client experiences. Box/Arrow In/Arrow Out zooms in and looks more closely at one issue the client wants to understand better and change. Box/Arrow In/Arrow Out helps clients identify triggers and maintenance factors for specific issues of concern. This model could be used with Mateo a few sessions later in therapy when he focuses more closely on one of his issues (e.g., sleep difficulties, anxiety, depression, or conflict with his wife) in order to identify its triggers and maintenance processes.

Box/Arrow In/Arrow Out can also be helpful as a first strategy for collaborative case conceptualization when a client comes to therapy for problems maintained by maladaptive behavior patterns or avoidance. Thus, it can be appropriate to use Box/Arrow In/Arrow Out in the session following the intake interview when a client comes to therapy for help with anxiety disorders, addictions or interpersonal issues. Even though clients with these issues can still benefit from the overview the 5-part model provides, identifying triggers and maintenance early on in therapy can lead more quickly to client engagement in treatment plans that require taking steps that lead to greater discomfort in the short-term in order to attain long-term benefits.

The example below with Keysha who entered therapy for help with anxiety illustrates these features of early use of Box/Arrow In/Arrow Out. Her therapist could use the descriptive 5-part model with Keysha before employing this cross-sectional case conceptualization method. However, because anxiety was her primary therapy issue, Keysha's therapist decided the Box/Arrow In/Arrow Out's focus on triggers and maintenance factors for her anxiety would be an appropriate and more helpful starting conceptualization model. There are five steps to this approach:

1. Draw a box on a piece of paper with an arrow pointing toward it on the left and an arrow pointing away from it on the right. Ask a client to identify an issue they want to understand better or change. Ask them to write this in their own words in the box. The issue can be an emotion, a belief, a mental process (e.g., rumination), a behavior, a physical experience, or even someone else's behaviors (e.g., my parents yell at me).
2. Write "Triggers" above and to the left of the left arrow. Ask questions to help your client identify a variety of triggers for the issue in the box. Consider asking about situations, behaviors, moods, thoughts/images/memories, physical states,

interpersonal interactions or any other factors that could be triggers. Encourage your client to summarize and write a reminder of each one on the Triggers list.

3. Write "Responses" above and to the right of the right arrow. Ask your client, "and when [the issue in the box follows those triggers], then how do you respond?" Ask questions to help your client identify the behaviors (including avoidance and safety behaviors), moods, thoughts/images/memories, physical states, or interpersonal interactions that follow once the issue in the box is triggered.
4. Review each response with your client to see if it helps (i.e., reduces) the issue in the box or the triggers. Consider both short-term and long-term impacts of each response. Draw arrows from responses back to the Triggers or the Box if these actually serve to increase (i.e., maintain) them in either the short- or long-term. Put a star next to any responses that improve (i.e., reduce; provide good coping for) the Triggers or issue in the Box in the short-term. Circle any of these that also help in the long-term. Draw arrows to the Triggers or Box if the starred responses maintain the problem in the long-term.
5. Spend time discussing what the client can learn from the picture they have drawn. Use Socratic dialogue (Padesky, 1993; 2019) to help the client come to their own conclusions regarding links between their responses (e.g., avoidance; use of drugs) to the issue in the box (e.g., anxiety; conflict) and its maintenance. Express empathy for how their current pattern may help the person feel better in the short-term and yet keeps the person stuck in the long-term. Ask them to consider what they might do "outside of this pattern" to make a change that would help in the long run. Consider evidence-based treatment principles and client strengths that can prove good starting

points for change experiments. Ideally, the therapist will ask the client questions to empower them to devise behavioral experiments that can begin the change process.

Box/Arrow In/Arrow Out: Case Illustration

Keysha, age 23, sought therapy soon after beginning her first full-time job post-university. She reported significant anxiety at work and indecision in her personal life. At work she was highly perfectionistic and ruminated about any mistakes she made or even her inefficiencies relative to more experienced employees. She had been dating the same woman for 10 months and, although generally happy when they were together, she ruminated about the pros and cons of accepting her partner's invitation to share an apartment. At intake, her score on the *Beck Anxiety Inventory* (Beck & Steer, 1990) was 29, which indicated a severe level of anxiety. She met DSM-5 diagnostic criteria for generalized anxiety disorder (American Psychiatric Association, 2013). She displayed some traits of obsessive-compulsive personality disorder but did not meet full criteria. Her primary treatment goal was to reduce her anxiety.

In the second therapy session, Keysha's therapist suggested they get more details about her anxiety in order to better understand her struggles. Once again, therapist statements, questions, and interventions that are fairly standard regardless of client issue are noted in the dialogue below so readers can see the template for using the Box/Arrow In/Arrow Out case conceptualization model. Figure 2 summarizes the information written down during this session:

[Standard] Therapist: Keysha, I think it would be helpful to use a drawing I call, "Box/Arrow In/Arrow Out" to figure out how to best help you. Can I show you how it works?

Keysha: Sure.

[Standard] Therapist: Okay. I'm going to draw a box here with an arrow going into it on the left side and another coming out of it on the right side. We want to write on the box the issue that you most want help with today.

Keysha: Do you mean my anxiety?

Therapist: Last week you told me your main struggles were with anxiety and making decisions. Which one do you want to focus on today?

Keysha: My anxiety.

[Standard] Therapist: Okay. Take this pen and write "My Anxiety" on the box. (*Pauses while Keysha writes).* Now, on this left side, I'm going to write "Triggers" at the top of the page. Beneath that title, let's make a list of the main things that you have noticed that trigger your anxiety.

Keysha: (*Writing)* Pressures at work, new work assignments, making mistakes, when my supervisor comes to my desk, if I don't know something.

[Standard] Therapist: What types of thoughts trigger your anxiety? For example, "If I make a mistake then…?"

Keysha: I'll get fired. I have lots of scenarios in my head of bad things that could happen.

[Standard] Therapist: Are they like movies? Or still images? Or a narration?

Keysha: I guess scenes that I imagine. Like I see my boss getting really fed up with me and making me clear out my desk and a security guard watching me leave.

[Standard] Therapist: So, in this "triggers" list, maybe you could write something that captures all these different types of images you have of bad things happening. (*Pauses while Keysha writes).* What did you write down?

Keysha: Disaster images!

Keysha and her therapist continued to identify triggers until she produced the list shown in Figure 2. Then her therapist continued:

[Standard] Therapist: So these are many of the things that trigger your anxiety. Next to this right arrow we are going to make another list. Could you write "Responses" at the top of the right side? (*Pauses while Keysha writes).* Let's make a list here of what you do after you start to feel anxious. What are some of the things you typically do?

Keysha: If I'm worried about making mistakes at work, I check things over and over again. This means I sometimes need to work longer hours. Should I write those down?

Therapist: Yes. Please. [*Pauses while she writes*]. What else do you do when you're anxious?

Keysha: Sometimes I do research on the internet… to see if there is information to help me. If I'm keyed up on the weekends I might clean my place or do something to distract myself from what I'm worrying about.

Therapist: Write those things down as well. [*Pause*]. What about when you're thinking about whether to move in with Jasmine?

Keysha: I usually weigh my options again. But it doesn't help me decide. If I get really tied up in knots, I'll take a Xanax. But I know that can be addictive so I try to save those for when I'm really anxious.

Therapist: So write those two ideas down, too. Weighing your options and taking a Xanax. [*Pause*]. It's interesting you say weighing your options doesn't help you decide. [Standard] I'm curious - which of these responses do help your anxiety go down?

Keysha: [*Silently looking over her list of responses*]. Well some of these help my anxiety a bit – like cleaning my place or doing something distracting, or taking a Xanax.

[Standard] Therapist: Why don't you put a star next to those? [*Pause*]. And would you say any of the other responses help your anxiety go down?

Keysha: No, not really. Actually they sometimes make my anxiety worse.

[Standard] Therapist: That's interesting. Maybe we should draw an arrow from those responses that make your anxiety worse back to the box labelled "My Anxiety" just to make sure we remember that. [*Pauses, while Keysha draws these arrows*]. And the two that make your anxiety better – do they help lower your anxiety for good or just for a short time?

Keysha: Just for a short time – maybe a few hours at most.

Therapist: Why do you think that is?

Keysha: After the Xanax wears off or my place is all clean, I just start worrying again.

Therapist: That's a good observation. Why don't you draw an arrow from those two items back to worry? [*Pauses while Keysha draws these arrows*].

[Standard] Therapist: So we have a long list of things that trigger your anxiety and your typical responses to it either make your anxiety worse or, at best, give you a few hours break from it before you return to worrying. It seems like you are stuck in a loop. I can understand why you feel so trapped in this anxiety.

Keysha: [*Sighs*]. Yeah. I'm a real mess. What can I do?

[Standard] Therapist: What ideas can you think of to get out of this loop we've drawn?

Keysha: [*Thinks, staring at the model shown in Figure 2*]. The only thing I can think of is to either get rid of those triggers or figure out some responses that don't keep the loop going. But I don't know what would do that.

Therapist: Those are both good ideas. We can try to reduce how often you experience those triggers. And we can figure out some different responses to try to see if they actually reduce your anxiety in the long run, not just for a short time.

[Insert Figure 2 about Here]

Figure 2. Keysha's initial case conceptualization using Box/Arrow In/Arrow Out.

[End Figure 2 about Here]

Just as strengths can be identified and added to the 5-part model, during this form of conceptualization it can be helpful to identify strengths when figuring out alternative responses to the issue written in the box. Padesky and Mooney (2012) suggest strengths can be found in everyday positive activities not linked to a person's problems. Her therapist followed this idea to help Keysha identify strengths-based strategies that could help her manage her anxiety differently:

[Standard] Therapist: Before we go any further, I'd like to ask you if there is something you do every day that you look forward to and that does not make you anxious.

Keysha: I don't know. I'm anxious most of the time right now.

[Standard] Therapist: It can be a little thing that you try never to miss. Something simple like taking a walk or caring for a pet or watching a favorite TV show.

Keysha: I do have some bloggers I follow who are pretty funny. I get their posts on my feed and read them every morning.

Her therapist expressed interest and got details from Keysha about these bloggers and their posts. [Standard] After determining that reading these blogs was a "never miss" daily activity, her therapist used this activity to help Keysha figure out some alternative responses for her anxiety.

Therapist: Those blog posts sound really funny. I can see why you love them so much. I'm wondering, though, if you have a lot to do at work or you are facing time deadlines for the day, do you skip reading the blogs?

Keysha: No. It only takes a few minutes. And doing something fun can put me in a better mindset to face the rest of the day.

[Standard] Therapist: That's interesting. Can we write those two ideas down? The first is that doing something enjoyable often only takes a few minutes. And the second is that doing something fun can put you in a better mindset to face the rest of the day.

Discussions of Keysha's assumptions and behavioral experiences related to her positive enjoyment of following blogs led to a variety of ideas that Keysha was later able to apply to her Box/Arrow In/Arrow Out conceptualization. For example, she realized that once she began to feel anxiety, her responses kept her in a "stop anxiety" mindset. In future sessions, she and her therapist devised behavioral experiments in which she would do something enjoyable or just observe her anxiety to see if that might put her "in a better mindset to face it" rather than trying to stop or avoid it. After doing these experiments, she added these alternative strategies to her Responses list for Box/Arrow In/Arrow Out. When a strategy took her out of the anxiety loop, she drew an arrow to an alternative box that she labelled "Facing It." In this way, her case conceptualization was referenced and modified as therapy proceeded.

Box/Arrow In/Arrow Out: Discussion

Box/Arrow In/Arrow Out is designed to identify triggers and maintenance factors for a particular recurring issue. It can be very similar to functional analysis' ABC model (antecedents, behaviors, and consequences) when a behavior is put in the box because it helps clients identify antecedents and consequences for those behaviors (Hanley, Iwata, & McCord, 2003). It can

closely match Ellis' ABC model (Activating events, Belief, Consequence) when a belief is put in the box (Ellis, 1958). However, this approach does not require someone to put a behavior or a belief in the Box. The box can contain an emotion, someone else's behavior (e.g., "My spouse gives me the silent treatment"), a thought, physical sensations, and even broader cultural issues such as social injustice (e.g., racism). Similarly, triggers and responses can encompass a wide range of personal experiences (emotional, physical, cognitive, and behavioral) and also environmental, interpersonal, or social ones.

Identified responses are not always maladaptive. When Box/Arrow In/Arrow Out identifies effective coping responses it can increase a client's commitment to make those responses instead of responses that maintain the problem. Effective coping responses are those that help resolve the issue in the box or reduce triggers in the long run. When responses are maladaptive and yet help clients feel better in the moment (e.g., avoidance, use of drugs/alcohol), therapists can ask about the long-term effects these rewarding responses have on both the triggers and the issue in the box.

For recurrent or longstanding issues, this conceptualization model is highly likely to identify a circular loop of experience. By definition, if an experience repeats often, then the person's responses to it are not successfully managing the triggers or the issue in the box. When clients write down their own responses and then are asked to consider how effective these are in managing what is in the box, they often have an "aha" experience. They realize their responses provide short-term relief at best and sometimes actually aggravate their struggles. In this way, this form of collaborative case conceptualization increases client motivation to try something different. It helps focus both therapist and client on planning targeted interventions to address maintenance factors for a presenting issue.

Therapists using this conceptualization approach who are familiar with evidence-based models for particular client issues can directly inquire whether expected triggers or responses are present. For example, clients often don't mention their imagery that accompanies or triggers intense emotional responses and therapists can make direct inquires to elicit this information. Therapists can ask anxious clients about avoidance or safety behaviors when these are missing. To enhance collaboration, we recommend therapists make direct inquiries after clients first have an opportunity to record their own observations on each section of the model.

Evidence-based therapies will suggest a number of avenues to pursue in order to reduce triggers or experiment with new responses. When client strengths and/or positive interests are identified, therapists can see whether there are analogous applications of these that fit with evidence-based treatments. For example, Keysha's insights about how certain activities changed her mindset provided a naturalistic rationale for trying out alternative responses to her anxiety.

The Role of Collaborative Empiricism

Therapists employing either of these two models of collaborative case conceptualization are encouraged to employ collaborative empiricism to inform and evaluate the resulting conceptualizations and treatment plans. Collaborative empiricism means several things (Kuyken, et al., 2009; Padesky, 2020). First, the therapist brings an awareness of relevant evidence-based models and treatments to conceptualization discussions in order to guide questioning and help ensure that those aspects of a presenting issue that are likely to be relevant are fully explored. It also means case conceptualizations are (a) grounded in information gathered from client observations of their own experience and (b) tested as therapy proceeds to see if they map well onto actual client experiences. Finally, collaborative empiricism expects that conceptualizations will be modified over time to accommodate new or conflicting information and observations.

Use of collaborative empiricism increases the likelihood that therapists and clients will co-construct interventions to directly target relevant triggers and maintenance factors.

Limitations and challenges

Both the 5-part model and Box/Arrow In/Arrow Out are appropriate to use with most adolescent and adult clients and issues addressed in therapy as long as therapists adhere to the guidelines of collaboration, use of client language, and concepts as recommended here. For clients with lower IQ or cognitive impairments, these models can be simplified. Like most therapy tasks, clients with cognitive deficits will often need to review these models more often and more slowly than is required for more intellectually able clients. For example, the 5-part model can be reduced to a 2- or 3-part model, with an emphasis on whatever elements seem most germane to the client's concerns. Box/Arrow In/Arrow Out could prove too complicated for some clients with cognitive limitations. For others, if the therapist uses simple language and lists just two or three triggers and responses to draw a simple Box/Arrow In/Arrow Out, it is possible to achieve all the purposes outlined here. Clients who are illiterate can often still benefit from these models if they are drawn in pictures or constructed from a collage of photos (e.g., cut out from magazines) to represent the various parts of the 5-part model or triggers and responses.

CONCLUSION

The 5-part model and Box/Arrow In/Arrow Out are two approaches that facilitate client-therapist collaboration in co-constructing case conceptualizations. The 5-part model demonstrates the links among internal client experiences and broader environmental and cultural contexts for presenting issues. It provides a comprehensive descriptive conceptualization capable of incorporating the presence of significant diagnostic co-morbidity and sociocultural factors. Box/Arrow In/Arrow Out offers a cross-sectional level of conceptualization that helps clients

identify triggers and maintenance responses for specific presenting issues. It is an especially good match for conceptualizing anxiety disorders, interpersonal difficulties, and issues such as addictions that are maintained by maladaptive behavior patterns and avoidance. Both models are constructed using clients' language and can incorporate client strengths. The unseen hand of empiricism informs therapist questions during use of these models so that empirically supported theories, models and treatments are considered in their construction. Once models are constructed, they can be empirically evaluated in the light of subsequent client experiences and observations.

Collaborative case conceptualization has a variety of advantages over those primarily generated by therapists. Case conceptualizations are more easily understood and more likely to include all the relevant information when clients directly help construct them. Collaborative case conceptualization offers clients an opportunity to be more directly engaged in treatment decisions including the design and rationale for therapy interventions. It seems reasonable that active engagement in case conceptualization would increase client understanding of maintenance factors and also their sense of control and efficacy while making change efforts. Empirical studies are needed to investigate these associations. Recent research suggests that clients are more likely to complete homework assignments when the content of these tasks is congruent with ideas the client wants to remember from sessions (Jensen, Fee, Miles, Beckner, Owen & Persons, 2019). Thus, collaborative case conceptualization can be a first step in a seamless integration of empowering client input into and engagement with every stage of psychotherapy. In addition, it can help therapists achieve a better understanding of client issues insofar as we recognize that the client knows best.

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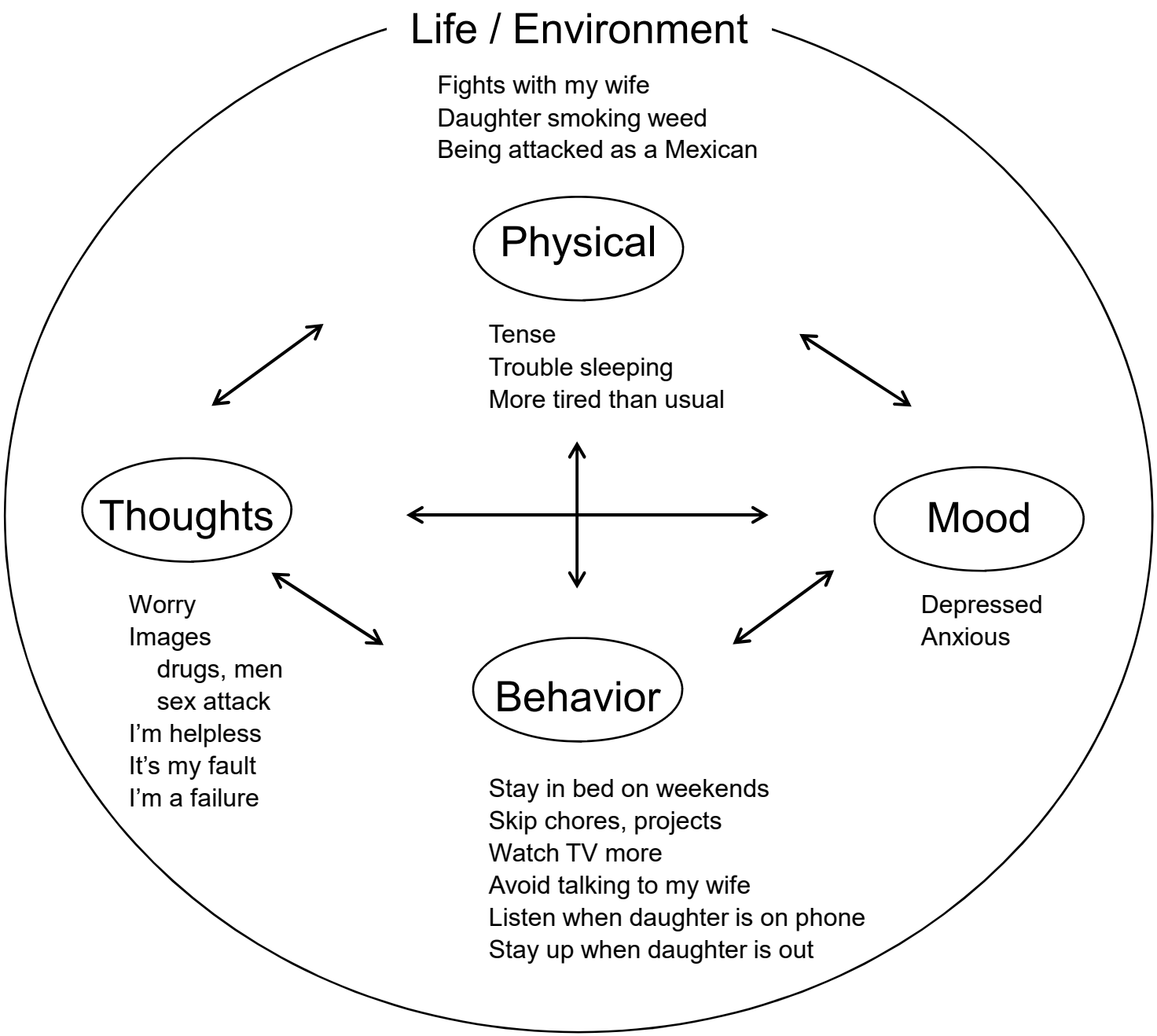

Figure 1. Mateo's initial case conceptualization using the five-part model.

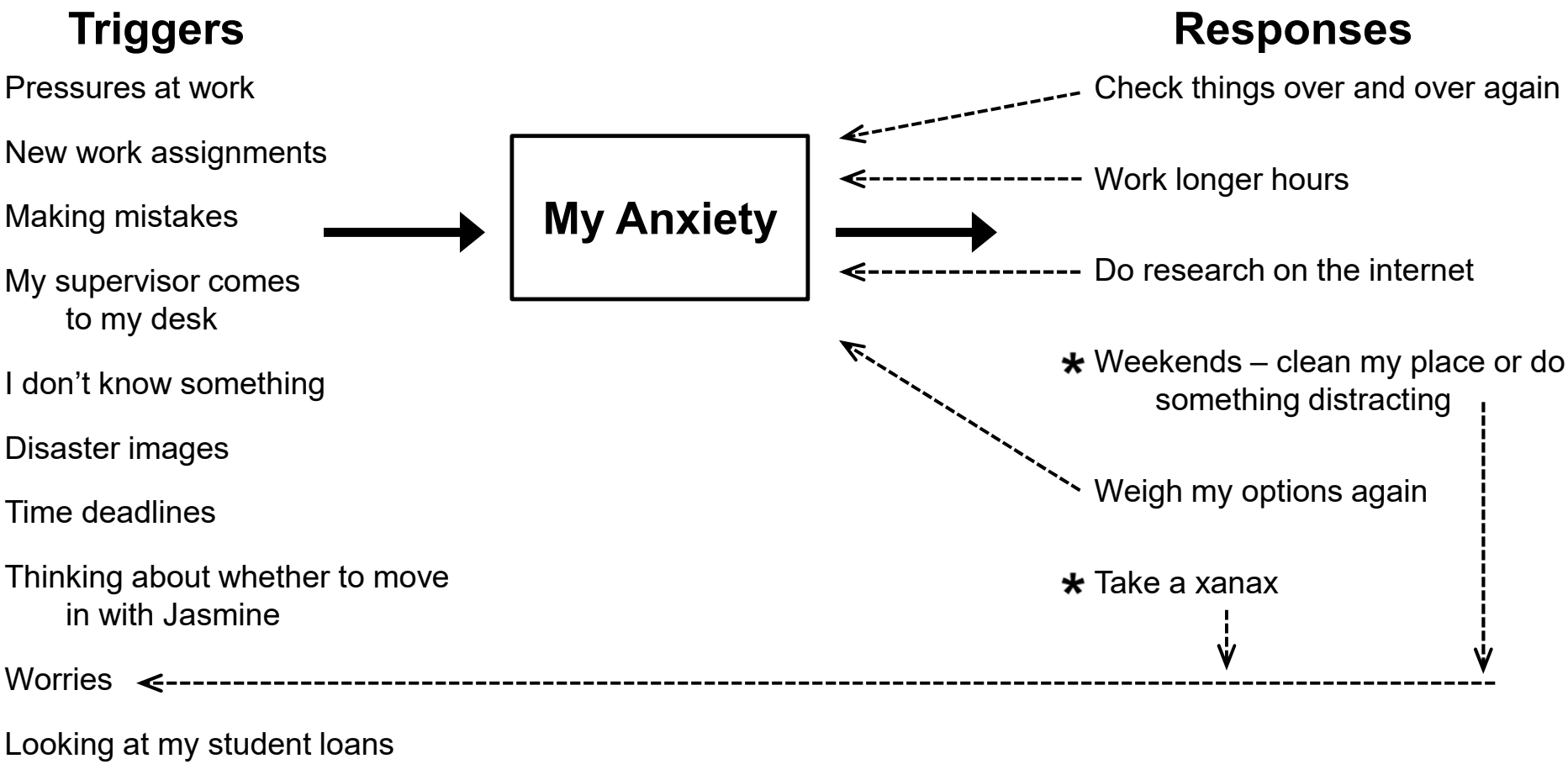

Figure 2. Keysha's initial case conceptualization using box/arrow in/arrow out.