The aim of this article is to present and analyze the core clinical hypothesis concept (Ingram, 2006) as one of the proposals for the case conceptualization. The author presents arguments showing that the use of this concept can increase quality of the case conceptualization. The benefits may include, e.g., avoiding or minimizing such errors in diagnosis as the fundamental attribution error (the context minimization error) or the confirmation bias.

**Keywords:** case conceptualization, psychological assessment, heuristic, cognitive error

**INTRODUCTION**

There are many studies on case conceptualization within particular schools, including the *Psychodynamic Case Formulation* by Nancy McWilliams (2012) and *Schema Therapy* by Jeffrey Young et al. (2013). I believe that focusing on a single theoretical approach carries a certain risk. For instance, a psychologist or psychotherapist may overlook the significance of a cultural context or cognitive schemas if these components are missing from specific proposals of case conceptualization. I see thus an opportunity to minimize this problem by also drawing from additional trans-theoretical concepts in the case conceptualization area. One such proposal is the concept of core clinical hypothesis by Barbara Ingram (2006).

Ingram’s core clinical hypothesis concept (2006) proposes a structured formulation of a case. Bearing in mind this characteristic, I shall take as the starting point the advantages, described in literature, of imposing a complex structure upon a diagnosis (including case conceptualization). The structured formulation of a case may lead to: 1) identifying complex causes of behavioral issues of a client (cf. Bandura, 1981, Haynes, 1992, as quoted in Virues-Ortega, Haynes, 2005); 2) reducing bias in clinical assessment (cf. Garb, 1998, as quoted in Virues-Ortega, Haynes, 2005). I would like to focus on the latter potential benefit of using the core hypothesis concept. Also, I will provide examples showing that relying on this kind of concepts in psychological diagnostic may contribute to reducing heuristics and cognitive errors in clinical evaluations. Therefore, the article aims not as much at demonstrating the significance of these concept premises for the formulation of efficient therapeutic strategy as for the diagnostic quality.

In literature, the discussions of cognitive heuristics and errors in diagnosis focus mainly on the description of their types (e.g. Croskerry, 2003; Elstein, Schwarz, 2005) and causes (e.g. Słysz, ...
The hypotheses the author has compiled refer to the potential causes (biological, situational, and environmental) of the client’s problems and models (behavioral, cognitive, existential, and psychodynamic), which explain the root of these problems. The key hypotheses formulated by Ingram (2006: 8–9) are listed below with a brief discussion of each group. Each hypothesis has been labeled with the same alphanumeric symbol as used by the author of the concept.

I. Biological hypotheses (B)
   - B1: The problem has a biological cause – the client needs medical intervention to protect life and prevent deterioration or needs psychosocial assistance in coping with illness, disability, or other biological limitations.
   - B2: There are medical interventions that should be considered.
   - B3: Mind-body connections lead to treatments for psychological problems that focus on the body and treatments for physical problems that focus on the mind.

The B2 hypothesis is of least importance for case conceptualization because it leads to a decision to make a medical intervention (e.g., medication or surgery). It may then be the role of a psychotherapist to draw the medical roots of the problem into attention and recommend a visit to a physician. Conversely, the hypotheses B1 and B3 may be included in psychological explanation (the mechanism of disorder development). The client may need psychological assistance in coping with a disease, disability, or other biological limitations.

II. Crisis, stressful situations, and transitions (CS)
   - CS1: The client’s symptoms constitute an emergency – immediate action is necessary.
   - CS2: The client’s symptoms result from identifiable recent situational stressors or from a past traumatic experience.
   - CS3: The client is at a developmental transition and deals with issues related to moving to the next stage of life.
CS4: The client has suffered a loss and needs help during bereavement or for a loss-related problem.

Ingram (2006) emphasizes that the hypotheses should be taken into consideration during the first session, given the serious consequences of neglecting to take appropriate action. For instance, this concerns cases where the patient should be hospitalized or was the victim of abuse or violence. When considering the CS2 hypothesis, it is important to assess whether the client’s symptoms and difficulties are proportional to the stress level. Interventions based on the CS3 hypothesis may prevent the transformation of a crisis (e.g., in adolescence) into a long-term disorder. With respect to the CS4 hypothesis, Ingram (2006) writes that the loss can be external (e.g., due to a death, divorce, or natural disaster) or internal (the loss of certain opportunities due to disease or age).

III. Behavioral and learning hypotheses (BL)

BL1: A behavioral analysis of both problem behaviors and desired behaviors should yield information about antecedents (triggers) and consequences (reinforcers) that will be helpful in constructing an intervention.

BL2: A conditional emotional response (e.g., anxiety, fear, anger, and depression) is at the root of excessive emotion, avoidant behaviors, or maladaptive mechanisms for avoiding painful emotions.

BL3: The problem stems from skill deficits, the lack of competence in applying skills, abilities, and knowledge to achieve goals.

A full behavioral analysis allows to detect the antecedents and consequences of a given person’s behavior. It is assessed if the desirable behaviors are in the client’s behavioral repertoire. Also, many problems recognized as pathological can be formulated as skill deficits (cf. hypothesis BL3).

IV. Cognitive hypotheses (C)

C1: The client is suffering from the ordinary “miseries of everyday life” and has unrealistic expectations of what life should be like.

C2: Limiting and outdated elements in the faulty cognitive map (e.g., maladaptive schemas, assumptions, rules, beliefs, and narratives) are causing the problem or preventing solutions.

C3: The client demonstrates faulty information processing (e.g., overgeneralization, all-or-nothing thinking, and “mind reading”) or presents an inflexible cognitive style.

C4: The problem is triggered and/or maintained by dysfunctional self-talk.

In reference to the C1 hypothesis, Ingram (2006) states that psychotherapists should avoid setting in contracts such goals like attaining a perfect, problem-free life. The client may wish to completely eliminate unpleasant emotion, which are an inevitable part of life. With respect to the C2 hypothesis, the author suggests that assisting the patients in modifying their way of thinking does not result from some arbitrary standard of proper thinking but rather from the fact that faulty cognitive maps may limit, e.g., meeting the needs, achieving goals, and satisfaction with life (Ingram, 2006). According to the C3 hypothesis, the client’s problems may be defined as the lack of necessary skills and the maladjustment of the cognitive style to the client’s goals and the context in which he or she is placed (Ingram, 2006). With respect to the C4 hypothesis, Ingram (2006) remarks that dysfunctional self-talk causes painful feelings and maladaptive behavior.

V. Existential and spiritual hypotheses (ES)

ES1: The client is struggling with existential issues, including the fundamental philosophical search for the purpose and meaning of life.

ES2: The client is avoiding the freedom and autonomy that come with adulthood and/or does not accept responsibility for present and past choices.

ES3: The core of the problem and/or the resources needed for resolving the problem are found in the spiritual dimension of life, which may (or may not) include religion.

As regards expanding the ES1 hypothesis, existential problems may include the purpose and
meaning of life, morality, death-related issues, and the sense of loneliness (Ingram, 2006). The author points out that, while considering this hypothesis, psychotherapists should remember that everyone has to find his or her own answer to existential questions. A therapist should refrain from taking the role of a guru or omniscient expert (Ingram, 2006). Next, in her commentary to the ES2 hypothesis, Ingram (2006) writes that avoiding freedom in humans take one of several forms: maintaining childhood illusions, blaming others, or becoming dependent on other people. When clients are ready to engage in responsible behavior, they may need assistance in making decisions (e.g., which educational path to choose, which job, etc.), as well as in making and implementing plans. According to Ingram (2006), it is important to apply the ES3 hypothesis when the client is struggling with problems of religious nature, including the subject of the client’s representation of relation with God.

VI. Psychodynamic hypotheses (P)

P1: The problem is explained in terms of parts and subpersonalities that need to be heard, understood, and coordinated.

P2: The problem is a reenactment of early childhood experiences: feelings and needs from early childhood are reactivated and patterns from the family of origin are repeated.

P3: Difficulties stem from the client’s failure to progress beyond the immature sense of self and conception of others that is normal for very young children.

P4: The symptoms or problems are explained in terms of unconscious dynamics; defense mechanisms keep thoughts and emotions out of awareness.

With regard to the P1 hypothesis, Ingram (2006) points out that the client’s problems may result from, among other things, the lack of awareness of certain subpersonalities, conflicts between various subpersonalities, suppression of various subpersonalities, or domination of one of them. An increased awareness of individual subpersonalities and their dynamics may contribute to solving the problem.

The P2 hypothesis refers to the assumptions of various theories that early childhood experiences may deeply influence the life as an adult. Many problems of adults can be defined as efforts to resolve internal conflicts and meet the needs which were not fulfilled in childhood (Ingram, 2006). In reference to the P3 hypothesis, Ingram (2006) writes that one can precisely determine the developmental phase when the disturbance took place based on the diagnosis of skills and deficits of adults. Whereas in the discussion of the P4 hypothesis, the authors indicates problems which may ensue the from a person’s unconscious conflicts or defensive reactions to traumatic events.

VII. Social, cultural, and environmental factors (SCE)

SCE1: The problem must be understood in the context of the entire family system.

SCE2: Knowledge of the cultural context is necessary to understand the problem and/or to create a treatment plan that shows sensitivity to the norms, rules, and values of the client’s cultural group.

SCE3: The problem is either caused or maintained by deficiencies in social support.

SCE4: Difficulty meeting demands for social role performance contributes to the client’s distress and dysfunction.

SCE5: A social problem (e.g., poverty, discrimination, or social oppression) is a cause of the problem; social problems can also exacerbate difficulties stemming from other causes.

SCE6: The problem is causally related to disadvantages or advantages to the social role of mental patient.

SCE7: The problem is explained in terms of environmental factors: solutions can involve leaving the environment, obtaining material resources, or accepting what can’t be changed.

Compared to all other groups of hypotheses recognized by Ingram (2006), this one is the largest, containing seven hypotheses. Regarding the SCE1 hypothesis, the author points out situations in which the symptoms of an individual contribute...
to the maintenance or stabilization of family homeostasis, and an improvement in the client may result in the symptoms appearing in another family member. Therefore, in some cases it is useful to apply an intervention to the whole family. The SCE2 hypothesis takes into account the client’s cultural identification and life experience in a specific culture. In her commentary to the SCE3 hypothesis, Ingram (2006) points out the social support as a factor playing an important role in preventing mental health problems. Social isolation may be both the cause and result of problems. Most interestingly, the author writes in regard to the SCE4 hypothesis that role models and mentors may be more helpful in this area than psychotherapists. Whereas one of the implications of the SCE hypothesis is that social activism may be a more appropriate form of activity than therapy (Ingram, 2006). While explaining the idea behind the SCE6 hypothesis, the author supposes that the client may simulate symptoms of a mental disorder for material gain.

By definition, all core hypotheses are fairly generally formulated. Thus, they may only guide psychological explanations, and each of them could be supplemented by at least several detailed hypotheses. It would be difficult to compile such a universal list, however, since more detailed hypotheses in diagnosis are meant to reflect the specificity of the examined person. Only lists of hypotheses remaining on a more general level can have practical significance, as is the case of the concept developed by Ingram (2006).

The main objective of the author (Ingram, 2006) was to provide the clinicians with a tool to support the multitheoretical diagnosis of the client and integration conceptualization of a case. Even though other authors (Lampropoulos, 2009; Stricker, 2009) stress that Ingram’s (2009) concept is meant for therapists favoring the integration approach to psychotherapy, the author herself also points out the opportunities of applying her concept within a single theoretical approach. Ingram (2006) also notes that core clinical hypotheses can be isolated within each theoretical orientation. Some components, such as the hypotheses on potential causes of disorders, are similar in various theoretical approaches. For instance, cognitive-behavioral, existential, and narrative trends in psychotherapy present the client’s problems as resulting from his or her faulty cognitive structures related to life experiences (Ingram, 2006). In her description of core clinical hypotheses, the author of the concept provides the examples of theories which a psychotherapist may employ (such as Ellis’s rational emotive behavior therapy in the discussion of cognitive hypotheses), but she does not consider them to be the only options. It is a clear indication of the open nature of this case conceptualization concept. Moreover, it is noticeable that among the proposed theories suitable for the development of the P1 hypothesis (explaining the problem in terms of subpersonalities which need to be identified, understood, and coordinated), classified with psychodynamic hypotheses, Ingram (2006) lists not only Transactional Analysis but also Gestalt Therapy, which is part of the humanist current in psychotherapy. This group of hypotheses is thus not identical with the psychodynamic paradigm. Similarly, one should not identify the respective groups of hypotheses (behavioral, cognitive, and existential) with the respective theoretical paradigms: behavioral, cognitive, and existential.

The nature of Ingram’s (2006) concept (integrative vs. eclectic) is not totally clear. The author herself declares (Ingram, 2006, 2009b) that her case conceptualization concept belongs to integrative theories and is based on the metatheory of problem solving. Such a classification is suggested, above all, by the focus on theory and not on therapeutic techniques, and by combining the components of two or more theories. It should be added, however, that the concept remains at a very general level. Whereas the author presents the rules for and examples of combining selected components, they do not combine into a comprehensive, integrated explanatory concept. It is rather fragmentary and leaves much freedom to the psychotherapist. Two
general ways of using the core clinical hypothesis concept can be distinguished: 1) application of hypotheses matching a single theoretical approach and formulation of a case conceptualization based on this approach, and 2) formulation of a case conceptualization based on a chosen existing integrative concept or one’s own synthesis of elements of various theories. In the case of the former, it is not possible to make full use of the core clinical hypotheses proposed by Ingram (2006), as no single theoretical approach contains all elements comprised by these hypotheses. The latter way enables taking a larger number of core hypotheses into consideration. The examples from her own practice given by Ingram (2006, 2009a) show that she adopted this very approach.

Using a list of core clinical hypotheses can serve two main functions: it prevents a premature closure of gathering information about the client and leads to posing appropriate clinical questions (Lazare, 1976, as quoted in Ingram, 2006). It is noticeable that clinicians tend to attach excessive value to certain causal factors, depending on the theoretical trend in which they work, and to seek those factors in their clients when other, overlooked clinical hypotheses could lead to a more effective intervention (Ingram, 2006). A list of problems and their possible causes requires diagnosticians to take into consideration all the psychological categories it contains. Even though, in a way, the facts are being “adjusted” to fit hypotheses, the range of the hypotheses by is by definition very broad and allows a multispect approach to the client’s problem. It is particularly important since naming problems and determining their causes enables setting a goal for intervention.

To conclude the presentation of Ingram’s core clinical hypotheses (2006), I shall give an example of case conceptualization. Claudia is a married woman, aged 58, and mother of three grown children, living with her husband and her 90-year-old mother who requires support. It is known that the client described her loss of control of her emotion and excessive severity towards her mother. Hypotheses were made to explain the client’s problem in dealing with the sense of guilt, frustration, and anger when caring for her mother (Ingram, 2006).

### Table 1. Case conceptualization (Claudia).

<table>
<thead>
<tr>
<th>Core hypotheses</th>
<th>Hypotheses according to the analysed case</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS2 – Situational stressors</td>
<td>When details were elicited, it became clear that there is no elder abuse or risk of abuse. The woman feels guilty over crying and raising her voice. She describes her mother as uncooperative, having tantrums and insulting speech that confirms that she is dealing with high level of external stress (situational), and most women in her situation would feel angry and frustrated. As Claudia’s mother condition deteriorates, client’s stress level rises.</td>
</tr>
<tr>
<td>SCE2 – Cultural context</td>
<td>The guilt caused by her feeling of anger and resentment has roots in her culture’s definition of a „good daughter“. The woman believes that any negative thought negates the assistance she provides for her mother. She has internalised the following conviction: „a good daughter should be happy to help her mother“ (the cultural message). She believes that it unacceptable in her culture to place her mother in an assisted-living facility, even though she and her siblings could afford it.</td>
</tr>
<tr>
<td>C2 – Faulty Cognitive Map</td>
<td>As long as the woman believes that she is a bad daughter if she show anger, she will lack the ability to cope successfully with her normal emotional responses. The more the woman tries to suppress negative thoughts, the more likely is that they erupt in screaming.</td>
</tr>
</tbody>
</table>


In this example of conceptualization, three core hypotheses were taken into account. Each of them comes from a different group of hypotheses (I. Crisis, stressful situations, and transitions; VI. Social, cultural, and environmental hypotheses; III. Cognitive hypotheses). It may be said that this
is a broad approach to the problem reported by the client and not limited to a single key aspect. I shall refer to this example in the latter part of the article.

**CONCEPT OF CORE CLINICAL HYPOTHESES AND THE QUALITY OF CASE CONCEPTUALIZATION**

The core clinical hypothesis concept can be useful in diagnosis due to the opportunity to improve the quality of case conceptualization by using it. In my analysis of this question, I will make use of the following criteria of case conceptualization quality: comprehensiveness, complexity, and coherence of interpretation (Strupp, 1955, 1958, as quoted in Eells et al., 2005; Sherwood, 1969, as quoted in Stemplewska-Żakowicz, Pałuchowski, 2008; Eells et al., 2005).

The comprehensiveness of interpretation is defined as the number of important categories used in the formulation of a given case. For the quality assessment of case conceptualization, it is not only important if a certain category is present at all but also how thoroughly it has been developed. A good conceptualization contains a sufficient number of details to support the intervention (Sturmeay, 2009). Using Ingram’s core clinical hypothesis concept (2006) may contribute to improve the completeness of interpretation. Even when psychologists/psychotherapists work within a single paradigm, using a list of hypotheses comprised of many different psychological categories may allow them to see more of the latter. A few examples of the categories which are components of individual core hypotheses include: developmental transition, social support, stress, cognitive schema, autonomy, defensive mechanisms, family system, social roles. These categories are derived from various psychological perspectives, such as developmental psychology, cognitive psychology, social psychology, and others. Taking them into account may improve the comprehensiveness of interpretation. Still, it depends on the psychologist/therapist in how much detail each category will be described.

The complexity indicator of case conceptualization is the integration of several aspects of the problem or a person’s functioning. More complex conceptualizations integrate a number of aspects of the problem and the person’s functioning, whereas low complexity means the discussion of just a single such dimension. In her book, Ingram (2006) gives many examples of integration of several elements (aspects of a person’s functioning). It is, however, the conceptualization stage, which can be directed within the discussed concept of conceptualization only to some extent. Even when the conceptualization of a certain case contains the same components as another similar case, the relations between these components may differ. As one may reasonably expect, Ingram’s concept (2006) does not provide ready guidelines on how to connect various elements of case conceptualization with one another.

The coherence of case conceptualization is the internal consistency of assertions about an individual. Similarly to the complexity of case conceptualization, using the core clinical hypothesis concept does not directly translate into greater coherence.

Out of the three above criteria of case conceptualization quality, only the comprehensiveness of interpretation can be directly influenced by employing the core clinical hypothesis concept. It is related to how the cognitive processes function. For instance, the availability of the list of hypotheses and the diagnostic categories it contains enables to increase the range of categories available in memory and to avoid potential errors associated with using heuristics in diagnosis.

**CONCEPT OF CORE CLINICAL HYPOTHESIS AND THE APPLICATION OF HEURISTICS IN DIAGNOSIS**

Another criterion which can be recognized as indicative of higher case conceptualization quality is the minimization of the application of classic heuristics in the diagnostic process. When diagnosti-
cians have much information available about their clients, they tend to use heuristics (Virues–Ortega, Haynes, 2005). For one thing, they may accentuate the pieces of information which confirm prior assertions about this person (confirmation bias) or those similar to the information gathered from other clients (availability heuristic). I discuss below the significance of the core clinical hypothesis concept for the minimization of classical heuristics in diagnosis.

1) Availability heuristic

Thinking subordinated to the availability heuristic (Tversky, Kahneman, 1974, as quoted in Nęcka, Orzechowski, Szymura, 2006) involves developing evaluation criteria based on the current events available in the perception field or in memory. While it is easy to grasp the availability heuristic in the case of typological, classification, or nosological diagnosis, it is much more difficult during a functional or causal diagnosis, when a psychologist refers to a similar case known to him or her and to the circumstances conditioning the given patient’s way of functioning. The same pertains to case conceptualization.

Using an inventory of various possible causes may prevent one from stopping at a single cause, most available in one’s memory. Using a list of core clinical hypotheses, such as that proposed by Ingram (2006), enables the activation of many alternative hypotheses in working memory, and thus limits the application of availability heuristic in diagnosis.

2) Representativeness heuristic

In general terms, representativeness is the adequacy between the case and the category or model (Sokołowska, 2005). In the case of diagnosis, representativeness heuristic involves the assessment of the extent to which, for an instance, a certain behavior corresponds to a personality type or a certain symptom to a (physical or mental) disorder entity. Similarity is both the component of representativeness and the basis for categorization. Moreover, the coherence of information about the examined person increases the representativeness of the latter (Sokołowska, 2005). The application of this heuristic manifests itself in a situation where a physician estimates the likelihood of a disease by evaluating how much a given case is similar to a category or prototype (Elstein, Schwarz, 2005).

It is a mistake to unthinkingly include a person in a given category (based on the characteristics they have in common) ignoring the fact that some other characteristic may exclude the membership in that category or that there are other categories with which the person shares common characteristics (Lasoń, 2000). Regarding the first hypothesis of category assignment as relevant may lead to ignoring some of the information (Zdrahal–Urbanek, 2004). A systematic analysis of possible causes comprised in Ingram’s (2006) core clinical hypothesis concept may prevent one- or two-cause explanations and encourage a diagnostician to take into consideration many causes of a problem or disorder. Even though the list of hypotheses is not enough to rule out careless inclusion of a person to a given category, it will make the diagnostician consider other categories, with which the client shares common characteristics. Thus, the risk that the client is finally included in a given category by mistake is decreased.

3) Anchoring heuristic

Anchoring heuristic is the tendency to regard the characteristics presented first as the most relevant and not to change the first impressions in the light of further information; it may overlap with the confirmation bias (Crooksey, 2003). In the case of diagnosis, the first assessment of various diagnostic aspects may serve as and “anchor”, with all modifications being carried out with respect to it (Shysz, 2008). A psychologist/psychotherapist may evaluate the same data differently, depending on which test results and other information were received first. This heuristic is relatively difficult to “detect.” Using a prop in the form of a set of possible causes, e.g., core clinical hypotheses (Ingram, 2006), may prompt a diagnostician to research further and not to stop at the first proposed hypothesis.
CONCEPT OF CORE CLINICAL HYPOTHESIS AND COGNITIVE ERRORS IN DIAGNOSIS

Apart from heuristics as rules which may lead to errors in thinking, the literature knows many cognitive errors which may lead to making faulty diagnostic decisions. They are by no means specific to psychological diagnosis. Avoiding these errors may also increase the case conceptualization quality. I discuss several examples of such errors below.

1) Context minimization error

The context minimization error involves not taking into consideration the external (environmental, cultural) factors when interpreting the behavior of a given person. It is a specific variant of the fundamental attribution error (Stemplewska–Żakowicz, 2009). In the field of diagnostics, it may lead for example to evaluating and blaming patients for their mental disorders (dispositional causes) and disregarding situational factors, which can also be responsible (Croskerry, 2003). A special case of this error is the omission of the cultural context.

In her book, Ingram (2006: 386) points out the tendency among clinicians to make this error during case conceptualization, and thus to overestimate the significance of dispositional causes. The author states that the majority of the clients who report to a psychotherapist have both dispositional and situational problems. The core clinical hypotheses which take into consideration a broad range of external factors include group VI. Social, cultural, and environmental factors (SCE) and the CS2 hypothesis (The client’s symptoms result from identifiable recent situational stressors or from a past traumatic experience).

The core clinical hypotheses, which are the basis for case conceptualization, also include the cultural context. Two of the hypotheses suggested by Ingram (2006) involve the cultural context: SCE2 (Knowledge of the cultural context is necessary to understand the problem and/or to create a treatment plan that shows sensitivity to the norms, rules, and values of the client’s cultural group) and SCE5 (Social problems, e.g., poverty, discrimination, or social oppression, are causes of other problems). According to Ingram (2006), the question of the acculturation of an individual and his or her family members is an important element to be considered during diagnosis. Apart from isolating the core hypotheses SCE2 and SCE5, the author points out yet another aspect of cultural context to be considered in diagnosis – psychotherapists should understand how their own native culture shapes their therapeutic relations (Ingram, 2006).

The sample analysis of the case of Claudia, added in the former part of this article, shows that the list of core clinical hypotheses may facilitate avoiding the context minimization error. In the discussed case, Ingram (2006) proposed two hypotheses related to external factors: CS2 (situational stressors) and SCE3 (cultural context). Ingram’s works (2006, 2009a) contain many examples of case conceptualization taking context into consideration, including cultural context.

2) Hypothesis confirmation bias

Hypothesis confirmation bias is a tendency to overestimate the information which confirm our views or beliefs with a simultaneous tendency to ignore or dismiss the data which contradict them (Holtz, 2009). It leads to looking for the data which support the diagnosis rather than the information which contradicts it and may disprove it, even though the latter are often more convincing and definitive (Croskerry, 2003). For instance, a psychologist hypothesizes that the examined person has a schizoid personality disorder, so he or she asks questions in order to find the symptoms of this disorder while disregarding facts which might exclude this hypothesis. In such a situation, even a faulty hypothesis can be confirmed.

It is justified to suppose that going beyond the hypotheses in the spotlight of the theoretical approach in which the psychologist/psycho-
therapist works may, at least partially, prevent the hypothesis confirmation bias. This function may be fulfilled, for example, by using the core clinical hypothesis concept proposed by Ingram (2006), which comprises various explanatory models, psychodynamic, cognitive, behavioral, as well as existential. In her handbook, the author herself indicates the tendency among therapists to confirm hypotheses and recommends caution in this matter (Ingram, 2006: 403).

3) Overconfidence bias

Overconfidence bias is a universal propensity to believe that we know more than we actually do (Croskerry, 2003). Overconfidence leads to a tendency to act based on incomplete information or intuition alone. Often it is subjective opinions rather than carefully gathered evidence which elicit much confidence. This bias may be reinforced by the anchoring and availability heuristics.

The prospect of plurality and diversity of hypotheses found in Ingram’s (2006) core clinical hypothesis concept may weaken the propensity for the overconfidence bias in case conceptualization. Since the confidence in one’s own diagnosis is greater when one falls for such errors like hypothesis confirmation bias, fundamental attribution error, or the narrow construal of a diagnostic problem (Smith, Dumont, 2002), minimizing them — through basing on an inventory of hypotheses — may in turn decrease this unjustified confidence.

CONCLUSION

As shown by the results of research (Eels et al., 2005), using more than one theoretical approach minimizes the fundamental attribution error in case conceptualization. A diagnosis in the framework of a single theoretical approach with the use of the core clinical hypothesis concept may have a similar effect. Even though the set of categories and hypotheses proposed by Ingram (2006) comprises the main thoughts of all theoretical currents (psychodynamic, cognitive–behavioral, humanistic, and systems psychology), the list is not exhaustive and can be developed further.

The merit-based analysis of the question makes it possible to recognize the core clinical hypothesis concept developed by Ingram (2006) as a useful tool for understanding the client in various perspectives. What is still required, however, are empirical studies which could demonstrate the effect of the application of the discussed concept on the quality of case conceptualization. How efficiently this tool is employed and to what extent it serves to minimize heuristics and cognitive errors in case conceptualization is largely dependent on the attitude of the psychologists and psychotherapists themselves. It is my opinion that this type of concepts is of particular use for students and young practitioners, who do not have much professional experience and need a clear structure of case conceptualization.