

The Conceptualization Issue: An Update

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Introduction

This article is based on my presentation at the 23rd Annual Neurotech Convention held in Los Angeles, April 16-19, 2026. My goal during the presentation and in this article is to present a different perspective on the question of “the conceptualization issue”.

The standard definition of case conceptualization refers to a structured, clinical framework used by medicine to understand a patient’s unique challenges, their history, and their behaviors. It seeks to integrate assessment data through a theoretical lens to explain the causes, the development, and the patient’s daily maintenance of their illness, disease, or injury. Conceptualizing cases in medicine is often synonymous with the idea of case formulation. And this usually involves focusing on the following factors:

In what ways does the patient present in the treatment?
What are the patient’s predispositions prior to seeking treatment?
What are the precipitants of their illness, disease, or injury?
What are the protective factors for their sense of self?
What mind/body/brain patterns are they involved with?
What is the clinician’s plan for treatment?
What is the prognosis?

Case conceptualization/case formulation can also involve asking these questions:

The presenting problem. Historical factors.
Maintenance factors. Strengths and resources.
The theoretical orientation of doctors and patients.
A biopsychosocial model of the patient’s life.

I note that most of this kind of medical assessment involves external factors. And while this does give the clinician a sense of who the patient is, none of these indexes directly address the internal dynamics of the patient. Psychological treatment would be an exception here, but at the same time psychological work seldom addresses the brain. This article explores the internal factors involved in conceptualizing a medical case, addressing both the mind and brain. Which I believe takes us to places where medicine doesn’t usually go for diagnosis, assessment, and treatment.

In general, I do not find the traditional, fragmented, reductionist, drug treatment based western medicine approach to working with patients to be helpful enough. And my experiences working with chronic illness, disease, and injury patients have influenced me to explore other perspectives, other conceptualizations of their suffering.

In working with highly traumatized patients, I began to sense that they all carried with them, in the “back of their mind so to speak”, a dialogue about their trauma (especially patients with C-PTSD) that resided in yet a deeper layer of consciousness. My research into this finding led to publishing my article “The Conceptualization Issue [1]”. In the article I explored 4 ideas about how the brain/mind processes internal events, particularly traumatic events. and how doctors and patients might choose to conceptualize in this manner rather than through the standard case formulation models. Here I want to expand on my original ideas toward the further development of this concept. Again, the question for clinicians and patients, why is this person’s health suffering and where do we go to find answers?

Exploring Internal Conceptualization Issues

Let’s start by looking at the insights psychoanalysis has provided us for conceptualizing illness, disease, and injury. Psychoanalytic theory and practice are organized around the idea

that we all possess a conscious mind, a pre-conscious mind, and an unconscious or subconscious mind. This is a well-established idea that psychoanalysis has worked with for over a century now. Here is the perspective that the unconscious mind “runs” all of us. I note neuroscience has demonstrated that before there is any action taken by anyone, the brain/mind is already at work preceding the moment! Yet, we are not at all aware that this is what is happening in the brain/mind.

Psychoanalytic theory and practice work with the perspective that the unconscious holds our repressed memories, our hidden desires, and our traumatic experiences. All of which continue to shape our thoughts, feelings, and behaviors, but without our conscious awareness. As a framework for understanding human behavior psychoanalysis offers us many valuable insights into the hidden motivations and conflicts that continue to influence our thoughts, feelings, and actions. And what is relevant here about psychoanalysis is its successful history of understanding the powerful influence played by that which is outside of our conscious awareness. Yet this body of theory and practice is seldom tapped into with current medical practice. It remains outside the scope of most medical practice. Which leads to the question, why should it be included in the day-to-day practice of medicine? (See below).

A second factor in my exploration of the “conceptualization issue” is the recent discovery from neuroscience, the existence of the Default Mode Network. The DMN is a set of interacting brain regions (primarily the medial prefrontal cortex, the posterior cingulate cortex, and the angular gyrus) that are most active when the mind is at rest, daydreaming, or focusing internally. This function is crucial for self-referential thought, memory retrieval, and planning for the future. In a fascinating way the DMN is active during wakeful rest, daydreaming, self-reflection, and remembering the past, where it functions as a kind of internal narrator, time machine, that allows for self-referential thought, remembering and planning, social cognition, daydreaming, and creativity. It integrates and broadcasts memory, language, semantic representations (the ways in which meaning is represented in computational techniques) to create a coherent, internal narrative reflective of our individual experiences. It is central to the construction of our sense of self, how we perceive ourselves, and how we interact with others. In short, the DMN is super important in our daily lives.

I also note that the DMN plays a crucial role in brain development during childhood and adolescence. This is a time when many head injuries often go unnoticed, leading to cognitive decline issues that then later affect their academic performance. Sadly, the original head injuries are rarely seen as the cause of this decline. (See “The Complex Architecture of Traumatic Brain Injuries”) [2].

Thirdly, there is the idea of a stream of consciousness flowing through the mind that William James explored in 1890 from Harvard University. James viewed the stream of consciousness as an unending parade of thoughts, feelings, images, ideas, sensations, conceptions, emotions, problems, strategies, etc. He understood

that instead of a mind full of chaos, of disconnected experiences, we experience a stream of consciousness within which our last thought is recognized as a part of a stream of thoughts that our current thought is also a part of. In other words, they are connected.

For William James, the stream of consciousness was a subjective, continuous flow of our conscious experience. Like an unbroken river or a waterfall rather than a series of chopped up, disconnected parts. Our stream of consciousness is:

- 1) Personal to each of us.
- 2) Is continuously changing, because our experiences are constantly altering our perceptions.
- 3) Is continuous, because the mind does not experience any gaps in its continuity.
- 4) Is selective because the mind chooses to focus on certain sensations while ignoring others.

Consciousness can also be seen as a succession of discrete instances that all flow together. Or as individual drops or pulses that all flow together.

Discussion

Now, what does any of this have to do with the conceptualization issue? If we blend together the dynamic presence of the unconscious from psychoanalysis. Blend in the presence of the default mode network from neuroscience. And understand the human brain/mind as a continuous stream of consciousness which we are mostly unaware of. What conclusions do we arrive at regarding how we understand the practice of modern medicine?

As I mentioned earlier (see above), it was my work with highly traumatized patients that led me to explore deeper answers to the sources of their suffering. As well as understanding exactly what kind of treatment structure they needed to recover from their trauma (both psychological and physical). Here is where I came upon my understanding that there are two levels/layers to our stream of consciousness. As one of my patients recently share with me: “It felt like I had two streams of thought going on at the same time, one stream that I had complete control over and another I had no control over”. Other patients I have worked with, in treatment for severe trauma, have voiced a similar experience. There is a streaming dialogue going on “behind the scenes” in their daily lives. One that is always present, and that from time to time reaches their conscious awareness. But always presents as a stream of thoughts, feelings, and past experiences. From another patient: “I would hear voices in my head saying random things, bringing up random memories out of the blue, repeating my thoughts back to me, repeatedly repeating certain words, and saying things that would contradict my emotions. The constant talking in my head made it impossible for me to focus on anything”. Needless to say, this is an extremely difficult way to live your life. And for this patient this second stream of consciousness began around 2-3 years of age.

Exploring another example, a long-term patient told me repeatedly that he was able to survive living with a sadistic father by distracting

himself through academic work and sports in high school. But after graduating from high school, and without the academic and athletic structure of high school, he had a psychotic break for several months before entering college. And the psychotic break consisted of a bizarre stream of all the traumatic events he had been through growing up with his sadistic father. These traumatic events were there all along, but he managed to keep them out of his conscious, stream of consciousness through the distracts of school, a consistent girlfriend, and high school sports.

These examples from my clinical work have led me in the direction that all of us have a deeper level of our stream of consciousness that contains our negative experiences, and that without this “protection” we would be overwhelmed by difficult thoughts and feelings. Which also leads me to believe that this is the basis of psychosis. The breaking through into our conscious awareness of that which is negative and problematic for the person. In other words, traumatizing for the person. And if I follow the logic of my novel series, “Moon Over Seaville” in 4 Episodes, then negative energy has a force/influence factor of 13, while positive energy only has a force/influence factor of 5 [3]. In this case, it takes 3 times the amount of positive energy available to contradict the force field of negative energy. And this is exactly what happened to Mr. C (above and written about in my original “Conceptualization Issue” article [1], after he graduated from high school and he no longer had the structure of school to contain his traumatizing experiences growing up in a household with a very sadistic father.

Here is another case that explores the “conceptualization issue” from the perspective of physical injury and major depression. I find all these cases related to the conceptualization issue fascinating, while I believe they lead us to some very different and difficult places in medicine. Any valuable theory, idea, or perspective in medicine needs to promote healing and health in the long run. And I have been asking myself whether a deeper level of our stream of consciousness is one accurate. And two will help the patient and their doctor create a successful treatment outcome.

I have written about Mr. M elsewhere [4] exploring his case in terms of Symptomatology and Complexity Science. Here I will add another dimension to his struggle to regain his health. In terms of diagnosis, impairments, and symptomatology, Mr. M had a mild, undiagnosed, case of CP (my opinion) that at present he does not believe is entirely accurate. This diagnosis might hold some truth for him but for now he prefers not to think that he might have been struggling with CP all his life. For him, this diagnosis is just one more burden to have to deal on the path to regaining his health.

His major medical issues are constant dizziness throughout the day (especially when he is standing up), and an inability to walk because his leg muscles contract and don’t relax, making walking impossible. Since he has always been an active individual, he now finds that he can’t enjoy his life anymore. No more trips to the racetrack to watch his horse run. No more travel adventures. And no more daily hiking adventures. A huge crimp in his lifestyle! His health took a downward spiral following surgery for cervical

stenosis several years ago. At first the surgery appeared to have helped his situation, but six months following the surgery his life began a steady, downhill course as he began to lose functionality in his life, and he could no longer do what he was enjoying with his retirement. Then I ask what else might be going on that is affecting his health? He has a running dialogue with major depression and suicidal thoughts. He has repeatedly told me that he would not take his own life, but the suicidal thoughts are always in “the back of his mind”. But is “the back of his mind” really the unconscious stream of consciousness that I am observing. The dialogue is always there, but he is not conscious of it until certain moments, and it is always in continuous motion as is our conscious stream of consciousness.

All of which leads to the question: what influence on Mr. M’s health does this mostly unconscious “running dialogue” about major depression (from the losses he is experiencing) and suicidal thoughts (feeling that his life is no longer worth living) have on his health?

The Importance of the Sense of Self

In the decade now that I have been working with neurological disorders (TBI, strokes, seizures, brain infections, hydrocephalus, dementia, major mental illness, and PTSD), I have come across an interesting perspective on the healing of trauma to the brain. That the patient’s sense of self matters a great deal in the recovery process.

Our brains create a “sense of self” by integrating bodily sensations, memories, and emotions through specialized neural networks, primarily involving the medial prefrontal cortex and the posterior cingulate cortex. These neurological processes create a “narrative self” (personal history) and a “bodily self” (a physical presence) that together constitute a stable sense of identity across time (The Self) [5]. The key brain mechanisms for self-creation include: The DMN (default mode network). Neural representations of the body, where the brain is constantly monitoring physical sensations creating a foundational “I” that feels, thinks, acts, and exists in space. The mPFC, an area of the brain central to self-reflection and evaluating information relative to the Self. The anterior cingulate cortex (aPCu), identified as a key hub connecting the physical narrative with aspects of the Self [6].

Cultivating a healthy sense of self and acknowledging the patient’s “sense of self” is essential for a compassionate, effective, and sustainable practice of medicine. However, I seldom see this perspective in practice. The brain preserves our “sense of self” through a complex network of regions that integrate bodily sensations, autobiographical memories, and self-reflective thoughts. But rather than a single location in the brain, the Self is a dynamic construct (constantly being constructed) that is sustained by constant communication across many neural systems. But again, the issue of the Self is seldom if ever fully addressed in modern medicine.

For a patient like Mr. M, addressing how he is experiencing his

medical issues is crucial. He is receiving some attention for how he is feeling, but not at the depth I believe he should be receiving it.

Conclusion

Stepping back to take a broader view of the practice of modern medicine and the issue of conceptualization, I see the need for a major shift in perspective. As I mentioned at the beginning of this article, I am not satisfied with a medical treatment protocol that empathizes with a reductionist, fragmented, drug-based treatment approach. I believe modern medicine needs to address the process of illness, disease, or injury and not the labels. We need to stop treating labels and start re-wiring the brain. And this would include treating a nervous system that is overwhelmed, integrating sensory stimulation in ways that the brain/mind can absorb and process accurately, and treating emotional dysregulation as it takes a person off a healthy life-course. Basically, we are exploring the processes behind the problem and not medicating away the causes. Within this perspective we are looking at: affect regulation, increases in sensory overwhelm, internal conflicts, relational problems, and too little regulatory scaffolding. Stating another way, I am suggesting a shift from disease models to processing models. And understanding how the brain/mind is organized to meet these challenges, and when it is unable to do so.

Following this major change in perspective from labels to mind/brain/body processes and brain/mind organization, where does the Sense of Self and Conceptualization fit into this picture? I am suggesting from my experiences with trauma patients, both mind and brain trauma, that the Sense of Self should be at the center of treatment. Not just the heart problem or the kidney infection/disease, but the person who is experiencing these physical symptoms. In my work with brain trauma patients, over and over again I found that patients want to talk about themselves. And as I

discovered, the more they worked on their Sense of Self the more rapidly their healing progressed. As I worked with more brain injured patients, it became very clear that along with the physical injuries to the brain, the person's Sense of Self was also damaged. And in a fascinating way, the more that the Sense of Self was repaired/healed the greater were the chances for patients to recover their daily functionality because their brains were recovering.

In terms of conceptualization, I have come to understand that unconscious processing matters to all of us, that our Sense of Self is directly related to the DMN, and that our brain/mind functions as a stream on 2 levels. And that the deeper level is where the trauma, pain, confusion, frustration, and primitive emotions reside in all of us. What I have found by listening to my patients describe their brain/mind experiences, is that given time, patience, support and a good work ethic by both the patient and the clinician, PATIENTS DO GET BETTER!

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