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Understanding Generalized Anxiety Disorder: Effective Case Conceptualization Using the Temporal/Contextual Model

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Abstract

This article examines generalized anxiety disorder (GAD) using a new holistic case conceptualization model, the Temporal/Contextual Model, which was first presented in the authors' book, *Case Conceptualization and Effective Interventions for Counselors*. Clients with GAD can present a challenge for counselors because of their deeply ingrained belief systems, the pervasiveness of the anxiety symptoms, and problems with emotional regulation, which may be long-standing. Having a thorough understanding of both the symptoms of the disorder and the environmental factors contributing to the development and maintenance of the disorder are critical for gaining an understanding of the client's problems, establishing a strong therapeutic alliance, and helping the client confront and begin to recover from a disorder that impacts many aspects of the client's life. However, counselors are often overwhelmed by the volume and breadth of information needed to understand a client with GAD and struggle with making sense of precipitating and contributing factors. In this article, we describe a new case conceptualization model that helps counselors compile, organize, and analyze intake information, examine the various biopsychosocial factors that put individuals at risk for anxiety disorders or help maintain them, and thus more effectively help clients dealing with the challenges of GAD.

Keywords: case conceptualization, generalized anxiety disorder

Introduction

The word *anxious* is part of our everyday conversation. Most of us have felt anxious about an upcoming test or doctor's appointment, or experienced a feeling of anxiety before going to a social event. You may even have noticed that sometimes you feel "anxious" without a clear understanding of why.

Anxiety is a normal part of the human condition and can be useful when it helps us anticipate and appropriately respond to possible danger. When we experience a stressful event, whether real or imagined, the body reacts by activating the sympathetic nervous system, which leads to a fight-or-flight response. Normal stress, or "eustress," is part of everyone's daily life. Richard Lazarus (1966) first used the term eustress to describe the healthy reaction to stress that leads to a positive behavioral response and feelings of success. Lazarus (1966) believed that people had to perceive a situation as anxiety provoking in order to trigger this stress response—the thoughts that an individual associates with an event determine if it is perceived as threatening and if a positive outcome is viewed as achievable (Lazarus, 1966). If a positive outcome is viewed as possible, we face the stressor, do what we have to do, and feel good about it afterward. In fact, there is a great deal of research that shows that some stress or anxiety (but not too much) actually increases performance (Davies, Matthews, Stammers, & Westerman, 2013).

Unfortunately, for some, the normal level of anxiety can become extreme and excessive, and the ways of responding to it can then become dysfunctional, negatively impacting mental and physical well-being (Wagner, 1990) and leading to an anxiety disorder. Our current understanding of anxiety disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) is as a cluster of mental health disorders marked by feelings of excessive worry, physical distress, irrational fears, and apprehension about the future. This severe anxiety occurs during situations where most people would not experience a significant level of concern or worry, and reactions are markedly different from normal reactions to stress (). Unlike the comparatively mild and transitory anxiety caused by a stressful event, such as a minor car accident or a presentation at work, anxiety disorders last much longer and get progressively worse if not treated.

Anxiety disorders are among the most common mental health issues in the United States (Kessler, Berglund, Demler, Jin, & Walters, 2005). Anxiety disorders impact roughly 10% of the adult (over 18) population at any given time, translating into over 40 million individuals (Kessler, Berglund, et al., 2005; Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012). Numbers are similar if not larger for children and adolescents (Beesdo, Knappe, & Pine, 2009; Burstein, Beesdo-Baum, He, & Merikangas, 2014). Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance abuse, which may start as a form of self-medication. In some cases, these co-occurring disorders need to be treated before or simultaneously in order for the client to respond to treatment for the anxiety disorder (Kessler, Chiu, Demler, & Walters, 2005).

A variety of therapeutic interventions for anxiety disorders are available that can help individuals lead satisfying and productive lives. Many individuals, however, do not seek treatment because they are ashamed to seek help or feel that they are coping the best

they can under difficult circumstances (van Beljouw, Verhaak, Prins, Cuijpers, Penninx, & Bensing, 2010). When not treated, anxiety disorders can become debilitating, impacting personal relationships, career, or school, and can even make such common activities as shopping, driving, or making a phone call extremely difficult. Anxiety disorders have been shown to affect morbidity and mortality rates, work productivity, and alcohol and other drug use (Hoffman, Dukes, & Wittchen, 2008; Leon, Portera, & Weissman, 1995; Wittchen & Fehm, 2001).

In this article, we focus on one of the most commonly treated anxiety disorders in counseling settings, generalized anxiety disorder (GAD). We utilize a newly developed case conceptualization model (the Temporal/Contextual Model) to explicate the various biopsychosocial factors that put individuals at risk for anxiety disorders or help maintain them, with the goal of increasing understanding. By applying a case conceptualization model, counselors can more effectively help clients deal with the challenges of GAD.

Case Conceptualization for Clients with Anxiety Disorders

All counselors recognize the importance of case conceptualization; however, there are few models of case conceptualization that provide an articulated framework of the process. The models that do exist are tied to a specific theoretical orientation, making their broad application to the diverse clients with whom counselors work difficult. The Temporal/Contextual (T/C) Model is a holistic, atheoretical model designed to facilitate the counselor's understanding of the client, which can be used with clients dealing with a

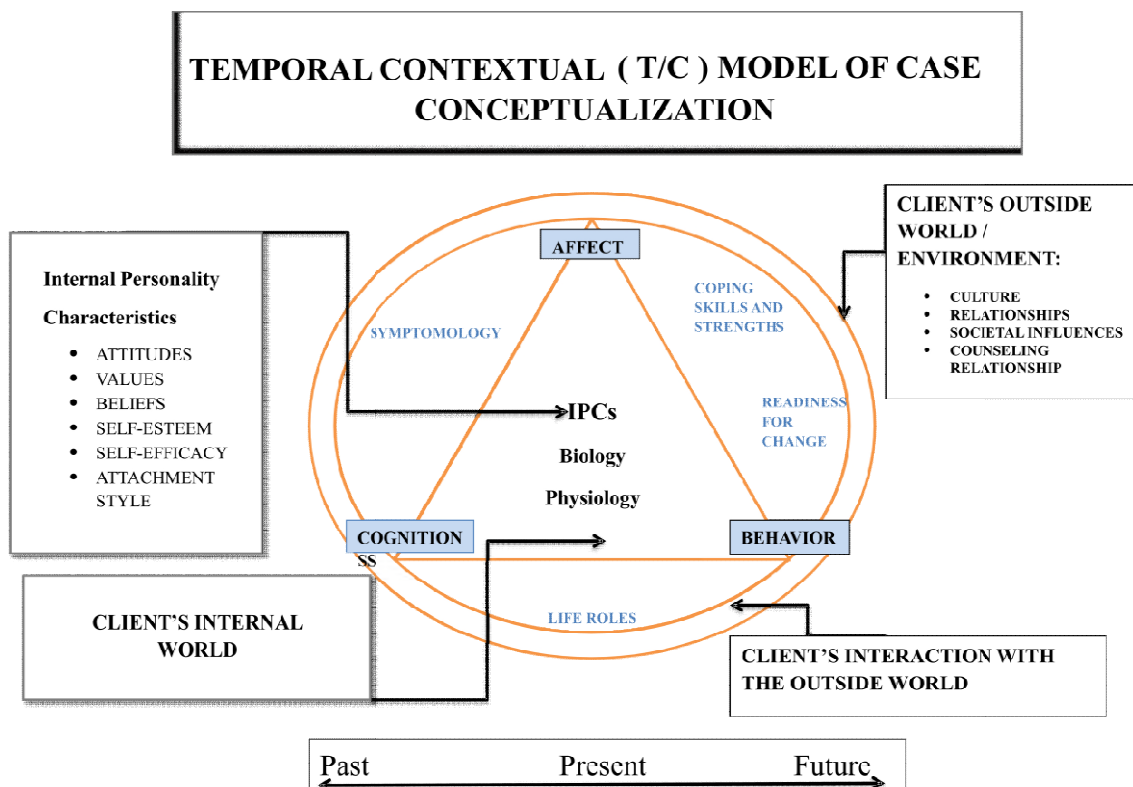


Figure 1.

wide range of presenting problems. The Model is both comprehensive and streamlined, with a visual flowchart in addition to a full description, making it easy to utilize in practice and teach to students. Highlighted within the model are the client's internal world, including attitudes, values, and belief systems; the client's external world, including environment, relationships, and culture; and the important processes of interaction between the internal and external worlds (behaviors, symptoms, readiness for change, coping skills, and life roles). The model also includes a timeline, which allows a focus on past experiences and future goals, as well as a reminder of the importance of the here and now of the present counseling experience.

The Model

A brief description of each domain of the T/C Model follows.

The Triangle

The triangle represents the three major elements of human experience and expression: behavior, cognition, and affect (emotion; Greenberger & Padesky, 1995)—the client's experienced world, both psychological and physiological. Represented within is the client's personality, which embodies the internal personality constructs (IPCs) that form the client's values and beliefs, self-concept, and world view. These internal personality constructs also include the client's attachment style, sense of self-efficacy, and self-esteem. IPCs impact the way that the client perceives their environment, including perceptions of risk, and how well they cope, and influence the client's readiness for change.

The points of the triangle—behavior, cognition, and affect—also connect to the outside world. Cognition includes the client's perception and interpretation of information, beliefs about self and others, attachment status, and relationship style, developed over time through interaction with the environment. Behavior encompasses what clients “do”—eating, sleeping, activity level, and withdrawal, as well as the counselor's observations of the client in session. Affect includes the client's ability for emotional regulation, which can be a challenge for clients with GAD, leading to anxiety and panic. Affect also encompasses awareness and expression of emotions. The relationships among the points of the triangle and the outside world are reciprocal. The client's beliefs (cognition) and emotions (affect) impact behavior, while emotions are tied to thoughts and experience. The client's perceptions of biological and environmental experience influence thinking style (Bronfenbrenner, 2009; Bronfenbrenner, & Morris, 1998). In order to understand and empathize with clients, counselors can be most effective by keeping in mind the interrelationships between constructs.

Physiology and biology take into account clients' individual differences as well as strengths and vulnerabilities in physical health and constitution. This construct also includes an understanding of genetic predispositions and temperament, reaction to stress, biochemical differences in neurotransmitter function, and other brain chemistry factors, which are often implicated in GAD. Genetic and physiological factors influence the client's thoughts, emotions, and behavior, the points of the triangle. For example, the client's beliefs, developed from the interaction of personality, biology, and experience (environment) create “hot thoughts,” which are directly connected to affect (Beck &

Beck, 2011). A “hot thought” is a thought that causes an emotional reaction such as anxiety, usually based on the present environmental stimulus and the individual’s attitudes, values, and beliefs regarding the meaning of that stimulus.

The Inner Circle

The inner circle represents the boundary between the client’s internal and external worlds, the space where the client interacts with the environment and the environment is in turn impacted by the client (Bronfenbrenner, & Morris, 1998). Symptomology is the first and perhaps most obvious construct on the inner circle. Both somatic symptoms and psychological symptoms must be assessed and understood before moving forward to a diagnosis. Also included in the inner circle are the client’s coping skills and strengths and their readiness for change (Prochaska & DiClemente, 1986), which must be uncovered before the client moves into the process of change (Prochaska & DiClemente, 1982). These coping strategies, client strengths, and motivation for change are located on the inner circle since they can impact the development of either symptoms or healthy adjustment.

The final construct in the inner circle is an understanding of the client’s life roles. We all play multiple roles in life—mother, daughter, sister, coworker, accountant, friend—and each role influences both what we do and how we view ourselves (Clark, 2000). Life roles are depicted along the inner circle since these impact the way the client responds to stressful environmental events and are in turn influenced by the norms, values, attitudes, and beliefs that the client has learned. The client’s negotiation of multiple and sometimes conflicting roles has an influence on identity development and can impact the client’s self-esteem and level of stress and anxiety.

The Outer Circle

The outer circle represents the multiple environmental and relational influences that impact the client (and are in turn impacted by the client). These include the client’s interpersonal relationships (family, peer, romantic, and the client/counselor alliance), culture, socioeconomic status, community, social structures, and societal norms that influence identity and experience (Bronfenbrenner, 2009; Clark, 2000). These constructs are interrelated. Environment, for example, plays a critical role in how the client’s IPCs are constructed, and various environmental conditions have differential impacts depending on the client’s developmental stage (Greenberger & Padesky 1995). Within the environment reside the precipitating stressors that may have brought the client to counseling. Symptoms occur when the person’s risk factors and vulnerabilities overwhelm their strengths and coping strategies, and are depicted in the diagram as located in the intersection between person and environment.

Timeline

The line at the bottom of the model represents time: past, present, and future. The timeline implies both context and setting and reminds both counselor and client that events that happened in the past can be interpreted differently in the light of the present. Environmental factors from the client’s past may have shaped thinking style and self-concept, creating a vulnerability to stressors. Thus, it may be important to explore the client’s early family experiences in order to gain insight into whether certain cognitions

are distorted or behaviors are maladaptive. All of us learn some irrational beliefs as part of the socialization process of childhood (Corey, 2009). The incorporation of the timeline allows counselors to be flexible in assessing a client's current circumstances by examining a client's identity across time and focusing on the future.

Counselors take into account the client's behaviors, thoughts, and feelings in the present by using a here and now focus to clarify and challenge whatever is getting in the client's way. The incorporation of the Timeline reminds us, however, that knowledge of the past can impact the client's progress in the here and now. A clear image from the past can also be used as a starting point to imagine a future self, with fewer problems and a healthy, positive identity. This imagined future self can serve as an aspirational goal, increasing motivation. The model, in this way, lends flexibility to the counselor, with the ability to focus on past experiences, the here and now, and future decisions and actions.

Generalized Anxiety Disorder (GAD)

Because GAD is often a long-standing problem, the T/C Model is particularly useful as an economical way of gathering data and making sense of the client's history, while at the same time facilitating a thorough assessment. Both biological and psychological factors may be relevant; there may be a genetic predisposition to anxiety, as well as a learned component. The T/C Model also explicitly reminds counselors to gather information on strengths, resources, coping skills, and supports. Such information allows the counselor to empower the client, who may be experiencing feelings of hopelessness in the face of a prolonged and pervasive disorder.

People with generalized anxiety disorder (GAD) suffer from extreme amounts of worry accompanied by physical distress and behavioral disturbances. This excessive worry has no specific trigger and lasts for several hours to most of the day, and includes thoughts of impending disaster that focus on family, finances, career, health or relationships. As the name suggests, the anxiety is generalized to almost all aspects of the client's life, unlike other anxiety disorders like specific phobias or social phobia. For some, the anxiety can be so severe that getting out of bed is a struggle (American Psychiatric Association, 2013).

People diagnosed with GAD feel like they have no control over their thoughts, even though they realize that much of their anxiety is irrational or unjustified. They have trouble sleeping or staying asleep and often describe themselves as being in a heightened state of arousal. This excessive worry is associated with specific physical symptoms such as muscle tension, being easily fatigued, difficulty concentrating or mind going blank, irritability, sleep disturbance, and feeling keyed up, restless, or on edge (Rowa & Antony, 2008).

GAD affects about 3% of the population, or 6.8 million American adults (Kessler, Berglund, et al., 2005; Kessler, Chiu, et al., 2005). GAD can begin at any age, but usually develops between childhood and middle age. Although a specific cause is not known, there is evidence that heredity and environment may play a role (Hettema, Neale, & Kendler, 2001). Many people with GAD report having feelings of anxiety and fear for as long as they can remember. Though there are periods of lesser symptoms at times of relative calm, the anxiety always returns, and rates of full remission are unfortunately low (American Psychiatric Association, 2013).

The key feature of GAD is an excessive amount of worry about some future event or occurrence. The worry occurs in multiple situations (e.g., school, work, driving); happens more days than not; and lasts for at least 6 months (American Psychiatric Association, 2013). Individuals with GAD feel like their thoughts are spinning out of control and become preoccupied with fears of imminent disaster, making it hard to concentrate and resulting in a strong emotional response. The sense of fear is so strong that they may be reluctant to give their hypervigilance up, wanting to be prepared for what is coming (Rowa & Antony, 2008).

Comorbidity

People with any anxiety disorder are likely to fit the diagnostic criteria for one or more of the other anxiety disorders as well; these include depressive, eating, or substance abuse disorders (American Psychiatric Association, 2013; Brown & Barlow, 1992). One study found roughly 60% of clients receiving treatment for an anxiety disorder met criteria for major depression (Brown, Campbell, Lehman, Grisham, & Mancill, 2001) or an eating disorder (Godart, Flament, Perdereau, & Jeammet, 2002; Kaye, Bulik, Thornton, Barbarich, & Masters, 2004). There is also a high comorbidity with substance abuse, with studies suggesting that as many as 54% of clients with some type of anxiety disorder also have a co-occurring substance disorder (Jané-Llopis & Matytsina, 2006; Kessler, Chiu, et al., 2005). Clients with GAD are especially susceptible to having another anxiety disorder (Yonkers, Dyck, Warshaw, & Keller, 2000).

Differential diagnosis is essential to make certain that the client's symptoms are not due to substance use/abuse or a medical condition. In order to develop an accurate case conceptualization, the possibility of co-occurring disorders and substance use must be assessed and considered.

Cultural Considerations

Both gender and culture are linked to prevalence and symptom variation of anxiety disorders (American Psychiatric Association, 2013). Different cultures vary in norms for how anxiety and worry are expressed. In some cultures, physical symptoms may predominate in the expression of anxiety, while in other cultures cognitive symptoms are more prevalent (American Psychiatric Association, 2013). Therefore, it's important to take background and culture into consideration during case conceptualization, as the T/C Model stresses.

For example, a large-scale epidemiologic survey found that Caucasians had a higher risk for generalized anxiety disorder and social anxiety disorder; however, while there were lower rates for Hispanic subjects, the difference was only found in younger age groups (i.e., under the age of 43; Hoffmann, Asnaani, & Hinton, 2010). The situations that trigger anxiety in a particular culture tend to relate to environmental challenges and belief systems that are specific to that culture (Kirmayer, 2001).

Cultural variation in symptoms may also be impacted by variation in common fears and thought patterns. When there is a pervasive cultural fear, clients may be hypervigilant for those specific symptoms and may overreact to any indication of those symptoms (Lewis-Fernandez et al., 2009). The counselor's own cultural beliefs about the meaning of anxiety symptoms can influence diagnosis as well (Lewis-Fernandez et al., 2009).

Until recently, anxiety in children was viewed as less serious than anxiety in adults, with more children referred for behavioral problems, acting out, substance use, or suicidal thoughts than for anxiety (McKay & Storch, 2011). Yet, anxiety disorders are the most common type of mental disorder in children as well as in adults and can have a significant impact on child development (Kessler et al., 2012; McKay & Storch, 2011). Anxiety interferes with children's ability to make friends, with their academic success, with career options, with self-esteem, and with family relationships. Children who suffer with anxiety have fewer friends on average (Rapee & Melville, 1997), which may then delay the development of their socialization and relationship skills. Since they often struggle with assertiveness, these children may be more likely to be bullied and may avoid group experiences, such as dances or class trips. Anxious children and adolescents who do not receive treatment may grow up to be anxious adults, putting them at risk for substance abuse, depression, and relationship problems (McKay & Storch, 2011).

While many of the symptoms of anxiety in children are similar to those of adults, some symptoms vary with age. Both children and adults may be overly focused on negative outcomes, experience somatic symptoms, and avoid frightening situations. Young children may also exhibit additional symptoms of anxiety, such as bedwetting, selective mutism, acting out, or may be unusually dependent on a parent or caregiver. Because of their developmental stage, children usually have less cognitive insight into what is causing the anxiety.

Parents, teachers, and clinicians sometimes misinterpret children's symptoms as being due to oppositional behavior instead of anxiety. For example, an anxious child may refuse to go to school because of fear and due to avoidance, whereas an oppositional child may refuse to go to school in order to be able to remain at home playing video games. The behavior is the same, but the motivation—and thus the treatment—is different (Mash & Barkley, 2014).

In general, anxiety disorders are more prevalent in women than in men, with women twice as likely to be diagnosed with an anxiety disorder (American Psychiatric Association, 2013; de Graaf, Bijl, Ravelli, Smit, & Vollenbergh, 2002). The difference may be related to gender roles, with men pressured to confront their fears, a strategy which can be more effective than avoidance in reducing the cycle of anxiety (Wittchen, 2002). The same gender differences in referrals are found for children. Parents may be less willing to accept and recognize anxiety symptoms in boys, and thus less likely to seek treatment for them. Women are also more likely to have experienced some sort of trauma, including higher rates of sexual assault, which can lead to an increased sense of vulnerability and the perception of danger (Tolin & Foa, 2006). Males, however, tend to have more comorbid diagnoses of substance disorders (American Psychiatric Association, 2013).

Biological and Genetic Risk Factors

Studies suggest that anxiety disorders can be caused by biological, genetic, and environmental factors, and researchers are continually striving for a more comprehensive model of the roles that stress, biology, and genetics play in anxiety (Bystritsky, Khalsa, Cameron, & Schiffman, 2013). Some of the current research focuses on brain chemistry, including chemical imbalances (norepinephrine and serotonin; Charney, 2003; LeDoux,

2000). Regions of the brain that control the fear response seem to play a large part in some anxiety disorders (Wehrenberg & Prinz, 2007).

Temperament factors may play a role in genetic predisposition toward anxiety. For example, individuals who are highly reactive to changes in their environment may experience an elevated stress response when faced with life stressors and transitions (American Psychiatric Association, 2013; Carthy, Horesh, Apter, & Gross, 2009). There are several individual characteristics associated with an eventual anxiety disorder diagnosis, including: behavioral inhibition (Hirshfeld-Becker et al., 2008), negative affectivity or neuroticism (Carthy et al., 2009), heightened physiological response (Weems, Zakem, Costa, Cannon, & Watts, 2005), emotional dysregulation (Carthy et al., 2009; Suveg & Zeman, 2004), and harm avoidance (American Psychiatric Association, 2013).

Anxiety disorders also tend to run in families, suggesting that a combination of genes and environmental stressors can produce the disorders, with risk factors associated with both a genetic predisposition and the ways that heredity interacts with environment. Twin and family studies of anxiety disorders estimate heritability across the anxiety spectrum in the range of 30% to 50%. This is a lower percentage than for disorders such as schizophrenia and bipolar disorder, however, which allows for the largest amount of the variance to be explained by individual and environmental factors (Abel & Zukin, 2008; Hettema et al., 2001).

The Role of Experience

Research on environmental factors linked to anxiety disorders suggests that while some individuals' anxious tendencies may be inherited, anxiety and worry can also be learned from significant others who regularly exhibit anxiety around them. Environmental factors linked to anxiety disorders include parental anxiety and overprotection (van Brakel, Muris, Bogels, & Thomassen, 2006), mothers with depressive disorders (Field, Henandez-Reif, & Diego, 2006; Pelaez, Field, Pickens, & Hart, 2008), and exposure to traumatic events (Briggs-Gowan et al., 2010; Litrownik, Newton, Hunter, English, & Everson, 2003). A traumatic experience may also trigger excessive anxiety in a person who had previously been coping in an adaptive way with stressors (American Psychiatric Association, 2013). Parental overprotection and childhood trauma have been linked with anxiety disorders in general.

It is clear from the research that anxiety disorders, including GAD, are complex and caused by multiple factors. Heredity and biology, as well as learning and experience, combine to create a predisposition for anxiety. Further, multiple stressors can tip the balance into developing GAD, making the assessment and conceptualization process crucial to effective counseling.

Case Conceptualization for GAD

Clients who suffer from anxiety are often “triggered” by a situational context, physical sensation, belief, or thought. On the T/C Model, these triggers reside at the intersection of the client's outside world and Internal Personality Constructs. Many clients are unaware of these triggers and often report that their anxiety “came out of nowhere.” Thus, a crucial part of the case conceptualization is an exploration of the

client's environment to identify these triggers and how they intersect with the client's internal world. The counselor may ask the client to keep a daily log so that client and counselor can together discover what preceded an episode of anxiety. What were the client's thoughts at that time? Where were they? What are the associations the client has for that situation? What are the client's beliefs about themselves and their ability to handle situations perceived as dangerous (self-efficacy beliefs)?

Internal Personality Constructs, including belief systems, attitudes and thinking styles, are thus an important part of the T/C conceptualization. Self esteem and self efficacy also fall under this component, impacting the client's assessment of risk.

Clients with anxiety disorders often have thoughts that revolve around over-evaluation of the threat of danger, as well as the undervaluation of their coping abilities. Common "hot thoughts" for both children and adults with anxiety are about disastrous outcomes like "I'm going to fail" or "Everyone will laugh at me" or "If I try this, I'll get hurt." Children are also likely to worry excessively that something bad will happen to their parents.

Not all triggers fall within the cognitive domain. Inside the T/C Model triangle, along with IPCs, are the client's biology and physiology. Sometimes even the physical signs of stress, like an elevated heart rate, coupled with hypervigilance, can trigger anxiety. Clients who suffer from anxiety and panic may want to avoid caffeine and other stimulants that can create some of the physiological symptoms of panic (Eysenck, 2013). The T/C Model is particularly useful in helping clients understand the ways in which physiological, cognitive, and emotional aspects of anxiety disorders intersect to create and maintain symptoms, leading to an increased sense of self efficacy.

Clients with anxiety disorders may be hypervigilant, always on the lookout for something that sets off their fear. This constant sense of imminent disaster creates a great deal of stress and further increases the client's anxiety level. Clients with high levels of anxiety have a strong sense of personal vulnerability, so it is important to gain a good understanding of their Internal Personality Constructs (Richards, Benson, Donnelly, & Hadwin, 2014). Clients often avoid or attempt to escape a situation because of this tendency to over appraise the threat level of circumstances. Thus, the client never gets a chance to see if they can be successful or learn positive coping skills. Paradoxically, this heightened state of vigilance may be reinforced when the disaster does not happen, since the client may believe that their efforts were rewarded. The cycle of fear and avoidance which is created for many people with anxiety disorders creates a reinforcement schedule that unfortunately increases anxiety symptoms.

Long-standing beliefs about having to stay vigilant against threats, coupled with beliefs that their internal/external resources are not enough to cope, can create feelings of foreboding for the future. Clearly, an assessment of the client's coping skills, strengths and resources is crucial, which can be used to modify dysfunctional beliefs about being able to cope. The T/C Model explicitly reminds the counselor to thoroughly assess this important component of functioning.

It is important to thoroughly investigate environmental factors contributing to the anxiety disorder, including the use of the Timeline to examine influences from the past. Experiencing multiple stressful life events can reduce feelings of safety and make the world seem like a dangerous and threatening place. This sets the stage for the

hypervigilance and avoidance behaviors that put an individual at risk for an anxiety disorder.

There also can be a learned component to the anxiety which stems from important relationships: the client's relationships, past and present, are part of the Environmental component of the T/C Model. Clients may have learned their responses from others (anxious parents, teachers, caregivers, or peers), so some exploration of past experiences may lead to greater understanding and client insight. There may also be some genetic predisposition to generally higher levels of anxiety or difficulty with mood regulation, which can also be explored in the client's history (Forsyth, Eifert, & Barrios, 2006; Gross & Hen, 2004). Finally, the T/C Model includes an assessment of cultural beliefs which may impact both the specific triggers and expression of anxiety symptoms, and an assessment of the client's readiness for change.

With these considerations in mind, what follows is a case conceptualization using the T/C Model with a client named Adam.

The Case of Adam

Adam is a 32-year-old man who has recently decided to go back to college. He is married with two small children. He and his wife, Carol, both work full time. Adam works as a car salesman and Carol as a preschool teacher. Adam has recently sought counseling for what he describes as uncontrollable anxiety and feelings of impending doom. He is having difficulty sleeping and complains of recurrent stomach pain, headaches and muscle aches. Some days, the physical symptoms are so severe that Adam is unable to go to work. He has missed five days in the past month and is terrified that he's about to lose his job.

Adam says that he has always struggled with anxiety, especially when he feels like he is being evaluated. He has had stomach troubles since he was a small child and remembers getting sick before school on many occasions. Adam went to a very competitive private school and describes his high school years as difficult and demanding. He was always under a great deal of stress to perform well academically and in extracurricular sports. His parents are both faculty at a local college, and Adam describes them as strict and demanding and has difficulty remembering times that they showed any warmth. Adam was always afraid in class that teachers would call on him and that he would be unable to answer the questions correctly. Although he got high grades (As and Bs), he attributes this to hours of preparation and worry, and not to any internal positive characteristics. Adam decided because of his debilitating anxiety, and to the great dismay of his parents, to postpone college even though he got into several good schools.

While Adam does not describe his parents as warm or loving, he says he does believe they love him, but didn't know how to show it. Adam also spent time with his maternal grandparents while his parents worked. He remembers his grandmother would not allow him to play outside with the other children, insisting that it was "too dangerous." Both his grandmother and his mother would sometimes "take sick" and withdraw from the family; Adam now realizes that both women used alcohol as a means of coping with their own fears and admits that drinking has helped him "calm down" on occasion.

Adam chose his current profession because he felt he would have limited contact with people and would not experience the feeling of being evaluated or looked down upon by his coworkers and supervisors. He has little face-to-face contact with his coworkers and works independently. Although he does a good job and has been successful so far, he is limited in his upward mobility by his anxiety, which keeps him from advocating for himself and limits his relationships with coworkers, as well as by his lack of a college degree. His wife has been pushing him to get at least an associate's degree so that they can increase their family income, which led to Adam finally enrolling in classes at the local community college. On his first night of classes a week ago, however, Adam was barely able to listen to the professor, he was so nervous. He says he was preoccupied with a terror of being called on, not knowing the answer, and looking stupid.

When Adam arrives at the counselor's office, he slumps in the chair. He has dark circles under his eyes and is quite pale. When he speaks, he does so in a soft voice.

"I should just give up. Nothing's ever going to get better. I don't even know what I'm scared of half the time – I just am. My wife thinks I'm a failure. My family would be better off without me."

Below, we use the T/C Model to begin to develop a case conceptualization and an understanding of both the issues Adam is facing and the strengths and resources he can call upon to face them. The initial conceptualization organizes the material presented so far, which helps the counselor uncover patterns and themes that will guide understanding of core issues and eventual treatment planning. In addition, the conceptualization encourages the counselor to be thorough in gathering information, clearly indicating the areas in which more information is needed with an asterisk. The process facilitates the development of empathy and a strong therapeutic alliance, as the counselor comes to truly "get it."

As the counselor proceeds to develop the case conceptualization, he or she indicates with an asterisk those areas where more information is needed, thus helping to organize the next session. The case conceptualization is a dynamic, interaction formulation that can be used at all phases of the counseling process.

T/C Case Conceptualization Model Outline

(* denotes areas that require more information and exploration by the counselor)

Presenting Problem: Pervasive anxiety that is impairing Adam's ability to function in school, at work, and with the family; somatic problems; sleep difficulty

Internal Personality Constructs and Behavior:

Self-efficacy: low, dismisses past history of academic success in the midst of challenge; dismisses relationship success in his marriage; details of academic history*

Self-esteem: low

Attitudes/Values/Beliefs: Others are judgmental and harsh; the world is a dangerous place

Attachment Style: possibility of insecure attachment

Biology/Physiology/Hereditry: 32-year-old young adult; male; medical history*, family history of anxiety and substance use*

Affect: depressed, anxious, fearful

Cognition: Worries about failure (job, school, marriage); possible suicidal ideation *
Hot Thoughts: “My wife thinks I’m a failure.” “Nothing is ever going to get better.” “My family would be better off without me.”

Behavior: avoidant behaviors, unable to fully function at work and school, calls in sick frequently; alcohol use*

Symptomology: difficulty sleeping, stomachaches, headaches, anxiety attacks

Coping Skills and Strengths: insight into issues, past academic achievement, relationship with partner

Readiness for Change: action stage—aware of need for change and motivated toward treatment, sought counseling

Life Roles: husband, father, student, salesman, son

Environment:

Relationships: married with 2 children, wife supportive until recent anxiety attacks, conflict with father/mother; past relationship history*

Culture: family background*; upper class upbringing, parents both university faculty; specific cultural information*

Family Norms and Values: high parental expectations; academic and work success highly valued; gender roles and beliefs*; client feels like he needs to support family better

*Religious or spiritual beliefs**

Timeline:

Past Influences: Parental pressures for achievement, experiences of anxiety in K–12

Present Influences: increased anxiety, recent conflict with wife, job-related issues, school-related issues

Future Goals: job security and upward mobility, associate’s degree, ability to support family, diminished anxiety

With the initial case conceptualization in place, the next step is to think about what other information is needed before counseling can move forward. What else do you want to know? What are the initial hypotheses that flow from your understanding of the client so far?

In the case of Adam, the case conceptualization highlights areas of possible intervention. For example, because there are a number of dysfunctional thoughts and beliefs associated with Adam’s anxiety, as well as problematic behaviors such as alcohol use to numb the fear and avoidance of necessary life tasks, a cognitive behavioral approach might be most effective. In addition, Adam’s strengths and resources are clear

in the formulation and can be used to challenge his current hopelessness and create motivation and optimism for a brighter future.

As treatment proceeds, the counselor will add to the case conceptualization, further refining his or her understanding of Adam and developing intervention strategies accordingly.

Conclusion

Clients with GAD can present a challenge for counselors because of their deeply ingrained belief systems, the pervasiveness of the anxiety symptoms, and problems with emotional regulation, which may be long-standing. Having a thorough understanding of both the symptoms of the disorder and the environmental factors contributing to the development and maintenance of the disorder are critical for gaining an understanding of the client's problems. The T/C Model provides a powerful tool for developing such an understanding. The Model both allows for the complexity and breadth of a client's symptoms, background, and personality, and streamlines the assessment process. By utilizing the Model, the counselor is not overwhelmed by information, and the client feels both heard and understood. Thus, use of the Model also contributes to a strong therapeutic alliance, as the counselor helps the client confront and begin to recover from a disorder that impacts many aspects of the client's life.

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