

THEORY

Case Conceptualization: Improving Understanding and Treatment with the Temporal/Contextual Model

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Case conceptualization is a critical component of diagnosis and treatment. This article introduces a comprehensive, holistic model of case conceptualization called the temporal/contextual model. This model aims to improve the accuracy, efficiency, and effectiveness of the case conceptualization process. The temporal/contextual model is applied to a case example, illustrating its efficacy in helping a client with an eating disorder.

Before counselors can decide on interventions and set goals with clients, they must have a thorough understanding of who the client is and the context within which that individual has developed and is currently living. Case conceptualization is the process by which counselors come to this understanding, by eliciting and organizing information, developing and testing hypotheses, and working collaboratively with the client toward an integrated concept of the client's life. Case conceptualization is a core competency for counselors and considered as integral to counseling effectiveness (Betan & Binder, 2010; Sperry, 2010).

Case conceptualization includes diagnosis, but this is only the beginning of the process. Once the client's presenting problem and symptoms are known, the counselor and client together begin to explore the etiology and construct a framework that allows them both to understand the nature of the symptoms and what is maintaining them. Case conceptualization gives the counselor a blueprint for how to interact with, listen to, and ultimately help the client (Seligman, 2004). Neukrug and Schwitzer (2006) define case conceptualization as a tool that helps the counselor observe, understand, and integrate a client's behaviors, emotions, and thinking. When a thorough case conceptualization is constructed, the counselor can better understand both the client's needs and their strengths and support systems. Thus, interventions are likely to

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be more appropriate and effective, which is a benefit in today's managed care climate, with its focus on timeliness and efficacy.

The case conceptualization developed by a counselor subsequently impacts the way in which the counseling relationship proceeds. The conceptualization guides the counselor's choice of theoretical perspective, suggests which questions need to be asked, and frames interpretation of the client's answers. By employing an organized model of case conceptualization, the counselor can more easily see clearly where the client has been, where they are now, and where it is possible for them to go.

Case conceptualization includes assessment and evaluation—observing current symptoms and assessing the context within which those symptoms developed. The process also includes gathering background information—family history, relationships, identity, culture, sexual orientation, educational background, past trauma, and a plethora of other variables that together create the context of the client's life. Background information includes not only data on the challenges facing the client, but also the strengths, coping skills, and support systems that have enabled them to be in the counselor's office and will inform treatment interventions. In addition, the client's readiness for change must be assessed, as this impacts the ways in which the counselor can most effectively encounter the client. Finally, the precipitating factors that brought the client to treatment are part of the evaluation phase.

Once the information is gathered, the organizational phase of case conceptualization begins. Case conceptualization is far from a passive process; the counselor actively organizes data and observations in order to make inferences and identify themes and patterns. Once the client's core issues become clear, the counselor can develop hypotheses about the etiology and maintenance of the presenting problem and begin to set goals for change along with the client. The amount of information a client may divulge can seem overwhelming for the counselor who is hearing it; an articulated model of case conceptualization helps the counselor organize and make sense of this information and determine which is relevant and which may not be. This helps the counselor focus subsequent sessions, again enabling effective and timely treatment outcomes.

During the organizational phase, the counselor begins to piece together an explanatory framework for the client's issues, creating a "map" of the client's life story, which can then guide treatment decisions. This framework is based on culture and environment as well as on internal personality constructs (IPCs) and physiological factors. The counselor's understanding of how the client's problems developed and what is sustaining them is also informed by the theoretical perspective adopted. As the case conceptualization process unfolds, the counselor selects and draws from relevant theories of change, which also guides hypotheses and intervention possibilities. Research has not demonstrated the relative efficacy of any one theoretical model; rather, case conceptualization allows the counselor to choose the theoretical approach that fits their emerging understanding of the client's issues.

CASE CONCEPTUALIZATION USING THE TEMPORAL/CONTEXTUAL MODEL

The importance of case conceptualization is well recognized by counselors. However, the process is often not explicitly taught in training programs. In addition, many models of case conceptualization are specific to a particular theoretical orientation, limiting their usefulness. The temporal/contextual model (T/C model; Zubernis & Snyder, 2015), in contrast, is a holistic and atheoretical model that can be used with a wide variety of clients and presenting problems. A visual flowchart and worksheet demystify the process and make the model well suited for collaborative work with clients. The model's developmental approach encourages an accurate reflection of the complexity of the client's experience, while helping the counselor identify specific targets for change.

The T/C model provides a framework for gathering information and making sense of the client's often complex history; assessing a wide range of internal and external influences; and explicitly reminding counselors to gather information on strengths, resources, coping skills, and supports. This emphasis on strengths is particularly important when working with clients with long-standing issues who may feel hopeless and helpless after years of struggle. Finally, the model includes a timeline, which allows a focus on past experiences and future goals and reminds the counselor of the importance of the here-and-now experience. While the incorporation of a timeline is not unique to the T/C model (see Bronfenbrenner's [1981] chronosystem, for example), the inclusion of the timeline in the graphic model encourages the counselor to "go backwards" if needed and always to keep the client's imagined future in mind.

THE TEMPORAL/CONTEXTUAL MODEL

The Triangle

In the T/C model, a triangle represents the three major elements of human experience and expression: behavior, cognition, and affect (Greenberger & Padesky, 1995). The triangle can be viewed as the client's experienced world, both psychological and physiological. The client's personality is part of the triangle, including the IPCs that form the client's values, beliefs, self-concept, worldview, attachment style, sense of self-efficacy, and self-esteem (see Figure 1). IPCs influence how the client perceives their environment and how well they cope, which connects to the client's readiness for change (Prochaska & DiClemente, 1982, 1986).

Behavior, cognition, and affect are the points of the triangle and also connect to the client's external world. *Behavior* is what clients do, including eating, sleeping, and level of activity, and the counselor's observations of the client during a session. *Cognition* includes the client's beliefs about self and others, the way in which the client perceives and interprets information, their attachment status, and the customary ways in which they relate to others. These beliefs and interaction patterns are developed over time through inter-

TEMPORAL CONTEXTUAL (T/C) MODEL OF CASE CONCEPTUALIZATION

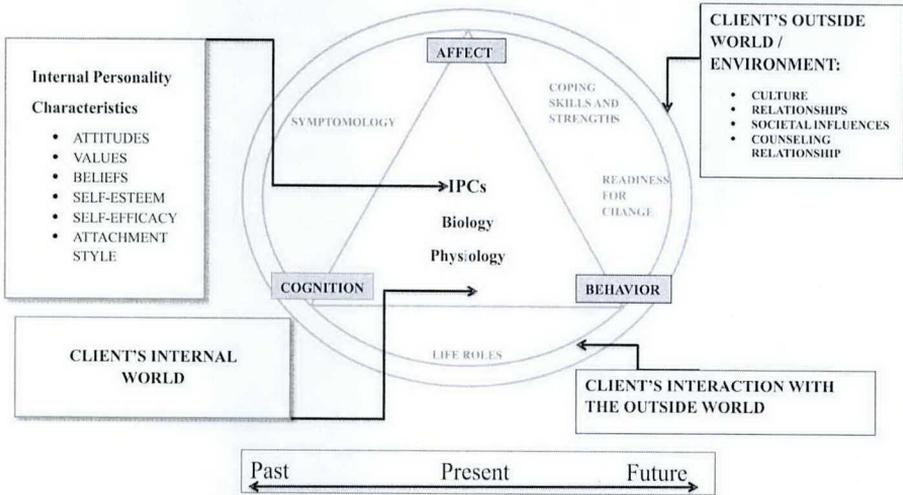


Figure 1. The temporal/contextual model of case conceptualization. From *Case Conceptualization and Effective Interventions: Assessing and Treating Mental, Emotional, and Behavioral Disorders*, by L. Zubernis and M. Snyder, 2015, Thousand Oaks, CA: SAGE (p. 55). Copyright 2016 by SAGE Publications, Inc. Reprinted with permission.

action with the outside world. *Affect* includes the client’s emotional awareness, expression, and regulation. All three have a reciprocal influence that is clearly seen in the model. The client’s beliefs and emotions impact their behavior, and their emotions are tied to thoughts and experience. The client’s perceptions of biological and environmental experience influence the client’s thinking (Bronfenbrenner, 1981). The T/C model allows counselors to be effective by illustrating the interrelationships between these constructs, which helps the counselor understand and thus empathize with clients.

The components of physiology and biology include clients’ strengths, vulnerabilities, physical health, genetic predispositions, temperament, reactions to stress, biochemical differences in neurotransmitter function, and other brain chemistry factors. Once again, these factors have reciprocal influence. Genetic and physiological factors impact the client’s thoughts, emotions, and behavior, the points of the triangle. For example, the client’s beliefs, which have developed from the interaction of personality, biology, and experience (environment), create *hot thoughts* that are directly connected to affect (Beck, 2011). A hot thought is a thought that causes an emotional reaction, usually based on both the current 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 client interacts with the environment, and the environment is in turn impacted by the client (Bronfenbrenner, 1981). Both somatic symptoms and psychological symptoms are included, along with the client's coping skills, strengths, and readiness for change (Prochaska & DiClemente, 1982, 1986).

The client's life roles represent another important factor within the inner circle. All of us play many roles throughout our lives—for example, mother, daughter, sister, coworker, physician, friend. Each role that we play influences our behavior and self-concept (Clark, 2000). Life roles are influenced by the values and beliefs the client has learned, and the roles taken on in turn impact the way the client responds to environmental events. The client's negotiation of multiple and sometimes conflicting roles has an impact on identity development, self-esteem, and stress level.

The Outer Circle

Environmental influences that impact the client (and are in turn impacted by the client) are included on the outer circle. These include interpersonal relationships (whether family, peer, romantic, or client/counselor), cultural norms and values, and socioeconomic status (Bronfenbrenner, 1981; Clark, 2000). There is again an interrelationship between constructs; factors in the client's environment have an effect on the client's developing IPCs at each stage of development (Greenberger & Padesky, 1995). Stressors in the external environment are often what trigger a client to ask for help, combined with preexisting vulnerabilities, which together exceed the client's coping skills, creating symptoms. Thus, symptomatology is located at the intersection between person and environment.

The Timeline

The timeline is used in several ways during case conceptualization. For example, there are times when a consideration of past events is warranted. Relationships and events that happened in the past shape IPCs; we all learn irrational beliefs and maladaptive behaviors as we develop. The model helps client and counselor explore early experiences to gain insight into which patterns of thinking are distorted and which are healthy. It serves as a reminder that events that happened in the past can be interpreted differently in the present. The timeline also allows an examination of the client's identity across time and is a reminder to set goals for the future, which will contribute to the client's motivation for change.

APPLICATION OF THE TEMPORAL/CONTEXTUAL MODEL

One of the strengths of the T/C model is its emphasis on client thoughts, feelings, and behavior as embedded in cultural contexts. This makes the model particularly useful in treating complex disorders such as eating disorders. In the

next section, we briefly review the research on eating disorders, focusing on the complex etiology and symptom variability that make case conceptualization and effective treatment challenging. Finally, we demonstrate the utilization of the T/C model in helping counselors understand and treat eating disorders more effectively.

Eating Disorders

According to the National Eating Disorders Association, one-third of the 30 million Americans who develop an eating disorder will be men (as cited in Birli, Zhang & McCoy, 2012). In addition, research shows that 43% of men are dissatisfied with their bodies. Concerns may focus on bulking up as well as being thin, and men may be reluctant to seek help due to shame (Birli et al., 2012).

Eating disorders also cut across age groups. A recent study in the *International Journal of Eating Disorders* reported that 13% of women over 50 had some disordered eating characteristics (Shallcross, 2013). Mid-life stresses including physiological changes, environmental transitions such as children launching, stressors related to caring for aging parents, and loss from death or divorce may trigger the disorder. Eating disorders can be especially dangerous for older women, because their health may be more fragile.

Research also shows that the rates of eating disorders do not differ between white women and women of color, though minority clients may be underdiagnosed (Shallcross, 2013). Therefore, when working with minority clients, the impact of prejudice, racism, acculturation, and body concerns specific to each cultural group should be considered, as these may have an effect on body and self-image. The comprehensive nature of the T/C model, showcasing an emphasis on cultural influences and societal roles, is helpful in reminding counselors to take all of these considerations into account.

Eating disorders also have a complex etiology, which encompasses multiple influences; thus, a comprehensive way of organizing and making sense of information, as with the T/C model, is particularly useful (American Psychiatric Association [APA], 2013). Environmental pressure related to body image and appearance is a key risk factor, as well as holding unrealistic ideals of thinness from an early age. In a recent study, 40% to 60% of girls ages 6 to 12 expressed concern about their weight or about becoming overweight (Cash & Smolak, 2011). Environmental stressors are not, however, the entire story. More recently, genetics and biology have been found to play a larger role in the development of eating disorders than originally considered (Collier & Treasure, 2004). Eating disorders cannot be traced back to one single causal factor, but rather they develop when both internal and external environmental influences combine, including genetic vulnerabilities, family standards, cultural pressures, and stressful life events (Birmingham, 2015).

For example, losses such as death or divorce or a traumatic event can lead to a sense of loss of control, which motivates individuals to attempt to regain control through restricted eating. Transitions such as reaching puberty,

pursuing autonomy, leaving home, or having children leave home are also risk factors for developing an eating disorder (Fairburn & Harrison, 2003). Therefore, it is critical that an assessment of risk factors include both environmental and interpersonal factors. This could include information about the client's family of origin, since people learn values and norms regarding appearance and behavior within the family. Certain personality traits are also risk factors, including perfectionism, high need for approval, and obsessive traits (APA, 2013).

Case Conceptualization for Eating Disorders Using the Temporal/Contextual Model

The multifaceted etiology and complex symptomatology of eating disorders make thorough assessment and comprehensive case conceptualization critical. Complicating the assessment process is the fact that clients are often ashamed about their disordered eating and therefore may come to counseling with presenting problems that focus on other issues. The organized, comprehensive nature of the T/C model, which emphasizes a wide range of both internal and external influences, makes a thorough assessment more likely as well as more time efficient.

For example, because most treatment approaches consider eating disorder behaviors as a coping strategy for dealing with overwhelming emotion or loss of control, the case conceptualization should include the client's ability for emotional regulation and stress management. Cognitive factors include perfectionism, low self-esteem and self-efficacy, obsessive thoughts, a strong sense of shame, and distorted beliefs and perceptions. A thorough understanding of the behaviors surrounding the client's eating disorder is also necessary, as is an assessment of findings from a medical exam, current physiological symptoms, and weight, as eating disorders can have serious physical consequences. Utilizing a comprehensive, organized case conceptualization such as the T/C model prompts assessment of all these domains. Once the case conceptualization is complete, it also provides a road map to enable effective intervention. Treatment interventions for eating disorders are often multidisciplinary in approach, involving additional health care professionals in a treatment team; the comprehensive information included in the case conceptualization can be utilized by a team to improve treatment efficacy (Costin, 2006; Grilo & Mitchell, 2010).

The T/C model includes information about the specific targets for intervention recommended during treatment. When a client with anorexia nervosa (AN) is medically stable, for example, counseling interventions can focus on the client's experience of their illness, distorted thoughts, body image issues, emotional regulation, and coping skills, which have been assessed with the T/C model. Many interventions for AN challenge irrational beliefs (encompassed in the T/C model as IPCs) in an attempt to modify the distorted thoughts that trigger restrictive and controlling behaviors. If the individual can change the

way they see themselves, then the motivation for these behaviors will diminish (National Institute for Clinical Excellence, 2004; Petrucelli, 2004).

The T/C model illustrates how both past events and present environmental cues impact the disorder. Because issues related to body image, self-efficacy, and self-esteem may be connected to early childhood experiences, the T/C model's timeline reminds the counselor to explore the past, as well as to take a here-and-now focus on the current goal of helping the individual gain insight into how their beliefs and values are affecting their behavior and health.

The Intersection of Case Conceptualization, Theory, and Intervention

One of the strengths of the T/C model is its ability to be used in conjunction with multiple theoretical approaches. For example, cognitive behavioral therapy (CBT) interventions that focus on a client's irrational beliefs, negative self-image and worldview, and associated maladaptive behaviors are often used to treat eating disorders (Hsu, 1990; Murphy, Straebler, Cooper, & Fairburn, 2010; Waller et al., 2007; Wilson, Grilo, & Vitousek, 2007). The use of the T/C model facilitates thorough assessment of the client's thoughts and thinking patterns and the origin of these thoughts. A newer variant, enhanced CBT (CBT-E; Fursland et al., 2012), is a collaborative modality that helps the client recognize their own cognitions and behaviors (Fairburn, 2008; Poulsen et al., 2014). The T/C model is an effective tool for collaborative methods such as CBT-E, intentionally organized and visually presented so that counselors can share the model with clients to increase understanding and motivation.

Family therapy interventions are also used for treatment of AN, especially for adolescents or young adults who are still living at home (Hay, 2013). Family therapy focuses on the family system, exploring the client's position in the family and the role the client's disorder maintains in the family system (Lock, Couturier, & Agras, 2006; Lock & Le Grange, 2013). The T/C model's emphasis on relational roles as well as family norms and beliefs creates a solid foundation for these interventions. The client and family can also utilize the visual depiction of the model as a way of recognizing the roles they are playing in sustaining the client's problem behaviors.

From a psychodynamic perspective, internal psychological conflict and problematic family dynamics are the underlying cause of eating disorders. For example, insecure attachment may lead to ambivalence about independence, which can then contribute to eating disorders (Milan & Acker, 2014; Tasca & Balfour, 2014; Thompson-Brenner, 2014). If the client's internal struggles are identified and processed, the need for the symptom is reduced (Gilbert & Miles, 2014). Treatment focuses on assisting the client in understanding the impact of past experiences on present symptoms and how disordered eating functions as a coping mechanism, both of which are facilitated by the T/C model (Haase et al., 2008; Leichsenring & Klein, 2014).

Interpersonal therapy has also been effective by focusing on improving the client's interpersonal relationships instead of focusing directly on eating behaviors. Once relationships are strengthened, emotional needs can be met

through those relationships instead of through disordered eating (Murphy, Straebl, Basden, Cooper, & Fairburn, 2012). The T/C model facilitates this work with an exploration of the client's relationships, both past and present, including the client/counselor relationship. Motivational interviewing (MI) is also used with clients in the early stages of AN who may be ambivalent about change (Price-Evans & Treasure, 2011; Treasure & Schmidt, 2008). The use of the T/C model specifically assesses the client's stage of change, helping the counselor to be more effective in determining when an MI approach might be helpful.

Recently, mindfulness-based interventions have also shown some efficacy in treating behaviors such as binge eating (O'Reilly, Cook, Spruijt-Metz, & Black, 2014). These approaches incorporate awareness of physiological cues, which are assessed with the T/C model. Finally, feminist models emphasize a systemic basis for eating disorders, from resistance to a culture that does not support female development and maturity (Steiner-Adair, 1991). An eating disorder may be a way for women and girls to be heard and noticed in a culture that does not routinely hear them (Wastell, 1996). The T/C model's assessment of contextual, familial, and cultural factors provides a thorough understanding of these contributing factors.

The following section introduces a client named Jessica and utilizes the T/C model to develop a case conceptualization, which will guide subsequent treatment.

THE CASE OF JESSICA

Jessica is a freshman in college. She came to the counseling center because she became concerned about episodes of purging behavior. Jessica says she started binge eating in high school around the time of her parents' divorce and a breakup with her boyfriend. Jessica is doing well academically and is very achievement oriented; however, she reports feelings of anxiety and depression and says she never feels "good enough for anyone."

Jessica attended a single-sex private high school, which placed a great deal of emphasis on appearance and achievement. She was successful there both athletically and academically and was considered popular and good-looking. However, Jessica did not feel good about herself and felt a strong sense of shame and embarrassment about her parents' alcohol-fueled screaming fights, some of which spilled out onto the lawn of her otherwise pristine, quiet neighborhood. Her parents eventually divorced, but Jessica's externally perfect image is in part a defense against this deeply held shame. After the divorce, Jessica became a surrogate parent for her younger sister, whom she had always tried to protect from their parents' fights.

Jessica finds her feelings for her parents confusing and upsetting. When they're sober, they are warm and loving, but when they drink, they are angry and verbally abusive. Jessica grew up being hypervigilant, constantly worrying that her household would erupt in rage and violence.

She started binge eating after her high school boyfriend broke up with her to date a friend of hers, right around the time of her parents' divorce. She also tried to be there for her boyfriend and take care of him, but felt that her boyfriend saw too much of her "true self" and that "it was too much for him." She was especially worried about her little sister's emotional well-being during that time.

Jessica tends to engage in binge eating when she is overwhelmed by strong emotions. She describes her eating as being out of control and expresses shame over her lack of control. Jessica also talks about being hopeless. "I'm just like my parents. Nobody will ever stay with me. They'll leave, just like my boyfriend did."

The college environment, which does not have a strict schedule like Jessica had in high school, has resulted in an increase in Jessica's binge eating. She kept busy with sports practice and studying in high school, and having so much unscheduled free time makes her anxious. Jessica says she has gained "a few pounds," and consequently, she has begun purging after eating. This worried her enough that she made an appointment at the counseling center.

TEMPORAL/CONTEXTUAL MODEL CASE CONCEPTUALIZATION

The initial case conceptualization for Jessica follows. An asterisk (*) denotes areas that require more information and exploration.

Presenting Problem: Disordered eating, anxiety, depression, relationship conflict

Internal Personality Constructs and Behavior:

- *Self-Efficacy:* Low, perfectionistic tendencies, lack of awareness of past successes
- *Self-Esteem:* Low, negatively impacted by sense of shame regarding parents' rages and perceived inability to "control" her binge eating behaviors
- *Attitudes/Values/Beliefs:* Exaggerated importance of appearance; achievement oriented; high valuation on what others think and how perceived by others
- *Attachment Style:* Possibility of insecure attachment

Biology/Physiology/Hereditry: College-age young adult; female; family history of substance use and difficulties with emotional regulation; medical history*

Affect: Depressed, anxious, difficulty with emotional regulation

Cognition: Perfectionistic thinking; she must take care of others; she is emotionally overwhelming to others. *Hot Thoughts:* "I have to do everything right"; "If people truly knew who I was, they wouldn't love me"; "Nobody will ever stay with me."

Behavior: Binge eating; restricted eating; hypervigilance; perfectionism

Symptomatology: Binge eating; restricting; weight gain; emotional dysregulation

Coping Skills and Strengths: Academic success; athletic ability; intelligence; sought treatment

Readiness for Change: Entering action stage/aware of need for change and motivated

Life Roles: Caretaker for sister, ex-boyfriend; Adult Child of Alcoholics; student; athlete

Environment:

- *Relationships:* Conflict with father/mother; protective of younger sister; breakup with boyfriend; past relationship history*
- *Culture:* Family background;* parents economically successful; high socioeconomic status; single-sex school
- *Family Norms and Values:* high parental expectations; academic and athletic success highly valued; appearance highly valued
- *Religious or Spiritual Beliefs:**

Timeline:

- *Past Influences:* Parental pressures; parents' alcoholism; parents' divorce; breakup
- *Present Influences:* Escalating binge eating and restricting behavior; academic motivation; transition to college; concern about younger sister
- *Future Goals:* Healthier eating; college graduation; romantic relationship;* career goals*

With the initial case conceptualization in place, the next step is to think about what other information is needed before counseling can move forward. The counselor fills in missing information and develops a hypothesis about the presenting problem. In the case of Jessica, the case conceptualization highlights areas of possible intervention. For example, because there are a number of dysfunctional thoughts and beliefs associated with Jessica's disordered eating, as well as problematic behaviors, a cognitive behavioral approach might be most effective. Jessica's interpersonal difficulties seem to stem from growing up in a family struggling with alcoholism and have led her to develop certain beliefs about her life roles, which need to be explored and challenged as well. At the same time, Jessica's strengths and resources are clear in the formulation and can be used to challenge her current depression and irrational thoughts 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 Jessica and developing intervention strategies accordingly.

CONCLUSION

Case conceptualization is the cornerstone to counselors' ability to understand a client's lived experience and the key to effective treatment. Clients with complex conditions such as eating disorders can present a challenge for

counselors. A thorough understanding of internal and environmental factors contributing to the development and maintenance of such disorders is critical for gaining an understanding of the client's problems. The T/C model provides a powerful tool for developing such an understanding, allowing for the complexity of symptoms while streamlining 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 begin to recover.

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