

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

Lynn Zubernis, Matthew Snyder, and Kelsey Davis

Understanding and treating depressive disorders can be challenging because of the complex etiology and multiple layers of influence surrounding depression. In this article, we introduce a model of case conceptualization that facilitates a comprehensive understanding of client issues and the contextual factors that influence their development, course and treatment, and describe the utilization of the Temporal/Contextual Model (Zubernis & Snyder, 2016) in treating DSM-5 disorders. The Temporal/Contextual (T/C) Model takes a holistic approach to case conceptualization, making it widely applicable and useful with a variety of theoretical orientations and for a wide range of client problems. The T/C Model can help counselors improve their accuracy, efficiency and effectiveness in treating these common presenting problems.

Keywords: depressive disorders, case conceptualization, DSM-5, Temporal/Contextual Model, depression

Case conceptualization is crucial to effective counseling, providing the lens through which counselors encounter their clients and the template through which we understand their challenges and strengths. Neukrug and Schwitzer (2006) define case conceptualization as a tool for observing, integrating and understanding a client's feelings, thoughts, physiology and behavior. The process requires counselors to think integratively, formulating and testing hypotheses which take into account the diverse information gathered. Seligman (2004) describes case conceptualization as critical to understanding the client's needs and situation. Once that understanding is in place, the case conceptualization serves as a blueprint for how to interact with a client. The process of case conceptualization is considered a core competency for counselors (Betan & Binder, 2010; Sperry, 2010).

Case conceptualization allows counselors to make sense of the flood of information which clients often bring to their first session, to discriminate important from peripheral information and to formulate a hypothesis about core issues and the mechanisms which are sustaining them (Stevens & Morris, 1995). The case conceptualization also helps the counselor develop an explanation of how the client's issues developed and a cultural formulation of the problem which allows an

understanding of how gender, ethnicity, socioeconomic status, sexual orientation and other factors impact the client's situation. Another important aspect of the process is assessing the client's readiness for change (Prochaska, DiClemente, & Norcross, 1992).

The way in which a counselor conceptualizes a client's situation impacts the course of counseling (Anderson, 1997; O'Hanlon & Weiner-Davis, 1989). For example, if the counselor is aware of the client's strengths and resources from the start, the client too is likely to be more hopeful about the possibility of change. Conceptualizing skills enable the construction of a model that represents the client's world and experiences. It is only from this understanding that counselors can effectively help clients change.

Counselors recognize the importance of case conceptualization; however, most existing models of case conceptualization were developed for use with a specific theoretical orientation. In contrast, we developed the Temporal/Contextual (T/C) Model, a holistic, atheoretical model which can be used with a wide range of presenting problems. The model is comprehensive, making it useful for understanding disorders such as depression, which are multi-faceted and often involve a complex etiology and a wide range of symptoms. Individuals may gain weight or lose weight, sleep too much or hardly at all, experience

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extreme restlessness or extreme fatigue. Feelings of hopelessness, helplessness, guilt or self-blame may be a part of the disorder. There may be few physical symptoms or the client may suffer from chronic pain, stomach disruption, or severe headaches. Relationships, work, school and daily life may all be negatively impacted. Thus, it is critical to have the means to make sense of the many facets of depressive disorders in

order to facilitate effective treatment. We developed the T/C Model to help counselors increase both their effectiveness and efficiency.

A visual flowchart and worksheet make the model easy to use in practice, even for beginning counselors. In keeping with a collaborative model of counseling, the T/C Model can be shared with the client and is useful as a tool for self-understanding and goal setting.

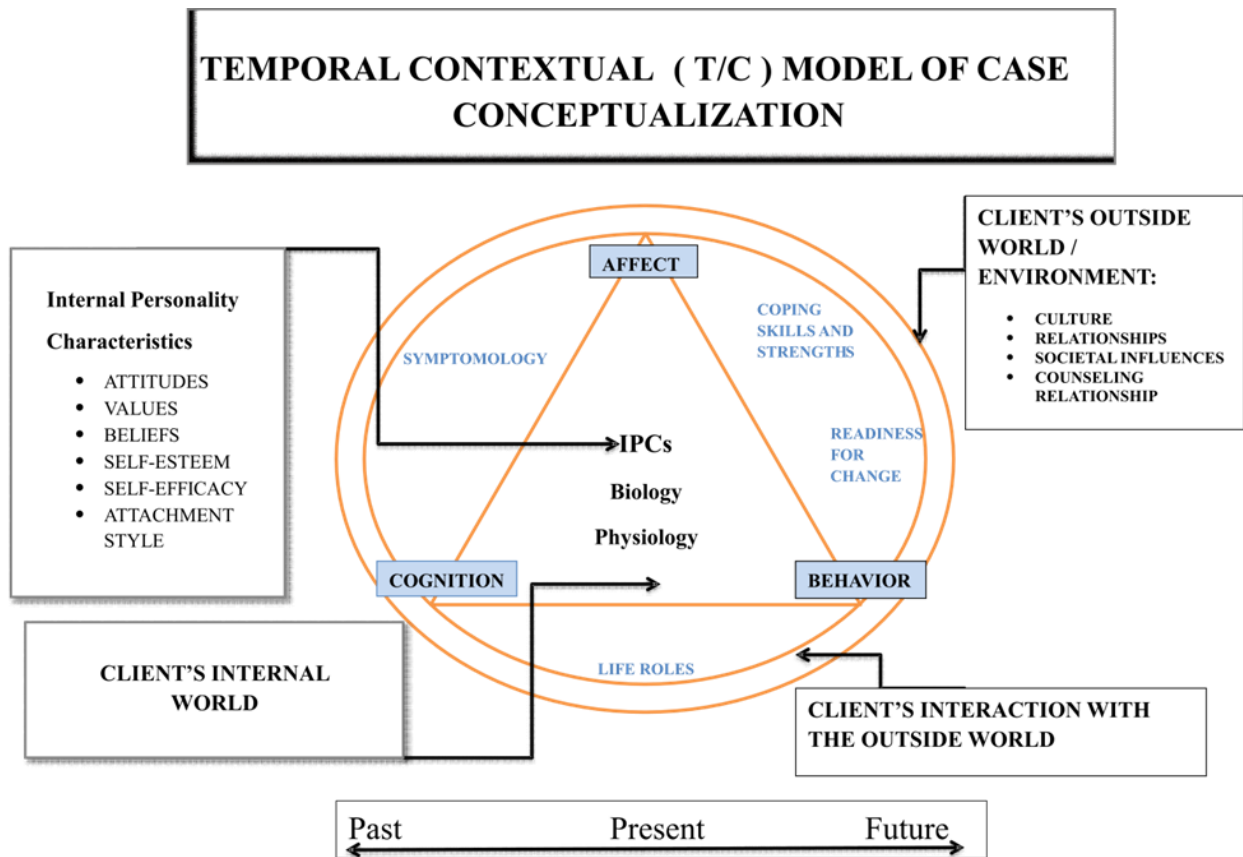


FIGURE 1
TEMPORAL CONTEXTUAL (T/C) MODEL OF CASE CONCEPTUALIZATION

The T/C model highlights the client’s internal world, including attitudes, values, and belief systems; the client’s external world, including environment, relationships, and culture; and the interaction between the internal and external worlds (behaviors, symptoms, readiness for change, coping skills, and life roles). The timeline in the model focuses on both past experiences and future goals in addition to an assessment of present functioning. The T/C Model also reminds counselors to gather information on strengths, resources, coping skills and supports, so that the counselor can empower the client in the face of the hopelessness, helplessness and self-blame. Following are the components of the model.

The Triangle

In the visual layout of the T/C Model (Figure 1), the triangle represents the three major elements of human experience: behavior, cognition, and affect (emotion) (Greenberger & Padesky, 1995). Behavior includes eating, sleep, activity level, and the counselor’s in-session observations. Cognition encompasses the way in which the client takes in and interprets information, as well as beliefs about self and others. Affect includes emotional regulation and expression. The three elements have reciprocal relationships with one another (Bronfenbrenner, & Morris, 1998; Bronfenbrenner, 1981).

The visual layout of the T/C Model locates the domain of the client’s internal personality constructs (“IPCs”) -- values and beliefs, self-concept, world view, attachment style, self-efficacy and self-esteem, and the

domains of the client's physiology and biology within this elemental triangle. Physiology and biology include genetic predisposition, temperament, stress reactivity and neurotransmitter function, all of which may be implicated in depression. There is interactivity between these domains and the elements of human experience surrounding them as well as between the domains and elements themselves. Finally, the points of the triangle—behavior, cognition, and affect—connect to the outside world. The T/C Model emphasizes the relationship between constructs, which helps counselors understand and empathize with their clients. An example of this interaction can be seen in the uncovering of a client's hot thoughts (Beck & Beck, 2011). A "hot thought" is one that causes an emotional reaction, usually based on the current environmental stimuli and the individual's attitudes, values, and beliefs regarding the meaning of that stimulus. In this example, beliefs (IPCs), constructed from both temperament and experience, directly influence affect. The client's environment and experience have formed the IPCs, which in turn impact how the client perceives and copes with environmental events.

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). The inner circle includes somatic and psychological symptoms, as well as the client's coping skills, strengths, and readiness for change (Prochaska & DiClemente, 1982; 1986). The inner circle also includes an understanding of the client's life roles, which are influenced by learned beliefs and values (Clark, 2000). Many of us negotiate multiple roles that sometimes conflict, leading to significant stress and putting strain on coping ability.

The Outer Circle

The outer circle includes environmental influences that impact the client (and are in turn impacted by the client). The client's relationships, including the client/counselor relationship, are located here, along with cultural norms and socioeconomic data (Clark, 2000; Bronfenbrenner, 1981). The reciprocal relationship is once again evident, as environmental factors impact the client's personality development (Greenberger & Padesky 1995) and may also motivate the client to seek counseling, if risk factors overwhelm coping ability.

Timeline

The timeline includes past events and relationships which may have shaped current personality, identity and beliefs, some of which may be maladaptive (Corey, 2009). The timeline facilitates a focus on the future in terms of goal setting. In addition, the timeline can be utilized to increase the client's understanding that events in that the past can be interpreted differently in the present, which can change dysfunctional beliefs and negative thinking styles.

The T/C Model is particularly useful for developing a case conceptualization in working with clients faced with complex disorders such as depression. In the next section, we review the DSM-5 diagnostic criteria for depression; finally, we discuss the application of the Model to case conceptualization for depression, using a case example to enrich the discussion

DSM-5 Depressive Disorders

Everyone feels sad from time to time when life is particularly stressful or we are faced with losses. Most of the time, feelings of sadness are transitory. Depression, however, is longer lasting, often manifesting with cognitive and behavioral difficulties and persistent sadness. Depression has a significant impact on day to day activities, interfering with the person's academic, vocational or relational life, or the ability to concentrate, eat or sleep (American Psychiatric Association, 2013). Symptoms include depressed mood most of the day nearly every day, which can be described as "feeling flat" or without feelings. Clients may lose or gain weight, sleep too much or have difficulty sleeping at all, and have changes in energy level ranging from restlessness to extreme fatigue. Physical symptoms may include chronic pain, gastro-intestinal problems, and headaches. Cognitive symptoms such as hopelessness and helplessness are common, and clients may blame themselves for their symptoms. Because of the multifaceted nature of the disorder, people may lose interest in maintaining relationships or doing the things they used to find enjoyable, and may consider or attempt suicide.

Etiology and Risk Factors

Depressive disorders have a complex etiology. These disorders are not caused by a single precipitating factor, but are impacted by genetic, biological, chemical, psychological, social and environmental influences. Because depression is multiply determined, the 'cause' is not always easily ascertained, making the case conceptualization process critical.

Biological and Genetic Factors

Certain mood disorders tend to run in families. A close relative of someone diagnosed with Major Depressive Disorder has a two to four times higher risk for depression, suggesting a genetic contribution to the disorder (Tsuang & Faraone, 1990). MRI scans show differences in people with depression, and neurotransmitter imbalances have been found to contribute to depressive symptoms. Certain temperament types are also associated with risk of depression, including high levels of negative affect (American Psychiatric Association, 2013).

Cognitive Factors and the Role of Experience

A history of environmental stressors and losses, which may include abuse or trauma, can lead to the development of an explanatory style which is unrealistically negative. This negative filter creates a pessimistic view of both self and others that impacts identity and self-esteem, and is also a risk factor for depression (Beck, Rush, Shaw, & Emery, 1979). In addition, certain current environmental stressors may serve as precipitating factors for an episode of depression, especially major life transitions such as divorce, partner death, job loss or retirement. For children and adolescents, the experience of bullying may be a trigger for a depressive episode. Even expected developmental transitions such as puberty, getting married, childbirth or adult children launching can be a precipitant of depression (Cassano & Fava, 2002).

Cultural Considerations

While individuals of all cultural backgrounds, genders, ages and ethnicities may experience depression, there are differences in prevalence and symptomology. Research has shown that, in general, members of disadvantaged ethnic groups do not have an increased risk for psychiatric disorders such as depression (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005; Riolo, Nguyen, Greden, & King, 2005). There are, however, differences in how the symptoms present, the likelihood of seeking treatment, comorbidity factors such as drug and alcohol abuse, and the probability of depressive symptoms becoming severe, debilitating, and chronic in nature (Breslau et al., 2005; Alegría et al., 2008; American Psychiatric Association, 2013).

The most striking relationship can be seen with respect to depression and socioeconomic level. The data from the National Health and Nutrition Examination

Survey conducted by the U.S. Department of Health and Human Services found that 15% of those living under the federal poverty line reported moderate to severe symptoms of depression, compared with just 6 % of those living above the poverty line (Pratt & Brody, 2014). Again, no significant difference was found in depression rates by race when controlling for socioeconomic level.

There are some significant gender differences in relation to the onset of depression. Females are 1.5 to 3 times more likely to be diagnosed with Major Depressive Disorder in adolescence, and tend to report more sadness, feelings of guilt and worthlessness. Males, on the other hand, report more anger, irritability, sleep problems and fatigue (Cyranski, Frank, Young, & Shear, 2000; Silverstein et al., 2013). Physiological and hormonal changes due to menstruation, childbirth and menopause, as well as cultural norms which can lead to role conflict and stress, may be an explanation for the higher prevalence of depression in women (Rubinow, Schmidt, & Roca, 1998).

The literature on differences with regard to depression and ethnicity or culture are less clear. Some research data finds that the prevalence of Major Depressive Disorder is significantly higher in Whites than in African Americans and Mexican Americans (Riolo et al., 2005). These findings, however, may be due to the stigma associated with depression and mental health issues in certain cultures and ethnic backgrounds. When depression does impact African Americans and their families, it tends to go untreated for longer periods of time and be more severe and debilitating than in non-Hispanic Whites (Williams et al., 2007). For example, roughly 25% of African Americans seek mental health care, compared to 40% of Whites. This reluctance may be impacted by lack of health insurance, distrust or misdiagnosis, treatment options in the community, and a lack of African American mental health professionals (Alegría et al., 2008). On the other hand, some research has suggested that a strong ethnic identity can be a factor contributing to resilience and coping in African Americans (Williams, Chapman, Wong, & Turkheimer, 2012).

With regard to age differences, children with depression may exhibit symptoms of anxiety or irritability instead of sadness, may refuse to attend school or may act out behaviorally. Adolescents may struggle with identity issues of ethnicity and sexual orientation, and substance abuse and eating disorders often co-occur. Suicide is also a significant risk (Weissman et al., 1999; Shaffer et al., 1996). For the elderly, medical conditions such as hardening of the blood vessels can contribute to depression, as well as more frequent experiences of loss. The risk of suicide among white males over 85 is higher than other age groups. (Luoma, Martin & Pearson, 2002).

Counseling is an effective treatment for mood disorders for a wide range of populations, from children to older adults, clients living in poverty and people with disabilities (Kazdin, 2008; Kazdin et al., 2010). Interventions may need to be adapted, however, so it is important to assess clients' specific challenges. The information included in the T/C Model facilitates this process and helps counselors be sensitive to client differences.

Comorbidity

Effective case conceptualization also takes into account the possibility of co-occurring disorders, which can be precipitating factors for depression or can make the course and treatment of depression more complicated. The breadth of the T/C Model facilitates a thorough understanding of all the factors impacting the client, allowing accurate assessment of comorbid disorders. The most common co-occurring disorders with depression are anxiety disorders, including post-traumatic stress disorder (PTSD), panic disorder, social phobia, generalized anxiety disorder and obsessive-compulsive disorder (OCD) (Regier, Rae, Narrow, Kessler, & Schatzberg, 1998; Devane, Chiao, Franklin, & Kruep, 2005). The environmental experience of trauma can be a risk factor for depressive disorders, with over 40 percent of people who developed PTSD also experiencing depression in an NIMH study (Shalev et al., 1998). Clients dealing with depression may also self-medicate with drugs or alcohol (Conway, Compton, Stinson, & Grant, 2006). As assessed in the biological/physiological and cognitive domains of the model, chronic or disabling medical conditions can be risk factors for developing a depressive disorder, since these conditions can create a sense of hopelessness and helplessness (Cassano & Fava, 2002).

Case Conceptualization for Depression Using the T/C Model

A multi-faceted case conceptualization is critical when working with clients struggling with depression. In the biological/physiological domain, problems with appetite, sleep, activity level and concentration are relevant. Somatic symptoms, including chronic pain, headaches, and stomach problems may also be present. It is important to consider family history of mood disorders, timing of depressive episodes (recurrence at a particular time of year, for example), and whether the depression may be related to the menstrual cycle or childbirth for women.

In the cognitive domain, the clients' customary ways of seeing themselves and others may be a risk factor for developing depression. As discussed

previously, a negative explanatory style, as clients view self and others through a negative filter, increases vulnerability for depression. An important component of case conceptualization for clients with depression involves the uncovering of strengths and resources, since these are often invisible through a negative filter. Clients may also struggle with guilt and shame, have low self-esteem, or express a sense of hopelessness and helplessness that can lead to suicidal thoughts or intent. Assessing suicidal ideation is a critical part of the case conceptualization.

Relevant factors in the client's environment include both current and past stressors, such as loss, relationship problems, financial stress and academic or vocational difficulties. The use of the timeline reminds counselors to consider the impact of past events on current functioning, as well as to consider the client's vision of the future as an aid to goal setting.

Finally, the incorporation of an exploration of culture in the T/C Model takes into account factors such as gender roles, ethnicity, cultural values and beliefs, and socioeconomic status, all of which inform the counselor's understanding of the client and the development of a plan of treatment.

From Case Conceptualization to Intervention

Research identifies several theoretical approaches which can help clients dealing with depression, including cognitive behavioral, client centered, and interpersonal therapy, with few differences in effectiveness found (Castonguay & Beutler, 2006; Norcross, 2011). The majority of clients who receive counseling show improvement and are able to resume a normal level of functioning (Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009; Stiles, Barkham, Connell, & Mellor-Clark, 2008; Wampold & Brown, 2005). Counseling is an effective treatment for children and adolescents (Weisz, McCarty, & Valeri, 2006; Kazdin et al., 2010) and for older adults (Alexopoulos et al., 2011; Areán et al., 2010; Bohlmeijer, Smit, & Cuijpers, 2003).

Medication has also been found to be an effective treatment for depressive disorders, targeting brain chemicals which are out of balance (Robinson, Berman, & Neimeyer, 1990), and the combination of medication and counseling can be particularly effective (Arnold & Constantino, 2003; Friedman et al., 2004; Pampanolla, Bollini, Tibaldi, Kupelnick, & Munizza, 2004; March et al., 2004).

Specific aspects of the comprehensive case conceptualization developed with the T/C Model are particularly helpful to counselors as they consider appropriate interventions and how to put these into place. For example, problem solving interventions and

supportive therapy are helpful for older adults with depression (Alexopoulos et al., 2011; Areán, et al., 2010), so a focus on the cognitive aspects of the model and the client/counselor relationship are therefore critical. Older adults also benefit from reminiscing and engaging in a life review, which is facilitated by the timeline's focus on the past (Bohlmeijer et al., 2003).

The data gathered and organized by the Model can also facilitate decision making as counselors select the most appropriate and effective interventions. For example, if the T/C Model conceptualization identifies cognitive distortions and dysfunctional beliefs which are contributing to the client's depression, the counselor may want to consider cognitive behavioral therapy. Cognitive models of depression emphasize the impact of core beliefs and cognitive schemas (Beck et al., 1979). According to Beck, these beliefs about the self and others develop from early experience and create a negative filter; the timeline in the T/C Model, with its emphasis on past experience, is useful when working from a cognitive theoretical lens. The T/C Model helps the counselor identify dysfunctional beliefs and "hot thoughts" (thoughts connected to strong affect), which can then be challenged in CBT. The visual layout of the T/C Model (see Figure 1) and its collaborative use can help the client identify problematic beliefs, understand their etiology, and help develop goals for change. More flexible, positive ways of thinking reduce hopelessness and depressive symptoms.

The T/C Model also emphasizes an understanding of the client's relationships, both past and present. Problematic relationships contribute to depression; reworking past relationship difficulties and developing the skills to maintain healthier current relationships can be an effective route to change. If the T/C Model conceptualization suggests a problematic pattern of relationships, Interpersonal Therapy, also an empirically supported treatment for depression, may be beneficial (Lemmens, DeRubeis, Arntz, Peeters, & Huijbers, 2016). Family systems treatment is also useful for treating depression, uncovering the ways in which family relationships may create a vulnerability for depression or sustain depressive symptoms (Titelman, 2014). Because the T/C Model conceptualization includes the client's environment, an understanding of family roles and relationships is developed which facilitates both of these approaches. Clients exist in interconnected networks and relationships, making change more sustainable when the environment is also changed. The emphasis on values, beliefs and life roles learned within the family makes the T/C Model a good fit for family systems treatment.

Finally, the incorporation of biological and physiological factors in the T/C Model assists counselors whose clients would benefit from medication. The client's learned beliefs and values

surrounding the use of medication are relevant; the counselor gains an understanding of these beliefs through use of the model, and can then address any which might make compliance an issue.

The T/C Model is not only useful for explicating the client's challenges; the Model is specifically designed to identify existing strengths, coping skills and support systems. A client dealing with depression may lose sight of any positives in their lives, viewing past, present and future through a negative filter. The T/C Model's visual nature assists the counselor in bringing these positive aspects to awareness in a powerful manner, contributing to the development of hope. Together, counselor and client identify experiences of success and uncover strengths, allowing clients to set goals for the future and develop a more positive identity.

The following is a fictitious case example of how a case conceptualization using the T/C Model could be developed with a client dealing with depression.

The Case of Finn

Finn, a 32-year old man, finally sought counseling after feeling 'down' for some time. He sits slumped in his chair and does not make much eye contact. His clothing is somewhat dishevelled and he has a few days' growth of beard. Finn speaks softly and hesitantly as he tells the counsellor that he just doesn't care anymore. He has been having episodes of uncontrollable crying, and has been avoiding seeing friends or family. Even going to work is hard, as he feels extremely fatigued. Especially in the morning, Finn also has stomach pain, and finds he has little appetite. His girlfriend is very worried, and has encouraged him to seek help, as have several of his friends.

While Finn is able to tell the counselor that his friends are worried, he also says that he doesn't think his friends really miss him that much, as they never did really enjoy his company. He's even beginning to doubt that his girlfriend wants to be with him, although she repeatedly tells him that she does.

He has similar doubts about work, and has called in sick several times in the last month. His job as an accountant requires a high level of concentration, which Finn just does not feel capable of recently. He's convinced that he's going to be fired, and says that he's always been a failure; it's just a matter of time. When the counsellor asks how long Finn has been feeling this way, he says "as long as I can remember. My dad always said I'd screw things up. I'm supposed to be the strong one, the successful one. I'm his only son."

Finn shares that as the only son of a working class Mexican American family, he feels like he isn't "much of a man" at this point. His mother is pressuring him to

get married, but he does not think he can hold onto a job that would allow him to support a family. Finn's parents, while still married, have had a troubled relationship for years. Their religious beliefs do not allow divorce, but Finn is well aware that his father has had several extramarital relationships and drinks heavily on the weekends. His mother had to leave the family twice when he was young to go stay with her mother, though no one would tell him why. He recalls many instances of her sobbing in her bedroom and telling him not to come in when he knocked.

Near the end of the session, Finn sighs and says "everyone would be better off if I wasn't here."

The first step in working with this client is for the counsellor to organize the data gathered using the T/C Model. The following is an example of a T/C Model Case Conceptualization Outline prepared by the counselor working with Finn.

T/C Model Case Conceptualization Outline

(* The counselor needs more information in this area)

Presenting Problem: Depression, isolation, suicidal ideation

Internal Personality Constructs and Behavior:

Self-efficacy: feels hopeless, doubts efficacy in relationships and at work

Self-esteem: low, feels paralyzed by depression and hopelessness

Attitudes/Values/Beliefs: Strong sense of responsibility; belief that men are supposed to be "strong" and successful "breadwinners"; raised with strong religious convictions

Attachment Style: possible insecure attachment impacted by maternal depression and paternal alcohol use

Biology/Physiology/Hereditry: male, 32, stomach pain, loss of appetite, fatigue, family history of depression, temperament (negative affect), medical history*

Affect: depressed, hopeless, ashamed, bouts of crying

Cognition: Difficulty concentrating; belief that people only spend time with him because they're obligated

Hot Thoughts: "My friends don't really miss me." "My girlfriend doesn't want to be with me." "I'm a failure."

Behavior: bouts of crying, isolating, missing work, visibly distraught, disheveled, poor self-care

Symptomology: stomach aches, fatigue, trouble concentrating, appetite changes, crying, withdrawal

Coping Skills and Strengths: has friends, stable romantic relationship, professionally successful

Readiness for Change: contemplation stage – ambivalent about change but willing to consider; impacted by hopelessness

Life Roles: only son, believes he should be the breadwinner, wants to be a husband

Environment:

Relationships: conflicted relationship with father and mother, relationship strain with girlfriend

Culture: Hispanic American, traditional values around marriage, men as breadwinners, divorce

Family Norms and Values: Belief that men are supposed to be strong and successful breadwinners; family culture of secrecy around mental health challenges and infidelity

Societal Influences: gendered beliefs about masculinity, social pressure toward marriage, social pressure for job success

Timeline:

Past Influences: father's criticism and drinking, mother's unavailability due to depression

Present Influences: work stress, isolation, depressed mood, fatigue, difficulty eating and concentrating, conflicted relationship with father, pressure from mother to be married

Future Goals: resume friendships, healthy relationship with girlfriend, attend work regularly, increase confidence at work

Integrated T/C Model Conceptualization for the Case of Finn

The complexity of the course, etiology and symptomology of depressive disorders is clear in the case of Finn as we apply the T/C Model. The Model first assists with formulating a diagnosis. Incorporating the timeline's lens on the present, Finn exhibits many of the symptoms which suggest a diagnosis of depression, including withdrawal from friends, bouts of crying, problems with appetite and concentration, fatigue and hopelessness. His physical complaints, disheveled appearance, and body posture also corroborate the diagnosis. Finn's suicidal ideation is also commonly associated with depression. The detailed picture of Finn's current situation and functioning which the T/C Model allows the counselor to paint makes a diagnosis clear. The next step is to develop an understanding of etiology as well as factors maintaining Finn's depression.

Using the timeline to review factors in Finn's past

which might have contributed to his current depression, we can identify cultural and family norms and values which have had an impact; specifically, Finn has absorbed his family's gendered beliefs about what is expected of a man, including marriage and job success, which have likely been influenced by the family's religious and cultural background. Finn's role as an only son makes these expectations more intense; both of his parents continue to make their expectations clear, which has not given Finn the psychological space to challenge these beliefs even as an adult. The persistence of these problematic cognitions in the present is seen in Finn's "hot thoughts", which are connected to his feelings of failure, sadness, and hopelessness. Identifying these dysfunctional ways of thinking suggests that a cognitive behavioral approach might be beneficial to challenge their realism and help Finn understand that these are learned beliefs.

The model also encourages an examination of how the client's history has contributed to self-esteem and identity. In Finn's case, his father's criticism, alcohol use and infidelity and his mother's depressive episodes and periodic absence may have resulted in insecure attachment. As a result, Finn's self-esteem and self confidence in adulthood may be easily shaken – in this case, by doubts about his work success or relationship problems with friends or his girlfriend. An understanding of these impacting factors makes clear the importance of a strong therapeutic relationship and the development of trust and rapport. In addition, the presence of a family history of both depression and alcohol suggests the possibility of a biological component; the counselor and Finn may want to consider medication as a part of treatment.

The T/C Model also illuminates the client's strengths. In this case, while Finn's relationship difficulties are clear, so are his successes. He has friends who care about him enough to be worried and a girlfriend who is sticking by him and encouraging him to get help. He has been academically and vocationally successful and until recently has been motivated to work hard at his job. While Finn is expressing doubt about whether he can feel better – or possibly about whether he deserves to feel better – nevertheless, he agreed to come in for counseling and has been open with the counselor about his thoughts and feelings. The counselor can build on these strengths, using this awareness to challenge irrational beliefs about how others feel about him and to remind Finn of the support system he has in place and encourage him to use it. The counselor will want to empower Finn as well, reminding him of his successes and demonstrated intelligence.

Conclusion

Depressive disorders remain a common problem, disrupting clients' lives with a detrimental impact on productivity, economics, parenting and relationships. As counselors, we need workable, effective tools to enhance our understanding of the multiple ways in which disorders such as depression develop, are sustained, and are treated. We also need the means through which to understand our clients holistically, allowing us to treat the whole person using whatever theoretical approach is most effective.

One of the strengths of the T/C Model is that its comprehensive conceptualization organizes the information the counselor has gathered, allowing the counselor to develop a thorough understanding of the client. In addition, the model highlights information that is missing, allowing the counselor to go back and investigate other relevant data that will be useful in making sense of the client's world. The T/C Model is thus a beneficial tool for initial assessment as well as an ongoing, evolving framework for both client and counselor to come to a deeper and more accurate understanding of the client's challenges, strengths and life context.

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